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GENERAL PSYCHOTHERAPY

The Restoration of Morale

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General Psychotherapy: The Restoration Of Morale

Psychotherapy encompasses all those activities by which one person seeks to relieve the distress and beneficially affect the behavior of another through psychological means. At first glance, the variety of psychological healing procedures seems virtually endless. It encompasses all helping activities based on symbolic communications that arc primarily although not necessarily exclusively verbal, such as religious healing and a range of secular activities that aim to modify behavior, expand consciousness, or enhance personal growth. The target of these efforts is an individual, but he is often treated in a group. Proponents of each method of psychotherapy enhance the impression of diversity by stressing how their particular approach differs from and is allegedly superior to all others.

The varieties of distress and disability for which psychotherapy is offered seem equally diverse, including psychoses, neuroses, character and personality disorders in children, and bodily diseases with an emotional component. The only feature these conditions have in common is that they involve disturbances in the person's communicative behavior.

The thesis of this chapter is that the diversity both of psychotherapies and the conditions that respond to them is more apparent than real, and that

in actuality all candidates for psychotherapy suffer from a single condition that takes protean forms. This condition may be termed demoralization. Similarly, all forms of psychotherapy, beneath their superficial differences, share certain features that combat demoralization and thereby account for most of their actual effectiveness.

This presentation attempts to define demoralization, to explore some of its causes and its relation to patients' complaints, and then to review evidence from various areas for die hypothesis that all psychotherapies essentially endeavor to overcome the demoralized state of mind. This is followed by a brief consideration of the features shared by all psychotherapeutic procedures that promote this outcome. Finally, some implications of the demoralization hypothesis for the selection and preparation of patients for psychotherapy and then for the conduct of psychotherapy are explored.

The Demoralization Hypothesis

Definition of Demoralization

Demoralization is a state of mind that ensues when a person feels unable to cope with a problem that he and those about him expect him to be able to handle. Demoralization can vary widely in duration and severity, but the full-blown form includes the following manifestations, not all of which

need be present in any one person. The person suffers a loss of confidence in himself and in his ability to master not only external circumstances but his own feelings and thoughts. The resulting sense of failure typically engenders feelings of guilt and shame. The demoralized person frequently feels alienated or isolated. He may also feel resentful, because others whom he expects to help him seem unable or unwilling to do so; their behavior, in turn, may reflect their own irritation with him, creating a vicious circle. With the weakening of the person's ties often goes a loss of faith in the group's values and beliefs, which had helped to give him a sense of security and significance (Adler, n.d.). The psychological life-space of the demoralized person is constricted in space and time. He becomes self-absorbed, loses sight of his long-term goals, and is preoccupied with avoiding further failure. His dominant moods are usually (1) anxiety, ranging from mild apprehension to panic, and (2) depression, ranging in severity from being mildly dispirited to feeling utterly hopeless.

Most episodes of demoralization are self-limiting. These crisis responses (Caplan, 1963; Rusk, 1971) can enhance a person's mental health by stimulating him to seek better solutions to his problems, strengthening his emotional ties with others, and demonstrating to himself that he can overcome obstacles. Prolonged states of demoralization, however, are self-perpetuating and self-aggravating, since they lead to increasing discouragement, which impedes recovery. Some evidence will be adduced

below that neurotic and psychotic symptoms contribute to demoralization and, in turn, are aggravated by it.

Causes of Demoralization

A person experiences demoralization when his coping capacity is inadequate to meet a stress that he is experiencing. Factors affecting coping capacity—or, in negative terms, vulnerability—may be modifiable or unmodifiable by psychotherapy. Constitutional vulnerabilities (those built into the structure of the organism) may be primarily genetic in origin or may result from damaging experiences, during critical periods of pre- or postnatal development, that leave permanent defects in the growing nervous system. That traumata or deprivations of early life can permanently affect the organism has been amply demonstrated by animal experiments, and it seems to account for some of the personality characteristics of adults who were raised in exceptionally brutal or depriving environments. However, many vulnerabilities created by trouble-making distortions of perception and behavior, or by stress-producing value systems arising from past experience, can be modified by subsequent experience such as that provided by psychotherapy.

The severity of the stress component of demoralization depends on how the person perceives inner and outer events; and this is determined by his

own assumptive systems (Frank, 1973) as well as by the objective nature of the events. Some of these assumptions are widespread in a culture. For example, hallucinations in the United States in the twentieth century are viewed as signs of mental illness; hence they are much more stressful to Americans than to members of a culture that does not view them with alarm. The severity of other stresses depends on idiosyncratic assumptive worlds. Examples are promotions, which severely stress some persons, or deaths in the family, which may be experienced by some family members as a relief and by others as a maximal stress. The severity of such stresses may be aggravated or reduced by whether they remind the person of situations in which he has previously failed or succeeded.

Stresses built into the system of society may also create demoralization. American society contains a subtle but pervasive source of stress that seems amenable to psychotherapy—the collapse of traditional value systems and institutions for assuaging the "existential anxiety" that arises from awareness of the apparent transitoriness and insignificance of individual human life. The ways in which more gross and obvious societal stresses summarized by the term "socioeconomic oppression" may contribute to psychiatric illness, and their implications for psychotherapy, raise controversial issues which it would take us too far afield to explore here (Halleck, 1971).

Relation of Demoralization to Psychiatric Symptoms

Persons who seek psychotherapeutic help are usually in the middle range of demoralization. Mild forms are relieved by advice or reassurance from family or friends, or by changes in life situation (such as a change of job) that result in the person regaining his sense of mastery and connectedness with his group. At the other extreme, if demoralization is sufficiently severe, the person believes he is beyond help and simply withdraws into a shell. Such persons do not seek help; and some, such as derelicts, seem unable to use it.

In order to receive psychotherapy, the patient must experience certain symptoms viewed as especially amenable to this remedy. Many of these symptoms, such as anxiety, depression, and feelings of guilt, may be direct expressions of demoralization. Others, such as obsessions, dissociative phenomena, and hallucinations, have a variety of causes, many of which are still not understood. Sometimes they seem to be symbolic ways that the patient has chosen to express or resolve the problems that demoralize him.

That anxiety aggravates symptoms was shown by Lesse (1958). Using a simple anxiety rating scale administered to a wide variety of patients, he concluded that the anxiety level mounts before the appearance of clinical symptoms, and that under treatment "A given symptom or group of symptoms did not seem to completely disappear until the degree of anxiety decreased below a certain threshold which was unique for the individual patient." He concludes: "The greater the stress, the greater the degree of

anxiety; the greater the degree of anxiety the more symptoms and signs that are called into play."

A finding of Luborsky and Auerbach (Luborsky, 1969) suggests that symptoms apparently unrelated to demoralization may, in fact, be symbolic or indirect expressions of this state. Through detailed study of psychoanalytic sessions, they found that patients complained of migraine headaches in an emotional context of feelings of lack of self-control, helplessness, and hopelessness, and of stomach pains in a context of helplessness and anxiety.

Whatever their ultimate etiology, symptoms interact in two ways with the degree of demoralization. First, the more demoralized the person is, the more severe these symptoms tend to be; thus patients troubled with obsessions find them becoming worse when they are depressed. Secondly, by crippling the person to some degree, symptoms reduce his coping capacity and thereby aggravate his demoralization.

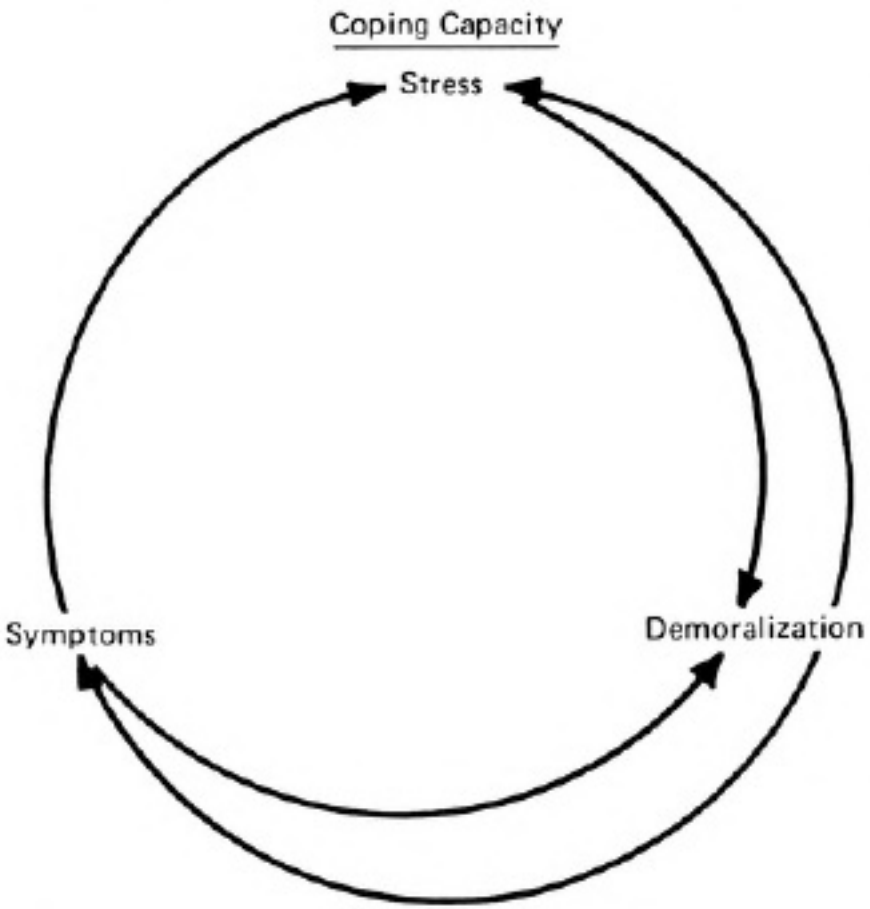
Symptoms alone do not bring persons to psychotherapy. Some degree of demoralization must also be present, and relief of this rather than elimination of symptoms is the main criterion of successful treatment. Restoring a person's morale has certain beneficial consequences. It restores his sense of control over that segment of his life experience which he felt he had lost. This reopens his future, increases his options, and diminishes his concern with his

symptoms, because he now feels that he can master them instead of their mastering him. Usually his symptoms will diminish, but he may also recover his zest and enjoyment of life despite their continuance. One is reminded of the old story of the stutterer who spent several years in psychoanalysis and then announced that he was cured because although he still stuttered, he now knew why.

Coping Capacity, Stress, Symptoms, and Demoralization

The demoralization hypothesis may be illustrated by Figure 7-1. Demoralization is a function of the relationship between stress and coping capacity. If coping capacity is greater than stress, a person presumably is not demoralized; if stress is greater than coping capacity, a person would be demoralized. Demoralization interacts with both the balance between stress and coping capacity and the patient's symptoms. The more demoralized a person is the less he feels able to cope, the more stress he experiences, and the more severe are his symptoms. Symptoms, in turn, increase his sense of demoralization by reducing his coping capacity and increasing his sense of stress. Psychotherapy functions chiefly to restore morale, thereby increasing the patient's coping ability and reducing his symptoms.

Figure 7.1



Coping Capacity, Stress, Symptoms, and Demoralization

Evidence for the Demoralization Hypothesis

Before considering the implications of the demoralization hypothesis

for psychotherapy, it may be well to review some of the data from surveys and questionnaires and, primarily, from studies of the processes and outcomes of psychotherapy itself that can be interpreted as supporting it.

Surveys of Treated and Untreated Populations

Surveys of stratified samples of the population, based on interviews and questionnaires, consistently reveal that psychopathological symptoms alone are not sufficient to bring persons to psychotherapy. For example, Srole et al. (Srole, 1962) found that about 80 percent of a stratified sample of city dwellers had "significant psychopathology," while Gurin, Veroff, and Feld (Gurin, 1960), in another survey of a similar sample, found that only 14 percent had sought professional help at some time in their lives. This discrepancy is usually attributed to the unavailability of psychiatric resources or lack of information as to their existence. The latter survey found, however, that "The presence of mental health resources made it easier for people who are already disposed to look for this help to obtain it, rather than motivating people to seek assistance;" that is, many persons with "significant psychopathology" presumably do not see themselves as needing help.

This conclusion is confirmed by comparing samples of treated and untreated persons, the former being designated as "patients" or "neurotics." The samples show not only a high prevalence of so-called psychopathological

symptoms in a nontreated group but also a much greater prevalence of attributes associated with demoralization in the patient group. For example, Vaillant (1972), using a questionnaire survey of male alumni twenty-five years after their graduation from a liberal-arts college, compared the 17 percent who had sought psychotherapy (defined as a minimum of ten visits to a psychiatrist) with the 83 percent who had not. He found that persons who experienced subjective ill health and also had less than four social supports were more than six times as likely to have sought psychotherapy. Since social supports per se were not correlated with physical and mental health, he concluded: "Ready recourse to psychotherapy may reflect social isolation from a variety of causes . . . people who seek psychiatrists have trouble in sustaining relationships." A sense of alienation characterizes demoralization.

Katz (1971) asked relatives of a large sample of "normal" persons to fill out a questionnaire concerning them, and compared the findings with those obtained on the same questionnaire from persons in outpatient treatment. Among the normals he singled out a subgroup whose relatives reported them to be as depressed as the mean severity of depression of the patients. The patients, however, were distinguished from the normals by being much more self-accusatory and helpless. Again it appears as if features associated with demoralization, notably guilt feelings and helplessness, rather than a depressed mood in itself, brought the patients to psychotherapy.

Finally, Kellner and Sheffield (1973) compared samples of persons not receiving psychiatric treatment (whom they called normal) with those receiving psychiatric treatment (whom they labelled neurotic), in both England and America. The results were consistent in the two samples. Many normals complained of symptoms associated with mild demoralization, such as tension, worry, unhappiness, and nervousness. These were about three times more frequent in the neurotic group, however, accounting for about 90 percent of the patients as compared to about 30 percent of the normals. Two complaints, a sense of failure and unworthiness (65 percent as compared to 13 percent) and "no hope" (60 percent to 6.5 percent), were very much more heavily represented in the treated group. These are similar to the self-accusatory feelings and feelings of helplessness reported in the survey by Katz (1971).

The central point is that psychological symptoms alone do not bring patients to psychotherapy. Whitehorn had distinguished between "compensated" and "decompensated" neuroses (1944). The material here reviewed suggests that it is the decompensation and not the neurosis which leads the patient to seek help.

Prognosticators of Therapeutic Outcome

Just as demoralization is the main incentive for seeking psychotherapy,

so do (1) ability to use this form of help, and (2) general coping capacity seem to be the major prognosticators of therapeutic outcome. That is, most of the factors contributing to improvement lie in the patient's personal qualities rather than in his symptoms or the therapeutic procedure. The universal clinical impression, borne out by the findings of the Menninger Foundation's Psychotherapy Research Project (Kernberg, 1972), is that persons with good ego-strength—a concept that includes coping capacity and ability to form rewarding personal relationships—do well. Facility in expressing feelings and problems is also associated with a good prognosis. So is a desire for help, indirectly revealed by emotional tension and self-dissatisfaction. These impressions are firmly supported by Luborsky et al.'s (Luborsky, 1971) detailed, quantitative analysis of over 100 reported studies of interview psychotherapy. Prognosticators of a good outcome were adequacy of personal functioning, motivation, intelligence, anxiety, and educational and social assets. The researchers conclude: "High affect. . . with high integration or ego strength form a good combination of prognostic conditions for change through psychotherapy." Persons with these attributes probably are able to utilize many other forms of personal help.

The scanty findings on the relation of attributes of therapists to the therapeutic outcome are consistent with the hypothesis that features of the therapists' personality and style that counteract demoralization are more important determinants of their success than are their specific procedures.

Truax and Carkhuff (1967) found warmth, genuineness, and empathy to characterize the successful therapist. Whitehorn and Betz (1954) found that "active personal participation," associated with successful therapy with schizophrenics, would seem to be related to the therapist's ability to inspire the patient's hopes and raise his morale.

The fact that all therapies seem to work best when first introduced is also consistent with this assumption. Novelty inspires the patient's hopes and the therapist's zeal. In this connection, a major finding of Malan's (1963) elaborate study of short-term psychoanalysis involving eleven analysts and fifty analysands was that the best predictor of improvement was the patient's chronological place in the series of patients seen by each analyst. Of the eight patients who received maximum-improvement scores, four were the analyst's first patient and two were his second one. The role of novelty in maintaining the interest and hopes of both therapist and patient suggests that the therapist's flexibility and ingenuity, within the limits imposed by his conceptual scheme, may contribute to his success. Observations of video tapes of well-known therapists confirm this supposition. Perhaps one of the virtues of behavior therapies, seldom mentioned by their advocates, is that their under-lying conceptual scheme permits and encourages flexibility. The approach is openly experimental, and whatever the therapist does he can justify and explain by the extremely loose body of concepts known as learning theory.

Patients' Improvement and Psychotherapy

A final line of evidence for the concept that the main function of all psychotherapies may be to combat demoralization derives from studies of improvement. With rare exceptions, it has been impossible to show that one form of therapy is more successful than another. The exceptions are that circumscribed phobias and fetishes have apparently responded better to behavior therapies than to interview therapies, but Davison and Taffel (Davison, 1972) have reviewed recent studies that cast doubt on many of these findings. Agras et al. (1972) examined thirty phobic patients discovered in an epidemiological survey who received no treatment for five years, and found that their rate of improvement was the same as that from two studies of treated phobics. For both untreated and treated phobics, moreover, the degree of generalization of the phobia and the degree of general tearfulness carried a poor prognosis. These findings are consistent with the assumption that if phobics are not severely demoralized, they recover, and that what keeps them "ill" may be their degree of demoralization.

In any case, regardless of initial diagnosis (according to Stone et al. [1961]), the symptoms of those psychiatric outpatients most likely to show prompt improvement are anxiety and depression—the cardinal manifestations of demoralization. Moreover, most patients show progressive improvement over time, and this overall trend typically washes out the

differences in improvement observed immediately at the close of therapy in patients treated by different methods. Whitehorn (1960) found this to occur with schizophrenics, and Liberman et al. (1972) with neurotics. This suggests that the chief function of psychotherapy, as with most medical treatments, may be to accelerate improvement that would have occurred anyway. Just as the healing power of the body may require time to overcome a bodily illness, so may the patient in psychotherapy take awhile to regain his morale. The process is often aided by his ability gradually to mobilize respect, reassurance, and affection from others, as Stevenson (1961) suggests.

That improvement is closely associated with gains in morale is suggested by a study of Lorr et al.'s (1962) psychiatric outpatients, in whom improvement in anxiety and other symptoms was accompanied by subjective feelings of increased aggressiveness, personal resourcefulness and self-reliance, and independence. More recently Gillis and Jessor (Gillis, 1970), Smith (1970), and Liberman et al. (n.d.) have all found that improvement in psychotherapy parallels an increase in the degree to which a person sees himself as controlling his life rather than being controlled by external forces.

One way of raising morale is to provide a person with experiences of success. Loeb et al.'s study (1971) showing that depressed persons respond more strikingly to such experiences than do nondepressed persons therefore seems relevant to this discussion. A simple task was given to twenty

depressed patients; ten were led to believe that they were succeeding at it, and ten that they were failing. In contrast to a control group of nondepressed patients who worked faster after failure experiences, the depressed patients worked faster after success experiences. They also showed a higher level of aspiration and better actual performance after success, compared to the nondepressed patients.

Schools of Psychotherapy and Demoralization

In the light of these findings, it seems appropriate to ask why so many different schools of psychotherapy continue to thrive. One reason, of course, is that they all obtain enough favorable results to justify their existence, and proponents of each school can attribute its successes to the features that distinguish it from its rivals. Differences in conceptualization and procedure, however, may primarily represent different views concerning the major sources of the patient's demoralization and the ways of restoring his morale. The following descriptions are greatly simplified in order to make this point.

Proponents of behavior therapies view the *symptom* as the reason the patient seeks treatment, and see it as resulting from faulty environmental reinforcement schedules, present and past. Restoration of morale, if considered at all, is presumed to result from relief of the crippling symptom. That relief of symptoms and improved morale go hand in hand cannot be

doubted, but a growing body of data indicates that even behavior therapies may reduce symptoms largely because they have restored the patient's morale by aspects of the therapeutic situation that escape their purview. For example, all behavior therapies provide clear and definite experiences of success, and it is these that may enable the patient to overcome his symptoms, rather than the reverse.

Along the same lines, the effectiveness of implosion therapy may lie in its showing the patient that he can tolerate his fears in their most extreme form. This proves that he is the master of his feelings rather than being controlled by them. Analytically oriented insight therapies see patients' complaints as resulting from unconscious inner conflicts and seek to help him resolve these, thus helping him to regain a sense of control over his thoughts, feelings, and behavior. As Freud put it, "Where Id was, there shall Ego be."

The conceptual schemes of existential therapies are closest to the one advocated here. They view the patient's distress as an expression of his struggle to achieve a sense of identity, purpose and meaning, and their approaches are aimed at combating the sense of isolation, meaninglessness, or despair. The therapist combats these feelings, basically, by entering into the patient's experiences and thereby validating them (Liang, 1967). Some existential therapists such as Frankl offer the patient an explicit philosophy that helps him to achieve a sense that life has meaning (1965). Therapists

who attempt to produce in the patient a "psychedelic" experience through the use of LSD have the same aim (Abramson, 1967).

It should be added that from many standpoints group therapies may be more effective than the individual approach in restoring the patient's morale. Since group methods are described in detail elsewhere in this volume, however, they will not be further considered here.

This short survey of the psychotherapeutic spectrum leads to the conclusion that psychotherapy can be defined only in the broadest terms. It clearly has escaped from the medical model of a form of treatment for a disease. The term "psychotherapy" includes all types of planful interactions by which the therapist, with or without a group, tries to enhance the patient's subjective life by providing new interpersonal experiences that help him to cope with sources of subjective distress and to behave in a more socially desirable way. Characteristically, these objectives reinforce each other. Behavior that yields rewarding rather than stressful interactions with others enhances subjective experience, and persons who feel serene are more able to initiate mutually rewarding interactions with others. Either way, the patient's morale is improved.

Common Features of Psychotherapies

What are the features shared by all forms of psychotherapy that help

the patient to overcome his sense of alienation and regain a sense of control or mastery over his inner feelings and external events? Four can be readily distinguished.

The first feature is a certain type of relationship, often described, between a therapist who offers help and a patient who seeks it. The therapist conveys concern for the patient's welfare and enters into a trusting, confiding, emotional relationship with him. The relationship, however, has definite spatiotemporal boundaries and is structured by the requirements of the therapeutic role. While in one sense this role places constraints on both participants, in another it permits maximal spontaneity within its limits by assuring both patient and therapist that the relationship will remain within bounds. Typically, the relationship is mediated exclusively by words; however, certain therapies permit or even require bodily contact, which can be strongly supportive, between therapist and patient. The therapist's attitude always conveys genuine acceptance of the sufferer, not necessarily for what he is but for what he can become. It also conveys the therapist's belief that the patient can master his problems. The therapist being a representative of the larger society and often of the patient's subculture as well, his acceptance helps to overcome the patient's sense of alienation. Since most patients reach the psychotherapist only after they have failed to gain consideration or help from others, their discovery that someone has enough faith in them to make an effort to help is in itself a powerful boost to morale.

In the initial phases of therapy, the patient may be said to borrow hope and confidence from the therapist.

While some demoralized persons may indulge in displays of emotion or even violence, most are timid. Because they are so unsure of themselves, they fear to express their anxiety or resentment lest others take advantage of them or retaliate. This feature of demoralization is counteracted by a second shared feature of psychotherapies, their setting. Psychotherapeutic settings ordinarily are sharply distinguished from the arenas of daily living by possessing features that identify them as sanctuaries and places of healing. In many societies the favored place for healing is a temple; if healing rituals are conducted in the patient's home, it is first sanctified by appropriate rites. In industrialized nations the therapist's office or the hospital has an equivalent aura. In this sanctuary, presided over by a tolerant protector, the patient can safely let himself go, releasing his pent-up emotions and trying out new ways of behaving, secure in the knowledge that he is safe from retaliation.

The third common ingredient of all psychotherapies is a cognitive structure, or conceptual scheme. Such a scheme enables the patient to explain and label his inchoate or bewildering subjective states and behaviors, thereby gaining a sense of control over them (Hobbs, 1962; Torrey, 1972). To be effective, the scheme must be convincing to the patient; hence it is characteristically validated by being linked to the dominant cosmology of his

culture. In the Middle Ages the conceptual scheme underlying what we today call psychotherapy was demonology. In many primitive societies it is witchcraft, while in the United States it is science. At a conference on psychotherapy in which proponents of various schools described their methods, each introduced his procedure by invoking symbols of science. One showed anatomical charts, another used polygraphic tracings, and a third referred to experimental work with animals. Psychotherapists who have been trained as physicians or psychologists automatically carry the mantle of science, and the same is true, to a lesser degree, of social workers. (Reflecting the growing disillusionment with science, however, an increasing number of therapies are appearing that arc validated by religious or mystical cosmologies.) From the standpoint of the therapist, an underemphasized function of the conceptual scheme is to maintain and enhance his relationship with the patient by sustaining his own interest and reassuring him as to the validity of his procedure in the face of therapeutic failure. As one young adherent of a rigid therapeutic school remarked, "Even if the patient doesn't get better, you know you are doing the right thing."

Fourthly, every therapy prescribes a procedure (based on the conceptual scheme) that requires the active participation of both patient and therapist and that is believed by both to be the means for restoring the patient's health. This procedure serves as both a vehicle and a justification for the maintenance of the therapeutic relationship (Pande, 1968). Through

repetition it divests anxiety-laden symbols of their anxiety, and it impels the patient to experiment with new behaviors. Interview therapies do this indirectly by offering insights that imply that the patient should be doing something different, whereas behavior therapies convey the message directly. The task enables the patient, through repetition, to practice the new behaviors that are helpful, first in the therapeutic setting and then outside. Since the autonomic nervous system learns slowly, extinction of autonomic symptoms may require much repetition; it is this that may largely account for the need of some patients for long term therapy. And finally, if the procedure is sufficiently impressive, it affords the patient a face-saving device for relinquishing his symptoms after he no longer needs them. Procedures such as hypnosis, relaxation, or emotional flooding, in which the therapist alters the patient's subjective state, are especially convincing demonstrations of the therapist's competence. Any procedure that can alter one's state of consciousness must be powerful indeed. The central point is that the therapeutic efficacy of rationales and techniques may lie not in their specific content but in their morale-building functions. Their contents differ, but their function may be the same.

Common Effects of Psychotherapies

All forms of psychotherapy have certain similar effects. The first is that they produce some degree of emotional arousal, which seems to be a

prerequisite for change in patterns of attitudes and behavior (Hoehn-Saric, 1968). Many currently popular therapies try to produce intense emotional states, thereby following a tradition that can be traced at least as far back as Mesmer. In all therapies, however, the relationship itself, with its hope-inspiring qualities and its sense of trustful intimacy, is emotionally arousing, especially when the therapist is enthusiastic. Many therapies also stir the patient's anxieties by forcing him to dwell on distasteful feelings, thoughts, or behaviors, and to discover and face previously disowned aspects of himself.

Secondly, all therapies expand the patient's horizons and increase his options by helping him to develop fuller awareness of himself, a more accurate perception of others, and a wider range of behaviors. This comes about through a combination of cognitive and experiential learning. The patient not only learns new ways of formulating his problems and gains new information about himself but also has new experiences and may model himself, wittingly or unwittingly, on certain aspects of the therapist. The lessons he learns in therapy are reinforced and extended by new experiences in daily life resulting from his greater self-awareness and from changes in the responses of others generated by his own changed behavior.

Thirdly, all therapies arouse and maintain the patient's hope for improvement, initially through the optimism of his therapist and later through evidence that he is making progress (Frank, 1973; Frankl, 1965).

This evidence typically takes the form of success in gaining new depths of self-understanding and overcoming behavioral blocks, or of other experiences regarded as signs of improvement by the particular therapy in question. These experiences increase the patient's sense of mastery or self-control.

Ideally, then, all successful psychotherapies enhance the patient's sense of personal integration and security and his ability to enter into warm relationships with others. This implies an increased ability to accept his limitations as well as a fuller recognition of his assets. All these changes can be summed up as greater self-acceptance—the healed patient can comfortably say, with the cartoon character Popeye: "I yam what I yam." Concomitantly, the symptoms for which he sought therapy diminish or may even disappear.

Some Implications of the Demoralization Hypothesis

Diagnosis

If the purpose of diagnosis is to determine appropriate therapy, then current diagnostic schemes have been resounding failures. Proponents of every school claim to be able to successfully treat patients who fall into all the conventional diagnostic categories. All agree that some patients in each are

inaccessible to their method, but insist that these patients are equally impervious to the approaches of their competitors.

In the light of the demoralization hypothesis, diagnosis has two functions: first, determination of the relative importance of modifiable and unmodifiable sources of demoralization; and, second, identification of personal qualities that would make the patient more accessible to one therapeutic approach than to another. Constitutional aspects of the person that determine the limits of his responsiveness to any form of psychotherapy have been discussed earlier (see p. 118). They are clearly prominent, for example, in cyclical illnesses and in defects of mentation such as over-inclusiveness. They probably also prove to play a part in severe neuroses, as well as in such temperamental qualities as the patient's emotional lability and threshold for anxiety.

The treatment of choice for constitutional disabilities is medication that corrects the biochemical defects underlying them. Although psychotherapy cannot directly correct such defects, it can help the person to live within his limitations or to avoid situations to which he is especially vulnerable. For example, although psychotherapy cannot overcome the enzyme deficiencies in some schizophrenics, as May (1969) points out, it can help such patients to identify and avoid or cope more effectively with the stresses that overtax their adaptive capacities.

From the standpoint of the environment, the therapist obviously cannot abolish stresses created by poverty, a brutal parent, or a querulous, senile relative in a small apartment. In such circumstances, the primary goal must be to help the patient change his environment or to tide him over until the environmental crisis resolves itself. Psychotherapy can help the patient to endure and cope with unmodifiable environmental pressures, however, by changing his stance toward them (Frankl, 1965). On the other hand, sources of demoralization that *are* modifiable by psychotherapy arise from the reversible results of early life experiences that lead to the acquisition of maladaptive behaviors, distorted perceptions of self or others, and stress-producing value systems. Having been created by symbolic communications, these sources of difficulty are alterable by the same means; hence are ideal targets for psychotherapy.

Adequate diagnosis must include not only the determination of the patient's accessibility to any form of psychotherapy, but also his relative accessibility to the particular kind of help-giver and procedure that would be most likely to gain his confidence and inspire his hopes. Most patients will accept a wide range of therapists, but sometimes a patient is accessible only to one with quite specific qualities. Au example is a man in his sixties who had lost his father in infancy and for twenty-five years sought periodic reassurance from a male psychiatrist older than himself, to assuage bouts of free-floating anxiety. After the death of this older man, an attempt to

substitute a psychiatrist younger than the patient failed, but an older one was again able to form a therapeutic relationship with him. With respect to the therapist's professional identification, some persons are most accessible to psychiatrists, others to psychologists, others to those who bear the imprimatur of various schools regardless of their academic qualifications, and still others to persons like themselves who have conquered similar difficulties. Thus addicts are often best helped by ex-addicts (Borenstein, 1971) and alcoholics by ex-alcoholics (Alcoholics Anonymous, 1953).

A related diagnostic question is: what conceptual scheme and procedure is most likely to increase the patient's sense of mastery or give him feelings of success? Are these feelings best provided by new insights, by the discovery that he can tolerate emotional states that he had feared, or by the discovery that he can change his behavior in ways that elicit more favorable responses from others? Is he seeking increased self-confidence, resolution of existential anxieties, a greater sense of personal integration, relief of a circumscribed symptom, or merely help in tiding himself over a transient period of strain? The patient mentioned immediately above, for example, controlled his anxiety for years through brief telephone conversations, often months apart, with the older psychiatrist; he definitely did not wish anything more. A patient's expectations and accessibilities depend on qualities such as psychological-mindedness as well as on his previous knowledge of psychotherapy (gained through reading or conversations with friends and

acquaintances) and the attitudes of his subculture (Kadushin, 1969). Psychotherapists in private practice can assume that many persons who appear before them are familiar with and predisposed to benefit by their concepts and methods. Since the choice of a therapist often involves an element of chance, however, the patient's familiarity with the therapeutic approach cannot always be taken for granted. Clinic patients, in particular, often have either no knowledge of psychotherapy or else gross misconceptions of it.

Preparation of Patients for Therapy

The psychotherapist himself is usually the main determinant of the accessibility of patients to his type of psychotherapy, and preparing them for his ministrations is a major purpose of the initial interview. In it the therapist obtains information needed to plan treatment, establishes his competence and credibility in the patient's eyes, describes the treatment plan, and elicits the patient's cooperation with it. To these ends he sounds out the patient's attitudes and expectations about psychotherapy, sometimes directly but more typically indirectly, by exploring the patient's explanation (or lack of it) for his complaints, his account of what led him to seek therapy at this particular juncture and the path by which he reached the therapist's office. If the patient has had previous therapy, the therapist seeks to determine in what respects it succeeded or failed, including why the patient did not return to his previous

therapist. In addition, although schools of therapy emphasize different aspects of the patient's functioning, all try in the initial interview to elicit information about past and present circumstances related to his complaints. From all this material the therapist arrives at a tentative formulation of the patient's problems and a program of treatment.

As a result of this exploration, the therapist should be prepared to entertain the possibility that a therapy in which he is not skilled might more closely accord with the patient's expectations and therefore have a greater likelihood of success. In such circumstances, the conscientious therapist will accept his limitations and refer the patient to someone he believes can be more helpful.

If, as typically occurs, the therapist accepts the patient, he may find it useful to spend some time and effort to align the patient's expectations with what he has to offer. Depending on the patient's sophistication, this may require discussion of the therapeutic rationale, but in any case it should include a description of the procedure, including frequency of visits, total duration, and hoped-for outcome (Hoehn-Saric, 1964; Orne, 1969). Since formulations of problems and expectations of outcome may both change in the course of treatment, it is well to re-examine these matters from time to time.

The Conduct of Therapy

The demoralization hypothesis does not prescribe any particular conceptualization or form of procedure for the conduct of psychotherapy. Rather it implies that a therapist should familiarize himself with a wide variety of approaches, master those that best suit his personal style and, within this range, choose the combinations that best fit the predilections of different patients. Since, as already mentioned, most conceptual schemes have more in common than their proponents recognize, it is not difficult to pick and choose features from different ones and weld them into a loose integration.

Thus, using the conceptual scheme outlined below, I can comfortably use nondirective interviewing, interpretation of dreams, relaxation exercises, covert aversive conditioning," and so on, without feeling confused or intellectually dishonest. According to this conceptualization, the patient's demoralization results from handicaps to successful coping that were created by inadequate awareness of his own motivations, distortions of his self-image, and unawareness or misinterpretation of the effects of his behavior on others. His symbolic communications with himself and others are disturbed. The aim of therapy is to expose and correct these disturbances through interventions that are mainly verbal. The therapeutic conversation aims to alleviate pathogenic emotional states and to offer the patient corrective experiences

and information. The therapist is the primary agent for the achievement of these aims, but he can often increase his effectiveness by including relevant others—strangers, in conventional group therapy, and members of the patient's family, in marital or family therapy. Such interaction systems more efficiently expose and correct the disturbances in the patient's communications, especially since these usually dovetail with disturbances in the communications of others.

A few of the implications of this view for the actual conduct of therapy follow.

The Therapist's Behavior

Except when the patient expects the therapist to be a "mirror," the therapist is most effective if he acts as a real person with whom the patient has a genuine encounter. This means, first of all, that he should not try to imitate a style that does not fit his own personality, since the patient will almost surely sense and be constrained by the artificiality. Accordingly, the therapist should not fear being spontaneous within wide limits, expressing pleasure, concern, sorrow, or even anger, admitting when he is sleepy or when he is uncertain as to what is going on, and the like. If humor is within his repertoire, it can be a great help in enabling the patient to achieve some detachment from his troubles, as long as the patient feels that the therapist is

laughing with him and not at him.

By being open with the patient, the therapist makes it easier for the patient to be open with him and also to use him as a model. While relying on spontaneity increases the likelihood of making errors, it is my experience that if the therapist has convinced the patient of the sincerity of his effort to be helpful, the patient will forgive and forget almost any stupidity he may commit. As an aspect of his regard for the patient as a person, the therapist should assume that the patient is potentially capable of handling his own problems once he has recognized the blocks to their solution or has been helped to change his behavior by more direct means. Over the long run the therapist therefore discourages the patient's dependency, although he may let it develop initially so that patient can borrow confidence from him. To this end he may offer to let the patient call him at home or to make an extra appointment on request. This tangible demonstration of concern is more convincing than any amount of statements to this effect. In my experience, very few patients avail themselves of the invitation. Those who do rarely repeat the action, since their real purpose was almost always to test if I really meant what I said.

The therapist's assumption that the patient is capable of managing his life is conveyed by being chary with advice. This does not preclude informing the patient about relevant matters on which he is ignorant or misinformed,

such as the relationship between psychic and bodily perturbations.

Along the same lines, the therapist should convey the expectation that therapy will be time-limited. Patients who seek therapy while in the throes of a transient crisis may need only one or two interviews to tide them over. The therapist must resist the temptation to turn them into candidates for longer therapy by dwelling on their personal weaknesses rather than their coping capacities and by underestimating the role of the immediate stress in their decompensation. This contributes to the patient's demoralization rather than combating it.

The assumption that therapy will be time-limited is an implicit vote of confidence in the patient and may also speed up the therapeutic process. Accordingly, early in the proceedings, it is well to discuss a possible date for termination, with the understanding that treatment may be extended beyond this date by mutual agreement. As termination approaches, it is sometimes useful to test the effect of reducing the frequency of interviews. Spacing them out, if handled properly, can enhance the patient's self-confidence.

The Facilitation of Communication

It is well for the therapist to keep in mind that the patient may not be able to communicate honestly and freely with him at first. Not only does he bring distorted ways of communicating characteristic of his daily life into the

interview, he will also be partly preoccupied with testing the therapist to determine how open he dares to be. The therapist's success in facilitating free communication depends primarily, of course, on his general ability to win the patient's trust and confidence, but attention to certain specific aspects of the situation that can hamper free communication may also sometimes be helpful.

For example, for most patients the face-to-face position is most natural, with the chairs arranged so that the patient or therapist can comfortably look away if either wishes to do so. Some patients, however, are able to communicate more easily when lying on a couch, with the therapist out of the direct line of vision. I have found this useful with patients who seem excessively alert to my facial expressions and guide themselves accordingly. Lying down also seems to ease the flow of thought in some patients by facilitating muscular relaxation.

Along the same lines, some patients at times communicate more easily through reports of dreams than direct accounts of events, perhaps because they have been led to believe that the therapist expects this, or because attributing feeling or attitude to a dream relieves the patient of full responsibility for it. An occasional patient may wish to rely on a diary or journal, to be read by the therapist between visits.

The therapist's skill in picking up and interpreting nonverbal cues accompanying the patient's words can significantly improve communication. These include communicative behaviors such as changes in voice tone, facial expressions, gestures, and bodily postures, as well as evidences of emotional tension that signal the importance of the topic under discussion. If the therapist learns that these evidences have no outward manifestation—for example, stomach pain—it may be useful to ask the patient to report when he experiences such a reaction. Since commenting on nonverbal communications may create considerable anxiety, especially when they are discrepant with verbal ones, the therapist, having noted them, sometimes reserves comment until he feels that the patient's trust is sufficiently strong to enable him to hear and use the information.

The Temporal Focus of the Interviews

Ordinarily therapy should focus on the patient's current life, for several reasons. The patient comes for therapy for help in resolving a present crisis, not past ones. He wants to talk about the here and now, and encouraging him to do so helps to establish rapport. From a theoretical standpoint, moreover, only forces operating in the present can be changed.

In this connection, attention to the patient's reaction to the therapist during the interview can be useful. For one thing, these are the only reactions

that the therapist can directly observe instead of having to rely exclusively on the patient's reports, which may be considerably distorted. For another, how the patient handles the interview may be a valid sample of his behavior in important confrontations of daily life, especially when (as is not uncommon) the therapist is a stand-in for other persons significant to the patient. Finally, the therapist can offer immediate feedback on his own reactions. For the patient this may illuminate reactions of other persons that had bewildered or upset him. This is most apt to happen when the patient is unaware of aspects of his communicative behavior that disturb others. In this connection, a useful therapeutic maneuver is to call the patient's attention to any discrepancy between his verbal and nonverbal communications—for example, pointing out that he says he is angry in a sweet tone of voice while smiling. Videotape playbacks, by sharply confronting the patient with the way in which he presents himself to others, can enhance this aspect of therapy.

Exploration of the patient's past history, however, is essential to a full understanding of his present situation. We screen objective events and react to them, not as they exist in the eye of God, but in terms of what they mean to us. As suggested earlier, the same objective event, such as the death of a close relative, may be experienced as a tragedy or a relief, depending on its meaning to the survivor (Frank, 1973). Since the meanings of present events are largely determined by past experiences, considerable review of the past may be needed to understand the patient's predicament today.

Review of the past can also serve to enhance rapport. A patient may be able to reveal embarrassing or anxiety-provoking features of his history before he can discuss their repercussions in his current life. That is, he may need to test the therapist's reactions to remote material before he can bring up immediate feelings. Finally, although the explanation remains unclear, the therapeutic value of abreaction in different guises cannot be gainsaid. Some patients clearly gain self-confidence and an increased sense of mastery by emotionally reliving traumatic early experiences while in the protective context of therapy.

Other Therapist Interventions

What the therapist actually does or says in the interview varies considerably depending on his conceptual scheme. However, a few observations on certain types of intervention that seem applicable to almost all forms of therapy seem in order.

Simply repeating what a patient has said, especially if the patient was hesitant to say it, indirectly conveys certain messages that facilitate therapeutic interaction. It shows that the therapist has heard the patient, understood him, and accepted his statement. This implicitly gives the patient permission to continue further along the same lines.

Interpretations that link feelings or behaviors not previously connected

by the patient may be therapeutic in several ways. The interpretation "You feel to your wife as you did to your mother," for example, may be supportive by demonstrating the therapist's competence and enabling the patient to make sense of feelings (in this case, toward his wife) that had been mysterious, thereby enhancing his sense of mastery. At the same time, since such an interpretation implies that the patient's current reactions are inappropriate, he may feel it as an attack. Inexperienced therapists, not appreciating this, may be thrown off by the patient's defensive or hostile response. Such a reaction, however, is not necessarily bad—in fact, it may create a useful emotional stir and open up new areas for exploration.

If at the end of an interview the therapist can single out a theme linking many of the patient's superficially unrelated comments, this is a powerful way of demonstrating his attentiveness and skill. It also enhances the patient's self-confidence by indicating that his thoughts and feelings were better integrated than he had realized.

Finally, it is well for the therapist always to keep in mind the importance of "accentuating the positive." Given a choice, he should take the optimist's view of the glass as half full rather than half empty. It is very easy to become absorbed in those aspects of the patient's life that are working badly; it is for these that he sought treatment in the first place, after all, and his demoralization leads him to dwell on them. This tendency may be

reinforced if the therapist focuses on evidences of illness rather than health. An example of the value of reinterpreting a bit of behavior as a sign of strength rather than weakness is afforded by an anxious, depressed night school student who started and then dropped a day course, on the grounds that it was too hard for her. As she went on to elaborate the reasons for her decision, it became clear that she was actually doing satisfactory work and probably could have continued to do so had she wished to expend the necessary time and effort. However, she found her daytime (as opposed to evening) classmates uncongenial, and the course was interfering with activities that were more rewarding. In short, she had dropped the course not because she had to but because she wanted to. Thus the act became evidence of her ability to make a sensible choice rather than a sign of failure. With this realization she experienced an immediate rise in morale.

Accentuation of the positive by no means implies that the therapist should offer superficial reassurance. This usually makes matters worse, by conveying to the patient that the therapist does not take him seriously or has failed to appreciate the gravity of his predicament. It is reassuring, however, to listen fully to the patient's worst misgivings without sharing them, and to seize every appropriate opportunity to remind the patient of what has been working well, or of his latent abilities that he is not using to full advantage.

In prolonged therapy, the patient's goal often seems to become more

ambitious as he improves. Because it keeps receding before him, he may feel he is making no progress. If the therapist senses this, a reminder of the patient's state when he first entered therapy and the gains he has made since then can be powerfully reassuring.

Bibliography

Abramson, H. A. *The Use of LSD in Psychotherapy and Alcoholism. Indianapolis*: Bobbs-M errill, 1967.

Adler, H. M. and V. B. O. Hammett. "Crisis, Conversion, and Cult Formation: An Examination of a Common Psychosocial Sequence." unpublished paper.

Agras, W. S., H. N. Chapin, and D. C. Oliveau. "The Natural History of a Phobia," *Arch. Gen. Psychiatry*, 26 (1972), 315-317-

Alcoholics Anonymous. *Alcoholics Anonymous: Twelve Steps and Twelve Traditions*. New York: Alcoholics Anonymous, 1953-

Borenstein, D. "The Relative Value of the Medical Staff versus Addicts in the Rehabilitation of the Drug Users in a Drug Abuse Program," *Johns Hopkins Med. J.*, 129 (1971), 290-297.

Caplan, G. "Emotional Crises," in A. Deutsch and H. Fishman, eds., *The Encyclopedia of Mental Health*, Vol. 2, pp. 521-532. New York: Franklin Watts, 1963.

Cautela, J. R. "Covert Conditioning," in A. Jacobs and L. B. Sachs, eds., *The Psychology of Private Events*, pp. 109-130. New York: Academic, 1971.

Davison, G. C. and S. J. Taffel. "Effects of Behavior Therapy." Paper presented at 80th Ann. Conv. Am. Psychol. Assoc., Honolulu, 1972.

Frank, J. D. "The Influence of Patients' and Therapists' Expectations on the Outcome of Psychotherapy," *Br. J. Med. Psychol.*, 41 (1968), 349-356.

----. Persuasion and Healing: A Comparative Study of Psychotherapy, 2nd ed. Baltimore: The Johns Hopkins Press, 1973.

Frankl, V. E. *The Doctor and the Soul: From Psychotherapy to Logotherapy*. New York: Knopf, 1965.

Gillis, J. S. and R. Jessor. "Effects of Brief Psychotherapy on Belief in Internal Control: An Exploratory Study," *Psychother. Theory Res. Pract.*, 7 (1970), 135-137.

Gurin, G., J. Veroff, and S. Feld. *Americans View Their Mental Health*. New York: Basic Books, 1960.

Halleck, S. L. *The Politics of Therapy*. New York: Science House, 1971.

Hobbs, N. "Sources of Gain in Psychotherapy," Am. Psychol., 17 (1962), 741-747.

Hoehn-Saric, R., J. D. Frank, and B. J. Gurland. "Focused Attitude Change in Neurotic Patients," *J. Nerv. Ment. Dis.*, 147 (1968), 124-133.

Hoehn-Saric, R., J. D. Frank, S. D. Imber et al. "Systematic Preparation of Patients for Psychotherapy: 1. Effects on Therapy Behavior and Outcome," *J. Psychiatr. Res.*, 2 (1964), 267-281.

Kadushin, C. *Why People Go To Psychiatrists*. New York: Atherton, 1969.

Katz, M. M. "The Classification of Depression," in R. R. Fieve, ed., *Depression in the 1970's*, pp. 31-40. Amsterdam: Excerpta Medica Foundation, 1971.

Kellner, R. and B. F. Sheffield. "The One-Week Prevalence of Symptoms in Neurotic Patients and Normals," *Am. J. Psychiatry*, 130 (1973), 102-105.

Kernberg, O. F., E. D. Burnstein, L. Coyne et al. "Psychotherapy and Psychoanalysis: Final Report of the Menninger Foundation's Psychotherapy Research Project," *Bull. Menninger Clin.*, 36 (1972), entire issue.

Laing, R. D. *The Politics of Experience*. New York: Pantheon, 1967.

Lesse, S. "Psychodynamic Relationships between the Degree of Anxiety and Other Clinical

Symptoms," *J. Nerv. Ment. Dis.*, 117 (1958), 124-130.

Liberman, B. L., J. D. Frank, R. Hoehn-Saric et al. "Patterns of Change in Treated Psychoneurotic Patients: A Five-Year Follow-up Investigation of the Systematic Preparation of Patients for Psychotherapy," *J. Consult. Clin. Psychol.*, 38 (1972), 36-41.

Liberman, B. L., S. D. Imber, A. R. Stone et al. "Mastery: Prescriptive Treatment and Continued Change in Psychotherapy," (in preparation.)

Loeb, A., A. T. Beck, and J. Diggory. "Differential Effects of Success and Failure on Depressed and Nondepressed Patients," *J. Nerv. Ment. Dis.*, 152 (1971), 106-114.

Lorr, M., D. M. McNair, W. W. Michaux et al. "Frequency of Treatment and Change in Psychotherapy," *J. Abnorm. Soc. Psychol.*, 64 (1962), 281-292.

Luborsky, L. and A. A. Auerbach. "The Symptom-Context Method: Quantitative Studies of Symptom Formation in Psychotherapy," *J. Am. Psychoanal. Assoc.*, 17 (1969), 68-99.

Luborsky, L., A. H. Auerbach, M. Chandler et al. "Factors Influencing the Outcome of Psychotherapy," *Psychol. Bull.*, 73 (1971), 145-185.

Malan, D. H. *A Study of Brief Psychotherapy*. Springfield, Ill.: Charles C. Thomas, 1963.

May, P. R. A. "The Hospital Treatment of the Schizophrenic Patient," *Int. J. Psychiatry*, 8 (1969), 699-722.

Orne, M. T. and P. H. Wender. "Anticipatory Socialization for Psychotherapy: Method and Rationale," *Am. J. Psychiatry*, 124 (1968), 1202-1211.

Pande, S. K. "The Mystique of 'Western' Psychotherapy: An Eastern Interpretation," *J. Nerv. Merit. Dis.*, 146 (1968), 425-432.

Rusk, T. N. "Opportunity and Technique in Crisis Psychiatry," *Compr. Psychiatry*, 12 (1971), 249-263.

Smith, R. E. "Changes in Locus of Control as a Function of Life Crisis Resolution," *J. Abnorm.*

Psychol., 75 (1970), 328-332.

Srole, L., T. S. Langer, S. T. Michael et al. *Mental Health in the Metropolis: The Midtown Manhattan* Study. New York: McGraw-Hill, 1962.

Stevenson, I. "Processes of 'Spontaneous' Recovery from the Psychoneuroses," *Am. J. Psychiatry*, 117 (1961), 1057-1064.

Stone, A. R., J. D. Frank, E. H. Nash et al. "An Intensive Five-Year Follow-up Study of Treated Psychiatric Outpatients," *J. Nerv. Ment. Dis*., 133 (1961), 410-422.

Torrey, E. F. *The Mind Game: Witchdoctors and Psychiatrists*. New York: Emerson Hall, 1972.

Truax, C. B. and R. R. Carkhuff. *Toward Effective Counselling and Psychotherapy: Training and Practice*. Chicago: Aldine, 1967.

Vaillant, G. E. "Why Men Seek Psychotherapy: 1. Results of a Survey of College Graduates," *Am. J. Psychiatry*, 129 (1972), 645-651.

Whitehorn, J. C. "Guide to Interviewing and Clinical Personality Study," *Arch. Neurol. Psychiatry*, 52 (1944), 197-216.

----. "Studies of the Doctor as a Crucial Factor in the Prognosis of Schizophrenic Patients," *Int. J. Soc. Psychiatry*, 6 (1960), 71-77.

Whitehorn, J. C. and B. J. Betz. "A Study of Psychotherapeutic Relationships between Physicians and Schizophrenic Patients," *Am. J. Psychiatry*, 111 (1954), 321-331.