OBJECTIVE PSYCHOTHERAPY: SOME THEORETICAL CONSIDERATIONS

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Neurotic behaviour has been defined as 'persistent unadaptive learned behaviour in which anxiety is almost always prominent and which is acquired in anxiety-generating situations.'[1] Behaviour which is learned can also be 'un-learned'. The processes by which responses are ordinarily diminished in magnitude and frequency of occurrence are 'extinction' and 'inhibition'. Extinction of a response is gradual and occurs after many unrewarded evocations. Non-adaptive responses which do not disappear in time by the process of extinction are, by definition, neurotic- A distinguishing feature of neurotic behaviour is in fact, its resist. ance to the normal process of extinction.[2]

INHIBITION OF NEUROTIC BEHAVIOUR

Neurotic behaviour is, however, open to modification and elimination by the process of inhibition, which may be defined as the imposition

of a new response (or response tendency) upon an older one such that the old one is no longer evoked. The numerous types of psychological inhibition which have been observed or postulated include proactive, retroactive, external, reciprocal, reactive and conditional inhibition. For several reasons, mainly of a practical nature, conditioned inhibition has received the greatest amount of attention in psychotherapy. Conditioned inhibition is generated when stimuli are associated with the cessation of a response in the presence of reactive inhibition (a negative drive tending to cause cessation of activity).[3] Conditioned inhibition is acquired in the same way as positive behaviour patterns are learnt. It increases progressively as a function of the number of rewarded or reinforced trials and like all habit patterns is relatively permanent. It does not dissipate spontaneously even over long periods of time. Because of these characteristics, conditioned inhibition has been widely employed by psychotherapists in their attempts to eradicate neurotic behaviour.

Wolpe's technique of psychotherapy is an attempt to produce a conditioned inhibition of neurotic behaviour by the repeated simultaneous presentation of incompatible response tendencies (reciprocal inhibition). This usually takes the form of presenting anxiety-producing stimuli while the patient is deeply relaxed in the consulting room. In this way, the tendency to respond anxiously to the noxious stimulus (e.g. blood) is superseded by the stronger and incompatible relaxation response. Repeated doses of this reciprocal inhibition (which is by itself temporary in effect) in the consulting room will steadily build up a *permanent* conditioned inhibition of the neurotic behaviour. This type of learning process has been demonstrated experimentally by various workers.[4, 5] Clinically, it has been employed by Jones,[6] Max,[7] Wolpe,[1] and Lazarus and Rachman.[8]

For every behaviour pattern there is another type of behaviour which is incompatible with the first. The task of therapy is to find an acceptable response pattern which is antagonistic to the neurotic activity of the patient and to substitute this adaptive behaviour for the non-adaptive, neurotic behaviour. Wolpe has proposed relaxation or feeding or avoidance or sexual or assertive responses as possible substitutes for neurotic behaviour, according to the requirements of the case.

ANALYTIC AND NON-ANALYTIC THERAPIES

An objection which is frequently presented by psychoanalytic-orientated critics of neo-behaviourist therapy is the concept of 'basic causes'. They argue that non-adaptive therapies deal only with symptoms and leave the basic cause or causes of the neurosis untouched; that this 'superficial approach' to the treatment of neurotic behaviour is destined to bring about only temporary alleviation of symptoms (at best) and may well aggravate the patient's condition. They claim that it is only when the 'inner forces of the psyche' have been restored to harmony by free association, transference and interpretation that the person is normal again. The major objections of the analysts may be summarized as follows: Neo-behaviourist therapy (*a*) is superficial, (*b*) is symptom-oriented, (*c*) ignores the deep inner causes of the neuroses, (*d*) can effect only temporary improvements, and (*e*) smothers certain symptoms only to provoke other new ones.

Neo-behaviourist therapy is not superficial if by this is implied either that such treatment is 'not complete' or that it can be applied with success only in certain *minor* types of behaviour disorders. There is considerable clinical and experimental evidence which proves, on the contrary, that such therapy is both complete and capable of being applied in many types of disorder, including those which analysts would regard as 'deep-seated', e.g. phobic states and anxiety neuroses of long-standing. Examples of therapeutic successes with enuretics,[9] hysterics,[10] stutterers,[1, 8] drug-addicts,[11] homosexuals,[7, 11] phobic states,[6, 1, 10, 8] alcoholics,[12] and tension-states,[13] have been reported in which the 'superficial approach' has provided *complete* or near-complete recovery. In many of the cases referred to here, the improvement has been obtained without either therapist or patient knowing what the 'basic cause' of the illness was. A particularly striking example of such a case is provided by Wolpe:[10]

'A 37-year-old miner was seen in a state of intense anxiety. He had a very marked tremor and a total amnesia for the previous 4 days. He gave a story that his wife, on whom he was greatly dependent, had cunningly got him to agree to "temporary divorce" 6 months before, and was now going to marry a friend of his. No attempt at this juncture to recall the lost memories. The patient was made to realize how ineffectual his previous attitudes had been and how he had been deceived. As a result he angrily "had it out" with his wife and a few others, anxiety rapidly decreased, and he soon felt strongly motivated to organize his whole life differently. At his 5th interview (10 days after treatment began), he said that he felt "a hundred per cent" and looked it, and was full of plans for the future. *Yet he had still recalled nothing whatever of the forgotten 4 days*'. The patient later recalled the lost memories under hypnosis. 'No important consequences ensued. A few months later he married another woman and was apparently very well adjusted generally.'

Other examples are provided by Lazarus and Rachman,[8] Mowrer,[9] and Salter.[11]

Can this evidence be taken to mean that a knowledge of the causative factors is unnecessary? The answer to this problem would appear to be a qualified affirmative. In some instances it seems unlikely that improvement in the patient's condition can be effected without such knowledge. On the other hand it would appear from the numerous therapeutic failures reported by analysts and other therapists that in certain cases insight and interpretation do *not* assist. A very obvious example of such a state of affairs can be observed in the treatment of psychopathy. An appraisal of the data leads us to the conclusion that while a knowledge of the causative process and genesis of the individual neurosis can be of considerable value in therapy, improvement can nevertheless be obtained in many cases without such knowledge.

Too great a concern with 'underlying causes' may under certain circumstances even impede therapeutic progress. The case of the miner treated by Wolpe and quoted above is one such instance. The 'forward-looking approach' as opposed to the historical technique of psychoanalysis has much to recommend it. It is quite conceivable that a patient with some pressing, immediate problem (e.g. pending divorce) may receive a severe and unnecessary jolt from the apparent lack of concern of the non-directive therapist. Several instances of intense frustration and annoyance reported by patients who have been to non-directive therapists only to have their difficulties apparently ignored or brushed aside have been observed by Lazarus.[14]

With regard to the observation that objective psychotherapy is symptom-oriented, this is generally true. The treatment of the symptom or symptoms is quite logically one of the first considerations of the psychotherapist. In numerous cases there is little else that is required as 'the deep inner causes', if they exist, cease to be relevant. The 5 cases reported by Lazarus and Rachman all bear this contention out. In case 3 the precise reason or reasons for the ambulance-phobia developing in this 13-year-old boy were never discovered. The fear was inhibited and extinguished by systematic desensitization and this *removal of the symptom* was sufficient. Case 4 was treated successfully for his stutter and again no 'deep inner causes' were revealed.

Does objective, non-analytic psychotherapy effect only temporary improvement? There is some evidence that improvements obtained by these techniques are long-lasting or permanent, but it must be admitted that the design of research work in the field of therapy, *both objective and psychoanalytic*, has been for the most part, inadequate in this respect. There is not sufficient evidence either way to justify a categorical answer. The available data on this point is provided by Wolpe,[1] Rachman and Lazarus[8], Mowrer,[9] Salter,[11] and others. Much of the evidence presented to date however, is of an anecdotal and uncontrolled nature.

Objective psychotherapy has also been criticized on the grounds that it merely smothers the neurotic symptoms. Because the 'basic causes' of the maladaptive behaviour have not been treated, it is said that new symptoms will necessarily arise to replace the extinguished behaviour patterns. For example, training an enuretic to relieve himself in the lavatory or teaching a stutterer to speak fluently will merely result in the patient 'adopting' some new deviant response. As there is no detailed evidence regarding the nature and frequency of this phenomenon it is difficult to assess its importance. While such 'transfer' of symptoms does undoubtedly occur, its frequency has probably been unduly exaggerated. In those cases where transferred symptoms arise the therapeutic procedure is quite uncomplicated. The therapist after having de-sensitized the patient to the first noxious stimulus situations when confronted with a so-called 'replacement-symptom' proceed,

to de-sensitize this new symptom in turn. When this treatment has been successfully completed, the probability of recurrence is extremely slight. It will be agreed that all neurotic symptoms in the patient have some degree of interdependence and the weakening or extinction of any one symptom is likely to affect all the others in like manner. The symptom which is treated first is usually the most resistant.* Behaviour patterns treated subsequently are more easily modified. If a new symptom arises it can be expected to be of rather weaker strength and hence readily amenable to inhibition or extinction. This 'symptom-replacement' phenomenon and its treatment has been described by Lazarus and Rachman.[8] Their case 5, a married woman of 29, had developed a phobic reaction to dogs as the result of a traumatic incident 5 years earlier. After 3 years of psychoanalysis her fear of dogs had disappeared but instead she had developed a chronic anxiety state with numerous, varied phobias ('symptom-replacement'). After 6 weeks of intensive psychotherapy (28 sessions) she was much improved, but her dog-phobia returned. After a further 28 sessions devoted mainly to the inhibition of this phobia, she was discharged 'much improved'. A year later she was still healthy and the extinction of the dog-phobia had been maintained. This case-history illustrates the treatment of 'symptom-replacement' by objective psychotherapy and also the development of 'replacement' with psychoanalysis.

* Case 1 reported by Lazarus and Rachman[8] required 21 sessions before the elimination of the first anxiety hierarchy and only 4 for the last in the series.

It is contended that objective psychotherapy is of considerable promise and that none of the criticisms presented to date are damaging. Objective psychotherapy also has the advantage of being firmly based in scientific methodology and has arisen out of basic, well-established psychological principles.

SUMMARY

The role of inhibition in psychotherapy is discussed. Five common criticisms of objective psychotherapy are examined and the conclusion reached that they are not damaging to either the theory or practice of non-analytic psychotherapy.

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