IS PSYCHOTHERAPY DEPENDENT UPON DIAGNOSIS?

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At first glance, such a question as that posed in the title of this paper may seem absurd. The tendency would be to answer immediately: "Yes, of course", and to refer to the field of medicine, where it is quite apparent that therapeutic measures are determined by differential diagnosis. Thorne writes in this connection: "It seems elemental that rational treatment cannot be planned and executed until an accurate diagnosis has been made" (9, p. 319).

On the other hand, Rogers has just as positively stated that "diagnostic knowledge and skill is not necessary for good therapy" (7, p. 421).

Before proceeding further it should be made clear that we are concerned with the so-called functional disorders in which psychotherapy is applicable. It is recognized that there are mental disorders of definite organic origin, involving neurological disease, physiological disturbances, toxic conditions, and traumatic injury. There are also certain mental disorders which are possibly organic in nature, on a constitutional or endocrinological basis, e.g., the so-called endogenous depressions. Diagnosis of organic factors is an important medical function in these cases (assisted often by the use of psychological tests), and obviously influences therapy. Such diagnosis is, however, often difficult, and sometimes inconclusive, and psychotherapy should not be denied pending decision as to the presence or absence of organic pathology. Moreover, although psychotherapy may not be indicated for a purely organic disorder there are often mixtures of organic and psychological components in which psychotherapy is beneficial. In addition, the presence of a purely organic condition may, and often does result in psychological reactions to which psychotherapy may be directed. However, the present discussion is primarily concerned with the recognized functional disorders, including psychosomatic dysfunctions, of psychogenic origin, which are regarded as suitable for psychotherapy.

It might seem that a logical analogy could be drawn between internal medicine and psychiatry. Psychiatry, it might be maintained, is a branch of medicine, and therefore the principles, methods and techniques which are applicable in internal medicine apply also, of necessity, to mental disease and maladjustment. This approach is the basis of a recent article by Thorne (10), in which clinical psychologists are urged to learn from medicine by adopting its methods.

If one looks a little more closely into the matter, however, a question might be raised regarding the validity of the analogy between physical disease and mental disease. The two are, as a matter of fact, entirely different in many respects. In the first place, the nature of the primary malignant process is entirely different. In one case it involves primarily the physiological and chemical processes of bodily functioning; in mental disease of a functional type the disorder is primarily one of psychological and social behavior. Two distinct levels of functioning are represented which are different enough to raise considerable doubt as to the validity of any analogy between them. Again, physical disease is the result of specific experimentally verifiable foreign agents, whether chemical, bacteriological, or virus in nature. Such a statement cannot be made regarding functional mental disease, although it is the hope of some that eventually it will be possible to do so. Finally, in physical medicine there exists a wide variety of specific and experimentally or empirically verified remedies. Again, this is not the case in the field of mental disease. In other words, while in physical medicine accurate differential etiological diagnosis is possible, leading to the selection of specific remedies, in the field of mental disease no such specific etiological diagnosis is possible, nor are there specific, discrete psychotherapies which have differential effects from which to choose.

As a matter of practice, psychiatric diagnosis has little rational connection with choice of psychotherapy. Methods of therapy depend more upon the specific training, experience, and preferences of the therapist than upon the diagnosis. Those who feel that psychotherapy should be selective and specific, and thus "rational", chosen on the basis of diagnosis, have been unable to relate specific therapies to specific diagnoses, in terms of indications and contraindications, except possibly on the basis of severity of the condition. Attempts to list indications or contraindications are more often in terms of symptomatic or basic treatment or the depth of therapy desired or possible, the time available, etc. In other words, the distinctions are based upon the limits of the therapist and therapeutic situation rather than being related to the diagnosis or etiology of the disorder.

The difficulty, according to the usual argument, is chiefly with the diagnostic system of classifying mental disorders. Perhaps if we could develop a system of diagnosis based upon etiology we could apply specific types of therapy (provided they exist or could be differentiated) to specific types of mental disease. The idea sounds intriguing, particularly when we consider what has been accomplished in physical medicine, but the prospects are not promising (2). But granted that the classification of mental disorders is not possible in the present state of our knowledge, it might be expected that a thorough study of the individual case would yield an understanding of the etiological factors, and lead to a rational choice of therapy. Thorne, in his use of the term diagnosis, refers to "the description of the organism and its behavior by a variety of methods whose basic purpose is to discover the personality dynamics of each individual case. It is implied that the more complete the description, the more complete will be our understanding of why, when, where, and how the individual got that way" (10, p. 161). Elsewhere he states that "no rational plan of treatment can be accomplished without detailed knowledge of each individual case history" (9, p. 320).

Rogers, however, maintains that a case history is not a prerequisite for therapy (6, pp. 80-84). It is rather common experience that, given a detailed case study of an individual, wide differences and disagreements concerning its analysis and interpretation, in terms of etiology and personality dynamics, occur, not only between different professional groups, but within these groups. Indeed, the number of diagnoses on the basis of such material is about as great as the number of analysts (1). Rational or specific therapy is obviously impossible in such a situation. If we are unable to agree upon the etiology and specific dynamics of individual cases, we certainly cannot set up diagnostic classification based upon etiology or dynamics.

Part of the difficulty no doubt lies in the fact that behavior is multiply determined-there is no single cause which can be isolated, to the extent that this is possible in physical medicine. But also, in terms of basic etiology there may be no fundamental or essential differences which will allow us to distinguish classes of mental disorder on an etiological basis. All maladjustments may be essentially alike in terms of basic etiology, and the various behavior, or symptomatic, manifestations which appear to distinguish various types of disorder may be determined by contingent influences. In that event, specific therapy would not be possible, necessary, or desirable, except on the basis of severity of the disorder, and the presence or absence of organic disease or insult.

That there is a common basic etiology of all functional mental disorder is not a new idea. In fact, most discussions of maladjusted behavior take such a point of view. Work on experimental neuroses in animals, e.g. that of Masserman (3), indicates that the same experimental procedure results in widely different types of maladjusted behavior in different animals of the same species. Moreover, a variety of apparently different procedures are capable of inducing maladjusted behavior. The variety of manifestations of mental disorder, leading first to a symptomatic classification, has perhaps blinded us to the common origin of all maladjustment.

In the field of psychological testing, the failure to find diagnostic test signs to differentiate the various classifications of mental disease may be as much the result of the absence of basic differences as of the inadequacy of the present primarily symptomatic classification. In fact, the obtained overlapping of the various diagnostic categories in terms of test results would tend to support the theory of a basic common etiology, with differences being relatively unessential or determined by other contingent factors.

Instead of assuming that we need a new classification, based not upon symptomatology but upon some other more fundamental difference such as a genetic origin, we should develop a rational therapy directing attention to the basic elements of maladjustment common to all mental disorder. If we found that there is a common basic etiology, then, rather than being concerned about developing specific therapies, a rational psychotherapy would be concerned with principles and techniques which are most effective in reaching and remedying the underlying causes of maladjustment.

As a suggestion of the line such an approach might take, the following discussion is offered in outline. It involves first a statement of a theory of behavior and its

maladjustment, followed by a statement of therapeutic principles and practices which arise from a consideration of the nature of maladjustment. The discussion draws from the work of many people including that of Masserman (3), Mowrer and Kluckhohn (4), Rogers (7, 8), and many others who have written in the field of personality and its disorders.

OUTLINE OF A THEORY OF BEHAVIOR AND ITS ABERRATIONS

I. *Assumptions:*

1. The living organism, by definition, is never at rest but in a state of constant activity, with physiological tendencies to approach or withdraw, contract or expand.

2. It is characteristic of living matter that it tends to seek a state of equilibrium, both within itself and in relation to its environment, and to maintain its organization when threatened.

3. In the realm of personality and behavior, this characteristic is exemplified by the tendency of the individual to become and remain integrated and consistent within itself.

4. Since the organism is constantly subject to stimuli, both from within and from without, equilibrium is never maintained for long, but is dynamic and unstable.

5. This dynamic equilibrium allows for change, so that all living organisms are normally characterized by change, or growth and development, from lesser to greater complexity, from immaturity to maturity, from dependence to independence, from irresponsibility to responsibility.

II. *Principles*:

1. Although the organism is constantly active, this activity is not random, but is directed or motivated by needs, drives, etc., on a physiological level, and by wishes, desires, etc., on the psychological and social levels.

2. The organism reacts to its environment or to a stimulus as it is perceived and experienced, not as it may actually exist. Interpretive or symbolic (meaningful) processes thus intervene between the stimulus and the response of the organism.

3. Motives are directed toward the preservation and enhancement of the organism (Assumptions 2 and 3).

4. All behavior is thus goal-directed, or a purposeful attempt to satisfy the needs of the organism, either through the approach toward beneficial stimuli, or the avoidance of noxious stimuli.

5. Behavior which succeeds in satisfying a need or desire is rewarded by the reduction of tension, or an approach to equilibrium or integration. Such behavior tends to be repeated again in similar circumstances, and if it continues to be successful in reducing tension it becomes fixated, or is learned, so that it becomes habitual.

6. The presence of unsatisfied drives or desires creates a state of physiological and/or psychological tension or disequilibrium.

7. When a need or desire is frustrated, either by external conditions or by conflict with another incompatible drive or desire, tension is not reduced, and the organism seeks for substitute or compromise satisfactions.

8. Such substitute satisfactions may or may not result in complete reduction of tension, and may or may not lead to the creation of additional tensions by arousing other antagonistic motives.

9. Behavior becomes maladjusted when substitute satisfactions do not result in sufficient tension reduction, and/or violate the integrity of the organism's organization, or result in behavior which is not acceptable to the (social) environment of the organism.

10. The repression of conflicts, or of unsatisfied needs and desires, occurs as the result of the tendency to maintain the integration and organization of the organism or personality. Conflicts and tensions may thus exist on an unconscious level.

11. Substitute satisfactions are retained because they supply partial satisfaction of needs. Since they thus become fixated they prevent further growth and development and lead to immature, dependent, maladjusted behavior.

PRINCIPLES OF PSYCHOTHERAPY

1. Since all maladjustment is similar in origin, diagnosis in terms of symptomatology or etiology or dynamics is not essential to therapy. Similarly, knowledge of the content of the conflict involved is unessential as a prerequisite of therapy, since the technique of therapy does not depend on the nature or content of the conflict but upon the presence of conflict and the resulting tensions.

2. Since the functions of the formal case history (9) can be satisfied, insofar as is desirable, during the process of therapy, such a history is not a prerequisite of therapy. During therapy pertinent material will be brought out. Whether or not these data are factually correct is unessential, since it is the patient's interpretation of them which is important for his adjustment.

3. Since the basic etiology of maladjustment is the presence of unrelieved tensions as a result of conflict and inadequate substitute satisfactions (which constitute the symptoms of maladjustment), a rational therapy should aim at providing an opportunity for the

individual to attain more satisfactory, acceptable, and direct satisfaction of his needs. Therapy should therefore be more than symptomatic, palliative, supportive, etc.

4. Therapy should result in bringing to consciousness the repressed conflicts so that they may be resolved in a more adequate manner, with consciously selected goals and methods of satisfying needs, and resulting reintegration of the self and more adjusted behavior.

5. Since the aim of development in the individual is ability to adapt and adjust to the demands of the environment in a mature, independent manner, therapy should avoid creating dependence. Therapy should therefore be directed toward aiding the patient to solve his own problems and developing problem-solving ability rather than solving his immediate problems for him.

6. Since one of the characteristics of the organism is the capacity for growth, this capacity should be capitalized on in therapy. Therapy should be directed toward freeing this positive energy in the individual so that more constructive, integrative, and adjusted behavior develops.

7. The therapeutic situation is a learning situation and the principles of learning apply. This means that the patient will learn what he is taught in therapy, whether dependence or independence, immaturity or maturity, where to go to have his problems solved, or how to solve his own problems.

THE PRACTICE OF PSYCHOTHERAPY

1. The positive growth forces will manifest themselves in the individual if:

    a. He is given responsibility for himself,

    b. He is allowed the freedom to explore his own conflicts, attitudes, and feelings,

    c. The drive toward maturity and independence is recognized, and the opportunity to practice and learn independence through experience is provided.

2. Repressed conflicts and attitudes may be brought into consciousness by:

    a. The conveying of a sense of understanding and acceptance in a non-critical, non-judgmental relationship, conducive to the expression of negative attitudes, with resulting release of tension, and the assimilation of negative feelings by the patient,

    b. The creation by the therapist of a free, permissive atmosphere in which the client can explore his problems and conflicts and develop a conscious awareness of the elements of the conflicts,

c. The clarification of expressed attitudes and feelings, enabling the patient to see himself in a somewhat different light, leading to insight into himself and the interrelationships among his attitudes and conflicts.

3. As a result of the application of these techniques a favorable situation for learning is supplied, in which the patient discovers and proposes alternative solutions for his conflicts and more adequate satisfactions for his needs. Insight, choice, and positive action arrived at by the client then follow, with resulting tension reduction.

4. Symptomatic or palliative therapy, involving suggestion, persuasion, reassurance, support, sympathy, etc., is admittedly ineffective in reaching at conflicts and tensions involved in maladjustment. In addition, these techniques, together with questioning, probing, advice, and interpretation, restrict the freedom of the patient and foster dependence, which are inimical to his progress in solving his own problems.

The practical significance of the foregoing is that the present emphasis on differential diagnosis is unnecessary for therapy. It would also follow that for purposes of therapy, neither extensive nor intensive case history techniques nor so-called diagnostic testing is necessary.

For therapeutic purposes all that is necessary is that the patient come for help and be in sufficient contact to be able to verbalize his behavior and attitudes and feelings. As long as the motivation to change or grow exists, the application of the principles and techniques of therapy outlined above is possible. The point at which this motivation is lost is possibly a function of the severity of the disorder; i.e., one of the characteristics of a severe psychotic disorder appears to be the loss, perhaps only temporarily, of the positive growth forces, so that the struggle has been given up, with a complete rejection or denial of drives or desires which disturb the integration of the individual.

If in the course of this type of psychotherapy a severe psychotic or organic condition becomes evident, no harm will have been done, and psychotherapy may be abandoned as being ineffective or inapplicable-although of course such therapy might be an adjunct and continuation of other chemical or physical therapies which might reactivate motives and conflicts which could then be expressed or verbalized. A lack of awareness of conflict and need for therapy in a non-psychotic individual may preclude the use of psychotherapy, since it is generally recognized that such awareness and desire for help is necessary. In some individuals this may develop with continuing experience in which their behavior leads to discomfort and unhappiness. It is possible that an awareness of maladjustment can be developed by the therapist by the induction of conflict, as suggested by Thorne (11). It would be desirable that such a technique be used by an individual other than the therapist who aids the patient in the solution of the conflicts, since it is inconsistent with the attitudes and principles of therapy discussed here, and is a preparation for, rather than a part of, therapy.

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