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CHANCE AND DESIGN IN PSYCHOTHERAPY*

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THE purpose of psychotherapy does not differ essentially from that of the treatment of sickness generally. It is to relieve distress and promote efficiency of mind while improving the patient's adaptation to the group in which he lives, to their mutual benefit. Before psychotherapy can be prescribed or undertaken, a diagnostic review is necessary of the relationship between the patient's psychophysical constitution and the stresses to which he has been and is being exposed. This relationship is a complex one which involves the effects of previous stresses and the way in which they have been surmounted or have left their mark. The introduction of a third complex entity, the method and personality of the therapist, renders the total situation too involved for detailed comprehension and logical analysis, especially if the therapy is to be of the causal-anamnestic or comprehensive kind which is not content simply to deal with symptoms and their immediate causes. In the presence of this degree of complexity—well beyond the range of mental encompassment by one mind at one time—the psychotherapist must walk in humility, for he can rarely feel justified in thinking that he knows exactly what is going on.

Psychotherapy cannot, therefore, be compared to the treatment of a physical disorder where the pathology is well understood and where a single agent can remedy the fault with a minimum of side-effects. This does not reduce its practical usefulness. Even if the statistical examination of large groups has blurred the clarity of its individual successes, there is no doubt that many patients benefit from psychotherapy. It is, on the other hand, a form of treatment which may have side-effects and is not without complications. To be a psychotherapist, optimism is needed as well as skill, and pre-occupation with possible side-effects and complications is not so easy for the optimist. This is not to say that they are to be ignored.

The operation of spontaneous healing, the *vis medicatrix naturae*, is not confined to physical disease. The passage of time and the effect of a benevolent relationship with another human being conduce to improvement more often

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than not in neurosis, so that psychotherapists are not infrequently confronted with a patient who has recovered for reasons unknown to them. The temptation to rationalize in favour of their own chosen method is great.

A psychotherapist, if he assumes that some kinds of psychotherapy at least are worthwhile and at the same time realizes that a detailed knowledge of the whole constitution *vs.* environment situation is out of the question, can approach the problem of complexity in a number of ways.

1. He can limit the field of operations. An example of this would be to confine himself to the removal of a symptom by conditioned reflex methods. Restriction takes place also where one major field of activity is explored in detail on the assumption that a change in attitudes in this field will be carried over into other attitudes to life. The analysis of an inferiority situation or a transference analysis are wider examples of this approach.

2. He can adopt a mathematical attitude to complexity, i.e. he can look for generalizations which are mainly true and base his therapy on these. The human brain is particularly suited to this exercise, although it does not operate at a high level of efficiency. It can arrive at valuable generalizations at the expense of a certain number of errors. When the consideration of a situation rich in detail reaches a certain level of involvement, a form of unconscious statistical thinking comes into play, but the individual is now no longer able to know how he arrives at the result and the operation achieves the status of an act of intuition. A great many creative discoveries can be traced to acts of intuition where the thinker has accepted the duty of checking his hunches against the facts of observation. Psychotherapy benefits from an intuitive approach, provided that, to reduce the possibility of false intuitions and wrong interpretations, the therapist does his best to test his conclusions against the realities of the situation. If this reveals that they fail by the only possible standard, i.e. if they are not likely to help the patient, it is his duty to emulate the scientist, scrap his first conclusions and try again.

3. While the classical mechanisms of psychopathology may be easy enough to understand, the genesis of any given psychoneurosis is determined by a large number of factors peculiar to the individual. One way of overcoming this difficulty is to assume a certain degree of psychopathological uniformity and to develop a single working hypothesis which is likely to apply to as many individuals as possible. It is this approach which has led to the theories of the different schools and their variations. The danger here is that of an exclusivism which ignores the exceptions. The psychotherapist who is rigidly attached to one approach is, however, fortunate in that if a patient is going to recover, such is the catholicity of the human mind that he will often do so as well with one system of psychopathology as another.

4. The fourth method is for the therapist to abandon the attempt to understand what is going on and to believe that an undirected analytical review by the patient of his life and attitudes can do nothing but good. His aim will be to intervene as little as possible. One can only say of this approach that it takes a great deal of time and that in the event the theories of the analyst usually become communicated to the patient at some stage. If, in fact, the therapy were entirely non-directive, the work of the analyst could only be regarded as unskilled.

The Planning of Psychotherapy

It will thus be seen that in planning the psychotherapy of any one patient one may adopt anything from a relatively rigid scheme to an entirely free

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relationship and that the therapist can play a strongly positive or an almost negative role. If insight is to be the objective, it is necessary to point out that it must be the patient's insight. It may be that the ideal of insight is overstressed by psychotherapists. Few people have very clear insight into the motives of their daily behaviour and yet they are able to achieve a satisfactory adaptation. If recovery with insight is preferable on theoretical grounds, a recovery without full insight may be equally satisfactory provided that it achieves the practical objectives of psychotherapy. Psychotherapy is for the relief of the patient's sickness, not the satisfaction of the therapist or the vindication of his theory. If ideal results cannot be achieved, the patient can at least be brought within range of full recovery. The general aims of psychological treatment may be summarized as follows:

TABLE I

The Objects of Psychotherapy

Relief of mental tension and its consequences.
Removal of functional disabilities.
More efficient use of mental potentialities.
Independence, especially to solve own problems.
Improved adaptation to circumstances.
Insight, if this helps to prevent relapse.
Increased capacity for responsibility.
Induction of a hopeful and positive attitude to problems.
Creation of a reserve to meet future stresses.

The course of treatment must be constantly under review in the light of its progress towards these objectives. Psychotherapy must also conform to a basic principle of all treatment, that of *primum non nocere*, i.e. that care must be taken to avoid doing harm by the induction of side-effects in the form of irrelevant activities or attitudes which may be a handicap to the patient's general adaptation. To this extent at least, design is necessary, for one does not wish to leave the future of a human mind to chance any more than one would a human life.

CHOICE OF METHOD

A necessary preliminary to psychotherapy is the matching of the type of illness in the kind of person with the available kinds of therapy and of therapists. The main kinds of psychotherapy may be arranged for convenience on an arbitrary scale according to the extent to which they are imposed upon the patient, or the patient himself solves his problem through his own efforts and insight. The scale *Symptomatic-Comprehensive* approximates to this.

TABLE II

Methods of Psychological Treatment
(Arranged as a scale)

Brief and Symptomatic

Legal or other sanctions.	
Reproof, moral lecture.	Imposed therapy
Direct suggestion.	
Suggestion with vehicle.	
Hypnotic suggestion.	
Reassurance.	
Advice and counselling.	Reconstructive counselling
Supportive supervision.	
Re-education.	

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TABLE II—*continued.*

Rehabilitation.	Conditioning and rehabilitation
Resocialization.	
Conditioned aversion.	
Other C-R methods.	
Therapeutic scrutiny.	Anamnesis and abreaction
Abreactive techniques.	
Narcosynthesis.	
Free group discussion.	Review and re-synthesis
Play, art and other media.	
Didactic group therapy.	
Persuasion technique.	
Distributive analysis (Meyer).	
Interpretative analysis.	Personal reorientation
Shorter methods of analysis.	
Free-association analysis.	
Logical analysis.	

Comprehensive and Analytic

Once the general method has been decided upon, it is possible to think of differences of emphasis within the technique used. Some of these are here given in the form of paired descriptive terms which are more or less opposite.

TABLE III

Polarities in Psychotherapy

Imposed	Analytic, anamnestic
Logical, persuasive	Cathartic, intuitive
Direct	Projective
Ego-analysis	Transference analysis
Individual	Group therapy
Specified goals	Generalized
Symptomatic, supportive	Depth and character analysis
Insight therapy	Affect therapy
Interpretative	Free
Integrated with non-semantic methods	Isolated
Social adaptation emphasis	Patient-centred
Advice and direction	Non-directive
Causal	Purposive
At work	In-patient regime

A central decision which has always to be made is whether it will be sufficient to deal mainly with a previously selected (and partially isolated) aspect of the personality in which the maladaptation appears mainly to lie. The difference between the shorter and more restricted methods and those which are more comprehensive where the personality is concerned is not of degree but of kind so that, after diagnostic exploration, a definite choice has usually to be made. If it is not made, the therapist may well be embarking on his task with no clear idea as to method or objective. In making this decision the general characteristics of the "shorter" and "depth" methods of individual psychotherapy have to be considered in relation to the patient's needs. They are given in the form of a table (Table IV, page 5).

While diagnosis in the sense of providing a label for a morbid state has only a restricted application to psychoneurotic breakdown, it is usually possible after the initial examination to produce a provisional formulation which allows of a rough classification of the illness in terms of those conditions known to respond to psychological treatment and those which have been found to make

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TABLE IV

Comparison of Symptomatic and Comprehensive Methods of Psychotherapy

Shorter Methods	"Depth" Methods
Limited aim of relieving presenting symptoms and their immediate causes with return to a relatively unmodified way of life.	Aim is to change basic attitudes rather than present symptoms. May lead to major alterations in relations with environment and with other people.
Main concern with the "here and now" problems and the immediate fears, conflicts and frustrations which underlie symptoms.	Causal-anamnestic approach at outset followed by analysis in accordance with one of the orthodox methods.
Insight may be superficial or limited to fields of immediate relevance.	Aims at a high degree of general self-insight as to causes and goals.
Effects on symptoms may be dramatic—on attitudes minimal.	Stable new attitudes evolved, the effect on symptoms being incidental.
Therapist may adopt dominant role, controlling the direction of the therapy, interpreting and using suggestion.	Therapist may accept changing relationship with patient but mobilizes the latter's own resources to solve his problems for himself.
Patient need not be capable of understanding finer points or of considering abstract matters.	Patient must be capable of some abstract thought and have the drive necessary for self-examination.
May be used in the presence of constitutional defect or organic nervous disease.	Not indicated in psychopathy, low intelligence or progressive organic nervous disease.
May be combined with physical treatment, rehabilitation methods and group activities.	Is essentially personal, individual and psychological. Difficult to integrate with other approaches.
Danger of superficial recovery, false insight, pointless abreaction and relapse with new symptoms.	Carries danger of egocentricity, morbid introversion and unresolved transference.
May be combined with appraisal of social circumstances and advice on adjustment of environment, employment, etc.	Changes in his circumstances may be made by the patient as the result of new attitudes.
Economical in time. Less disturbance of usual way of life.	Time-consuming. Life must be to some extent oriented about treatment.

little lasting response. The following list of psychiatric disorders begins with those which are likely to recover even with relatively inept treatment and ends with conditions in which psychotherapy has been said to benefit but in which it has not been found possible to prove that this is so.

TABLE V

Conditions Benefited by Psychotherapy

(In descending order of response to treatment)

Panic, amnesia and other psychological escape mechanisms.
Functional disabilities—hysteria.
Recent tension and anxiety.
Reactive anger, despair and protest.
Inefficient attitudes to physical illness.
Organ neuroses.
Psychosomatic disorders of recent origin.
Inefficient adaptation to depression and decline.
Disorders of habit—addictions. Economic barrier.

Depression and hypochondriasis.
Obsessions and impulses.
Ingrained disorders of character.
Major psychoses, including schizophrenia.

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Psychotherapy can be attempted with almost any patient with whom it is possible to communicate, verbally or otherwise. On the other hand, the number of experienced psychotherapists is quite small and in a health service at least it is desirable that they be employed in such a way that as much good shall be done to as many patients as possible. At a certain point in the list above, therefore, a line must be drawn below which therapy is likely to be uneconomic. Of the patients chosen for individual psychotherapy, those at the top of the list might qualify almost automatically and those further down should be considered on their merits with special reference to whether group methods or non-semantic treatment may do as well or nearly as well. Psychotherapy will necessarily be favoured in those conditions in which other methods of treatment are inapplicable. In the following groups wholly physical treatment alone has little more than symptomatic aid to offer.

TABLE VI

Conditions in Which Psychotherapy is More Efficient than Other Methods

Organ neuroses (effort syndrome, mucous colitis, gastric neurosis, etc.)
Anxiety of very recent origin.
Recent hysteria with evidence of anxiety.
Isolated obsessions in children.
Conditioned neuroses (fainting on injections, etc.).
Minor addiction in sound personalities.

There are certain other psychoneuroses in which, although psychotherapy is often attempted and in which it may comfort and support and although material of psychopathological interest is often elicited in profusion, the practical results of intensive and detailed psychotherapy are disappointing. It has taken a great deal of wasted time to come to the conclusion that comprehensive therapy in the following is likely to be uneconomic:

TABLE VII

Conditions Giving Disappointing Results with Comprehensive Psychotherapy

Multiple obsessions and compulsions.
Chronic phobic anxiety.
Adult homosexuality.
Chronic and degenerative hysteria.
Severe stammering.
Endogenous depression.

That these conditions are not altogether relieved and often not even improved by psychoanalysis and comparable methods has gradually become clear and it is the inclusion of patients with these disorders which has probably influenced the statistical studies of the results of long-term psychotherapy so that its major successes are lost to sight. That these conditions do not respond to the point of complete relief does not mean that they are not helped, but it is probable that symptomatic methods may actually help them more with less expenditure of time. By contrast, constitutional loading, psychopathic personality or chronic organic nervous disease, although they are contra-indications to comprehensive methods, may even make a response to shorter methods more likely. The objection usually raised, i.e. that the symptoms may return, is only valid if they return at once. Follow-up studies in chronic hysteria, for instance, suggest that two or three episodes of brief psychotherapy in a 20-year period are a small price to pay for a reasonably independent adjustment to life in a constitutionally vulnerable individual.

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Apart from giving weight to general evidence of psychopathic personality or severe constitutional vulnerability, it is important when deciding on the appropriate treatment for a psychoneurosis, to determine whether the symptoms are due to an isolated maladjustment or whether they are based on a more generalized state of psychoneurotic maladaptation. In making this decision the following general features found in those predisposed to or habituated to psychoneurotic breakdown form a sort of recognizable neurotic constitution.

TABLE VIII

General Features of the Neurotic Response

Failure to remain efficient under stress.
Presence of persistent tension or anxiety or of their somatic effects—or of detachment.
Exaggeration and facilitation of psychological defence-mechanisms.
Loss of ability to give priority to problems according to extent to which they threaten integrity of the psyche.
Failure to pay attention to unwelcome information from without and within.
Inability to decide firmly on conflicting issues. Uncertain or unrealistic goals.
Disproportionate emotional responses. Facility in rationalization.
Inability to cast off past attitudes and accept maturation or changed conditions. Return to childish attitudes.
Unhappiness, sense of fatigue. Discontent easily aroused.
Lowered adaptive efficiency due to anxiety, fear for the future, dissociative states, functional disabilities, despair, self-preoccupation, dependence and invalidism.
Egocentricity at the expense of responsibility.

Once a therapeutic situation has been established, improvement may come about for a variety of reasons. Except in a very strictly planned attack on limited symptoms, the therapist cannot hope to be in control of every possible favourable influence. He can, however, be ready to press an advantage which chance and his relationship with the patient make for him. All therapy must thus be to some extent opportunist. A number of factors which may bring about unplanned improvement may be mentioned at this point.

TABLE IX

Factors Which May Bring About Unplanned Improvement

Incidental reassurance that the illness is not unique and that the therapist thinks it worth treating.
Effects of formulating the problem in order to communicate it.
Acceptance of explanations which are inaccurate but which serve as working hypotheses.
Provision of immediate goals which divert the patient from his stress-producing situation.
Endogenous mood-change.
Solution of minor conflicts which unconsciously change attitude to major ones.
Effects of the discipline of the regular session and any regime prescribed with it.
Recall of false memories with beneficial catharsis.
Training in an attitude of anamnestic self-enquiry which allows the patient to solve his own problem.

If all incidental effects were beneficial, the only purpose of planning would be to reduce the time taken, i.e. to make psychotherapy more efficient and economical. Unfortunately there are complications which may leave the patient worse off from the point of view of personal and social adaptation than when he started.

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TABLE X

Complications to be Avoided in Psychotherapy

Unresolved transference.
Habitual catharsis.
False insight and paranoid reaction.
Excessive dependence. Psychological invalidism.
Use of therapy as escape, or as excuse.
Precipitation of psychosis.

In the course of treatment it is inevitable that a variety of changes in attitude and in the mental mechanisms used will make their appearance. These will arise partly in the maladjustment itself and partly from the patient's response to the therapeutic situation. It is advisable, if he is to understand these changes, for the therapist to observe and record at successive stages, events such as the following so that he can adjust his own role accordingly in the light of his objectives:

TABLE XI

Changes in Attitude in the Course of Psychotherapy

Positive and negative transference.
Suggestibility and negativism.
Independence—demands for advice.
Periods of rationalization and demands for explanation.
Selective inattention and evasion of central issues.
Phases of apathy. Cathartic phases.
Conversion of anxiety—crises of anxiety.
Variations in the presenting symptoms.
Use of therapy as an escape from conflict.

It is necessary to bear in mind any possible side-effects of psychotherapy which may reduce the usefulness of treatment when its results are considered simply in terms of adaptation. They will influence the decision as to when the patient has got all he can usefully get out of the treatment. The fact that the patient comes to like the therapeutic session or that it becomes a part of his established routine, or that further treatment may lead to a psychopathologically more satisfactory insight are not sound reasons for continuing treatment. In fact, it is often difficult to know when to stop or to reduce the frequency of the treatment sessions. "Side-effects" to be taken into consideration include:

TABLE XII

Side-Effects of Psychotherapy

Loss of working time—postponement of decisions about employment, moves, etc.
Excessive dependence on the therapist or on the system of explanation he uses.
Habitual egocentric self-analysis.
Addiction to psychotherapy and lack of an alternative audience.
Financial effects of treatment.
An excessively high ideal of what personal adjustment should be.
Diversion of energy from duty into analysis.
Permanent acceptance of tendentious explanations.
Becoming a "psychotherapy bore" who interprets other people's actions.
Conversion to a school of thought as a substitute for religion, with proselytizing tendencies and determination to become a lay therapist.

THE PLANNING OF RESTRICTED TECHNIQUES

Certain psychotherapeutic operations are particularly suitable for planning in advance. Even if the disability to be treated is related to a defect of the

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total personality, the dissociated treatment of single symptom-groups may still be well worthwhile. Treatment by direct suggestion under hypnosis, for instance, may allow a patient to return to work which itself has a beneficial effect on his general adaptation. In general medicine or surgery, treatment is often given which will not cure the patient but which will allow him to make the best use of reduced resources. This is comparable to symptomatic and supportive psychotherapy given to those known to be constitutionally handicapped. Some examples of simple and restricted psychotherapy which can be planned in advance will now be given. They are from my own cases.

1. *Simple Conditioned Neuroses*

These have included such conditions as fainting at the sight of blood, "drying up" in public speakers and vomiting in public vehicles. The example to be given, one of fainting when given injections, illustrates the method used. The process of conditioned extinction was in this case much more thorough than usual owing to the failure of previous treatment. In a suitable subject, a quicker method might have been to give injections under hypnosis, the conditioned extinction method being reinforced by direct and post-hypnotic suggestion. It is worthy of note that tics and compulsive utterances which appear only in special situations appear to recover on this regime in spite of the presence of an underlying cause in central nervous disease which may reveal itself later in other ways.

TABLE XIII

Simple Conditioned Neurosis

Example: Fainting when given injections

I.

Non-Semantic Therapy. (Unabbreviated.):

Session I:		
Patient lying down	After	40 minutes swab skin
50 mg. chlorpromazine		50 minutes inject 1 c.c. saline
4 gr. sodium amytal		70 minutes inject 1 c.c. saline
		90 minutes inject 1 c.c. saline
Session II:		
25 mg. chlorpromazine		40 minutes inject 1 c.c. saline
3 gr. sodium amytal		80 minutes smell ether and meth.—inject 1 c.c
		120 minutes smell ether and meth.—inject 1 c.c.
		150 minutes smell ether and meth.—inject 1 c.c.
Session III:		
10 mg. chlorpromazine		10 minutes smell ether and meth.
1 gr. sodium amytal		20 minutes inject 1 c.c. saline
		60 minutes inject 1 c.c. saline
		120 minutes inject 1 c.c. saline
Session IV:		
Placebo I		20 minutes inject 1 c.c. saline
Placebo II		60 minutes inject 1 c.c. saline
		120 minutes inject 1 c.c. saline
Session V:		
Lies down		20 minutes inject 1 c.c. saline
No drugs		120 minutes inject 1 c.c. saline
		180 minutes smell ether and meth.
Session VI:		
Lies down		At once inject 1 c.c. meth.
Stands up	After	10 minutes inject 1 c.c. meth.
Comes up to trolley		10 minutes smell ether and meth.
Imagines TAB injection		10 minutes inject 1 c.c. saline slowly
		10 minutes inject 4 c.c. saline slowly

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TABLE XIII—*continued.*

Session VII:
Injection TAB 0·5 c.c.

Two weeks later:
Injection TAB 1 c.c.
Tetanus toxoid

Time taken, three weeks.

The patient was a man of 26 in good health who had fainted when given injections since the age of 13, when a course given for hay fever had to be abandoned. The patient's sister also had a great fear of injections and was terrified when given them for hay fever. The patient had witnessed this and had then felt faint. He himself feared that he was unconsciously avoiding foreign travel by this means, a view which had been accepted by a psychotherapist to whom he was referred. He was in fact very hesitant to leave his home. After some months of treatment an attempt at innoculation was made. He once more fainted and, shortly after, treatment was abandoned. He clearly had little faith in psychotherapy and for this reason conditioned extinction was carried out very gradually. On completion there appeared to be no residual anxiety or other reason for further treatment. After three years he is well, yellow fever inoculation and vaccination had been carried out and he has travelled a great deal, mainly by air.

In this case the detail is given in full. It is, however, possible in the interests of generalization to represent the aetiology of a simple neurosis and the principle used in its treatment in diagrammatic form. A case of diarrhoea occurring in church in a child will serve as an example.

TABLE XIV

Simple Conditioned Neurosis

II. CHURCH DIARRHOEA:

Aetiology:

1. Anxiety expressed in vulnerable organ.

   Bowel —→ Diarrhoea.

2. Anxiety (unconditioned) + Church (conditioned) —→ Diarrhoea

   Leads to:

   Church —→ Diarrhoea

Treatment (by extinction):

1. Different Church —→ No bowel response (with sedative)

   Repeat with diminishing sedative

2. Leads to:

   Church —→ No bowel response (deconditioned stimulus)

2. *Organ Neuroses*

An outstanding example of the planned treatment of an organ neurosis is the large-scale management of Effort Syndrome which took place after a re-appraisal of the aetiology of this condition in military conditions in 1940. Neglecting its individual variations, the psychogenesis as it occurred in new conscripts can be represented by the following schema.

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TABLE XV

Aetiology of an Organ Neurosis

EFFORT SYNDROME IN RECENT CONSCRIPTS:

Background Conditions:

Protected previous environment.
Poor effort tolerance and fitness.
Anxiety mainly felt in c.v. system.
(Heart is constitutionally vulnerable organ.)
Previous attention drawn to heart
(e.g. murmur, or rheumatic pains in childhood).

Recent Predisposing Causes:

Anxiety and loss of sleep in barracks.
Call for unaccustomed effort.
Fear of humiliation, punishment, overstrain.

Conditioning Process:

Command to "Double"

(A) *Anxiety Response*	(B) *Effort Intolerance*
Cardiac acceleration	Cardiac acceleration
Air hunger—distress	Dyspnoea
Praecordial constriction	Distress
Palpitation	Palpitation

Established Condition:

Effort produces combined syndrome (A+B)
Patient then worries about his heart
Symptoms perpetuated by secondary gain.

On this basis the syndrome, which was remarkably uniform in a very large number of troops, could be dealt with by means of a regime which combined conditioned inhibition with rehabilitation. Essentially the process was as follows:

TABLE XVI

Treatment of an Organ Neurosis

EFFORT SYNDROME:

1. Counteract Secondary Effects:

   (*a*) Reassurance, without reservations.
   Single, final cardiac examination.

   (*b*) Discourage secondary gain
   Explain condition is always treatable.
   Assure that discharge from service is not considered in any circumstances.

2. Transfer to Special Unit:
   Eliminate conditional stimuli:
   At first: no sudden commands.
   Reasonable comfort. No injustice.
   Regular life but no sudden efforts.

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TABLE XVI—*continued.*

Extinguish conditioned response:

(*a*) Non-reinforcement:
Minor but increasing effort in recreational conditions. Increase of effort without commands. Re-training and testing effort response.

(*b*) Conditioned Inhibition:
Introduce commands when effort response is normal. Test with violent commands.

3. Re-train.

Once improvement had been produced, as it was in the majority, it was possible to decide, on individual constitutional differences, which soldiers were capable of giving full service and which could be exposed only to limited strain. Although in civilian practice cardiac neurosis is often associated with cardiac disease, especially after small coronary thromboses, treatment on the same lines is often remarkably successful provided that the cardiologist is willing to recommend graduated exercise without making over-cautious reservations. The principle that the remaining cardiac muscle must be kept in optimal condition is put to the patient.

Another organ neurosis, mucous colitis, has, in my own experience, rather surprisingly shown a considerable uniformity, the scheme below being a composite from seven cases in the course of six years.

TABLE XVII

Organ Neurosis

II. Mucous Colitis in a spinster of about 40.

Aetiology:

1. Since childhood, bowel active when anxious. (Bowel is vulnerable organ.) History of gain (absence from school, evasion of homework) from diarrhoea.
2. History reveals time-relations of onset and of exacerbations.
   Current stresses include affair with married man.
   1. This delays possibility of marriage.
   2. It is likely that he will tire of it, but he is too considerate to say so.
   Life as spinster would be less exacting than present situation.

A state of conflict has been set up:

3. Meeting with man causes anxiety—and diarrhoea.
   This prevents intercourse. (She feels it may disgust him, so that he will leave her and solve the problem.)
4. General anxiety and colitis increase as no decision is made.

Treatment:

1. Bring conflict to light—anxiety increases.
2. Patient shows catharsis and is convinced of relevance of conflict.
3. Further discussion shows origin of symptom.
4. Patient decides to leave man.
5. Period of vacillation with generalized anxiety.
6. She discusses it with man—he is only continuing out of sympathy.
7. Alternative interests discussed—recovery.

A number of other psychoneurotic disabilities are sufficiently uniform in general aetiology and manifestation to allow of an approach on lines which are mainly predictable. By way of example, a more generalized scheme will be given which is based on the treatment of a number of recent anxiety states in patients under 30.

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TABLE XVIII

Simple Anxiety State of Recent Origin

Aetiology:

Predisposing Causes:

Constitutional predisposition to anxiety (with physical over-reaction to stress).
Previous pathological anxiety.
Standing conflicts, frustrations, fears.
Difficulty in making decisions.

Precipitating Causes:

1. Conflict: with no obvious solution.
   with no satisfactory solution.
2. Rising tension aimed at bringing about a rapid decision and failing to do so.

Result:

A pathological tension-response to unsolved conflict.
Selective inattention to and retreat from conflict (with or without conversion) so that causes are not fully recognized.

Treatment:

(*a*) Withdrawal from immediate environment to allow full concentration on treatment. Give task which allows of consideration between sessions.
(*b*) Anamnestic approach—circumventing evasions and defence mechanisms:
   1. Conflict becomes evident.
      Anxiety increased—with some catharsis.
(*c*) Help patient to mobilize issues involved until grounds for decision are plain. Encourage decision, but do not advise.
(*d*) Discuss implications of decision (i.e. reality test). False decisions necessitate re-examination. When symptoms improve, encourage to think ahead and emerge with clear goals.
(*e*) Return to former environment. Retrospective discussion to ensure insight. Supervise until patient able to deal with problems as they occur.

The examples given will serve to illustrate the view that therapy restricted to the areas or complexes which have been the immediate cause of a psychoneurosis can be planned within the limits of individual variation, provided that therapy is preceded by a clear diagnostic formulation and general plan of treatment. There are, of course, many psychoneuroses which require a prolonged diagnostic investigation in which opportunities for helping the patient will arise and must be taken. In recent psychoneuroses time is usually on the side of patient and therapist alike and considerable economy in effort can be made and some danger of doing harm can be avoided by working to a general plan. In recent anxiety, treatment is urgent if the development of the less reversible features of chronic anxiety is to be avoided. Keeping the patient to the point lowers the incidence of conversion episodes. Such treatment requires considerable alertness and clarity of aim in the therapist. He must above all develop a knowledge of when to leave well alone.

When suggestion is the main instrument in treatment and the part played by the patient is passive and guided, it follows that the technique to be used can be worked out in detail beforehand. Since the effect of suggestion depends not only on the ideas conveyed to the patient but also in the patient's own conception of their meaning, misunderstanding is avoided if the suggestions are made unambiguously and in a definite order. If hypnosis is used it is often wise to write out the plan to be used in advance lest incidental phenomena of the trance-state such as spontaneous catharsis, amnesia or hyperventilation

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interfere with the intended course of treatment. When several suggestions are made at different sessions it is essential to keep a written record lest they prove contradictory in the mind of the patient. The process by which the success of one suggestion enhances the effectiveness of the next depends to a great extent on the avoidance of unintended effects.

The Significance of Mood

Of all the factors which introduce an element of chance into psychological treatment, changes in mood are probably the most important. The majority of patients suffering from psychoneurotic breakdown are subject to changes of mood of a significant degree while endogenous depression is perhaps the commonest of all psychiatric disabilities. Further, endogenous mood-change may make the difference to whether a given psychophysical constitution can adapt itself successfully to the stress it encounters. A considerable number of patients presenting themselves with symptoms of recent anxiety or hysteria have been dealing successfully with fears, conflicts and frustrations until a mood-change in the direction of depression renders their burden insupportable. While mood change is very often reactive, it may also vary with the metabolic state. Depression may be induced by infective states or by the drugs used to treat them or they may spring from endogenous causes at present little understood. Contact with patients in the professions whose lives are made difficult by manic-depressive variations of moderate degree indicates that in some the first depression has often precipitated an illness with psychoneurotic features which has been subjected to psychoanalytic treatment. In some of these no progress has been made for several months after which there has been a sudden improvement. As one Civil Engineer said, "I suppose it was the cumulative effect of the analysis which I admit I thought was getting me nowhere—I suddenly found the ability to examine and solve my own problems and I just got better." His subsequent history makes it extremely probable that his depression just came to an end and the analysis got the credit. Another patient, a lawyer in whom nearly four years of analysis was terminated by a classical attack of hypomania, said "The attempt at analysis in my depressed periods was a long-continued torture in which I dragged the depths of my mind for more and more sources of guilt-feelings—we made no progress as salt was steadily rubbed into my wounds." The sadness of these therapeutic efforts, in this case, lay not only in their lack of success, but in their economic consequences for the patient and their sheer irrelevance. The recognition of mood-change in the course of comprehensive therapy does not always call for abandonment of the treatment, but it does call for adaptation to the patient's variations in drive and outlook on his problems. In the course of detailed psychotherapy, changes in the direction of mild elation with relief of tension occur too frequently to be due to endogenous causes alone, but whatever their cause they can often be exploited in the patient's interests because of the fresh insights which come with them.

When to Stop

Much of the interest of psychotherapy to the therapist lies in the prospect that in the end the mystery of the illness will be explained and the loose ends will be tidied up as in a good detective story. But just as the surgeon cuts and stitches in the expectation that nature will heal and strengthen, the psychotherapist, if healing and not research is his object, need do no more than bring his patient to the point where he can heal himself.

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It is not always easy, when the planned objectives have been attained, to know when to replace participation by observation. Even more is it difficult to make the decision when it has become clear that the objectives are not going to be attained and that therapeutic time might be better employed elsewhere. Some of the reasons why comprehensive psychotherapy is carried on when no major improvement can be expected may be summarized:

TABLE XIX

Factors which Lead to a Continuance of Psychotherapy in Spite of Its Failure to Achieve Its Objects

Initial improvement raising hopes.
Emergence of psychopathologically interesting but therapeutically useless material.
Unresolved transference.
Confusion of causal with supportive treatment.
Bilateral reluctance to admit failure.
Mercenary considerations.
Therapeutic session has become patient's main interest.
Therapist's belief in universal application of his method.
Absence of alternative treatment.

THE ADJUNCTS OF PSYCHOTHERAPY

There are psychotherapeutic purists who feel that when a patient is referred for treatment by their particular method, to assist the cure by other means such as physical treatment, is rather comparable to shooting a sitting bird out of season. But psychotherapy is not a sport, it is a part of the vital battle of adaptation in which no holds are barred. Any kind of ammunition, pharmacological, emotional or semantic, is permissible if it can be used to support the patient's constitution against the rebel forces of unreason. It is better, too, if the different methods can be used so that they do not get in each other's way. A unified command leaves less to chance.

The principle of separating the individual approach to the patient's psyche from the treatment of the whole man has many adherents, but it can at least be questioned in many instances, and in planning treatment it is well to consider the adjuncts which may contribute to the success of psychotherapy. They are here summarized in tabular form.

TABLE XX

The Adjuncts of Psychotherapy

Regime. Occupation. Diversion.
Environmental Adjustment.
Health. Medical. General fitness.
Rehabilitation—Retraining—Education.
Homework—Writing appraisals—Prescribed reading.
Resocialization—Groups—Clubs.
Pharmacological—Abreactive.
Mood-changing.
Sedative and symptomatic.
Isolation. Weir-Mitchell. Sensory deprivation.
Non-Semantic. Conditioned inhibition.
Aversion. Play.
Religious. Reading. Retreat. Discussion.
Physical. Faradism. E.C.T.
Supervision. Probation. Antabuse.

In psychotherapy, as in love or in war, there must always be an element of chance. When art and science combine in the treatment of an individual, it is the

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function of science to reduce that element to a minimum. The therapist is no mere spectator even if his is not the major role. In that he participates and often holds the initiative, psychotherapy is a stress to the psychotherapist whose task is to hold his patient's interests in view and manifest his role of protector, receiver and friend by helping him over each obstacle in turn. Like a father who teaches his child to walk, he is content to know that when he himself has been forgotten the child will walk unaided.

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