NEW METHODS IN PSYCHOTHERAPY: A CASE STUDY

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'Cure comes through learning healthy personal relationships *now*, and not by stewing over past emotional frustrations.'
Salter[1]

The general medical practitioner is frequently quoted as saying that more than half the patients he encounters in his daily rounds are 'just plain neurotic'. Since the general practitioner cannot spend hours treating his neurotic cases, a large number of them receive no therapy other than tonics and sedation. Others, less fortunate, succumb to the exhortations of swamis, mystics and a host of pseudo-scientific practitioners. This is an alarming situation. The initial responsibility for the psychological welfare of his patients usually rests with the family doctor, but the field of psychotherapy is itself so confusing that many doctors have expressed undisguised scepticism about its value. Most medical men do not have time to venture into the complicated polemics of orthodox Freudian psycho-analysis, or the claims of Jungian analysts, or the counter-claims of any other deviant psycho-analytic school. Similarly, the average doctor is not concerned with the differences between the various eclectic therapists or any other of the numerous controversies which characterize the field. It is therefore confusing, even for the average professional person, to view the many methods of treatment that are employed for emotional illness. But even more confusing is the fact that 'roughly 2/3rds of a group of neurotic patients will recover or improve to a marked extent within about 2 years of the onset of their illness, whether they are treated by means of psychotherapy or not'.[2]

The last decade, however, has seen the growth of a new behaviourist psychotherapy built on the firm scientific bedrock of neurophysiology. Its concepts stem from carefully controlled laboratory experiments and its therapeutic tools are derived from the laws of learning. This *Journal* has already printed several articles dealing with the experimental and theoretical background, methodology, therapeutic efficacy and clinical advantages of behaviour therapy.[3–6] The present article is intended to provide the general practitioner with a broad working knowledge of this approach. We firmly believe that more intimate team-work between doctor and psychotherapist will, in the long run, prove most beneficial. We also hope to disprove the myth that psychotherapy, by its very nature, must always be difficult, time-consuming and inefficient.

Where necessary, the behaviourist or objective psychotherapist employs all the usual psychotherapeutic techniques, such as support, guidance, insight, catharsis, interpretation, environmental manipulation, etc., but in addition to these more 'orthodox'

procedures, the behaviour therapist applies objective techniques which are designed to inhibit specific neurotic patterns. His orientation is away from the analysis of hypothetical 'minds-within-minds', and his focus of attention is placed instead on his patient's behaviour. Patients learn to behave in a maladaptive fashion, and if one is to cure the patient these ways of behaving must be eliminated. Wolpe's[7,8] experimental evidence and clinical research have revealed that neuroses are acquired in anxiety-generating situations and that successful therapy of the neuroses therefore depends on the reciprocal inhibition of neurotic anxiety responses. His methods have yielded a 90% level of 'apparently cured or much improved' cases.[8] It is probably safe to say that regardless of differences in theory or technique, the 'cures' that occur are accompanied by kinds of changes in personality that can be interpreted as involving learning.[9] Recognizing that neuroses are learned within a social milieu, much emphasis is placed on the fact that the patient is not a clinical label but a human member of society and therefore all specific procedures are applied within the very broad context of social adaptation. This broad social and cultural emphasis by no means precludes the application of detailed or specific procedures where indicated. Behaviour science is concerned with the entire range of acitivity from the most complex aspects of human interaction right down to the firing of a single neurone. Thus the behaviour therapist does not limit himself to a specific technique—his repertoire of therapeutic methods is sufficiently large and flexible to fit the needs of the individual patient. Therefore the objective therapist is able to swing the focus of attention back and forth from the individual and his or her parts, to the individual in his or her social setting. Another difference between the behaviour therapist and most other psychotherapists is the fact that the behaviourist is not bound by any fixed ritual to delve into the remote history of *all* his patients. As Rachman[6] has shown, many impressive cures have been effected without any attention being given to the causative factors involved. In our view, 'the emphasis in psychological rehabilitation must be on a *synthesis* which would embrace a diverse range of effective therapeutic techniques, as well as innumerable adjunctive measures, to form part of a wide and all-embracing re-educative programme'.[10]

The presentation of a treatment project should clarify many of these issues and enable the doctor to appreciate more fully the advantages of modern behaviourist psychotherapy. The following case was selected for several reasons: (1) a variety of techniques was employed; (2) many of our general statements are clearly illustrated; and (3) the didactic elements of the case are not obscured by its complexities. We propose to present a fairly detailed account of each session from the initial diagnostic interviews until the termination of therapy.

THE CASE OF L.H.R.

Extract from G.P.'s Letter of Referral: 'This is to introduce Mr. L.H.R., aged 36 years . . . . He appears to be suffering from anxiety and tension . . . . tranquillizers have not helped and his condition seems to have deteriorated in recent weeks . . . . '

Initial Interview (time 75 minutes)*

After putting the patient at ease, a detailed life history was taken. Here are the relevant points: Youngest of 5 children; unhappy home life (inadequate father, stern and over-solicitous mother); poor sibling relationships; childhood terrors retained until early puberty (fear of the dark, nightmares, and kidnappers); extreme masturbatory guilts during adolescence; volunteered for active service but was rejected owing to high blood pressure and 'black-outs' (no 'blackouts' for past 12 years); work situation unsatisfactory (employed as a draughtsman although he has an architectural diploma); poor social and inter-personal relationships ('I have a few friends but most people try to ride me'); principal interests 'painting, sketching and science fiction'; present adjustment towards sex satisfactory ('We hope to get married if I can get a better job.'); his 3 brothers were killed on active service; his father died shortly after the war from 'heart failure'; his sister is married and lives in Canada; patient shares a 2-roomed flat with his mother.

Asked to express his problems in his own words, Mr. L.H.R. replied: 'I've always been jittery and too particular about things. I suppose I expect too much of myself. Anyhow most of the time I just feel . . . . miserable. I sometimes get stupid thoughts like doing away with myself . . . . I'm already 36 and what have I got to show for it? . . . . My worst trouble is that I'm always checking and re-checking everything. You know, even when I know for sure that the door's locked I've always got to go back and make sure again and again. It's like that with everything. At work, for instance, I'll check the scales again and again and even though I know that the detail is correctly mapped, I go over the figure about ten times before I do the next one. Sometimes it nearly drives me mad but I've just got to go on and on . . . . '

General impressions. Well-groomed, pleasant looking, slender build, active, tense and agitated, timid and reserved. He appears to have little (if any) insight. At this stage, he could be summed up as an anxious, compulsive and inhibited individual.

2nd Interview (time 40 minutes)

This session was largely an extension and elaboration of the previous interview. Certain areas of the patient's history were discussed and checked. Additional information emerged, such as the fact that he was still being dominated by his mother and that his compulsive acts (which started in early puberty) became more severe after the death of his father. 'In the last few months things have really been worse than ever—quite unbearably so. I don't know why this is, but I suppose that it has to do a lot with the way my mother has been carrying on . . . . She's been going at me pretty solid . . . . She says that it's a pity that I wasn't killed up North instead of the others. Of course she doesn't mean anything by it, but it's upsetting . . . . Also my girl friend and her don't get on so well and my mother said that if I marry her, she'll cut me out of her will.'

The discussion then turned to the more detailed and intimate aspects of his home background. The Willoughby Neurotic Tendency Inventory[11] was applied and the score (63) indicated a high level of neurotic disturbance. The qualitative conclusions were: 'This person shows obvious insecurity mingled with feelings of hypersensitivity and guilt.'

3rd Interview (time 2 hours)

This session (apart from a brief discussion on relaxation) was devoted solely to diagnostic psychological testing. The patient was shown to have 'superior' Mental Alertness as measured by the N.I.P.R. Test A/1/1[12] and his corrected IQ was 120 on the South African Individual Scale. Selected items on the Thematic Apperception Test[13] together with the Holsopple-Miale Sentence Completion Blank[14] revealed significant clinical trends. Apart from obvious compulsive features, these records indicated underlying trends of unexpressed hostility towards parental figures (especially towards the maternal figure), coupled with generalized anxiety. There was also evidence that he avoided personal challenge presented by others and offered little himself. Although aggressive responses were prevalent throughout, more often than not these impulses were intrapunitive (i.e. 'self-punishing').

Readers who are at all familiar with Freudian writings will find this case rife with analytic material. From the behaviouristic viewpoint, however, the important aetiological factors are briefly the faulty habits which were generated in the home situation and then reinforced by subsequent stress situations. It follows, therefore, that the therapy programme was designed to eliminate or reduce the frequency and intensity of these non-adaptive responses.

4th Interview (time 1 hour)

Approximately 30 minutes of this session were devoted to further discussion about the patient's early homelife. The patient was allowed free rein and dwelt mainly on the 'injustices of his upbringing'. Certain of his statements suggested paranoid elements but most of his remarks had the ring of helplessness and self-pity. After about 20 minutes, the interpretation was suggested that the patient's remarks seemed to indicate feelings of hostility towards the individual members of his family. He immediately countered with vehement over-protestations about their 'underlying good intentions'. The therapist's non-commital 'uh-huh' precipitated a severe reaction: The patient immediately covered his face and wept. After a while he looked up and said, 'You're right, I hate the . . . lot of them!' This significant admission led to further uncontrolled weeping which gradually subsided when the therapist finally managed to impart his acceptance, approval and sympathy together with the fact that the patient's feelings and reactions were 'normal and quite justifiable'. The remainder of the session consisted of training in progressive relaxation.[15]

5th Interview (time 1 hour)

Mr. L.H.R. stated that he was generally feeling much better, but that 'my mother is now getting me down more than ever

* Unless otherwise stated, the patient was seen twice-weekly.

before . . . . Let's face it, I'm financially dependent on my mother . . . . and my work has been slower than ever because of that . . . . checking and re-checking'. The patient then switched the emphasis to his early sexual difficulties and a frank discussion followed which was designed to dissipate residual guilt-feelings by sanctioning his conduct and by imparting non-moralistic insight into all matters pertaining to sex. The patient was then given preliminary training in 'assertive responses'[8,16] (i.e. he was provided with specific instructions on handling all interpersonal relationships adequately and spontaneously 'standing up for his own rights').

6th Interview (*time* 1 *hour*)

After a short discussion about Mr. L.H.R.'s girl-friend, further training in assertive responses was given. The patient was urged to be assertive in all situations. He complained that the mere thought of being assertive made him feel afraid, but he was told that with practice, these techniques would soon come to him automatically. Training in progressive relaxation completed the remainder of this session.

7th Interview (*time* 1 *hour*)

The patient spoke at length about his father and about his present attitude towards his mother ('If I ever want to live, I've got to break away from her'). His compulsive behaviour was then discussed and the patient summarized the situation as follows: 'If I could only stop myself from this business of re-checking everything ten times then I'd have a chance. I know I'm good at my work but I'll never get senior posts until I manage to work faster . . . . These compulsions are the things that mess up my whole life.'

8th Interview (*time* 40 *minutes*)

Approximately 20 minutes were devoted to additional training in assertive responses by means of 'psycho-drama' (i.e. the therapist assumed the role of various 'threatening figures' and the patient was required to oppose them). The rest of the session consisted of relaxation therapy with preliminary hypnotic suggestions. He responded well to the hypnotic procedures and a catalepsy of his right arm was easily induced.

9th Interview (*time* 40 *minutes*)

The patient seemed unusually excited. 'It's working,' he announced as soon as he walked in, 'yesterday for the first time, I stood up to my mother and she got such a shock that she just said nothing . . . . I even asked my boss for a raise. I didn't get it, but at least I asked . . . . ' The therapist expressed his approval and delight at his progress and encouraged him to continue practising this new habit of assertive responses. (One obviously has to use one's discretion in advising assertive behaviour as the aim is definitely not to make people become objectionably aggressive. In this instance, Mr. L.H.R. was so very inhibited that there was never any risk of making hom permanently aggressive and at best, by acquiring assertive habits, he would be able to achieve a better balance in his assertiveness-submissiveness ratio and not serve as a perpetual doormat for the rest of his life.) Hypnotic relaxation was then administered for 15 minutes and a glove anaesthesia was induced without difficulty.

10th Interview (*time* 30 *minutes*)

The patient was hypnotized and given more or less the following instructions while in a deep hypnotic trance: 'You feel calm and relaxed, deeply relaxed and peaceful. Now I want you to imagine yourself at work. You still feel ca'm and relaxed. Now imagine yourself drawing a plan and checking as you go along. You're quite relaxed. You check it once. Everything is correct. You make sure and go over it again. You are still calm and relaxed. You begin to check it a third time, but now suddenly you feel anxious. You feel uneasy and tense. Rapidly the tension mounts. (The patient was writhing and breathing very heavily at this stage.) You leave the plan. You do not check it again. Now you start a new drawing. Picture the new situation. As soon as you start the new activity you are once again calm and relaxed. You feel calm and peaceful . . . When I count up to five you will open your eyes.' When asked to recall what had transpired while under hypnosis, the patient at first appeared to be completely amnesic, but after a while he was able to recollect the entire session and reported that he had visualized the situation 'just as though I was there at the time'.

11th-19th Interviews (*time of each* 30 *minutes*)

The hypnotic procedure employed in the previous interview was applied, with slight modifications, until the end of the 19th interview, when the patient reported that his compulsions no longer troubled him in the work situation. 'I'm turning out five times more work than before . . . Sometimes I still tend to fuss over things more than I ought to, but that doesn't worry me.' Specific instructions in assertive behaviour were also given prominence throughout these interviews. On the 12th interview, the therapist was about 20 minutes behind time and Mr. L.H.R. politely reprimanded him by saying. 'You should have told me that you were running late and I would have slipped down for a haircut meanwhile.' This was indeed an impressive improvement from his previously inhibited and almost obsequious behaviour. The therapist apologised for the delay and later expressed his strong approval of Mr. L.H.R.'s assertive behaviour.

20th Interview (*time* 30 *minutes*)

The patient was not seen for nearly 5 weeks. He had had an emergency appendectomy and had developed certain complications after the operation. 'I've been back at work now for two days . . . I've been doing a lot of thinking this past month and you'll be surprised to hear what I've done . . . I've asked Betty (his same girl-friend) to marry me . . . I've accepted a job in Cape Town . . . My aunt recently lost her husband and she is coming to live with my mother . . . We plan to leave town as man and wife before the 16th (less than 3 weeks) . . . Do you approve of all this? . . . ' The therapist expressed his strong approval of all Mr. L.H.R.'s decisions. The need to continue practising assertive behaviour was again impressed upon him.

21st Interview (*time* 1 *hour*)

This interview took place 15 days after the previous one. Mr. L.H.R. was accompanied by his fiancée. She was interviewed privately and seemed a sensible person with considerable understanding and insight. At the end of the interview she said. 'Now that L. has learnt to stand on his own two feet, I'm sure we will make out just fine.' Mr. L.H.R. was then asked to come in, and the conversation terminated with a general discussion about their future plans.

Periodically he communicated with the therapist by letter. Eight months after therapy, en route to Rhodesia, Mr. L.H.R. telephoned the therapist and reported that he had maintained a satisfactory adjustment. 'I have conquered the compulsions for good and everything is better than I ever expected.'

DISCUSSION

This case was not presented for its dramatic interest, since it is by no means spectacular and it is certainly not intended as a 'model case'.

The first 4 interviews employ the usual diagnostic and psychotherapeutic procedures but, after that, the more objective techniques are brought into clearer focus. It is soon apparent that the patient's principal problems are 'inhibitions and compulsions,' and from the 6th interview onwards, the therapist is obviously of the opinion that if these two factors are eliminated, the rest will automatically fall into place. By the 8th interview, the emphasis is present-and-future orientated and, contrary to analytic preachings, little time is devoted to 'digging up the past'. The reader will have observed the fact that the compulsive features were adequately reduced without any attention being given to the causative factors involved.

We should like to give a brief theoretical explanation of our hypnotic procedure as applied to the patient's compulsive acts. It is generally agreed that obsessional or compulsive symptoms have the effect of allaying or inhibiting anxiety. We know, for instance, that if a patient is prevented from satisfying his compulsive urges he displays acute anxiety until he finally carries out his ritual. Now if we reverse this process, (i.e. the patient becomes anxious when performing his compulsive act and feels complacent when avoiding compulsive behaviour) the compulsive acts should automatically fall away. This, at least, is the theory behind the hypnotic procedure employed. Wolpe,[8] however, reports more sophisticated objective techniques, with wider applicability, for handling compulsive and obsessional neurotics. 'Orthodox' practitioners would argue that symptoms removal without the elimination of the 'underlying cause' does not constitute a 'cure'. Rachman,[6] however, has shown that 'too great a concern with "underlying causes" may under certain circumstances even impede therapeutic progress.' Eysenck[17] expertly summarizes the situation as follows: 'According to Freud, there is a "disease" which produces symptoms; cure the disease and the symptom will vanish. According to the alternative view,

there is no "disease", there are merely wrong habits which have been learned and must be unlearned.'

The bulk of the treatment (i.e. 19 interviews) extended over 10 weeks and the total time spent with the patient amounted to less than 16 hours. He was considered 'much improved' in terms of Knight's 5 criteria[18]—symptom improvement, increased productiveness, improved adjustment and pleasure in sex, improved interpersonal relationships, and increased stress-tolerance.

SUMMARY

Some important practical and theoretical advantages of behaviour therapy are outlined. These include objective techniques, controlled experimental backing, effective short-term therapeutic programmes, and a high level of cured and improved cases. A treatment project is presented in some detail in the hopes of providing the general medical practitioner with additional insight into the dynamics of behaviour therapy.

REFERENCES

1. Salter, A. (1953): *The Case Against Psychoanalysis.* New York: Medical Publications Ltd.
2. Eysenck, H. J. (1952): *The Scientific Study of Personality.* London: Routledge and Kegan Paul Ltd.
3. Wolpe, J. (1950): S. Afr. Med. J., **24,** 613.
4. *Idem* (1952): *Ibid.*, **26,** 825.
5. Lazarus, A. A. and Rachman, S. (1957): *Ibid.*, **31,** 934.
6. Rachman, S. (1958): *Ibid.*, **32,** 19.
7. Wolpe, J. (1948): *An Approach to the Problem of Neurosis Based on the Conditioned Response.* M.D. Thesis, University of the Witwatersrand, Johannesburg.
8. *Idem* (1954): Arch. Neurol. Psychiat., **72,** 205.
9. Bugelski, B. R. (1956): *The Psychology of Learning.* New York: Henry Holt and Company.
10. Lazarus, A. A. (1956): S. Afr. Med. J., **30,** 707.
11. Willoughby, R. (1934): J. Soc. Psychol., **5,** 91.
12. National Institute for Personnel Research—Mental Alertness A/1/1 (A Test for Matriculated Persons).
13. Murray, H. A. (1943): *Thematic Apperception Test Manual.* Boston, Mass. Harvard University.
14. Holsopple, J. Q. and Miale, F. R. (1954): *Sentence Completion: A Projective Method for the Study of Personality.* Illinois: Charles C. Thomas.
15. Jacobson, E. (1938): *Progressive Relaxation.* Chicago, University of Chicago Press.
16. Salter, A. (1952): *Conditioned Reflex Therapy.* London: George Allen and Unwin Ltd.
17. Eysenck, H. J. (1957): *The Dynamics of Anxiety and Hysteria.* London: Routledge and Kegan Paul.
18. Knight, R. P. (1941): Amer. J. Psychiat., **98,** 434.