PSYCHOTHERAPY AS SOCIAL CONTROL:
A CRITICAL ANALYSIS

by

Mary-Anne Kandrack

A thesis
presented to the University of Manitoba
in partial fulfillment of the
requirements for the degree of
Master of Arts
in
Sociology

Winnipeg, Manitoba

ISBN 0-315-33850-4

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ABSTRACT

This study examined the argument that contractual psychotherapy is a form of associative social control. In order to overcome ther problem of a polemical analysis of this issue, a content analysis of theories of psychotherapy was conducted in order to reconstruct the theoretical answers to the following questions: What is normal?; What is the appropriate unit of analysis in accounting for deviations from this ideal?; and How is deviance best ameliorated? The objective of this study was to explicate the a priori assumptions which guide clinical practice.

Normality is a nebulous concept which eludes precise definition. The goals of psychotherapy are to alleviate subjective distress and improve social performance, but it is impossible to distinguish normal from abnormal subjective experience and social performance for which psychotherapy may be indicated. The units of analysis that are used to explain deviance in theories of psychotherapy include, the individual, interpersonal interaction, and socio-structural factors. The conceptual parameters of psychotherapy are broad enough to incorporate this continuum, from the individual to the society, in explaining deviance. Clinical practice, however, focuses on changing the individual, or, in the broadest application of psychotherapeutic theory, changing micro social groups. Efforts to ameliorate deviance at the socio-structural level are virtually non-existent in theories of psychotherapy. The

ambiguity of the concept of normality, which renders every individual a potential candidate for psychotherapy and the disparity between the explanation and amelioration of subjective distress and disruptions to social performance, supports the argument that psychotherapy is a form of social control which assists in the maintenance of social order.

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to my committee, Steve Brickey, Rod Kueneman, Larry Douglas, and Marvin Brodsky. Each of these individuals has made a unique contribution to my development as a person and a student of Sociology. I will be forever grateful for the patience and encouragement they provided along the way. Thank you for the reassurance when my faith in myself dwindled.

I also owe a great deal to Alexander Segall who provided me with invaluable opportunities to learn during my studies. A very special thanks goes to my friend Daniel O'Connor whose support and encouragement went far beyond the call of the cohort. I thank my dear friend Dale Rayter for givng me the comfort and sanctuary which is rare in a friendship. I would like also to thank my friends and peers for their support, without which I would not have made it through the tough times. Finally, I thank my mother, father, and Baba for bringing me into this world and showing me there is a better way.

It is always up to a society to decide what individuals and what kind of contributions it will propagate and value. Perhaps when we have clearly understood the kinds of individuals to the which the 'syndrome' labels apply, these labels will no longer be useful (Ernest Becker, 1964:7).

Chapter I

INTRODUCTION

It has been argued that psychiatry acts as a form of social control. The study of this issue has tended to focus upon those instances in which psychiatry has exercised overt social control. That is, critical assessments of psychiatry have concentrated on: the medicalization of deviance (Conrad and Schneider, 1980; Robbins and Anthony, 1983); psychiatric labelling (Scheff, 1968; Daniels, 1970; Rosenhan, reprinted 1981); and institutionalization (Perucci, 1974; Szasz, 1977). This orientation has enhanced our understanding of the overt control of human behavior through labelling, hospitalization and the treatment technology employed therein. What is lacking is this approach, however, is a systematic analysis of the 'covert' dimension of psychiatry. More specifically, the concern of this study is with psychotherapy and its role in the control of deviance and the promotion of conformity.

Thomas Szasz (1973) has distinguished **institutional** from **contractual** psychiatry and while highly critical of the former, the argument is comparatively uncritical about the latter. Critical statements about contractual psychiatry, or psychotherapy and its role in the maintenance of social order tend to take the form of polemical debates (Halleck, 1970; Hurvitz, 1973; Glenn and Kunnes, 1973; Ingleby, 1983). Polemics notwithstanding, these arguments warrant an empirical assessment of the issue. Contractual psychotherapy must be drawn into the analysis of

psychiatry as social control insofar as it is the domain in which the psychotherapist has maintained **carte blanche.** The focus of this analysis is restricted then, to the psychotherapy provided to clients who seek assistance from private clinicians or out-patient clinics. The purpose of this study is to analyze the content of theories of psychotherapy with the aim of assessing the argument that psychotherapy is a form of social control.

Chapter II

CONCEPTUAL FRAMEWORK

2.1 THE CONCEPT OF SOCIAL CONTROL

Social control can be conceptualized within a functionalist or conflict paradigm of social order. Since the 1960s, the study of social control has tended to concern itself with those agencies which exercise the overt forms of such control, and marks a reorientation in the study of social control and social order, "moving from cooperation to coercion, from harmony to conflict" (Rothman, 1983:109). This approach uses a rather narrow model of social control which "focuses on the means deliberately employed by authorized agents to secure conformity to formal norms" (Clark and Gibbs, 1965:399). This orientation has been invaluable to an understanding of the maintenance of social order through the containment of particular types of deviance (eg. criminality or insanity). The conflict-based deviancy model of social control, insofar as it focuses on observable coercive control, may not provide for a systematic analysis of the more covert forms of social control and their role in the perpetuation of a given social order.[1] As stated at the outset, the concern of this study is with the contribution of psychotherapy in facilitating this end.

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[1] There are notable exceptions to this pattern, for example, Goffman (1959) and Scheff (1968).

One consequence of the deviancy model is that the term social control is often perceived in a pejorative manner (ie. is inherently evil and should be eliminated). It is, however, untenable, if not naive, to assume that social order is possible in the absence of control mechanisms. In any society, social control will vary along a continuum from overt coercion at one extreme, to subtle manipulation at the other, and at any level of analysis, social life necessarily involves social control (Rothman, 1983). As Berger sees it:

> society, in essence, is the imposition of order upon the flux of human experience...Coercion and external controls, however, are only incidental aspects of society's imposition of order. Beginning with language, every social institution, no matter how "nonrepressive" or "consensual", is an imposition of order (1971:3 emphasis in original).

This observation makes it imperative to delineate clearly the control mechanism under consideration so that blanket conclusions can be avoided.

Again, the deviancy model of social control tends to limit its analysis to the observablly coercive control of non-conforming or rule-violating behavior. In contrast, Rothman states that:

> those who think of social control as more or less synonymous with repression and coercion may be startled to discover that American sociologists first used the term to capture the very opposite quality, that of cooperation, of voluntary and harmonious cohesion (1983:107).

Similarly, the term social control was originally used to "describe the processes societies developed for regulating themselves" (Conrad and Schneider, 1980:7) which reflects a functionalist view of social order. This conceptualization is in accord with Berger's view of social order cited previously. Whereas the focus of the deviancy model is too narrow, this formulation is perhaps, excessively broad. This definition

encompasses virtually every aspect of social life, thus making it difficult to circumscribe meaningful sociological inquiry. Rothman suggests that because this specification of the concept was "almost synonymous with the totality of the society", its use has diminished (1983:109). That a society must/will shape the behavior of its members is self-evident; society by definition provides regulation in the service of social order. Social order is the **sine qua non** of the human condition. It is crucial for humans, because, in contrast to other animals, "man has no species-specific environment firmly structured by his own instinctual organization" (Berger and Luckmann, 1966:47). The absence of social order is tantamount to sheer chaos or anomie; survival for humans requires the production of an ordered environment. Coupled with the contradictions of the functionalist paradigm which emerged in the 1960s (Brickey, 1978), the result of this realization has been the adoption of the limited deviancy model for the study of social control.

Psychotherapy cannot be adequately nor accurately situated within either of these models. Again, the focus of this analysis is restricted to contractual psychotherapy offered in non-institutional settings. It would be inaccurate to conceive of psychotherapy in this context as an instance of the coercive control of deviance. Nor would it be accurate to treat psychotherapy as an illustration of the socialization process. Psychotherapy may be better understood as a sort of 'resocialization' necessary to correct or alleviate disruptions to the individual's normal social functioning. Contractual psychotherapy is generally thought of as **non-repressive** and is, to a large extent **consensual.** If "society, in essence, is the imposition of order upon the flux of human experience"

(Berger, 1971:31), then psychotherapy necessarily constitutes the imposition of order. In what way then, can social control be conceptualized in order to capture the mandate of psychotherapy?

Following the argument of Janowitz (1975), Mayer defines social control as essentially "the attempts by a group or by a society to regulate its own members' behavior without recourse to forcible coercion" (1983:24). This definition draws a clear distinction between force and social control. According to Mayer, a control system constitutes the two broad categories of: (1) coercive controls which either use or imply force, legal or extra-legal; and (2) social controls, which consist of group self-regulation outside the boundaries of force, and which can be used on both a macro- and micro-sociological level (1983:24). This conceptualization of the processes and structures through which societies regulate themselves avoids the labyrinth of socialization/indoctrination requisite for group membership, yet expands the analysis beyond the coercive control of deviance.

The overall control system is further differentiated into: (a) coercive controls; (b) semi-coercive controls; and (c) social controls (Mayer, 1983:27). This is a useful delineation of types of controls since psychotherapy can be discussed as a part of the professional practice of psychiatry and clinical psychology. The types of controls indicated above correspond to the following variations in professional practice: involuntary commitment; voluntary commitment and psychotherapy respectively. Moreover, this classification also explicates the varying degree of choice which can be exercised by the controllee relative to the differing amounts of power exerted over him/her (Mayer, 1983:26).

To illustrate, consider the freedom to choose to withdraw from a mental hospital under the conditions of involuntary commitment as opposed to the termination of voluntary psychotherapy. While it is apparent that psychotherapy may not be sought as the result of independent decision-making, it can be argued that as autonomy in decision-making decreases, coercion increases.

Social order is maintained then through a control system, entailing a pervasive system of social controls and the infrequent use of coercive controls. Again, it is argued that psychotherapy constitutes a form of social control as distinct from coercive control. More specifically, psychotherapy can be included under Mayer's category of "associative" social control to the extent that "persons consciously and freely associate themselves to a control process, that is, to an effort to shape or change behavior and outlooks" (1983:27). The concept of associative social control "includes as participants those voluntarily desiring to have their behavior influenced or changed" (Mayer, 1983:25). One of the implications of Mayer's conceptualization of social control mechanisms is that associations can be viewed as having both manifest and latent purposes. Although certain manifest benefits which can accrue from the association (eg. psychotherapy) may be easily perceived (eg. feeling better), a latent agenda may pass undetected (eg. bringing about conformity to societal norms/rules). This would seem to indicate that 'associative' social control may be preferred over forcible control because it is more effective. The controlling attempt may not be as obvious, thereby minimizing resistance and rendering it a more effective tool for the maintenance of a given social order.

An excessive use of force in the maintenance of any social order tends to be delegitimating. In a 'liberal democracy', it is delegitimating to the extent that it is antithetical to the "philosophical underpinnings and supposed organization of the democratic society; conflict is attempted to be subsumed or neutralized through various legal and social institutions of the state" (Lertzman,1984:20). This is not, however, peculiar to capitalist society; superfluous coercive control would also threaten the legitimacy of non-democratic states (Janowitz, 1975). With associative social control, the social order and the legitimacy of the rulers are simultaneously protected. In any society, control mechanisms/strategies of this nature may operate to obstruct social change. In the context of early capitalism and the 'secular rationalization' of society, Scull notes that:

> capitalism demands a reform of "character" on the part of every single workman....(because it was) soon discovered that physical threat and economic coercion will not suffice: men have to be taught to internalize these new attitudes and responses to discipline. More than that, force under capitalism becomes an anachronism (perhaps even an anathema) save as a last resort....control must now come from within....(Scull, 1979:71-72, emphasis in original).

It can be inferred from this that capitalism is best served by a control structure which decreases reliance on force to maintain social order and instead "persuasion, rhetoric, symbolism, operational rewards, and (non-forceful) punishments provide a broad context of social control possibilities" (Mayer, 1983:25). Clearly, it was more effective to employ social controls as opposed to force to expedite the development and smooth functioning of the capitalist economy.

In light of the political and economic changes which facilitated the development of psychiatry, it is not surprising that the state would

perceive the efficacy of a primarily social as opposed to coercive control system. By using force infrequently, the state could preserve its legitimacy through the adoption of a social control system, to which the majority would consent. Control exercised through majority consent can be referred to as "hegemony". As Joseph Femia defines it:

> hegemony is the predominance obtained by consent rather than force of one class or group over other classes; and it is attained through the myriad ways in which the institutions of civil society operate to shape, directly or indirectly, the cognitive and affective structures whereby men perceive problematic social reality (1975:31, emphasis added).

According to Ingleby, "this is consistent with the notion of the contractual relationship between citizens that was supposed to replace the repressive authority of the monarch" (1983:157). That social order must be maintained is a necessary objective in any society. The problem, however, is that the manner in which social order is sustained often deflects critical assessment of a given social order.

Psychiatry, as legitimated by the canons of science and the state, represents one institution that enjoys tacit consent to engage in social control. Such tacit consent presumes that psychiatry's position of authority is warranted and desirable, and its competence unquestionable. Psychiatry, in the context of secularized civil society, is construed as the only strategy for dealing with deviance or non-conformity, which is conveniently labelled as mental illness. Perhaps psychiatry's "authority may be unconditionally and uncritically accepted because the culture may not provide the individual with alternatives to the established mode of thought" (Lukes, 1978:641). It may be the case that psychiatry does have something to offer in the management of problematic social reality, however, this does not justify the extent to which it dominates our perception. In keeping with Hobbes, it is proposed that:

> authority by consent ... becomes inverted into the imposition of authority...there (is) no recurrent renewal of consent, but rather the establishment of a way of thinking about government and authority which suggests a basis of consent, setting indeterminate and flexible limits to the power of governments (Lukes, 1978:652).

One could conclude from this that the social order is maintained because any attempts to question its legitimacy are diffused. Steven Lukes states it rather well:

> Is it not the supreme and most insidious exercise of power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions, and preferences in such a way that they accept the existing order of things, either because they can see or imagine NO alternative to it, or because they see it as natural and unchangeable (1977:24, emphasis added).

Psychiatry has become a reality sui generis. It is perceived to be the only way to give meaning to seemingly inexplicable behavior. Inasmuch as the concept of hegemony constitutes an accurate portrayal of a given social order, it follows that psychiatry provides sustenance for this hegemony. As Scheff sees it:

> the implicit support given the **status quo** by current psychiatric concepts and practices is especially important since the man in the street takes psychiatry to be a scientific enterprise. To the extent that practitioners and researchers in the field of mental illness argue and act as if mental illness is largely a technical, scientific issue rather than an area that is almost completely governed by moral values, they are functioning as accomplices to the current moral **status quo** (1971:299).

For the most part, that psychiatry constitutes the only plausible account of human (mis)behavior has yet to be questioned. Hegemony implies that the perceptual sphere within which citizens understand social reality is limited by the minimization of disruptions to the social order. That is, a particular world view develops, which by virtue of its predominance, provides a lexicon of social reality

underscored by tacit consent. This can be seen to preclude both a critical consciousness of social order among the citizenry and the withdrawal of consent. The therapeutic relationship is only one example of the structuring of consciousness effected by the institutional order of a society. More specifically, institutionalization "controls human conduct by setting up predefined patterns of conduct, which channel it in one direction as against the many other directions that would theoretically be possible" (Berger and Luckmann, 1966:55).

Most criticisms of psychiatry tend to focus upon its use of coercive controls, and fail to address the more subtle use of social control. For analytical purposes, recall that force has been distinguished from social control. While forcible physical restraint is a significant dimension in the maintenance of social order, the present concern is with psychiatry's potential to control individuals through symbolic manipulation. Psychiatry, even in institutional settings, does more than contain bodies. Attempts are also made to alter one's thinking. Presumably, it is both thought and action which deliver the person to the institution. The concept of hegemony contends that individuals must think in a particular way in order to act in a particular way. Failing this, it is inferred that force will be deployed to suspend the behavior, and associative social control will be used to bring the person back to the right way of thinking and thus, acting in that social world.

2.2 PSYCHOTHERAPY IN CONTEXT

Societies have always had to devise methods for conceptualizing and correcting (if not eradicating) problematic behavior. It is not within the scope of this discussion to trace the history of these conceptualizations, or the concomitant remedial measures. Rather, the task at hand is to account for the emergence of the **therapeutic** approach to deviance and the rise to its contemporary position of pre-eminence.

In Museums of Madness (1977), Scull places the emergence of psychiatry within the context of a developing capitalist economy and the secularization of social life. It would seem that during this transformation, religious mechanisms for social control became incongruent with the needs of the capitalist economy. As noted previously, for capitalism to operate smoothly, control must come from within the individual, rather than by external imposition. The values of science which served to buttress the foundation of capitalism could also be employed to account for human nature (in this case, disruptive behavior). In short, what religion called demon possession, a secular science such as medicine would call mental illness. The peculiar behavior that religion would punish, psychiatry would treat. In Pearson's view, "the historical decline of religion and a spiritual view of nature was accomplished by the rise of science. This secularization of man's view of nature is generally conceived of as a dissolution of superstition and myth" (1975:87). Following Weber, Scull states of this transition that:

> it reflected the penetration of this realm of social existence by the values of science, the idea that there are no mysterious incalculable forces that come into play, but rather one can, in principle, master all things by calculation (1979:43).

Furthermore:

> economic competition and the factory system are the forcing house for a thorough-going transformation in the relation of man to man. For industrial capitalism demands a reform of "character" on the part of every single workman, since their previous character did not fit the new industrial system (Scull, 1979:71).

While it was undoubtedly a slow process, it is apparent that the advent of capitalism precipitated a massive restructuring of social life. According to Ingleby:

> madness threatened the very basis of the 'contractual society', because it removed the personal responsibility which necessarily underlay contractual relationships: so incarceration could not be invoked as a penalty. The solution was to make it a treatment like others deemed lacking in responsibility, the insane were placed under a **relation de tutelle,** which defined everything done to them as being in their own best interests (1983:158, emphasis in original).

It is often assumed that the medical/psychiatric response to deviance or non-conformity is an improvement over its religious predecessor. Such improvement is presumably evidenced by its **therapeutic** as opposed to **punitive** approach to dealing with problematic behavior. It is, however, somewhat simplistic to accept this reorientation and the concomitant benefits at face value. Ingleby (1983) contends that the language of punishment was simply replaced by the rhetoric of treatment. Consider Foucault's assessment of the meaning of confinement of the mentally ill in 18th century France:

> before having the medical meaning we give it or that we like to suppose it has, confinement was required by something quite different from any concern with curing the sick. What made it necessary was an imperative of labor. Our philanthropy prefers to recognize the signs of benevolence toward sickness where there is only a condemnation of idleness (1973:46).

Similarly, in the American context, Rothman notes that "of all the activities, asylums prized labor the most, going to exceptional lengths

to keep patients busy with manual tasks. This regime...inculcated regular work habits, precisely the trait necessary for patients' recovery" (1971:145-146). The paramount value of **labor** surfaces repeatedly in many accounts of the emergence of psychiatry. During the turbulent developmental stages of capitalism, Foucault contends that confinement provided:

> cheap manpower in the periods of full employment and high salaries; and in periods of unemployment, reabsorption of the idle and social protection against agitation and uprisings (1975:51).

The medical model of mental illness would suggest, however, that

> mental illness is a basic ingredient of the human condition, as natural as suffering itself...those who deal with it are primarily motivated by the humanitarian concern to relieve suffering...the dominating role of the medical profession is seen as a rational one, justified because the skills that mental problems call for are precisely those that medicine as a profession happens to possess (Ingleby, 1983:142).

It is this view which has characterized the profession of psychiatry since its emergence in the 19th century. It is a perspective which would preclude a critical analysis of the social component in the etiology of what is referred to as mental illness.

Psychiatry's treatment of its charges, which can be seen to have fostered its legitimacy, is argued to have been more humane than the approach taken by its predecessors. Scull (1979:73), however, cites the Report of the Select Committee on Madhouses of 1815 which describes asylums as, to say the least, abysmal. Psychiatry rose to dominance because it promised 'humane treatment' and because of the 'appeal of science'. Benevolent and humane treatment, however, also met the needs of secular society. Ignatieff argues that following release, those

confined "would return to society convinced of the moral legitimacy of their rulers" (1983:87). While confinement is a coercive control mechanism, many of the techniques employed within this context can be considered social controls. Despite the distinction between force and social control, they are not mutually exclusive categories with reference to psychiatry; physical containment is not the sole objective of confinement. In addition to suspending the objectionable behavior, attempts, presumably are made to alter the cognitive and affective structures which are assumed to underlie it. The inculcation of regular work habits by keeping people busy with manual tasks constitutes a social control strategy. Moreover, the **model institution** in 19th century England:

> was to be home, where the patient was to be known and treated as an individual, where his mind was to be constantly stimulated and encouraged to return to its natural state (Scull, 1979:102).

Confinement, in and of itself, would not suffice as a solution for the problem of madness. Programs such as psychotherapy have become included in the treatment milieu as part of the overall strategy and are considered to be symbolic controls (ie. create/sustain ideational patterns).

It is clear that by promising treatment instead of punishment, psychiatry's legitimacy would be enhanced, since force tends to delegitimate the controllers. It is within this context that medicine's psychiatry took root and has, through a complex process of **claim-staking** and **moral entrepreneuring,** expanded its domain of expertise to account for just about any human behavior imaginable (see the American Psychiatric Association's Diagnostic and Statistical Manual III).

Ingleby suggests that by the middle of the 19th century "the primacy of medical expertise in dealing with the insane [was] firmly established...and formally entrusted to members of the medical profession" (1983:161). Once this had been accomplished, "medical authority [was] extended beyond the asylum population; 'mental illness' overlaps insanity to cover deviations not severe enough to call for incarceration" (Ingleby, 1983:161). According to Armstrong, "toward the end of the 19th century a new problem of mental functioning began to emerge. It was observed that some people suffered from 'mental instability' which did not of itself constitute madness" (1983:19) and its manifestations were incorporated into existing "theories of madness by describing them as precursors of insanity" (Armstrong, 1983:20-21). This set the stage for human development in its entirety to be scrutinized, culminating in professional expansion and diversification (Ingleby, 1983) and the medicalization of the mind (Armstrong, 1983) in the therapeutic state (Kittrie 1971). The implication of this is that **therapeutic intervention** is permissible, perhaps even necessary, in virtually every arena of human life.

The advent of Freud's psychoanalysis and the development, by non-physicians, of alternative 'talking cures' brings us to the 'psy-profession' of today; an organization of professionals (and their para-professional counterparts) with the authority to engage in the seemingly unlimited control of human behavior, with:

> the power to eliminate moral considerations from their discourse, to make individual patients (rather than their situations in life) the focus of attention, and to subordinate them to their own authority (Ingleby, 1983:164).

Illich refers to the result as a symptom of the 'social iatrogenesis' of the medical model. In short:

> medical labelling has increased the number of people with exceptional consumer status to the point where people who are free of therapy-oriented labels have become the exception (Illich, 1975:56).

Illich further cites Karier's (1972) suggestion that "once the patient role becomes universal, medical labelling turns into a tool for total social control" (1975:60). Moreover, Ingleby contends that the human sciences now constitute "a system of knowledge whose radii penetrate into every corner of life, and thus make possible swift and effective control" (1983:164). One thing is clear, the medical model has come to dominate our perception of peculiarities/irregularities in the social world. In a society philosphically based upon the contract between citizens, this iatrogenesis is perceived as 'in our best interests'. Again, the medical model has become so widely shared that it is a reality sui generis. As a result, the fact that definitions of deviance are implicitly, if not explicitly, shaped by values fades from view. More specifically, this model ignores the problem that it is precisely because of the existence of a normative order that a distinction can be drawn between deviance and normality.

Further evidence that this model is better than religious conceptualizations is thought to be found in the presumption that the medical model is morally neutral. That is, "the medical model and the associated medical designations are assumed to have a scientific basis and thus are treated as if they were morally neutral. They are not considered moral judgements but rational, scientifically verifiable conditions" (Zola, 1975, cited in: Conrad and Schneider, 1980:35). In

contrast, it is argued that "medical designations are social judgements and, the adoption of a medical model of behavior, a political decision" (Conrad and Schneider, 1980:35). While medical definitions of deviance may appear morally neutral, countless examples of so-called 'mental disorders', which are clearly related to social status, contest this neutrality. To illustrate, consider "drapetomania", found only among blacks attempting to escape from slavery; or political dissidents in the Soviet Union, categorized as "paranoid with counter-revolutionary delusions" or alternatively, as struck with "manic reformism" (Conrad and Schneider, 1980:35). Furthermore, Rosenhan's classic study of 'psychiatric pseudo-patients' seriously undermines the contention that medical designations are rational, scientifically verifiable conditions (reprinted, 1981). Moral neutrality is an admirable aspiration but it is an improbable achievement because, psychiatric jargon may serve to obfuscate the inevitability of moral judgements. It cannot be taken for granted that the medical model is morally neutral. In fact, it can be argued that the processes through which such an account of deviance (or any account for that matter) rose to its position of dominance were anything but neutral. Treatment, however, would be understandably more palatable to the masses than punishment.

Thomas Szasz (1961, 1963, 1970, 1977) offers what is perhaps the most controversial critique of the medical model of human behavior. In discussing the Myth of Mental Illness, he argued that:

> psychiatrists have traditionally regarded mental illness as a problem apart from and independent of the social context in which it occurred....since mental illness was considered to be like bodily illness, it was logical that no attention was paid to the social conditions in which the alleged disease occurred (Szasz, 1961:52).

As the above quotation illustrates, those with a critical perspective call attention to the social forces influencing the underlying theory and practice of psychiatry/psychology. Moreover, "the presuppositions that enable natural-scientific methods to be transposed wholesale onto the study of people are clearly ideological in nature" (Ingleby, 1983:164). Szasz's critique focuses primarily on institutional psychiatry, characterized by coercive and manipulative control. Contractual psychiatry, however, poses no such threat since the individual's interests are protected by the freedom to withdraw from the 'contract'. Such social relations are assumed to occupy what Pearson (1975:43) has referred to as the 'liberated zone'. In a critique of the Politics of Thomas Szasz, Goldstein argues that

> Szasz overlooks the fact that entrepeneurial fee-for-service medicine [in this case, psychotherapy] is also tied historically and functionally to the government and other institutions (1980:576).

It is untenable to assume then, that contractual psychotherapy is insulated or exists apart from the influence of the discipline or the socio-cultural milieu in which it is formulated and practiced. Conceptualized as a form of associative social control, psychotherapy is seen as assisting in the maintenance of social order. While the present analysis is confined to an assessment of psychotherapy as social control, it is important to note that an implicit consideration in questions of social maintenance is the problem of social change vis-a-vis social control (Janowitz, 1975). It is not within the scope of this analysis to address the issue of social change proper, except to illustrate the potential for such transformation in the context of the way deviance is defined, for it can also be argued psychotherapy serves

to hinder social change while maintaining social order. Simply put, contractual psychotherapy may obstruct social change to the extent that it individualizes responsibility for a problem and negates social or socio-structural responsibility (Halleck, 1970; Hurvitz, 1973; Glenn and Kunnes, 1973; Ingleby, 1983). Szasz (1961) does not address this problem nor the problem of psychotherapy as social control in his consideration of contractual psychiatry.

It is traditionally assumed that psychotherapy exists primarily, if not exclusively, for the client. Moreover, we tend to believe that the sole aim is to alleviate the distress of the troubled individual. The purpose of this discussion has been to contest this assumption. While psychotherapy may serve the individual, the argument is that it also serves the social order. In the context of associative social control and hegemony, the discussion thus far questions whether the existence and activities of the psy-professions are aimed exclusively at the emancipation of human beings.

Consider the observation of Illich:

> Industrial society cannot function without providing its members with many opportunities to be diagnosed as suffering from real, substantive disease as a distinct entity... the more treatment people believe they need, the less they can rebel against industrial growth (1975:118-119, emphasis added).

Furthermore, Ingleby has argued that people tend not to accept their feelings as real, rather they are perceived as "worrying signs of illness" (1983:183). The ramifications of the theoretical and/or practical underpinnings of an associative social control program such as psychotherapy are more complex than the manifest goal of alleviating

subjective distress. Psychotherapy emerged as a form of treatment legitimized by association with the medical model (Szasz, 1961; Ingleby, 1983). This is only one of the treatments that people can come to believe they need. The nascent 'medicalization of life' indicates that this model is deployed with alarming frequency to account for and hence neutralize what must be perceived as potential threats to the integrity of a corporate liberal state.

2.3 PSYCHOTHERAPY AS SOCIAL CONTROL

Evaluations of psychotherapy can be characterized as attempts to establish the efficacy of different therapies (Luborsky, et al., 1975) and often the superiority of one strategy over another (Sloane, et al., 1975). The findings of such studies have been, since the inception of such research, inconsistent and inconclusive (Tennov, 1975). Grant (1983:342) contends, however, "that from a scientific standpoint, it can be asserted, more convincingly than ever before, that psychotherapy is a useful medical procedure whose curative properties are slowly becoming clarified in terms of client, therapist and technical variables". What remains, however, is that the relationship between psychotherapy and the social order in which it exists has yet to be fully investigated. While the formulation of the anti-psychiatry perspective offers a framework for such analyses, its claims have not been seriously considered in the sphere of contractual psychiatry. According to Pearson, the appeal of anti-psychiatry "which it undoubtedly does have for some professional malcontents is essentially one which is sentimental--that is, it reflects and voices the professional malaise rather than incisively analyzing its structure and revolutionizing its practice" (1975:38).

Gottman and Leiblum contend that "...many therapists are about as interested in the evaluation of therapy as they are in having someone else judge the quality of their lovemaking" (1974:92). If this observation is at all accurate, it is suggested that a socio-structural analysis is imperative.

Berger and Luckmann refer to therapy (of which psychotherapy is but one form) and nihilation as examples of 'conceptual machineries of universe maintenance' (1966:112). These two processes are used in conjunction to maintain the symbolic universe in the face of challenges to the taken for granted reality (Berger and Luckman, 1966). According to this perspective, 'reality' is a social construction which requires ongoing legitimation to insure its maintenance. The justification and maintenance of a given social order is problematic in light of the inevitability of deviations from the definitions of a taken for granted reality. In short, conceptual machineries of universe maintenance become necessary when the 'subjective' apprehension of reality is not in accord with the 'intersubjective' definitions of reality. In terms of the maintenance of social order, this incongruity must be corrected (if not eradicated) thereby preventing the objectivation of a competing definition of reality. Therapy appears to be the preferred technique (as opposed to force) for dealing with problems with the perception of reality. Berger and Luckmann state that

> therapy entails the application of conceptual machinery to ensure that actual or potential deviants stay within the institutionalized definitions of reality....it does this by applying the legitimating apparatus to individual cases.... Since therapy must concern itself with deviations from the "official" definitions of reality, it must develop a conceptual machinery to account for such deviations and to maintain the realities thus challenged. This requires a body of knowledge that includes a theory of deviance, a diagnostic

> apparatus and a conceptual system for the cure of souls (1966:112-113, emphasis added).

This excerpt illustrates the dual function of therapy and more important, suggests that a 'social ideology' is implicit in the formulation of therapeutic intervention. At the micro level, psychotherapy is presumed to reduce/allay subjective tension by re-establishing in the individual the intersubjective definition of reality. In this sense, it is not surprising that psychotherapy is perceived as non-repressive and consensual, or in some way liberating. What is not included in such a perception is that, at the macro level, it is the intersubjective reality that is maintained above all others. This can be seen to be a major form of social control.

In Berger and Luckmann's terms:

> successful therapy establishes a symmetry between the conceptual machinery and its subjective appropriation in the individual's consciousness; it resocializes the deviant into the objective reality of the symbolic universe. There is of course, considerable subjective satisfaction is such a return to normalcy (1967:114).

Consideration must be given then to the communication of implicit ideological messages in the context of psychotherapy. That social control occurs in this process is evident in the contention that official definitions of reality are left unquestioned, rather, it is the individual deviant's definition of reality that must be corrected. The result of this is "that people who talk about external factors are often "projecting" and not facing up to their own "inner selves" (Glenn and Kunnes, 1973:20).

In the course of maintaining social order, therapy must account for the 'cause' of <u>individual</u> deviance. The social order is not a problem,

thus the search for causality is restricted to the individual. Becker argues that we:

> attribute causality partly depending on where we can intervene in any system. What we call cause reflects our intention to act and the powers we dispose of....the greater our powers and the more comprehensive our intentions, the less narrow be our attribution of "cause" (1964:116, emphasis in original).

In the case of the psychotherapist, s/he is granted the power to intervene at the individual level, not the socio-structural level. If it is assumed that a social order provides the best environment in which to live, the mandate of therapy is reasonable and the search for causes of deviance is by definition appropriate. The search is restricted to causal factors which will not undermine the accepted social order. Despite this restricted power, the therapeutic agency could expand its sphere of expertise, but it is likely that its activity would be circumscribed in the interests of preserving its legitimacy. The question is, for how long would the state continue to sustain the legitimacy of an institution which endeavored to delegitimate the social order? Glenn and Kunnes have observed that "in practice, professional activities designed to change the **status quo** are political and therefore "unprofessional"; activities designed to strengthen the **status quo** are, of course, "medical", or "neutral", or "professional" (1973:47).

The expansion of power/authority pursued by the psy-professions has been confined to a substantial increase in the type and number of behaviors to which diagnostic labels can be applied (compare the American Psychiatric Association's DSM II and DSM III). Very few attempts have been made to address the causal factors external to the individual. It is suggested by some psychotherapists that the social

order may play a causal role, but it continues to be more pragmatic to restructure the individual rather than the society.

With regard to the search for causality, Becker further argues that the:

> psychiatrist has had to seek cause in the patient, because he had nothing else to work with. He could not attack the whole family, much less the whole society. Therefore he looked for chemical imbalance, brain damage, poor socialization ... (1964:117).

The tendency has been to adopt the "exceptionalist" approach to the causation of deviance. Regardless of one's professional affiliation (eg. psychiatry, psychology), from the exceptionalist perspective " abnormality is regarded as a disease which is located inside or as a part of the person" (Schulberg and Baker, 1975:56). This can be contrasted with the "universalistic" viewpoint whereby problems are deemed to be "inclusive rather than exclusive, public rather than private and general rather than special" (Schulberg and Baker, 1975:56). As is evident, the latter perspective is potentially threatening to the existing social order in the explicit call for an analysis of the social structure.

Psychotherapy's ability to engage in social control is facilitated by the 'individualization of deviance'. The implicit and often explicit message is that the social order is fine, it is you that is/has the problem. In a discussion of Negotiating Reality, Scheff (1968) illustrates the individualization process in the interaction between a psychiatrist and a 34-year old female client. The negotiation of reality refers to the "process of reconstructing past events for the purpose of fixing responsibility" through the use of offers and

responses (Scheff, 1968:87). In this example, the woman attempts to define the problem as being externally generated. The psychiatrist, however, subtly rejects this definition of the situation and continues to do so until the 'preferred' definition is offered. Scheff suggests that:

> after the patient has spent most of the interview blaming her current difficulties on external circumstances, she tells the therapist a deep secret, about which she feels intensely guilty. The patient, and not the husband is at fault. The therapist's tone and manner change abruptly. From being bored, distant and rejecting, he becomes warm and solicitous...the patient, not the husband is responsible (1968:95).

This excerpt is significant to the extent that it demonstrates that psychotherapy can be evaluated on the levels of theory and practice. While these are clearly not mutually exclusive categories, it can be assumed that theory provides an **a priori** framework within which psychotherapy proceeds. Put differently, if the theory assumes that the individual is the source of the problem, then the product of the negotiation of reality should mirror this assumption. What is lacking in Scheff's analysis is a determination of the theoretical perspective underlying the therapist's purported rejection of the external definition of the problem.

That the maintenance of social order is facilitated by the individualization process may not be readily apparent. Ingleby's argument requires restatement here, namely, that people tend not to accept their feelings as real, rather, they are perceived as "worrying signs of illness" (1983:183). Consider the implication of defining problems in living as caused by external circumstances at the macro level. For example, if perceptions of the family structure as the

problem were validated, the implication is that there would be a call for a corresponding change in that structure. The potential for significant socio-structural change has been created. Whether this potential will be realized is a separate issue, the potential exists nonetheless.

Berger and Luckmann (1966) indicate, however, that official definitions of reality are upheld and the individual is provided with the only acceptable (available) solution: adjustment. It should be noted that individualized definitions do not fall on deaf ears. A long tradition of individualization precedes the explanations of deviance advanced by psychiatry. This is to say that at a cultural level, we are socialized to think in individualized terms. Rarely, if ever, is the social order the unit of (psycho)analysis. It follows that "the productive power of the mental health professions thus lies in the generation of schemas for self-misinterpretation" (Ingleby, 1983:183). To the extent that psychotherapy fosters self-misinterpretation, a socio-structural analysis becomes more compelling.

2.4 SUMMARY

Psychotherapy has been conceptualized as a form of associative social control which is subsumed within a larger system of control to which the majority consents, or hegemony. Such consensual control is an efficacious system for the maintenance of a given social order to the extent that social institutions foster the cognitive and affective structures which perpetuate it, and thus the use of force can be minimized. Hegemony is effective in that fundamental socio-structural critique is excluded from the established mode of thought.

In this context, psychotherapy serves a dual function in social life. On the one hand, it attempts to ameliorate mental instability, which has been couched in the framework of alleviating the individual's subjective distress. Attempts to ameliorate such instability, on the other hand, facilitate the smooth perpetuation of a given social formation. An implicit ideological message is communicated via the official definitions of individual deviance. It is primarily a message of social maintenance. If psychotherapy is confined exclusively to the alleviation of individualized subjective tension, it obstructs from view the plausible role of social structure in the development of that tension.

It has been argued that to maintain social order psychotherapy must define, diagnose, and attempt to cure deviance. Clearly, this requires a conceptual framework which delineates normal human functioning in the sense that the aim of therapy is to cure the deviant, or return him/her to normalcy. It is further argued that to be 'normal' is to conform to the rules/ norms which prescribe acceptable cognitive and behavioral activity. The etiology of non-conformity must be understood in order to both diagnose and effect cure. The preceding argument suggests that the unit of analysis in accounting for the etiology of deviance is the individual. It is not the social order that needs to be changed, rather it is the individual who must adjust to the **status quo.**

Chapter III

METHODOLOGICAL FRAMEWORK

3.1 INTRODUCTION

Psychotherapy attempts to shape or change human behavior by modifying the cognitive and affective structures underlying subjective distress. In so doing, it must posit an hypothetical ideal, and by definition, those factors which detract from the realization of that ideal. In order to overcome the shortcomings of the polemical analysis of this issue, it is appropriate to delineate the ideal model that psychotherapy uses as its standard. The primary objective of this study is to examine theories of psychotherapy in order to explicate the **a priori** assumptions which guide clinical practice. According to Pearson, domain assumptions "are commonly one of the most powerful dimensions of a theoretical construction; they are the crude resonances from which the more subtly worked, but superficial, face of theory derives as mere harmonics" (1975:8-9). Psychotherapy must answer certain questions (either implicitly or explicitly). The purpose of this study is to reproduce its answers to the following questions: What is normal?; What is the appropriate unit of analysis in accounting for deviations from this ideal?; and How can these deviations best be ameliorated? These questions will be clarified in the forthcoming 'Method' section.

3.2 THE DATA SOURCE

There are several approaches one might use to study the assumptions that form the foundation of various theories of psychotherapy, including: a) observation and analysis of actual or recorded therapy sessions; b) interviews with practitioners; and c) an analysis of theoretical texts/training manuals for those entering the profession. The third source was chosen for a number of reasons. An analysis of psychotherapy sessions would be problematic in view of such issues as: confidentiality, access and detailed analysis of the clients' counselling history. Interviews with practitioners would involve lengthy, time-consuming appointments which might inhibit their cooperation. One might hazard the guess that these practitioners would respond unfavorably to a study which has conceptualized their practice as a form of social control, thereby decreasing the likelihood of their individual participation and provision of access to actual psychotherapy sessions. In keeping with the objective of this study, a content analysis of psychotherapy texts/manuals was the most direct and explicit method of reconstructing the logic (vs. logic-in-use, Kaplan, 1964:3) of clinical practice. This was considered to be the appropriate starting point for the study of psychotherapy in so far as theory guides practice. Such texts/manuals are attempts to codify, elaborate and specify the assumptions, approaches, techniques and goals of psychotherapy.

Seventeen faculty members of the Clinical Psychology and Psychiatry graduate programs at the University of Manitoba were contacted and requested to furnish a list of five psychotherapy texts that are

assigned for graduate courses in psychotherapy training (See appendix A for the correspondence). Of the thirty-seven texts that were suggested, twelve were selected for analysis, and included the three dominant perspectives in clinical practise (see appendix B for the list of texts used in the study). The three 'seminal' approaches are psychoanalysis, behaviorism and experiential-humanism. Three texts from each perspective were examined. The selection of texts was not arbitrary or random, but rather was based on theoretical concerns. For example, the three psychoanalytic texts provided an intensive discussion of the etiology of certain forms of deviance (Freud, 1936); a comprehensive overview of psychoanalytic psychotherapy (Fromm-Reichman, 1950); and a case study of one individual (Balint, Ornstein and Balint, 1972). In addition, three texts were listed by the Clinical Psychology and Psychiatry faculty that are not theories of psychotherapy per se (Fromm, 1941; Laing, 1969 and Halleck, 1971). These texts were included in the sample because they provided an indication of the range of theoretical perspectives which shape clinical training.

While this strategy for compiling a data source may represent a biased approach, alternative attempts proved unsuccessful. For example, the University of Manitoba bookstores were requested to provide a list of required texts for a number of graduate courses in these programs, but the records only go back three years and since the courses may not be offered every year, the final list consisted of five books. Such a small number of texts would seriously undermine the scope of the present analysis and could be considered more biased than the present sampling scheme. In view of the purpose of this study, the clinicians themselves

can be seen as the most appropriate source of suggested readings in psychotherapy.

3.3 METHODOLOGY

The purpose of this study was to explore theoretical answers to the following questions: What is normal?; What is the appropriate unit of analysis in accounting for deviations from this ideal?; and How can these deviations best be ameliorated? The most appropriate technique for studying this research problem is content analysis which Zito defines as:

> a methodology by which the research seeks to determine the manifest content of written, spoken, or published communication by systematic, objective and quantitative analysis (1975:27).

This conceptualization of the method restricts the analysis to the quantifiable manifest content of a communication. Budd, Thorp and Donohew (1967) argue that this usage, by concentrating on the manifest content, results in leaving unanswered the larger question of its relation to other variables. In addition to the manifest content of theories of psychotherapy, this study intends also to provide a contextual analysis. As Holsti (1969) indicates, content analysis can be used to detect patterns and regularities, which in turn, highlight the importance of latent content. Accordingly, Carney adopts the following definition of content analysis:

> any technique for making inferences by objectively and systematically identifying specified characteristics of messages (1979:25).

This formulation provides for a more flexible use of the method and expands its utility beyond an analysis of television, newspaper and magazine content.

The search for pattern and consistency is presented by Kaplan (1964) as an alternative to a hypothetico-deductive approach (which would be more compatible with manifest content analysis). Following Kaplan's view of pattern explanation, then,

> something is explained when it is so related to a set of other elements that together they constitute a unified system. We understand something by identifying it as a specific part in an organized whole (1964:333).

This approach to explanation is consistent with Glaser and Strauss's (1967) articulation of the process of generating theory. In contrast to conventional verification research, Glaser and Strauss (1967) argue that for the purpose of discovering grounded theory, theoretical sampling provides an alternative logic for reliability. Further, this approach affords the anomaly a central role in confirming pattern validity which represents an alternative logic of validity. Pattern and consistency are explained using the comparative method (Glaser and Strauss, 1967), which, in the case of this study, will involve a comparison of theories.

It should be noted that the present study was not intended to generate a theory of psychotherapy per se. Rather, the methodology espoused by Glaser and Strauss (1967; cf. Glaser, 1978) facilitates the emergence of the pattern from the data as opposed to pattern imposition. This analysis of psychotherapy texts did not involve a simple coding of key words or phrases but rather a search for theoretical statements which explicate the three primary questions asked in this study, and how they are intertwined.

3.4 METHOD

A content analysis was used to study theories of psychotherapy with the aim of analyzing key assumptions in order to reconstruct the logic implied by those variants. An attempt was made, then, to reproduce answers to the basic questions asked by this study. Again, the three questions with which we are concerned are: What is normal?; What is the appropriate unit of analysis in accounting for deviations from this ideal?; and How can these deviations best be ameliorated? Clearly, these are complex and interrelated questions that are not amenable to conventional operationalization. In the interest of clarity, however, it is necessary first to outline the questions more precisely, and second to provide an explicit discussion of the content analysis was conducted.

The question of what is normal human functioning might be better posed, what is abnormal? That is, an explicit definition of normality in and of itself is virtually impossible to formulate, and thus is not forthcoming without reference to an abnormal counterpart. Consider, for example, Webster's definitions of normal (excluding inanimate phenomena of course) which include: "according with, constituting, or not deviating from a norm, rule or principle; occuring naturally; of relating to, or characterized by average intelligence or development; and free from mental disorder" (1980:776). The point here is that what is normal is relative to norms, rules or principles, or is characterized by the absence of that which constitutes abnormal, such as a mental disorder.

By and large, the task of determining what is normal, notwithstanding explicit attempts at definition, would be one of inferring normalcy from descriptions of abnormality. For example, a phrase which describes an individual as having distorted perception would be the starting point for understanding or defining accurate or normal perception. Perception, however, is just one aspect of human behavior. A comprehensive definition of normality would require an examination of all dimensions of human experience in order to construct a profile against which it can be assessed. This would undoubtedly be a cumbersome, if not impossible task.

The question of what is normal was raised in this study in order to reconstruct the goals of psychotherapy. Rather than attempting to delineate the characteristics of normality, the aim was to describe what psychotherapy attempts or intends to accomplish for the individual. Definitions, descriptions, and discussions of normality and abnormality were examined to provide an outline of psychotherapeutic aspirations. These goals provide the context for the explanation and amelioration of deviance. For example, accurate perception can be considered a goal of psychotherapy. Deviations from this ideal can be explained in terms of a lack of information, or an inability to use information which is objectively available (Martin, 1983). Accordingly, the amelioration of distorted perception proceeds by talking the person out of the distortion by providing sufficient information or by helping him/her to recognize and use information that is objectively available(Martin, 1983). The implication is that perception is at one and the same time, a subjective and social phenomenon, which has subjective and social

ramifications. The question of what is normal was raised as an attempt to understand how subjective and social issues are incorporated into the formulation of psychotherapeutic goals. Again, the questions raised by this study are complex and interrelated. An understanding of the goals of psychotherapy was considered to be an appropriate starting point for this analysis of psychotherapy in terms of their relationship to the explanation and amelioration of deviance. This question was answered by examining explicit discussions of normality and by making inferences from definitions and descriptions of abnormal behavior or experience in order to determine what psychotherapy tries to achieve.

Deviance must be explained. The understanding of deviance and the formulation of a corrective strategy cannot by achieved without an account of its etiology. A unit of analysis must be delineated in order to understand the problem at hand and its concomitant remediation. It can be argued that the unit of analysis with which to explain a particular problem can range from the individual to the socio-structural formation. For example, alcoholism can be explained as a disease located inside a person, or as a response to socio-structural conditions such as poverty, racism, unemployment and so on. The manner in which the issue of alcoholism is to be dealt with will depend significantly on the unit of analysis that is used to account for the problem. If alcoholism is conceptualized as a disease, the individual is/has the problem and must be changed. Conversely, if alcoholism is understood as resulting from social or socio-structural conditions, the implication is that poverty, racism and unemployment must be eradicated, as opposed to the individual's disease.

Theories of psychotherapy must employ a frame of reference, either explicitly or implicitly, in order to define and discuss deviance (or normality). The etiology of fear or anxiety can be conceptualized in individual, interpersonal or socio-structural terms. It is clear that these analytical categories are interrelated, but the formulation of psychotherapeutic intervention demands the identification of appropriate targets for change. More specifically, fear or anxiety associated with sex or anger may be understood by reconstructing the individual's prior learning history (Martin, 1983). It would seen that such learning cannot be understood apart from normative expectations concerning the appropriate expression of sexuality or anger. One problem that arises is determining the parameters of abnormal fear or anxiety (i.e. what is normal?). It is untenable to assume that humans can pass through life entirely free of fear or anxiety. The question is when does fear or anxiety require corrective treatment? In one view:

> we all have problems that would be called neurotic if they caused enough trouble for us and/or those around us. The point at which "enough trouble" begins is arbitrary and is based on individual circumstances and even cultural norms (Martin, 1983:233).

What is significant in this formulation is the emphasis placed on 'individual circumstances' as opposed to 'cultural norms' as the unit of analysis in accounting for the problem. While the problem of the individual is understood in a social context, the individual remains the unit of analysis. That is, cultural norms may precipitate the development of fear or anxiety but neither the norms, or their transmission through social interaction are considered to be problematic. Rather, the norms are taken for granted and the task is to rid the individual or his/her fear or anxiety. The purpose of this

discussion is to specify with greater precision the questions raised in this study. It would be premature at this point to proceed further with a theoretical analysis. Suffice it to say that the second question was addressed in theories of psychotherapy by material in which a problem is defined in relation to individual, interpersonal or socio-structural circumstances.

The understanding of what a problem is and how it develops, permits/structures the formulation of a strategy to get rid of it. The question, then, was how can these problems best be ameliorated? Efforts to correct or solve a problem can range from changing the individual to transforming the social structure. The unit of analysis that is delineated for understanding the etiology of a problem is directly related to the effort to ameliorate it. While it is not appropriate at this point to provide a detailed discussion of psychotherapy in practice, it can be stated that answers to the third question raised in this study were explicitly embodied in the techniques espoused by the theory of psychotherapy. For example, the behaviorist approach employs a variety of strategies for modifying human behavior. An attempt was made, then, to reconstruct an outline of the theory of practice.

The three questions raised by this study are fundamental to psychotherapy, and are demonstrablly interrelated. Psychotherapy must formulate goals and explicate the etiology of deviance in order to conceptualize a strategy that will facilitate the realization of its goals. This study attempted to highlight and then, compare and contrast key assumptions underlying different psychotherapies by conducting a content analysis of theoretical texts.

The twelve texts selected for this study were read four times in order to insure that they were thoroughly examined. A face sheet was prepared for each text on which to record the pages that contained a discussion of the three questions raised by this study (see appendix C). This was analogous to preparing a subject index for each text that listed page references for discussions of the problem of normality, explanations of deviance, and methods for ameliorating it. These pages were also marked with paper flags with the question number(s) indicated on them to facilitate the analysis of the text. These flags highlighted the material directly relevant to an examination of, for example, normality and the goals of psychotherapy. The arguments of other theorists were included as part of the text when cited in support of the perspective perspective espoused by the author. These arguments or discussions were excluded when the author simply cited a contrasting view or provided a critique of the alternative view.

In the initial readings, there was no attempt made to quantify or otherwise code or categorize the texts other than to identify the material pertinent to the three focal questions. A rigid operationalization of the questions, or the imposition of a coding scheme would have obstructed the emergence of psychotherapy's own answer to these questions. Space was provided on the face sheet, however, to make initial observations on potential issues for the analysis and discussion. Using the subject index as a guide, detailed notes were taken from each text in order to record the fundamental assumptions and theoretical statements made by the authors with reference to the questions raised by the study. These notes provided the content of

psychotherapeutic theory that was analyzed and the texts were repeatedly consulted to retain the context of the discussion. Each question was examined separately despite the degree to which they are interrelated. The content of the texts was examined for pattern and consistency within and between texts as well as perspectives. Distinctions between schools of psychotherapy were relevant only when the analysis turned to the amelioration of deviance. The problem of normality or the goals of psychotherapy are conceptualized in comparable terms by all of the perspectives. Similarly, all of the perspectives employ explanations of deviance that range from the individual to the socio-structural unit of analysis. The specific manner in which deviance is ameliorated, however, differed significantly.

As the patterns emerged, quotations were selected which would best exemplify or clarify the characteristic elements of the theoretical formulation. These examples may not be representative in a statistical sense, but rather were selected purposively for their ability to illustrate the issues. Inconsistencies and gaps in the assumptions were identified and an effort was made to systematically integrate material which explained the inconsistency or bridged the gap. On the basis of this method, analytical categories emerged which explicated the focal concerns of the study. When all of the categories and illustrations thereof were exhausted, the essence of psychotherapeutic theory was discussed. Finally, a theoretical analysis attempted to evaluate the argument that psychotherapy is a form of social control.

Chapter IV

THE PROBLEM OF NORMALITY

4.1 INTRODUCTION

The content of theories of psychotherapy are analyzed in this chapter as a method for assessing the argument that psychotherapy is a form of social control. Psychotherapy texts have been content analyzed with specific reference to the issues of what is normal and how deviance is explained and ameliorated. These questions provide the focus for outlining the conceptual and practical parameters within which psychotherapy occurs. While the questions undoubtedly overlap, in the interest of clarity, the discussion has been organized into three chapters in order to explicate fully the implications of the psychotherapeutic framework. In the present chapter, the problem of normality will be discussed. While four theoretical perspectives can be delineated, it is not the purpose of this study to evaluate the extent to which particular approaches to psychotherapy do or do not constitute a form of social control. Rather, the aim is to provide an analysis of how a social order may be maintained by a therapeutic programme such as contractual psychotherapy. It is assumed that psychotherapy can be conceptualized in its various forms as a general system of treatment. This requires the inclusion of the different approaches to psychotherapy so that an adequate range of these theoretical formulations are considered.

4.2 DEFINING NORMALITY

Human behavior can only be understood in a social context. To say that an individual, or his/her behavior, is normal indicates an evaluation of the behavior with reference to a given set of standards. In this particular case, the issue that must be addressed is what is normal? More specifically, the question is what is the ideal that psychotherapy attempts to achieve? It is clear that 'normal' does not exist in and of itself, but rather is a social construction. The task at hand, then, is to explore the characteristics of normality.[2] This problem seems best approached by defining abnormality and inferring normality in the absence of indicators of the former. In addition to this method, attempts have also been made to provide explicit definitions of the characteristics of normality (for example, Martin, 1983; Rogers, 1959; Halleck, 1971; Fromm, 1965). The purpose of this discussion of what is normal is to provide a focus for assessing whether psychotherapy acts as a form of associative social control. No attempt will be made to determine what one has to be, display or possess to qualify as normal. Rather, the question is what does psychotherapy try to accomplish? It is only through a consideration of how normality can be defined that the purpose of psychotherapy can be assessed.

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[2] This question was originally formulated such that it demanded the specification of an equation for normality. That is, the answer to the question what is normal would have had to suggest that a given degree of A + B + C + ... Z = NORMAL. As one astute observer put it, "That's like trying to nail jelly to the wall". One must concur with this statement because human behavior is simply too complex for one to be able to reduce it down to an additive linear equation. The question is still raised here because it provides an important discussion of the aim of contractual psychotherapy.

The argument that psychotherapy is a form of social control contends that being normal constitutes conformity to the expectations (including subjective experience and social performance) of the group with individuality being circumscribed by those expectations. One way to define normal then is from the perspective of the group. Normal might also be conceptualized from the perspective of the individual's subjective experience. There are two broad dimensions of human behavior that are delineated in theories of psychotherapy which represent the goals it tries to achieve. The first focuses on the individual and his/her subjective perception of, and experience in, the world. The second emphasizes the social performance or functioning of the individual in the various roles and relationships in which s/he is involved. According to Fromm:

> the term normal or healthy can be defined in two ways. Firstly, from the standpoint of a functioning society, one can call a person normal or healthy if he is able to fulfill the social role[s] he is to take in that given society. More concretely, this means that he is able to work in the fashion which is required in that particular society, and furthermore that he is able to participate in the reproduction of society, that is, that he can raise a family. Secondly, from the standpoint of the individual, we look upon health or normalcy as the optimum of growth and happiness of the individual...The [former] is governed by social necessities, the [latter] by values and norms concerning the aim of individual existence (1965:159-160).

These two major dimensions of human reality are central to the problem of defining normality. While none of the texts that were considered relied exclusively on one or the other of these standpoints, differences in emphases were observed.

For example, Martin defines the effective person as one who possesses or displays:

> a quiet sense of personal worth; autonomy, and a sense of competence; accurate, full openness to feelings and thoughts; and the capacity to be intimate (1983:90).

Although elements of both views are present in this definition, it is argued that a greater emphasis is placed on the individual's subjective experience rather than social performance. Similarly, Rogers contends that:

> optimal psychological adjustment exists when the concept of self is such that all experiences are or may be assimilated on a symbolic level into the gestalt of the self-structure...[It] is thus synonymous with complete congruence of self and experience, or complete openness to experience (1959:206).

In addition, the fully functioning person "will have no conditions of worth" (Rogers, 1959:235): experience will be valued because it enhances the individual in and of itself, as opposed to winning the positive regard of significant others (Rogers, 1959:209). This emphasis does not mean, however, the the fully functioning individual can exist independent of others, rather, "he will live with others in the maximum possible harmony ..." (Rogers, 1959:235). This presupposes the group is comprised of other similarly fully functioning persons.

It is untenable to assume that a society could exist that was devoid of criteria for evaluating its members, or of structures which limit individuals' experiential world. To be sure, as Rogers (1959) acknowledges, assessing one's worth or competence, requires, the existence of an audience which contributes to the outcome of such an assessment. Similarly, one may be capable of intimacy but it can only be achieved in interaction with others. For the fully functioning person:

> satisfying living consists, not in a life without problems, but a life with a unified purpose and a basic self-confidence which give satisfaction in the continual attack upon problems (Rogers, 1942:218).

What appears to be important then, is that the individual is able to meet the challenge of life with some degree of independence from the expectations of others and with subjective satisfaction.

As stated by Fromm-Reichmann:

> emotional difficulties in living are difficulties in interpersonal relationships; and a person is not emotionally hampered, that is, he is mentally healthy to the extent he is able to be aware of, and therefore to handle his interpersonal relationships (1950:xiv).

These overt relationships with other people are crucial in terms of the individual's:

> ability to reach out for and to find fulfillment of his needs for satisfaction and security, as far as they can be attained without interfering with the law or the needs of his fellow-man (Fromm-Riechmann, 1950:34).

This theorist incorporates both the standpoint of the individual and the group in conceptualizing normal human behavior. However, to feel secure, for example:

> means the fulfillment of a person's wishes for prestige, that is, acceptance by and the respect of society as well as the achievement of self-respect (Fromm-Reichmann, 1950:9).

The implication is that it is only through overt relations with others that the individual can fulfill his/her goals or needs, in this case, security. The subjective dimension of human behavior facilitates or hinders overt social relations and vice versa. Thus, the emphasis has been placed upon observable interpersonal relationships. This represents a shift away from the subjective appraisal of experience toward an evaluation of one's performance in relation to others. Again, the fulfillment of one's need for satisfaction and security, requires, at least in part, adequate interpersonal skills. While Fromm-Reichmann is critical of psychotheraputic practice whose goal is to "cure symptoms

and effect social recoveries" (1950:x), she also argues that those who experience difficulties in living must make "some degree of cultural adjustment" (1950:33). This would seem to suggest that social performance is to some extent more important than subjective satisfaction. That is, subjective satisfaction can only be realized in relations with others.

We have yet to establish what is normal, except in the general sense of the subjective satisfaction of the individual on one hand, and the meeting of social requirements, on the other. The question that arises is which of these two dimensions is more salient in the definition of normal human behavior. Psychotherapy attempts to make people feel better which presumably will foster better behavior. It would be useful at this point, however, to consider how abnormal behavior is defined.

According to Martin and Pear:

> the point at which a particular behavior is considered deficient, excessive, or inappropriate is determined primarily by the practices in the culture and by the desires, wishes, and ethical views of concerned individuals (1978:10).

Furthermore:

> the social context is also important in determining whether a given behavior is regarded as deviant. Abnormal behavior is inferred from the degree to which behavior deviates from social norms. Because social norms vary across cultures and across groups and settings within a given culture, it is difficult to posit objective criteria for abnormal behavior (Craighead et al., 1981:107).

The first step that can be taken is to restate the argument in terms of normal behavior. That is, all behavior is evaluated in terms of cultural rules. Thus, the 'objective' basis for evaluating behavior <u>is</u> the particular norms and contexts within which it occurs. Therefore, it can

be argued that normal behavior is inferred from the degree to which behavior conforms to a given set of social norms. While it is clear that human existence can be assessed subjectively as well as from an external frame of reference, "the values of the individual [or group] who evaluates behavior play a major role in determining whether it is normal or deviant" (Craighead et al., 1981:170). In the final analysis, those values are derived from the group (Berger and Luckmann, 1966). That is, both standpoints from which behavior is defined are social. Whether it is a subjective or an external evaluation, the rules are derived from the group, and thus, are socially constructed.

In Freud's discussion of The Problem of Anxiety (1936), it is clear that human existence can be, at one and the same time, experienced internally and observed externally. For example:

> inhibition in the field of occupation ... is evidenced in diminished pleasure at work, or in its poor execution, or in such reactive manifestations as fatigue (vertigo, vomiting) if the subject forces himself to go on working. Hysteria compels the suspension of work by producing paralysis of organs and functions, the existence of which is incompatible with the carrying on of work. The compulsion neurosis interferes with work by a continuous distraction of the attention and by loss of time in the form of procrastination an repetition (1936:14).

What is emphasized in this quotation is overt role performance. Persistent physical illness or disability as well as inadequate performance, for which there is no obvious organic or other reasonable explanation, presumably signal subjective difficulty. Even though the subject's diminished pleasure in work is mentioned, it appears only to be significant to the extent that it manifests itself in the subject's behavior.

In keeping with the focus of this inquiry, it is important to note that the individual may identify his/her experience of diminished pleasure in work as problematic, in addition to, or independent of external evaluation. In fact, social performance may be acceptable to the observer, independent of the individual's experience of diminished pleasure in work. This can be understood in terms of the cultural definitions of what one should think about the way one feels. That is, the culture has taught us that our subjective experience may affect overt behavior. Or, as Fromm argues:

> in our society emotions in general are discouraged. While there can be no doubt that any creative thinking -- as well as any other creative activity -- is inseparably linked with emotion, it has become an ideal to think and live without emotions. To be 'emotional' has become synonymous with being unsound or unbalanced (1965:270).

Again, the group provides the criteria against which subjective experience and social performance are compared.

Two problems have emerged. On one hand, the individual may determine that his/her subjective experience or overt performance is unacceptable and voluntarily avail him/herself of psychotherapy. On the other hand, an external evaluation of behavior may render the person a candidate for psychotherapy, insofar as the behavior is inexplicable to the observer. It is suggested that the decision to enter contractual psychotherapy may result from either, but, given the complexity of human behavior, it is probably an interaction between the two. In any event, a set of normative expectations, however nebulous, govern both the subjective apprehension of experience and its external evaluation.

All dimensions of human behavior (physical, emotional, cognitive, and interpersonal) are involved in assessing normality. These processes interact with each other thus making it difficult to differentiate physical action from cognitive, emotional, or interpersonal activity and so on. Sexual behavior, for example, has certain physical requirements, but it also has cognitive, emotional, and interpersonal dimensions. Simply put, sex is more than a physical activity. Anxiety, to take another example, is generally described as an internal emotional state, but it also has physical manifestations that may effect or result from an individual's thinking or interpersonal relationships. Although distinctions can be drawn between these aspects of human behavior, it is important to note that in the analysis of a given phenomenon the distinctions disappear. In the psychotherapy texts, two aspects of behavior, namely, how the individual feels and/or acts, dominate the definitions of problematic experience. Moreover, one's experience/performance as a social actor is the measuring stick against which normalcy is assessed.

The most common descriptions and explanations for a person being in psychotherapy involve the individual's emotional state. In general terms, an individual may experience painful emotions or suffer great emotional difficulties. More specifically, anxiety, depression, fear, panic, despondence, unhappiness, despair, guilt, loneliness, low self-esteem, insecurity, to name a few, are among the emotions that are taken as indices of the need for psychotherapy. These emotions become particularly problematic insofar as they affect one's ability to think, act, and/or interact with others.

In every psychotherapy text examined, for example, the experience of anxiety surfaces as either a complaint or an explanation for particular behavior. While anxiety is experienced by all people, at one time or another:

> an individual whose arousal is too high before and during, [for example], an academic examination or may experience physical discomfort and draw a blank when attempting to answer a test question or think of conversation topics. Such experiences may make future tests or dates even more stressful, thus adding to the discomfort and further disrupting performance (Craighead et al., 1981:208).

This excerpt includes both the subjective experience (discomfort) and an external observation (disruption of performance). Either of these experiences or observations may signal a problem.

Anxiety has also been investigated in terms of its presumed effect on sexual functioning, locomotion and eating, in addition to the previous example of occupational performance (Freud, 1936). In Freud's analysis, anxiety may inhibit, that is, simply reduce the function [i.e. behavior] or may manifest itself as a "symptom when it is a question of an unusual alteration or a new modality thereof" (1936:11). Taking sexuality as an example, anxiety may result in the "non-occurrence of the pleasure of orgasm" or may inhibit the physical dimensions of executing the act (eg. "absence of physical preparedness, non-erectability") (Freud, 1936:12). Whether anxiety is the effect of engaging in certain behaviors or affects behavioral performance, what is at issue is the relationship between emotion, thought, and action. According to Craighead, et al.:

> a certain degree of arousal or activation is a prerequisite to adequate everyday functioning; a totally non-aroused person would be in a coma twenty-four hours a day. However, too much activation can also be debilitating; when response patterns referred to collectively as anxiety reach high levels of intensity, frequency, duration, and generality, the individual and those around him or her experience severe discomfort, and disruption of adaptive behavior occurs (1981:208).

Normal arousal or anxiety, then, underscores human action. When it registers as discomfort for the individual or others and effects adaptive behavior it is abnormal. It is impossible , however, to designate a discomfort threshold which distinguishes normal arousal from abnormal anxiety.

4.3 DISCUSSION

Contractual psychotherapy must have a goal or a set of goals that orient the process. The preceding discussion suggests that the goals of psychotherapy are to help the individual feel better and/or perform better than what is currently experienced or observed. The parameters of abnormality, however, are nebulous. That is, it is impossible to distinguish with any degree of analytical specificity when experience or performance falls within the category of normal. This can be contrasted with definitions of criminal behavior which clearly demarcate unacceptable behavior, and distinguish between the criminal and the non-criminal. In the case of psychotherapy, this type of analytical specification is absent. The ambiguity of the concept of normality renders every individual a potential candidate for psychotherapy.

The nebulous character of normality can be seen as an essential feature of psychotherapy as an associative social control programme. All human beings experience subjective distress and disruptions to social performance throughout their lifespan. If subjective distress and disruptions to social performance are culturally defined as problematic in general terms, and specifically as the signs of illness (Ingleby, 1983), then psychotherapy can be construed as an integral part

of individual and social life.[3] The religious parallel of this is confession in the Catholic tradition. The view is that sin is inherent in human existence. Sinning is inevitable and thus regular confession is essential to absolve oneself of the guilt (subjective distress) associated with sin, which also encourages the avoidance of further sinful activity and, ultimately, purgatory. The problem of sin pervades human activity and thus no one is exempt from confession. Subjective distress and inadequate social performance are similarly common in human life. In addition, confession can be seen as serving both a corrective (guilt expiation) and preventative function (avoidance of purgatory). Psychotherapy attempts to alleviate subjective distress and improve social performance, which have been assumed to presage, or culminate in insanity if untreated (Armstrong, 1983).

The goals of psychotherapy are not problematic in so far as it is desirable for the individual to feel and perform well. They become objectionable, however, to the extent that in explaining and ameliorating deviance, a given social order is maintained by explanations and ameliorative strategies which identify the individual as the source of the problem and thus the focus for change. The critical issues that arise in assessing the argument that psychotherapy assists in the maintenance of social order are; how are subjective distress and inadequate social performances explained, and in what way are they best ameliorated. The argument is that individualized explanation and amelioration obscures the features of the social order

[3] During the preparation of this thesis, the researcher noted that private psychotherapy/counselling centers in the United States have begun to advertise their services on television. The message is that we all could benefit from psychotherapy.

which may play a significant role in the development of subjective distress and disruption of social performance. Before deviance can be corrected, it must be explained. The unit of analysis that is employed to explain deviance, will, by definition, shape the strategy that is developed to correct it. It is to these units of analysis that this discussion now turns.

Chapter V

EXPLAINING DEVIANCE

5.1 INTRODUCTION

Human behavior is always explained from a particular frame of reference. In the preceding chapter it was noted that all human activity is shaped by, develops and occurs in, a social context, and cannot be understood apart from this reality. This broad perspective represents a starting point for the study of human existence, and can be broken down into the following three units of analysis: the individual; the interpersonal; and the socio-structural. This is the pattern that was observed in theories of psychotherapy. In combination, the study of these dimensions of a social environment would provide a comprehensive understanding of the factors affecting human action. Separately, they can only explain their particular influence on the subject of inquiry. The problem at hand is to outline these units of analysis with specific reference to the explanation of deviation from the normative order. In short, from which frame of reference is deviance, and the etiology thereof, explained in theories of psychotherapy?

Before proceeding with this task, it should be noted that these categories are not mutually exclusive. All three frames of reference provide a contribution to understanding deviance, or human behavior in general, and necessarily overlap. For example, sexuality is at one and

the same time, an individual, interpersonal, and a socio-structural phenomenon. Attitudes towards sex, though often individualized, are shaped by interpersonal relationships, both of which are socially structured (eg. heterosexual monogamy). For our purposes, what is significant is the relationship between the frame of reference from which the etiology of deviance emerges and the concomitant strategy for ameliorating that deviance. For analytical purposes, then, it is necessary to draw distinctions between the individual, interpersonal, and socio-structural units of analysis. This section will present illustrations of the unit of analysis used to explain the problems presented by persons in psychotherapy.

5.2 THE INDIVIDUAL

The individual unit of analysis identifies the individual as the source of the problem and includes a consideration of the role of biological and subjective factors in the explanation of deviance. The word psychotherapy itself focuses the inquiry on the psychological dimensions of individual human existence, so it is not surprising that the emphasis in psychotherapeutic theory is placed on individualized traits and internal processes.[4] Specifically, it is apparent that, with the exception of biological issues, cognitive and affective processes represent the common denominator in providing the means by which feelings and behaviors are altered. It is beyond the scope of this

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[4] Although the presentation of the material suggests that the theorist employs one unit of analysis, as stated at the outset, this is not the case. Freud (1936), for example, also addresses social issues in accounting for phobias. What is the superego, if not the internalized representation of external rules?

thesis to consider the biology of behavior as a distinct topic. Suffice it to say that within the confines of contractual psychotherapy, it is assumed that physiological intervention is used in conjunction with the exploration and change of what a person thinks or feels.

An individualized approach to explaining deviance employs such concepts as: castration anxiety, excessive eroticization, the oedipus complex (Freud, 1936), sublimated homosexuality (Balint et al., 1972), distorted perceptions, internal conflict (Martin, 1983), irrational thoughts and feelings, inadequate problem-solving skills (Martin and Pear, 1978; Craighead et al., 1981), which have been developed to account for such problems as phobias, anxiety, depression, inappropriate behavior, and so on.[5] What is common among such explanatory concepts is the emphasis placed on processes internal to the individual.

Balint et al. (1972), present an intensive case study of a person named Mr. Baker, who, among other things, was experiencing marital difficulties. Although this is an interpersonal relationship, Mr. Baker has entered psychotherapy alone, and thus the following excerpt illustrates the use of the individual himself as the unit of analysis:

> He then went back to his ruminations about Farah 'pretending' (a) to him that she had never had any doubt that she loved him; and (b) to James that she was in love with him and agreed to call him 'darling'. Again a long rumination followed which was stopped by my pointing out that it would be impossible to get a proper answer to his problems from outside. The problem we have to solve is 'what is he after', 'what has he got under

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[5] Inconsistencies in the use of the concepts and labels will emerge in the discussion that follows. For example, the term paranoia is usually used as a label for unacceptable behavior. It is also used, however, as an explanation, at least in part, for marital difficulties (cf. Balint et al., 1972). Similarly, anxiety may be designated as a problem (Craighead et al., 1981), but may also be used as an explanation of problematic behavior (Martin, 1983).

his skin' (Balint et al., 1972:85).

It is explicitly suggested that it is what is inside the individual that underscores the difficulties. Such internal processes mentioned include, for example: "a particular illness being kept precariously under control through obsessional character defenses" (Balint et al., 1972:104) and, "sublimated homosexuality" (Balint et al., 1972:85). That Mr. Baker's internal processes are viewed as the source of the problem is further evidenced by the therapist trying to show the spouse "in what way she could perhaps avoid colluding with her husband's illness" (Balint et al., 1972:4). While this also suggests that the interpersonal relationship warrants consideration, the marital difficulties are explained primarily by Mr. Baker's subjective difficulty.

From a similar perspective, the following explanation of delusions is provided:

> Delusions originate in the realm of thought processes...They are, at least partly, beliefs or interpretations of facts independent of the actual meaning of these facts. That is, they are false beliefs and false interpretations and exaggerations of facts which are the unrecognized expression of repressed or dissociated material...Persecutory ideas are delusions of being persecuted, most of the time, unknown to the patient, because of unacceptable inner impulses. Responsibility and blame for them are passed on to the alleged persecutor (Fromm-Reichmann, 1950:175).

Clearly, feeling persecuted is interpreted primarily as an internal cognitive problem, precipitated by "unacceptable inner impulses", about which the client has little awareness.

To take another example, a fear of horses might be explained by the castration anxiety arising out of an unresolved oedipus complex (Freud, 1936). Zoophobia, in this case, is defined in this way:

> The unintelligible fear of horses is the symptom, the inability to go out on the street is an inhibition, a restriction, which the ego imposes on itself in order not to arouse anxiety (Freud, 1936:29).

The following explanation is provided:

> [the client] finds himself in the jealous and hostile oedipus complex attitude to his father, whom, however, insofar as his mother does not enter into the picture as the cause of dissension, he loves devotedly. Thus we have a conflict springing from ambivalence -- a firmly founded love and a not less justified hatred, both directed at the same person. His phobia must be an attempt to resolve this conflict (Freud, 1936:30).

The symptom, that is the fear of horses, presumably masks the "fear of revenge or retaliation on the part of the [father], that a state of anxiety in relation to him would be engendered" (Freud, 1936:31) if the individual were to act on "the jealous and hostile oedipus attitude" toward him (Freud, 1936:30). The source of the problem in this example then, is internal to the individual. The implication is that the phobia can only be eliminated through the successful resolution of the oedipus complex, an internal problem.

As a final illustration, Martin's discussion of anxiety-based problems suggest that:

> foolish, self-defeating behavior seems to follow from distorted beliefs about others and about himself...this is largely because so much of the information needed for problem solving and living well is distorted or even not used by the person at all -- not because the information isn't available to be seen and used, but because the person is unable to use it...this is partly the result of anxiety; internal processes such as thoughts and feelings are so threatening that they are avoided one way or another, and this avoidance behavior becomes habitual and persistent, since it works so well to reduce the intense discomfort of anxiety (1983:73-74).

In order to avoid anxiety then, the individual may subjectively distort information or be unable to use it, with the result of self-defeating

behavior. Anxiety underlies the cognitive distortions which underlie foolish behavior. Those processes internal to the individual are emphasized. In short, an emotion (anxiety) interferes with the processing of information (cognition), which interferes with behavior. Conversely:

> Albert Ellis' (1962) **rational emotive therapy,** assumes that psychological disorders derive from irrational patterns in thinking...Ellis maintains that a variety of specific irrational ideas may cause and maintain maladaptive behavior...thought patterns are responsible for most problems in everyday experience. The actual events that one encounters, such as rejection by a loved one, are not themselves traumatic except insofar as one's assumptions, ideas, and interpretations of them make them catastrophic (Craighead et al., 1981:150-151; emphasis in original).

In this case, irrational cognitive processes may precipitate, for example, anxiety. In either case, however, what is occurring is inside the individual is used to explain what is observed.

5.3 THE SOCIO-INTERPERSONAL UNIT OF ANALYSIS

A view of deviance from an interpersonal frame of reference, in contrast, explains the behavior in question as emerging out of social interaction among spouses, family members, co-workers, friends, and so on. The focus is upon relations in social groups. The analysis proceeds then, by situating the individual within the context of these interpersonal relationships in order to explore their effect upon individual behavior. In short, the process of social interaction is viewed as underlying an individual's behavior. For example, "a parent may openly abuse or reject his child, or an employer may single out a given employee as a target for harassment or persecution", both of which may "lead to behavior that the individual himself and much of the

society view as inappropriate" (Halleck, 1971:23). While this does not exempt the individual from responsibility for his/her behavior, it shifts the focus to the group in accounting for its members' behaviors. According to Laing (1969:31), "one may see [the individual's] behavior as 'signs' of disease; [or] one may see his behavior as expressive of his existence". The latter clearly expands the analysis beyond the internal peculiarity of the individual to include the interpersonal process, or one's "being in the world" (Laing, 1969:19).

The interpersonal perspective may provide either a developmental or a situational account of deviance. That is, deviance can be viewed as the culmination of interpersonal relationships over time, or it can be seen as specific to a given social situation. In reconstructing the history of one individual, Laing argues:

> the total family situation may impede rather than facilitate the child's capacity to participate in a real shared world, as self-with-other (1969:189).

In this case, the individual's behavior is seen as emerging out of the patterns of interaction which surround him/her and in which s/he participates and develops as a social actor. In addition, Laing argues that the "behavior of the patient is to some extent a function of the psychiatrist in the same behavioral field" (1969:29). The argument is that human behavior cannot be conceptualized as if other actors in a given situation have no influence or produce no effect.

To illustrate the use of the interpersonal as the unit of analysis, consider first, alcoholism, which is conventionally thought of as a disease (Craighead et al., 1981). It is argued that:

> The factors that appear to initiate and reinforce drug use are primarily <u>social</u> in nature. An important prerequisite is the

> readily available access to the drug...A second important factor is the influence of cultural and subcultural norms that define the reinforcement contingencies governing the use of drugs. These norms are to a large extent transmitted vicariously through modelling behavior of parents and peers...excessive parental drinking...may result in the transmission of a similar pattern of drinking to their children ... (Craighead et al, 1981:268; emphasis in original).

Although these writers continue with an analysis of "predispositions for continued drug use" (Craighead et al., 1981:270), which individualizes alcohol use, the above quotation illustrates that the behavior develops and can be explained in an interpersonal context.[6] Put differently, alcohol use is learned in the process of social interaction, first by observing one's parents and later in interaction with one's peers. Alcohol use simply cannot be explained without reference to interpersonal processes. Fears and phobias can also be explained in this way (Martin and Pear, 1978; Craighead et al., 1981; Freud, 1936).

More generally, Fromm-Reichmann suggests that "emotional difficulties in living are difficulties in interpersonal relationships" (1950:xiv). Current difficulties are explained historically or developmentally. That is:

> our relationships with other people, including the relationship of the mental patient with his doctor are patterned by our early relationships with the significant people of our environment of infancy and childhood (Fromm-Reichmann, 1950:4).

The following case study illustrates this type of theoretical analysis:

> a patient suffered from severe jealousy and envy of the younger sister of the family, who was six years her junior...Lizzie [the sister] was endowed with the

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[6] This excerpt also raises issues that are considered to be socio-structural (ie. alcohol use vis-a-vis cultural and subcultural norms). Analytically, cultural norms about alcohol use are also transmitted systemically through the mass media.

> conventionally accepted charm and attractiveness of the very pretty American girl as we know her today. These attributes were very pleasing to the patient's mother, a metropolitan society woman. Until the birth of the very pretty infant sister, the patient had been only a girl...It was especially the mother, the most significant figure in the family group, who, [from the time of the birth of the sister], shifted her affection and interest from the patient to the newcomer. As the sister grew up, she promised to become the great social asset of the family, who would thereby glorify her mother. Being dethroned this way...was among the pathogenic factors determining the later rise of the patients mental illness (Fromm-Reichmann, 1950:89).

According to Fromm-Reichmann, the parents had "engendered the woman's envy and jealousy when, for example, they did not express their gratitude to the older one, who had saved their lives, [instead], suddenly relieved of their panic, [they] hugged and kissed Lizzie" (1950:91). Notwithstanding the other "pathogenic factors" contributing to the client's difficulties, it is clear that Fromm-Reichmann (1950) identifies the pattern of family interaction as having played a significant role in causing her difficulties.

Consider also Rogers' concept of "conditions of worth" (1959:209):

> a condition of worth arises when the positive regard of a significant other is conditional, when the individual feels that in some respects he is prized and in other respects not. Gradually this same attitude is assimilated into his own self-regard complex, and he values an experience positively or negatively solely because of these conditions of worth which he has taken over from others, not because the experience enhances or fails to enhance his organism (1959:209).

Psychological maladjustment is said to exist, to some degree, with the development or existence of these conditions of worth (Rogers, 1959). The individual's experience is structured in such a way so as to maintain the positive regard of significant others. Psychological maladjustment is explained vis-a-vis the conditions of worth authored by one's significant others. For example, consider the following account

of a "sixteen-year old girl, brought up in a family of very strict religious traditions" (Rogers, 1942:185). In the third interview:

> Barabara says: "All the opportunities are at my feet if I can take advantage of them. I wish to get everything out of every opportunity". Counsellor remarked: "You have to be perfect don't you?" She replied, "Yes. People would say, 'everyone has to have his faults'. I don't think so. I couldn't see any reason for that. It seemed to me I could do everything just right" (Rogers, 185-186).

It would appear that unless an opportunity is fully exploited and without fault, it does not meet the conditions of worth established by her significant others.

In summary, use of the interpersonal as the unit of analysis in accounting for human behavior seeks to explain behavior in the context of interpersonal relationships. While the individuals comprising these relations make a unique contribution to the process and outcome, the focus of the analysis is not on the individual but rather the group. It should be noted, however, that clinical intervention in these cases revolves around treating the individual and not the others who are identified as contributing to the individual's difficulties.

5.4 THE SOCIO-STRUCTURAL UNIT OF ANALYSIS

Deviance can also be explained with reference to the socio-structural milieu in which it occurs. In contrast to individual and interpersonal explanations, the analysis proceeds by identifying features of the social order that may produce deviance. Where the previous two perspectives study the problematic individual or group, this approach expands the analysis to provide a critical assessment of a given society; the (larger) context within which individuals and groups

(inter)act. More specifically, this type of analysis would include the study of the social structure itself, institutions, roles, norms, and so on. Deviance is explained by examining the behavior of individuals or groups in a broad socio-cultural context. This can be seen to provide the basis for a critique of both the social order and the narrower, albeit conventional, explanation of deviance.

Halleck suggests, for example, that society can impose indirect or direct stress upon certain individuals or groups which may produce inappropriate behavior (Halleck, 1971:21). Accordingly, Halleck contends that:

> when an individual is subject to stress caused by the social system, he is likely to feel substantial psychological discomfort. If the stress is direct he can usually detect the source of that discomfort; if it is indirect he may not. A black man who is directly exposed to brutality or humiliation on the part of bigoted whites has a clear idea of who his oppressors are...[but]...if he lives in a society in which racism is institutionalized, he may feel just as miserable, but he will have difficulty identifying the source of his sense of oppression. His frustration will engender feelings of aggression that are likely to be directed toward inappropriate objects or even toward himself. For that matter, any citizen who believes in the basic benevolence of his society but is not actually allowed to enjoy its benefits will have similar reactions (1971:22-23).

If the stress generated by society (eg. bigotry) is overt, the unacceptable behavior it precipitates can be explained without defining the individual as the problem. If it is indirect, however, the individual and those around him or her may be unable to see it and the behavior is rendered inexplicable. More specifically:

> many whites for example, cannot understand why black people, who have recently had so many opportunities opened to them, are still unhappy and restless. The whites in this case have failed to perceive how institutionalized racism continues to limit the black man's dignity and freedom... [Similarly], if a young person is too militant in his effort to change society, many who believe society is adequate will view his

> behavior as a symptom of emotional disturbance (Halleck, 1971:24).

In these excerpts there is an implicit critique of a racist society and an approach to explaining deviance that does not systematically address the relationship between the behavior and the social structure.

In a psycho-social analysis of the rise of Nazism, Fromm notes that "Hitler is looked upon as a madman or a 'neurotic', and his followers as equally mad and mentally unbalanced" (Fromm, 1965:232). In Fromm's view, however,

> Nazism is a psychological problem, but the psychological factors themselves have to be understood as being molded by socio-economic factors; Nazism is an economic and political problem...(Fromm,1965:232).

While the concern of this analysis is the "psychological aspect of Nazism, its human basis" (Fromm, 1965:232), this does not interfere with a systematic consideration of the historical, cultural, political and economic conditions which fostered its emergence. In fact, as this excerpt illustrates, the madman and the mentally unbalanced followers must be situated within the context of conditions prevailing at the time in order to appreciate fully Nazism as a politico-economic phenomenon.

The following excerpt from Fromm-Reichmann's discussion of "acting out" further illustrates the argument that cultural attitudes affect individual behavior:

> A lonely woman patient became engaged to an unsuitable partner each time that the psychiatrist, the only person with whom she had a meaningful interpersonal contact, took a vacation. Previous to her acting out her loneliness in this way, the patient had not been able to accept as a problem the fact of her being lonely nor could her interest be sufficiently aroused that she would enter into a scrutiny of the cause of her aloneness and her loneliness. The whole experience was too much under censorship because of the attitude of this culture toward it. A girl is not supposed to feel lonely or

> alone. She is supposed to be popular. If one is lonely, one is a failure. It is one's own fault (Fromm-Reichmann, 1950:121).

In this case, meaningless engagements represented an unacceptable escape from loneliness. Being unmarried in a culture where marriage, or at least popularity, defines one's success as a woman, is used to explain the 'acting out'.

In a different context, albeit similar vein, Fromm-Reichamnn argues that:

> [t]he psychiatrist may be afraid of appearing ridiculous in the eyes of his colleagues or the secretaries of his clinic. A patient may walk out on him or be markedly late for his interview...It would, of course, be desirable for the doctor to be able to overcome his fears of ridicule...The quest for prestige in our own culture is so great [however] that it will interfere with some doctors' efforts to become desensitized to it (Fromm-Reichman, 1950:30-31).

And:

> since he lives in a society and in a culture where the display of fear or anxiety are coexistent with an alleged or real decrease of prestige or self-respect, he may tend to convert his anxiety into anger, preferably against the person who is the cause of the anxiety (Fromm-Reichman, 1950:xii).

Individuals may engage in inappropriate behavior in response to threats, real or imagined, to his/her quest for prestige. This is particularly relevant in a stratified society where social status and the concomitant prestige are highly valued.

Consider also Martin and Pear's (1978) discussion of avoidance conditioning, or more specifically, the use of aversive stimuli to decrease a given behavior. Although this is a technique used to ameliorate deviant behavior, the argument is that it may have certain iatrogenic effects. It is observed that:

> [a]voidance conditioning influences us everyday. Unfortunately, it is common in the classroom, where children may be required to give the right answer in order to avoid the teacher's ridicule or anger and to avoid a poor mark. Our legal system is based entirely on avoidance conditioning. We pay our taxes in order to avoid going to jail. We put money into parking meters to avoid getting a ticket. We pay our parking fines in order to avoid a court summons...Like punishment [and] escape conditioning, avoidance conditioning involves aversion stimulation...Aversion stimuli can produce undesirable emotional behaviors, such as aggression and general fearfulness, which among other things, interfere with the learning process (Martin and Pear, 1978:197-98).

An effort to ameliorate deviance may produce, and thus be used to explain, subsequent deviance. If avoidance conditioning is common in the classroom and is the basis of our entire legal system, then it is likely that it pervades the entire society. Avoidance conditioning may explain many instances of deviance, either because the use of aversion stimuli produces it, or hinders the learning of acceptable behavior.

Finally, one of the previously given illustrations of an interpersonal explanation of alcohol use suggested that "an...important factor is the influence of cultural and subcultural norms that define the reinforcement contingencies governing the use of drugs" (Craighead et al, 1981:268). The importance of cultural and subcultural norms can be taken beyond the boundaries of the interpersonal context (ie., observing one's parents and peers), making it possible to explain deviance socio-structurally in terms of observational learning or modeling (Craighead et al., 1981; Martin and Pear, 1978). Although similar to the account provided by an interpersonal perspective, a socio-structural analysis questions the origin of the cultural and subcultural norms displayed by parents and peers. Deviance may result from the emulation of social actors who transmit and sustain cultural

attitudes and norms. For example, this might include an analysis of the mass media (eg. films, television, magazines) with reference to such issues as the use of alcohol as a social stimulant, and/or problem-solver; the objectification of women; immediate gratification and so on. The evidence is not unequivocal for this type of argument, but the issue of imitating "models who are high in prestige, status or expertise" (Craighead et al., 1981:111) is nonetheless worthy of examination. Consider, for example, the prime time hero, MacGyver, who explicitly demonstrates the preparation of home-made weapons.

5.5 DISCUSSION

Explanations of deviance have been developed using the individual, interpersonal or socio-structural unit of analysis. Deviance, however, cannot be understood apart from the social context in which it occurs, therefore, the three units of analysis that have been delineated must be integrated in order to develop an adequate understanding of human action, deviant or otherwise. This contention is supported by the inclusion of the three perspectives in all of the theories, despite the variations in emphasis within and between the texts. Although there was no attempt made to quantify this variation, individualized explanations are the most predominant. For example, Craighead, et al. (1981) provide an interpersonal account of initial alcohol use, but subsequently shift the focus to individual predisposition to explain alcoholism. Similarly, Fromm-Reichmann (1950) argues that cultural norms prescribe marriage and popularity, the absence of which is presumably synonymous with loneliness, or individualized subjective distress. A reliance on

individualized explanations of deviance supports the argument that psychotherapy is a form of social control insofar as the individual as well as interpersonal explanations of deviance do not encompass socio-structural factors. The social order is maintained because it is not questioned. If all three frames of reference are necessary for comprehending human behavior, the critical question, then, is how can deviance best be ameliorated? If the individual is identified as the problem, then s/he must be changed. If interpersonal interaction is problematic, then it must be altered. If the social structure itself produces deviance, then it must be transformed. The focus of this thesis is on the process of contractual psychotherapy sought by individual actors. In the following chapter, the argument that psychotherapy is a form of associative social control is assessed by analyzing the techniques used to ameliorate the difficulties an individual may be experiencing.

Chapter VI

AMELIORATING DEVIANCE

6.1 INTRODUCTION

There are, in any society, a number of forms that deviance may take and a variety of techniques that can be employed in response to it. For example, in response to criminal activity, society can mete out various forms of punishment. Mental illness can be dealt with through incarceration, as well as psycho-surgery, chemotherapy, or psychotherapy. Of the gamut of responses to, and forms of, deviance, the focus of this study is on contractual psychotherapy as the method for ameliorating subjective distress and/or disrupted social performance. Historically, the emergence of this type of deviance was assumed to presage insanity (Armstrong, 1983) and precipitated the development of contractual psychotherapy as distinct from institutional psychiatry. Although psychotherapy can be viewed as one aspect of a more general therapeutic response to deviance, this study is concerned with voluntary contractual psychotherapy. What is at issue is how psychotherapy attempts to ameliorate the deviant subjective experience or social performance of individuals who avail themselves of it voluntarily. The question is how is subjective distress and/or inadequate social performance best ameliorated in view of both the goals of psychotherapy and particularly, the units of analysis that can be used to explain such deviance. The focus in the discussion that

follows, then, is on the content of theories of psychotherapy in the formulation of its practice.

Before proceeding with this discussion, it should again be noted that the purpose of this study is not to assess the degree to which a particular theoretical perspective is or is not a form of social control. No distinction between schools were made in the material presented in the previous sections in order to demonstrate that in all cases the aim of psychotherapy is to foster subjective satisfaction and/or adequate social performance. Similarly, in all texts, three units of analysis are delineated and discussed in explaining the behavior in question, although the three frames of reference may not be integrated in discussing a single issue, nor integrated in practice. There was no reason to separate the theories into schools because all theorists use the same continuums for defining normalcy and for understanding the etiology of deviance. In these discussions, then, the range of psychotherapeutic formulations were considered. In the present context, however, it is necessary to distinguish the schools in order to investigate the degree to which the individual, interpersonal and socio-structural units of analysis are integrated and thus reflected in the effort to alleviate subjective distress and/or improve social performance. These distinctions are necessary, then, because there are significant differences in the methods used in psychotherapeutic practice.

Four approaches to clinical practice will be examined. It can be stated at the outset that the three seminal schools of psychotherapy (ie. psychoanalysis, behaviorism and experiential-humanism) aim their

efforts at changing the individual in psychotherapy. These efforts include attempts to change overt behavior directly, or indirectly by changing cognitive and affective processes. If it is only the individual that is to be changed in order to foster subjective satisfaction and adequate social performance, it can be assumed that the most appropriate unit of analysis in explaining deviance is the individual. There may be provisions made for the inclusion of other social actors (eg. family therapy) in an attempt to achieve the goal(s) of psychotherapy, but in the vast majority of cases the individual remains the primary focus of attention. If all three units of analysis in combination are necessary for the development of a comprehensive account of human action, then why is the individual the focus for change? According to a fourth perspective, the social psychological/psychiatric view of human behavior, it is not only the individual and the group, but also, and perhaps more important, the social order itself that warrants critical assessment and change (Fromm, 1965; Halleck, 1971). In this view, psychotherapeutic practice must integrate the three sources of explanations of deviance, thereby facilitating change not only in the individual and micro-social group but also the social order.

6.2 PSYCHOANALYTIC PSYCHOTHERAPY

Psychoanalytic psychotherapy endeavors to enhance social performance and improve subjective experience through the analysis and interpretation of symptoms which signal unconscious processes or impulses, self-reports, non-verbal communication and the therapeutic relationship (Freud, 1936; Fromm-Reichmann, 1950; Balint et al., 1972). As Fromm-Reichmann, sees it:

> if a person comes in to see the psychiatrist, this implies a need for changes in his personality, and if the psychiatrist accepts a person for treatment, this means that he recognizes that person's need for change and that he hopes to be instrumental in the patient's ultimate attainment of these necessary changes (1950:39).

It is clear in this excerpt that an individual arriving at the psychiatrist's office does not necessarily signal a call for micro or macro social change, but rather that the individual needs to be changed. In fact, a discussion of people who avail themselves of psychotherapy at the request of others indicates that:

> ... the psychiatrist should centre his efforts in the beginning on helping the patient convert his friends' decision into his own. The patient should learn to gain insight into his needs for psychiatric help and seek advice in his own right (Fromm-Reichmann, 1950:45).

Although interpersonal relationships and social structural factors may emerge as explanations for the person's difficulties, psychoanalytic psychotherapy primarily emphasizes individual change. Moreover, it is difficult to discern whether the host of interpersonal and socio-structural factors that are included as explanations of deviance are made available to the individual. Assuming these kinds of arguments are provided to the client, one can question whether they are presented in such a way as to identify both the group and the social structure as problematic, and more important, the appropriate target for change.

Fromm-Reichmann's The Principles of Intensive Psychotherapy (1950) provides a comprehensive discussion of psychoanalytic psychotherapy, including a wide variety of illustrations,as well as comments on the psychiatrist, and a detailed account of how psychotherapy proceeds from the initial contact to its termination. After establishing a diagnosis and prognosis in the initial interview:

> the first psychotherapeutic tool used by the psychiatrist is listening intelligently to patient's communications... Another integral part of the psychiatrist's task is to promote the production of patient's data by asking pertinent and simply meaningful questions; also one should encourage patient's associative thinking and production and their observation of and reports on marginal thoughts and physical sensations during the therapeutic interview (Fromm-Reichmann, 1950:69).

In the process of psychotherapy:

> the psychiatrist continues to utilize his tools by offering meaningful interpretations; by investigating patient's interpretive thinking through asking correct interpretive questions at the proper time; by tying together both with and for the patients the seemingly disconnected pieces of information and insight gradually obtained with the help of the aforementioned procedures;... and by guiding patients in repeatedly working through in various and sundry connections to the emotional experiences which have come to their awareness and to their understanding (Fromm-Reichmann, 1950:69-70).

What is particularly important in psychoanalytic psychotherapy are those issues about which the client has little or no awareness (Freud, 1936; Fromm-Reichmann, 1950; Balint et al., 1972).

In the case of 'compulsion neurosis', for example:

> the specific terms of the aggressive impulse are not at all known to the ego. A good deal of analytic work is necessary to bring them to consciousness (Freud, 1936:50).

The 'tools' discussed by Fromm-Reichmann (1950) assist in bringing the unconscious process or impulse into awareness. A patient may "[ramble] on about non-descript feelings as her weapon against evidencing her sense of anxiety" (Fromm-Reichmann, 150:74). It is recommended that the psychiatrist ask questions about daily life for example, in order to facilitate the client's recognizing a defense against anxiety. In one case, after revealing a woman's 'obsessional preoccupations':

> treatment then continued with the discussion centering around the obsessional preoccupations which filled the daily life of the patient. In due time this provided an opening for the exposure of further obsessional personality trends, subsequent

> to which she gradually dared to face further glimpses of her anxiety, thus making the first step toward eventually resolving her obsessional symptomatology (Fromm-Reichmann, 1950:75).

Interpretation of the data produced by the client plays a central role in the process of psychoanalytical psychotherapy, because:

> one may be or may become stable to the extent of one's awareness of, or ability to become aware of, interpersonal experiences (Fromm-Reichmann, 1950:80).

According to this perspective, the events in one's life do not necessarily require interpretation, but rather it is the "concomitant emotional experiences" that are problematic (Fromm-Reichmann, 1950:80). It is at the level of emotional reaction that the psychiatrist intervenes in attempting to alleviate subjective distress or improve performance. The "emotional difficulties of mental patients are to be understood in terms of their early history and [thus the role of the psychiatrist] is to make [his/her] patients view their problems in this light" (Fromm-Reichmann, 1950:48). Thus:

> by interpretation the psychiatrist translates into the language of awareness, thereby bringing into the open what the patient communicates to him without being conscious of its contents or of its dynamics, revealing connections with other experiences, or various implications pertaining to its historical or present emotional background (Fromm-Reichmann, 1950:80).

And in Balint, et al.'s case study of Mr. Baker:

> after listening to this dreary and very painful story, I brushed it aside, not brusquely but in a very friendly manner, and said that apparently it was not the details that were important, but what he felt about them, and that apparently he needed someone to act as a sounding-board in order that his fleeting ideas, fantasies, and emotions should be reflected upon him so that instead of vanishing into limbo they should make some impression on him (1972:23).

For the purpose of psychotherapy, the focus has been placed on how Mr. Baker 'feels' about the issue at hand, which, in this instance, is the

history of his marital relationship. The implication is that the problem is to change how Mr. Baker feels about his relationship as opposed to investigating the relationship itself. By the twenty-third session with Mr. Baker, to which he brought some notes that he had written, it is suggested that the:

> notes allow us a glimpse at the full intensity of the conflicting and complexly interwoven emotions in his internal life causing so much pain, suffering and torment both to his wife and to himself (Balint, et al., 1972:91).

The difficulties that Mr. Baker is experiencing, then, are attributed to his suppressed emotions, while the psychiatrist endeavors to bring to awareness either the emotions themselves, or their historical background, and ultimately give an interpretation of them.

By focusing on the "'specific means' (dynamisms, mechanisms) of trying to dispose of past and present anxiety-producing emotional experiences" (Fromm-Reichmann, 1950:58), the psychiatrist may provide an interpretation of the contents or dynamics of the person's difficulties such as, transference and parataxic distortions, security operations, resistance, intentional blocking, acting out (Fromm-Reichmann, 1950:85-127); and special mental operations including slips and errors, daydreams, dreams, hallucinations and delusions (Fromm-Reichmann, 1950:154-181). Interpretation can be viewed as providing an intellectual understanding of the problem at hand. The preceding list of materials that may be interpreted represent the means by which the individual avoids anxiety and insecurity, therefore they must be understood by the individual as performing this function. For example,

> 'transference' in the most general sense of the word means transferring to repeated early patterns of interpersonal relatedness with present-day partners...[I]n its special application to the therapeutic process [it] means transferring

> on to the therapist, as a present-day partner, early experiences in interpersonal relatedness (Fromm-Reichmann, 1950:97).

For example, a psychiatrist had apologized to a woman for interrupting an attempt at small talk (eg. commenting on the weather). According to the woman:

> "First you doctors suggest that we become more spontaneous and direct in our exchanges with you and then if we follow your suggestion you try to cut us off" (Fromm-Reichmann, 1950:102).

Although the psychiatrist admitted she was correct and apologized, the woman later repeated an attempt to be more spontaneous and direct six months later, because according to the psychiatrist, "she wanted to find out whether or not he had actually meant what he said, when he had previously apologized ..." (Fromm-Reichmann, 1950:102). This 'transference reaction' or 'parataxic distortion:

> could be brought into the open, and it became one step in the patient's understanding that not all people would let her down by their lack of reliability as her parents had, that is, her reality testing through an experience with the doctor helped her to do away with a significant parataxic misevaluation of other people (Fromm-Reichmann, 1950:102-03).

These processes must be brought into awareness and interpreted because "many of these childhood experiences have never been revised and reevaluated, because they had been dissociated up to the time the patient had entered the therapeutic relationship with the doctor" (Fromm-Reichmann, 1950:105). Through an intellectual understanding of transference as well as the other aforementioned processes, the individual is provided with knowledge s/he previously did not possess.

Although the knowledge acquired through interpretation is a necessary component, it is not sufficient for the alleviation of subjective distress, or improvement of social performance. A critical part of

psychoanalytic psychotherapy is "the process of 'working through' interpretively clarified material" (Fromm-Reichmann, 1950:127). It is argued that:

> it could appear as though one single interpretive clarification of the origin of a symptom or an interpersonal problem would have the effect of change and cure, if it were rationally well understood and clarified...The individual's mental or emotional experiences are...part of the person's pattern of reacting and thinking, but they are interlocked in multiple ways. Interpretive dissolution and understanding of some specific piece of dissociated material, therefore, can produce only a certain degree of actual change...As a result, any understanding, any new piece of awareness which has been gained by interpretive clarification, has to be reconquered and tested time and again in new connections and contacts with interlocking experiences...[this is] the necessity of repeatedly 'working through' the emotional experiences for the dynamics and contents of which awareness and understanding have been achieved (Fromm-Reichmann, 1950:140-41).

Gaining 'insight' into his/her difficulties, then, requires both a rational understanding of the interpreted material and working through the interpretation at the emotional level in order to achieve an "integrated creative understanding" of it (Fromm-Reichmann, 1950:142). As an illustration, after four unsuccessful relationships, a woman came to a psychiatrist and gained an intellectual understanding of the factors which created the patterns observed in these relationships (Fromm-Reichmann, 1950:143). However:

> ...in spite of understanding this, the patient was not able to integrate this knowledge constructively or to change her pattern solely by virtue of the interpretation, recall, and intellectual understanding of the underlying experiences. The childhood experience, its patterning influence and her intellectual understanding of it had to be worked through repeatedly in its reflections on the doctor-patient relationship and in various other contexts, before the patient's understanding of it was converted into real insight with curative effectiveness (Fromm-Reichmann, 1950:143).

Finally, to be most effective, interpretation and working through should focus on "the central dynamics of the patient's difficulties" (Fromm-Reichmann, 1950:145-50) which are also referred to as the focal aims of psychotherapy (Balint, et al., 1972). In the case of Mr. Baker, for example, the interpretations that were offered centered round:

> the guilt feelings caused by his triumph over his homosexual rivals: the officer in Cyprus; his father in law; his own father, but it is quite possible that this will prove to be too ambitious. In this case a secondary aim might be to enable him in the transference to find a man with whom he can share his wife (symbolically) (Balint, et al., 1972:27).

By the seventh session, according to the psychiatrist:

> it is remarkable how both aims given in the first write-up are running parallel. Until now I have described as my more ambitious aim to allow him to enjoy his victory over father and the other officer. After having done quite a bit about this aim, he himself is proposing to bring his wife to me, to 'share her' with me so to speak (Balint et al., 1972:45).

These were the two major issues, at least initially, round which interpretation and working through were centered. Although many issues may arise in the course of psychotherapy, whether they warrant interpretation and working through:

> ...should depend upon the usefulness for further clarification whether content material which patients produce after the doctor has recognized the central dynamics of the patient's difficulties may be included in, or discarded from, interpretive attention (Fromm-Reichmann, 1950:146).

Viewing psychoanalytic psychotherapy as a process, it is clear that the focal aims may change.

Psychotherapy, in the psychoanalytic tradition, can be terminated when:

> ...when the patient has gained a sufficient degree of lasting insight into his interpersonal operations and their dynamics to enable him, in principle, to handle them adequately...(Fromm-Reichmann, 1950:188).

This suggests that, upon completing psychotherapy, the sources of the individual's distress are brought into awareness, and that his/her performance in interpersonal interaction will facilitate the fulfillment of the needs for satisfaction and security (Fromm-Reichamnn, 1950:192).

In summary, psychoanalytic psychotherapy, through the use of interpretation and working through to gain insight, attempts to change the individual. Although a host of factors external to the individual may be used to explain his/her difficulties, it is the individual's cognitive and affective responses that are identified as the targets for change. As one writer sees it, psychotherapy "enable[s] him to understand and to cope efficiently with the troublesome aspects of his life or even to eliminate them, outer circumstances permitting" (Fromm-Reichmann, 1950:59). One can conclude from this that it is the individual who must adjust to or cope with what surrounds him/her if it is not amenable to change. No doubt changes in interpersonal relationships would result from the individual having undergone psychotherapy. There is no indication, however, that the individual would be prepared by this process to effect change in his/her socio-cultural milieu.

6.3 BEHAVIOR MODIFICATION

A behavioral approach to the alleviation of subjective distress and/or improvement of social performance is concerned primarily with overt behavior. The assumption that "current behaviors are caused largely by environmental experiences" (Martin and Pear, 1978:8), implies that interpersonal and socio-structural factors explain deviance and

thus would be identified as the targets for change. According to this perspective:

> nothing is gained by talking of the behavior as a symptom of some inner cause. Behavior modifiers agree that there are causes of the observable behavior, and that some of those causes may indeed be unobservable, complex inner "things" of some sort or another. Regardless of the cause, however, the behavior is still there and is still being influenced by the individual's immediate environment (Martin and Pear, 1978:9).

Although cognitive psychotherapy has become included in the behavior modification framework, this marks a shift away from internal processes, toward the alteration of environmental factors in the amelioration of deviance. Whatever the promise such a strategy may hold, in practice, it is the observable behavior of the individual upon which this method focuses. The basic assumption is that maladaptive behavior is learned, or is a function of not having learned certain skills.

This approach aims at the alteration of "behavioral deficiencies, behavioral excesses, and behavioral inappropriateness" (Marin and Pear, 1978:9). According to Craighead et al.:

> therapeutic interventions involve training clients to engage in certain behaviors and not to engage in others, that is, to learn new modes of behaving. A goal of behavior modification is to provide learning experiences that promote adaptive and prosocial behavior (1981:107).

The implication of this statement is that the identification of problematic environmental factors is limited to the promotion of adaptive and prosocial behavior. It is the behavior that gets changed and not the environment. That is, "if the client has an undesirable behavior pattern, it is only because he -- like everyone else -- is following natural laws. These laws cannot be changed, but the client can use them to change his own behavior" (Martin and Pear, 1978:368).

The result is that the broad concept of environmental experiences is reduced down to the immediate environment which is further reduced to the contingencies of reinforcement, in the case of operant conditioning (Martin and Pear, 1978; Craighead et al., 1981; and Gottman and Leiblum, 1974). This does not mean, however, that larger environmental issues are not addressed, as will be clear in the illustrations of role playing and assertiveness training.

A variety of strategies are used to alter behavior based on the principles of operant and respondent conditioning (Gottman and Leiblum, 1974; Martin and Pear, 1978; and Craighead et al., 1981). These techniques include, positive reinforcement, extinction, shaping, intermittent reinforcement, stimulus control, fading, conditioned reinforcement, backward chaining, generalization, punishment, escape and avoidance conditioning, as well as techniques based on respondent conditioning, such as systematic desensitization (Martin and Pear, 1978). These "procedures are ways of re-arranging an individual's environment and daily activities in order to help that individual function more fully in our society" (Martin and Pear, 1978:10). The choice of technique(s) that will be used to alter an individual's behavior depends on whether it is excessive, deficient or inappropriate. The first step in behavior modification then is the identification of the problem behavior. In one approach, "the reason the client is there can usually be conceptualized in terms of performance discrepancy...[and]...the objective may be eventually to reduce the discrepancy to zero" (Gottman and Leiblum, 1974:26-27).

The elimination of the performance discrepancy is determined by whether the problem is one of response acquisition, increment, or decrement (Gottman and Leiblum, 1974). It should also be noted that "behavior modification is best defined by a rationale and a methodology and not by a specified theory or set of principles" (Craighead et al., 1981:5), and represents an "experimental and functionally analytic approach to clinical data, relying on an objective and measurable outcome" (Craighead et al., 1980:24). In this approach the amelioration of deviance proceeds in keeping with the rules of the scientific method. In all of the behavioral texts, a central part of the discussion focuses on designing a strategy to change behavior that is "objective and measurable" (Gottman and Leiblum, 1974; Martin and Pear, 1978; Craighead et al., 1981). The behavior to be changed is regarded as the dependent variable with the treatment constituting the independent variable(s).

The first step in this method is to define the problem in behavioral terms, or to construct an operational definition. Some problems are readily observed such as excessive smoking, but it may be "very difficult to pinpoint the exact behaviors involved in a problem such as depression or anxiety" (Martin and Pear, 1978:368). Since it is observable behavior that is the focus for change, strategies must be devised to concretize the problem. Martin and Pear, for example, suggest that the person:

> imagine that Martians have landed on earth and are doing an observational study of its inhabitants...[they] know nothing about human feelings. They can observe only behavior...what will your Martian observe now, when you are still suffering from your problem...and what will he observe later, when the problem has been solved?...a depressed person might say that his Martian would see him sitting alone in his room staring at the walls a great deal before treatment, and spending more time reading novels and interacting with other people after treatment" (1978:368-369).

Furthermore, the general problem should be broken down into its component parts, also in behavioral terms. This suggests that the problem is compartmentalized in order to facilitate the modification of discrete, operationalized responses.

In addition, the behavior is placed in the context of its contingencies of reinforcement. The following things must be specified:

> (1) the occasion upon which a response occurs, (2) the response itself, and (3) the reinforcing consequences. The interrelationships among them are the contingencies of reinforcement (Martin and Pear, 1978:106).

The problematic behavior is understood in terms of what precedes and follows it. Efforts to modify behavior, then, require the alteration of the contingencies of reinforcement. This may involve changing the stimuli that elicit the response and/or the stimuli which maintain it.

Gottman and Leiblum (1974) suggest also that the objectives of the change efforts must be specified:

> An objective must contain four things: (1) Who? (2) will do what? (3) to what extent? (4) under what conditions? (Gottman and Leiblum, 1974:48).

For example:

> in discussing the issue of housework chores, Henry and Maude will share talk time. Henry will increase the frequency of expressing anger when he feels it; Henry will decrease the frequency of withdrawing from conversation; Maude will decrease the frequency of whining complaining, and blaming; Maude will increase the frequency of telling Henry directly how she feels. Each of them will use wrist counters to monitor talk time, clicking after each of their own statements. (Gottman and Leiblum, 1974:49).

This suggests that clearly defined goals, or the behavior to be changed must be explicitly stated. Again, the focus is on response acquisition, increment, or decrement. The formulation of treatment intervention will

be structured by what type of change in behavior is indicated and will result in the selection of one, or some combination, of the aforementioned techniques. Since this approach relies on the scientific method to monitor and establish that change has occurred, the intervention may be changed as indicated by the data. Some examples are provided as illustrations of the use of behavior modification in the alleviation of subjective distress and improvement in social performance.

To begin, anxiety can be alleviated in a variety of ways including systematic desensitization, modelling, flooding, and implosion (Craighead et al., 1981:213-222). Systematic desensitization is based on the principles of respondent conditioning and may be used when "people have fears that are so intense that they are virtually incapacitated by them" (Martin and Pear, 1978:215). It is assumed that:

> a response incompatible with fear could be made to occur in the presence of a stimulus that normally produced fear, then the incompatible response would inhibit the occurrence of fear on subsequent presentations of that stimulus (Martin and Pear, 1978:215).

Accordingly:

> systematic desensitization first involves teaching the client to readily induce deep-muscle relaxation. In addition, by interviewing the client thoroughly, the therapist obtains a detailed description of all the stimuli and situations that are related to the debilitating fear or anxiety that the client experiences...[in order to construct a fear hierarchy] (Martin and Pear, 1978:215-216).

In short, anxiety is inhibited by systematically relaxing oneself upon imagining the feared object. The therapist begins describing the least anxiety-producing stimulus and progresses through the hierarchy, coupling relaxation in the client with the presentation of the feared stimulus. The result is that:

> at each step, relaxation counteracts the anxiety elicited by the scene. When the client finishes the last scene in the hierarchy, he can generally encounter the actual feared situation without undue stress (Martin and Pear, 1974:217).

No questions are raised about the feared stimulus, rather it is taken as a given and thus systematic desensitization assists the individual in adjusting to this reality.

Anxiety can also be alleviated through modelling, which includes aspects of systematic desensitization. This approach assumes that:

> our behavior is strongly influenced by what we observe and/or hear about other individual's behavior and its consequences. Modelling techniques seek to reduce anxiety responses by providing a programmed learning experience which emphasizes such vicarious processes (Craighead et al., 1981:217-218).

Using this procedure, the individual's anxiety is alleviated by observing preferably a 'social peer' interacting with the feared object or engaging in the feared behavior. Again, it is the fear or anxiety that is questioned, not the stimulus.

Another example of efforts to decrease a response is aversive counter-conditioning (Gottman and Leiblum, 1974:74; Martin and Pear, 1978; Craighead, et al., 1981). It is suggested that:

> the rationale of aversive counter-conditioning is based on the fact that an object or an activity that is repeatedly associated with negative (painful, uncomfortable, aversive) properties will acquire some of the negative properties of the aversive stimulus. The individual will therefore come to avoid the object or activity. (Gottman and Leiblum, 1974:76).

The following fictional illustration of a male's masturbation pattern is provided:

> [he]...masturbated each evening to fetishistic fantasies revolving around angora sweaters. His wife was quite upset by Joe's behavior and their sex life had become one of marked abstinence. Joe finally decided to seek treatment for his difficulty. Aversion therapy was begun. Joe was asked to engage in his usual fantasies but to signal (raise his hand)

> when the fetishistic object (angora sweaters) was clearly visualized. At that time a strong shock was administered to his forearm. This procedure was repeated daily over two weeks (Gottman and Leiblum, 1974:76).

Since this is a fictional account of the application of aversive counter-conditioning, it must be assumed that it worked (i.e. eliminated the inappropriate behavior). Although this behavior had interpersonal ramifications, it was clearly identified as the individual's difficulty and thus, his behavior was targeted for change. One can question, however, whether the elimination of this behavior would mark an improvement in the marital relationship. Again, since this is a fictional illustration it is impossible to determine if decreasing the inappropriate behavior provided the solution for the sexual abstinence in the marriage. The question remains: is individualizing and compartmentalizing the problem an appropriate approach in the amelioration of deviance?

The following illustration demonstrates the use of assertiveness training and role playing in fostering response acquisition (Gottman and Leiblum, 1974:87-88). In this case:

> ...an eighteen-year-old college girl, entered therapy extremely anxious and depressed...she revealed that she was terrified of her upcoming marriage with her fiance, a youth of twenty-three, who was tyrannical and often irrational with her. He insisted that she cut off ties with her girlfriends and spend time with no one but him...Dorothy, a timid, painfully shy girl who spoke in a near whisper, was given practice in assertiveness training. She was lectured on the absurdity of John's views...Dorothy [then] took turns playing John and herself in scenes in which she challenged his assumptions and refused to go along with his irrational requests. These practice sessions were tape-recorded and Dorothy criticized her own performance. As she experienced success in standing up to John, Dorothy became less depressed... (Gottman and Leiblum, 1974:88-89).

In this example, the fiance is identified as the problem, and it would appear that Dorothy is depressed because she cannot stand up to him. By acquiring assertiveness skills her depression decreased, and thus the problem is individualized. The broadest context in which these issues are situated is the interpersonal situation. That is, John has a problem, (i.e. his views on relationships), and Dorothy's problem is that she cannot stand up to him. Both of these individuals, however, can be placed in a larger socio-structural context which fosters such domination and submission in male-female relationships. These issues are not questioned, nor raised in the effort to develop the individual's assertiveness skills.

As a final illustration, a behavior modification program was designed for a woman who:

> ...worked in a mental-retardation institution, where she experienced considerable difficulty because of her tendency to become upset with other staff members (Martin and Pear, 1978:378).

The problem and the goal were defined as:

> achieving a frequency of zero instances per day of anger in response to hearing someone lying or being dishonest or in response to remembering an instance of someone lying or being dishonest (Martin and Pear, 1978:378).

The reinforcement would be administered by the woman herself:

> If the target for that day...is reached, I permit myself to have my pillow when I go to sleep. If it is not reached, I must place my pillow in the kitchen cupboard and sleep without it (Martin and Pear, 1978:378-79).

This is a good example of behavior modification's effort to "promote adaptive and prosocial behavior" (Craighead, et al., 1981:107). The anger has been defined as inappropriate to the extent that it has caused the individual to experience considerable difficulty with her

co-workers. It can be assumed that these people do not respond favorably when someone perceives their lies or dishonesty. This is not to suggest that they lie or are dishonest in all instances, but the problem is that the anger, in response to lies and dishonesty in such a workplace can be defined as appropriate, particularly if it is with regard to the clients. If this were the case, it is the behavior of others that necessitates change not the individual's response to their behavior. In fact, the lies and dishonesty of others are irrelevant since it has been specified in the contract:

> whether or not the other person is lying is based on my own feeling that it is a lie (Martin and Pear, 1978:378).

The individual seems to have concluded that she is misinterpreting the behavior of others and thus her response is inappropriate. In the final analysis, one's co-workers can continue being dishonest indefinitely since it is the individual's response that is identified as inappropriate.

In summary, behavior modification alleviates subjective distress, or improves social performance either by altering the reinforcement contingencies that govern the behavior in question, or through the use of the principles of respondent conditioning. Intervention is formulated in terms of response increment, decrement and acquisition, and the scientific method is used to monitor its effectiveness so that an alternate strategy can be implemented if indicated. It is by far the narrowest approach insofar as compartmentalized operationally defined behaviors or responses are the targets for change. In its broadest application, interpersonal behavior may be changed but socio-structural contingencies are beyond the scope of its application.

6.4 CLIENT-CENTERED PSYCHOTHERAPY

Psychotherapy in an experiential-humanistic framework assumes that the innate tendency of the individual is toward health. Other social actors may confound this tendency by imposing upon the individual "conditions of worth" (Rogers, 1959:224), that result in an incongruity between self and experience, and thus problems in living. Subjective distress or inadequate social performance, from this perspective, are best ameliorated within and by the therapeutic relationship. In short, "the function of therapy is create a facilitative atmosphere within which self-actualization can take place" (Martin, 1983:226). According to Rogers:

> this theory is of the if-then variety. If certain conditions exist (independent variables), then a process (dependent variable) will occur which includes certain characteristic elements. If this process (now the independent variable) occurs, then certain personality and behavioral changes (dependent variables) will occur (1959:212).

The suggestion is that given the right conditions a relationship will develop in which self-actualization will be facilitated. Again, subjective distress will be alleviated or unacceptable social performance will be improved by participation in this relationship.

More specifically:

> For therapy to occur it is necessary that these conditions exist:

1. that two persons are in **contact.**
2. that the first person, [the client], is in a state of incongruence, being **vulnerable,** or **anxious.**
3. that the second person, [the therapist], is congruent in the relationship.
4. that the therapist is **experiencing unconditional positive regard** toward the client.
5. that the therapist is **experiencing** an **empathic** understanding of the client's **frame of reference.**
6. that the client **perceives,** at least to a minimal degree, conditions 4

> and 5, the **unconditional positive regard** of the therapist for him, and the **empathic** understanding of the therapist. (Rogers, 1959:213; emphasis in original).

For the purpose of this discussion, conditions four and five above are of primary importance. It seems clear, in the case of voluntary contractual psychotherapy, that the individual contacts a therapist for a problem that s/he is experiencing. Since it is not within the scope of this discussion to address the 'congruity', or normality if you will, of the therapist, it will not be questioned. It will be assumed then that conditions one, two and three exist and thus the discussion will focus on how subjective satisfaction or satisfactory social performance (i.e. self actualization) are achieved by the therapist experiencing and the individual perceiving conditions four and five.

Intuitively it would seem that, unconditional positive regard is necessary for the amelioration of deviance insofar as the individual's conditions of worth stem from the conditional positive regard of significant others. Martin suggests:

> ...many took [unconditional positive regard] to mean some kind of impossibly tolerant permissiveness in which no limits were set. Rogers clearly did not mean that, but rather meant that the therapist's positive feelings were not conditional on the client thinking, feeling and talking in certain ways and not other ways...the therapist somehow communicates the message that the client is a worthwhile person, regardless of what he or she is experiencing...He or she offers a chance to explore and think and feel in a context of acceptance and respect (1983:93-94).

The implication is that conditional positive regard by the therapist would in effect exacerbate the individual's problem. Assuming that conditions of worth underlie the difficulties the individual is experiencing, it is apparent that these conditions can only be understood and revised in the presence of a significant other (i.e. the

therapist) who does not impose his/her own set of conditions of worth upon the individual.

It would appear then, that the aim of psychotherapy in this approach is to foster 'positive self-regard' (Rogers, 1959:209). That is:

> ...positive regard must first be experienced from others, [which] results in a positive attitude toward self which is no longer directly dependent on the attitudes of others. The individual, in effect, becomes his own significant social other (Rogers, 1959:209).

It is apparent that the emphasis is on the development of subjective satisfaction with improved social performance being derived from it. The principal aim is to decrease the incongruity between self and experience (condition 2) which is a "state...of tension and internal confusion" (Rogers, 1959:203). Presumably, when self and experience are congruent there will be a concomitant decrease in "discordant or incomprehensible behaviors" (Rogers, 1959:203).

In addition to unconditional positive regard, the alleviation of subjective distress is facilitated by the therapist's "empathic understanding of the client's frame of reference" (Rogers, 1959:213). This has been defined as "the communicated understanding of the person's intended message" (Martin, 1983:3), or evocative empathy. Not only must the therapist communicate his/her acceptance of the client, s/he "must [also] make [him/her] feel deeply understood" (Martin, 1983:3). It is through this empathic understanding of the individual's communications that the goals of psychotherapy are accomplished. According to Rogers:

> ...empathy, or being empathic, is to perceive the internal frame of reference of another with accuracy, and with the emotional components and meanings which pertain thereto, as if one were the other person...(1959:210).

In an earlier formulation, he argued that:

> this newer therapy places greater stress upon the emotional elements, the feeling aspects of the situation, than upon the intellectual aspects ... most maladjustments are not failures in knowing, but that knowledge is ineffective because it is blocked by the emotional satisfaction which the individual achieves through his present maladjustments ... [with empathic understanding] ... the individual learns to understand himself, to make significant independent choices, [and] to relate himself successfully to another person in a more adult fashion (Rogers, 1942:29-30).

Thus, in contrast to the interpretation offered by the psychoanalyst, "the aim of evocative empathy is to open up the experience to form successively more accurate constructions of [the individual's] experience" (Martin, 1983:8). More specifically:

> [evocative empathy] is the fastest way to get to the client's truth, and to get there in a way that will help the client, is by helping him to face the leading edge of what he is trying to say but can't quite say (Martin, 1938:5).

There is an incongruity between self and experience which arises from conditions of worth. Thoughts and feelings that contradict these conditions of worth are perceived by the individual as threatening and produce anxiety or vulnerability (Rogers, 1959:226-227). The incongruity between self and experience that results from the existence of conditions of worth is ameliorated, at least in part, by the unconditional positive regard and the empathy of the therapist.

It should also be noted that in this approach the client is identified as the problem solver, not a person with a problem. That is:

> the individual and not the problem is the focus. The aim is not to solve one particular problem, but to assist the individual to grow so that he can cope with the present problem and with later problems in a better-integrated fashion (Rogers, 1942:28).

While all three approaches (psychoanalysis, behaviorism, and client-centered psychotherapy) share this ultimate aim, the two

approaches discussed previously make explicit attempts to identify the "central dynamics of the patient's difficulty" (Fromm-Reichmann, 1950:145) or define response increment, decrement and acquisition as the focus for psychotherapy (Gottman and Leiblum, 1974). In both cases a problem has been or is delineated. A client-centred approach, in contrast, emphasizes the process of the individual's growth that occurs in psychotherapy regardless of the specific problems that can be identified. As Martin sees it:

> you are following the client, it is not your job to determine the content or topic of what is talked about (1983:5).

In short, client-centred psychotherapy is non-directive, whereas psychoanalysis and behavior modification are, comparatively, more directive in their approaches. As an illustration:

> during [the] first hour the mother spends a full half-hour telling with feeling example after example of Jim's bad behavior. She tells of his quarrels with his sister, of his refusal to dress, of his annoying manner of humming at the table, of his bad behavior in school, of his failure to help at home and the like. Each of her comments has been highly critical of the boy...the counsellor's sole aim is not to impede this flow of hostile and critical feeling. There is no attempt to persuade the mother that her boy is bright, essentially normal, pathetically eager for affection, though all of it is true. The counsellor's whole function at this stage is to encourage free expression (Rogers, 1942:35-36).

This free expression is facilitated by the therapist communicating his/her acceptance and understanding of the client.

Acceptance and understanding on the part of the therapist that creates an atmosphere which encourages free expression is not the sole function of the therapist. Rogers argues:

> If the counsellor is to accept these feelings, he must be prepared to respond, not to the intellectual content of what the person is saying, but to the feeling which underlies it...Whatever they are, the counselor endeavors, by what he says and what he does, to create an atmosphere in which the

> client can come to recognize that he has these negative feelings and accept them as part of himself...(Rogers, 1942:37-38).

Recognition by the client that s/he has certain feelings requires empathic responses to what s/he says. For example:

> a client might say, 'It's not fair when less qualified people at work are given promotions'. At one level, this is an entirely accurate fact about simple justice. Obviously, however, it is a very feelingful message -- implicitly. Your job as a therapist is to bring the feelings to life in a way that leaves your client with the sense that you really understand what was meant. [For example] 'I guess you're feeling cheated at that.'...Maybe my client does feel more than cheated. Maybe he feels furious or hopeless or vengeful, but I have to be able to sense what he is trying to say right now and help him articulate that (Martin, 1983:4-5).

Or:

> Your client says, "A lot of the time it seems like people are...I don't know...really mean ...no, not mean ... They're loving, I guess...at least some...like some I know are." You might respond, "I'm not sure I got all that, but let me try. It sounds confusing...trying to know how you feel about the way people are toward you. The ones that matter to you seem to be loving, you guess, but at the same time that doesn't seem quite the whole truth because they seem mean in some ways too" (Martin, 1983:36-37).

It seems then that the central feature of client-centred therapy is the effort to make the individual feel understood and accepted by responding to him/her in a way that captures the feelings, implicitly or explicitly, communicated.

The development of positive self-regard and the process of decreasing the incongruity between self and experience is gradual. It cannot occur in one session. In this process:

> the client is approaching thoughts and feelings, many of which are threatening, as closely as possible and then backing off when the discomfort starts (Martin, 1983:47).

The goal is to prevent and decrease this avoidance in order to promote more complete experiencing. In psychotherapy:

> ...[when the client] faces the mildly painful thoughts in the safe surroundings of your relationship, nothing bad happens, and the fear dissipates...so that the client feels fear reduction ... what you have done is to help your client feel fear reduction immediately after an act of self-confrontation. If this happens hundreds of times in therapy, as it should, your client will become more and more self-confrontative, more open to his own experiences (Martin, 1983:55).

Presumably this will facilitate the individual's recognition that s/he has thoughts and feelings that are threatening to him/her and thus the reason why they are avoided.

It was also noted by the same psychotherapist that:

> I will follow the same general principles, but each client's content of therapy and solutions are unique to that client. I am objecting to the contention that evocatively empathic therapy treats everybody the same way; it treats everybody differently because there is no prescribed personality pattern and no best solutions that grow out of a particular theory (Martin, 1983:188-189).

This contention is evidenced in the case studies found in Rogers (1942) and Martin (1983). The fundamental features in the case illustrations are that the therapist accepts and understands the client and s/he perceives this acceptance and understanding.

As another illustration of this approach to psychotherapy, consider the following example:

> [There was] a client whose problem clearly involved a sexual incident for which the police had threatened him with legal action. Early in therapy, the client said "Well, I'm sure that sex doesn't have anything to do with this." I nearly choked, since he had talked so much about the incident. My response was "So the way you see it, sex isn't a central part of this...it looks now like the important part is worrying about losing control and doing something you don't even know you're doing". Notice that I haven't agreed with him or disagreed with him -- my version of the truth is not an important part of our process together. I am sure that a

> direct confrontation would have stopped him dead, although I probably could have done better than I did by including in my response some reference to the incident, while still acknowledging that it was not central to him. This particular client was in therapy for a relatively long time, but it is interesting that near the end of therapy he said "Its pretty obvious that all of this I've been through has been centered around sex." The fastest way to really get to the truth is to make the truth bearable (Martin, 1983:61-62).

A complete understanding of client-centered psychotherapy would require an analysis of the therapy sessions from the beginning to the end of the process. It is not within the scope of this thesis to reproduce nor to provide an analysis of these dialogues. For our purposes, what is necessary is a summary of how this method of psychotherapy is formulated in theory.

In summary, client-centered psychotherapy focuses primarily on the amelioration of subjective distress which arises from the incongruity between self and experience. This incongruity stems from the conditions of worth which must be satisfied in order to experience positive self-regard. The aim of psychotherapy is to promote unconditional positive self-regard by creating a relationship in which the individual is accepted and understood by the therapist. Presumably, the therapist's unconditional positive regard and empathy will foster positive self-regard and thus decrease the incongruity between self and experience in the individual.

This approach focuses itself explicitly upon the individual and his/her thoughts and feelings. The theory contends that it is up to the individual to determine the source of his/her problem by a persistent exploration of communicated thoughts and, more important, the feelings associated with, or implicit in, them. The focus for change then is the

internal processes of the individual. In keeping with the definition of empathy, it can be assumed that alternative frames of reference are not included in the "communicated understanding of the other person's intended message" (Martin, 1983:3), other than the emotional content. Therefore, it seems unlikely that the interpersonal and socio-structural issues that may be called on to explain conditions of worth will be raised, or identified as problematic. The alleviation of subjective distress and/or improvement of social performance, is achieved by changing the individual, not by formulating a strategy for changing micro-social groups or socio-structural factors.

As mentioned previously, a useful step in the assessment of psychotherapy as a form of associative social control would be to analyze these theories in practice. Although deviance can be explained with three units of analysis which are included in all of the theories, it is not clear whether they are incorporated into the practice of psychotherapy, with the exception of the use of the interpersonal unit of analysis in family or group therapy. The question is whether in addition to helping people to feel and perform better, psychotherapy can equip them also to effect interpersonal and, more important, socio-structural change. One can question as well whether psychotherapists, as members of the community, attempt to effect such change independent of, and in addition to, 'treating' individual clients. These are important questions in view of the three units of analysis that can be used in explaining deviance. At best, it appears that a therapeutic response to deviance changes individuals and micro-social groups and in so doing maintains a social order that will continue to reproduce deviance.

6.5 A SOCIAL PSYCHOLOGICAL/PSYCHIATRIC PERSPECTIVE

The final theoretical perspective that will discussed cannot be considered a theory of psychotherapy proper.[7] The texts (Fromm, 1942; Halleck, 1971), however, were included in the list of readings that might be assigned in graduate courses on psychotherapy. This is assumed to indicate that (at least some) psychotherapists-in-training may be exposed to alternate theoretical perspectives on the nature and amelioration of problems in living, thereby broadening the conceptual and practical parameters of psychotherapy (at least in theory). The issues raised by these theorists also provide a glimpse of what psychotherapy could look like with the systematic integration of all three units of analysis in the formulation of strategies for ameliorating deviance. What is of particular importance in this discussion is the presentation of socio-structural issues as they pertain to the etiology and amelioration of deviance.

A view of deviance which identifies society as problematic does not, however, ignore individual differences or problems within micro-social groups. It may still be necessary to provide psychotherapy to alleviate subjective distress and/or improve social performance, but the argument is that focusing exclusively on the individual or micro group maintains a social order that is viewed as problematic (Halleck, 1971). Thus, adjusting individuals or altering micro social processes without explicating the plausible effect, or objectionable aspects of the social order is to be seriously questioned.

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[7] The stlye in which this perspective is presented differs from the discussion of the previous three theories. This is the result of the nature of the text and should not be taken as an editorial discussion.

Since normal or healthy can be defined in terms of social necessities or human values (Fromm, 1942:160), it is suggested that:

> if the structure of a given society were such that it offered the optimal possibility for individual happiness, both viewpoints would coincide. However, this is not the case in most societies we know, including our own. Although they differ in the degree to which they promote the aims of individual growth, there is a discrepancy between the aims of the smooth functioning society and the full development of the individual (Fromm, 1942:159).

One can make sense of deviance by considering that a social order may be unable to make adequate provision for the satisfaction of human values, insofar as social necessity is pre-eminent. As Halleck sees it:

> a considerable amount of environmental stress is generated by society's failure to satisfy the basic psychological needs of its members...technological society [can be viewed] as one that is too complex to be able to provide all citizens with a sufficient degree of freedom, dignity, autonomy, and meaningful work (1971:22).

In the absence of an optimal environment for all group members, deviance can be viewed systemically. In a society where there are systematic differences in the distribution of, or access to, freedom, dignity, autonomy and meaningful work, the existence of deviance is not surprising. Deviance is not defined simply as an individual or interpersonal phenomenon. Rather, the perspective firmly situates the deviant individual and/or micro-group within the context of the social structure. In this view, it can no longer be taken for granted that deviance is best explained and ameliorated by changing the individual or the micro-group. Assuming that the social order produces subjective distress which may hinder appropriate social performance, the focus for change becomes the society itself. In short, a certain amount of deviance may be ameliorated by conventional approaches, but society will continue to replenish the supply.

Consider, for example, Halleck's (1971) discussion of psychiatric excuse-giving. He argues that this practice:

> ...tends to strengthen existing social systems. The person who is given an excuse may be one who would otherwise have confronted the system. If he is compelled to fulfill his obligation, his plight may arouse considerable public sentiment and concern. However, once a person is declared too sick to meet his obligations, society assumes that the issue has been justly settled. The excused person loses much of his motivation to confront the stressful system, and there is no pressure on society to examine the oppressive nature of the obligations it imposes on people, or to change the system (Halleck, 1971:136-137).

Since most psychiatrists give these excuses on humanitarian/moral grounds (eg. therapeutic abortion), this practice, by providing exemption from obligation, individualizes the problem, and thus, may forestall social change. Neither the individual or the psychiatrist calls for such change. In the case of criminal responsibility, it is argued that:

> ...a strong case could probably be made that social factors such as poverty and race, whose effects are easier to study and measure, should be given more weight in mitigating responsibility that the weight currently given to psychological factors (Halleck, 1971:151).

The implication is that an entirely new set of questions can be raised in the judicial system. By introducing socio-structural issues such as unemployment and institutionalized racism, the social order can no longer be taken for granted. The individual rule-violator can be viewed as a product of the socio-structural arrangements. In view of the selectivity of the excuse-giving, it is not surprising that these issues rarely surface (Halleck, 1971).

This argument can also be extended into the area of contractual psychotherapy. The focus on deviant internal or micro social processes

also serves to maintain the **status quo.** From a socio-structural perspective, psychotherapy, to the extent that it seeks to make people feel and function better by changing the internal subjective apprehension of that which surrounds him/her, assists in the maintenance of a given social order. More specifically:

> the patient's capacity to change an oppressive environment depends upon his psychological strength, his awareness of what that environment is doing to him, and his motivation to change it. Any treatment that makes the patient feel more comfortable and more sure of himself could conceivably increase his effectiveness in dealing with his oppressors ... Unfortunately, psychological strength is not a sufficient condition for social activism, the patient must also know what is worth changing in his environment ... Many therapists, preoccupied with the patient's internal dynamics, do not take the time to make themselves or their patients aware of his stressful environment ... A certain degree of frustration with the inadequacies of the environment is [also] a necessary ingredient for social activism ... The therapeutic process does not create the kind of frustration or ultimately the kind of motivation that would encourage the patient to change his environment (Halleck, 1971:41-42).

Although attempts to help people feel and function better are not inherently negative, Halleck points out that "tranquil men do not ordinarily make good revolutionaries" (1971:42). Even when the interpersonal group is identified as the appropriate object to be changed, the goal is to make the micro group function better while alleviating the subjective distress of the individuals whom it comprises, so that the society that produces these individuals and micro groups remains the same.

Halleck (1971) suggests, then, that psychotherapy can be improved in a number of ways. First, the **status quo** can only be challenged if people are aware that there is something worth changing. An integral part of psychotherapy would then be to provide the individual with as broad a view of his/her circumstances as possible. In short:

> when large numbers of people are "afflicted" with unhappiness, they cannot all be defective. The causes of their suffering cannot be totally personal or anomalous; they must also be within the nature of the immediate social environment (Halleck, 1971:28).

The implication is that individualized conceptualizations of subjective distress and/or inadequate social performance alone are inappropriate and that the individual is not alone or peculiar in his/her suffering. According to Halleck:

> ... In order for psychotherapy to be effective, the therapist must vigorously strive to increase his patient's awareness of all external stress. The therapist should try to show the patient what he is doing to himself or what his family or friends are doing to him; he should also try to show the patient how social institutions influence his behavior. Maladaptive behavior can be generated just as much by lack of awareness of the social environment as by lack of awareness of one's inner motivations (1971:55).

This awareness, coupled with an explicit analysis of the social order in the explanation of why so many people share these difficulties is a necessary part of the development of challenges to the **status quo.**

However, awareness, though a necessary starting point, is not in itself enough. The second issue then is motivation. In addition to a strategy for changing the individual (ie. alleviating subjective distress and expanding the awareness context), a second focus might also be incorporated, namely, the utility of social activism and the potential for social change. Halleck also argues:

> [p]sychiatrists have tried to convince themselves that it is possible to keep their political biases out of their work. They have sought to maintain a kind of therapeutic neutrality and have been extremely reluctant to share their political views with their patients ... [D]ealing with the harsh realities of life is not a resistance to the process of emotional growth; rather, it may be a critical factor in maintaining one's mental health, especially in a society in which realities are so grim (1971:55).

Human reality must be understood as a social construction. With the understanding that social reality is arbitrary, that it is socially constructed, may come the realization that it can be changed. When society is presented as given, inevitable, unchangeable, there is little to motivate efforts to change it. The psychotherapist who recognizes that reality is socially constructed, as well as the role of socio-structural factors in the etiology of deviance, becomes obligated to impart this knowledge to the client, thereby fostering a motivation for social activism (Halleck, 1971).

Finally, it is suggested that frustration with the environment is necessary for challenging the **status quo.** This is particularly problematic because it appears antithetical to the stated goals of psychotherapy. The alleviation of subjective distress and/or improvement of social performance on one hand, and the development or maintenance of frustration on the other, appear to be irreconcilable. For example, a black student who had been awarded an athletic scholarship was refused enrollment in the premedical program because the "school's athletic department was so intent to have him maintain his academic eligibility that it was unwilling to permit him to fail difficult courses" (Halleck, 1971:48). The individual ultimately was dismissed from the team and lost his scholarship for protesting against the racist attitudes which forced him to major in physical education. This frustration effected his studies which led him to a psychotherapist. Halleck claims:

> Before this student came to see me he had consulted another psychiatrist who advised him to forget about the injustices that had been perpetrated against him and try to overcome his neurotic problems ... [Seeking a second opinion] ... he told me that he wanted only two things: to get into medical school

> and to do something about the system that had hurt him so badly. I told him that I thought he had been treated inhumanly and agreed that he would never be at peace with himself until he succeeded in doing something about the system that had hurt him. We agreed together that he could more readily do something to change the system if he achieved a position of power in this society (Halleck, 1971:49).

Psychotherapy helped to alleviate this individual's subjective distress and improve his academic performance, but "[at] the same time he still retains a high degree of commitment to the struggle to end racism in America.

The implication is that the goals of psychotherapy must be changed, or frustration must be incorporated into those goals. If frustration with society could be construed as valuable and constructive (ie, it took the form of an intersubjective critique), it might result in an individual feeling "more sure of himself...[and]...increase his effectiveness" (Halleck, 1971:41). The individual can be frustrated with something, but this does not have to signal subjective distress for which psychotherapy is indicated. Rather, it can provide the foundation for sharing with others a critical evaluation of socio-structural arrangements, and the frustration. These three issues (awareness, motivation, and frustration) provide an interesting vantage point from which to assess whether conventional psychotherapy assists in the maintenance of social order, insofar as they may provide a foundation for challenging the **status quo.**

In summary, a social psychological/psychiatric perspective on psychotherapy questions conventional clinical intervention which focuses primarily on changing the individual. Although psychotanaltic psychotherapy forms the basis of Halleck's (1971) clinical practise, he

clearly argues that the alteration of interpersonal processes and the transformation of the social system are of equal, if not greater importance, in the amelioration of deviance. Individualized amelioration is not abandoned because the alleviation of subjective distress and improvements in social performance can benefit the individual. The implications of conventional psychotherapy's basic focus on the individual, however, are systematically addressed in terms of the maintenance of social order. By including the issues of awareness, motivation and frustration in the psychotherapeutic programme, suggestions are provided for changing pschotherapy such that it may facilitate challenges the to social order.

6.6 DISCUSSION

The practical application of the psychoanalytic, behaviorist, and experiential-humanist theories of psychotherapy have been examined. In addition, a fourth perspective was considered that provided a critique of conventional psychotherapy and suggestions for altering the process and its outcome. The issue that psychotherapy, by focusing on changing individuals (or micro groups), may assist in the maintenance of social order, does not surface in the seminal schools of psychotherapy. Although the conceptual parameters of these theories encompass the three units of analysis that can explain deviance, they are not integrated in practice. A social psychological/psychchiatric perspective, in contrast, argues that the failure of psychotherapy to incorporate socio-structural issues into practice, serves to assist in the maintenance of existing social systems.

Psychoanalyis attempts to bring to awareness the individual's emotional reactions to interpersonal processes; to work through these emotions to achieve lasting insight, which enables him/her to cope efficiently in life (Fromm-Reichman, 1950). Changing the individual's emotional reactions serves to improve social performance in interpersonal relationships. Similarly, client-centred psychotherapy focuses on helping the individual to decrease his/her avoidance of threatening cognitions and painful emotions in order to facilitate full openness to experience (Rogers, 1959). With empathy and positive regard, the incongruity between self and experience which creates subjective distress and disrupts social performance is eliminated. In both the psychoanalytic and client-centred approaches, subjective satisfaction and acceptable social performance are realized by changing the subject's cognitive and affective processes. The major difference between these perspectives is the extent to which the client is directed toward a particular view or interpretation of reality. Psychoanalysis is the more directive of the two, but in both cases, the focus is on changing the individual.

The behavioral approach, which is similar to the psychoanalysis terms of being directive, focuses on observable, compartmentalized, operationally defined behavior or responses. It is the narrowest approach to the amelioration of deviance in spite of the broad assumption that problematic experience or performance are caused by environmental factors. Subjective distress and inadequate social performance are ameliorated by altering stimulus and response contingencies which can be directly manipulated by the therapist or the

individual, in order to achieve response increment, decrement, or acquisition (Gottman and Leiblum, 1974). The focus for change in this approach, as well as psychoanalysis and client-centred psychotherapy, is the individual, although micro social intervention has been formulated.

There is a disparity, then between the explanation and amelioration of deviance in conventional theories of psychotherapy. Although deviance can be explained with reference to individual, interpersonal and socio-structural factors, the practical application of psychotherapeutic theory is confined to changing the individual, or in its broadest application, altering interpersonal interaction. The socio-structural issues that can be raised in the explanation of deviance are almost absent in the formulation of practice. The focus on internal processes and interpersonal interaction obstructs the examination of socio-structural problems, and therefore the identification of the social order as an appropriate target in the amelioration of deviance. The implication of this is that psychotherapy is a form of associative social control which assists in the maintenance of social order. This is the very issue raised by the social psychological/psychiatric perspectives on deviance (Fromm, 1941; and Halleck, 1971).

Chapter VII

CONCLUSION

The purpose of this thesis was to assess the argument that psychotherapy is a form of social control in the service of the maintenance of social order. More specifically, contractual psychotherapy was conceptualized as a form of associative social control (Mayer, 1983), which can be understood as a part of a larger system of consensual control, or hegemony (Femia, 1975). The argument is that the structural arrangements of society are maintained by social institutions which shape the conceptual processes through which humans perceive and understand social reality (Femia, 1975). In short, the processes of socialization shape the cognitive and affective structures with which the individual engages in and perceives social action. Socialization establishes a normative order against which the individual's performance and experience are compared. Society can be seen then, as providing definitions of both normal and deviant behavior. Since deviance represents a threat to the normative order, society must equip itself to control it, thereby preserving its integrity. The social institutions which perform this function can be seen to sustain this hegemony.

As stated at the outset, social order and mechanisms which assist in its maintenance are essential to human existence. The conflict-based deviancy model of social control has made a significant contribution to the understanding of the maintenance of social order in its focus on

coercive control. Social control, however, is often perceived as a repressive process with little or no redeeming value. Again, social control assists in the maintenance of social order and is crucial for humans. It is simply naive to assume that social order can be maintained without control mechanisms. Human action simply cannot proceed in the absence of social order, therefore social control can be seen as organizing individual and social life. Social control, vis-a-vis the maintenance of social order, warrants critical analysis when it perpetuates societal inadequacies in the socialization of group members and obfuscates them in the amelioration of deviance. The question that arises, then, is, does psychotherapy sustain hegemonic control in the amelioration of deviance?

The deviance upon which this thesis focused was subjective distress and inadequate social performance, not disruptive enough to call for incarceration (Armstrong, 1983), but for which individuals might voluntarily avail themselves of contractual psychotherapy. Psychotherapy pervades the entire practice of psychiatry and clinical psychology. It is not used exclusively with one class of deviants, but rather it underscores the genderal therapeutic approach to ameliorating deviance. That an individual would identify his/her performance or experience as deviant and thus seek psychotherapy can only be understood as due to ideas emerging out of the socio-cultural milieu, because society defines for its members the parameters of normative subjective experience and social performance. Cultural definitions structure the evaluation of subjective experience and social performance and suggest solutions in the face of subjective distress and inadequate performance.

This constitutes the imposition of order upon the flux of human experience in general (Berger, 1971). Psychotherapy, as a solution to the problematic experience and performance also constitutes the imposition of order, or more accurately, maintains the particular order that has been imposed. This is the fundamental feature of hegemonic control; society directly and indirectly shapes the the cognitive and affective structures which guide social action (Femia, 1975).

In theories of psychotherapy, the stated goals are to foster subjective satisfaction (eg. happiness) and improve social performance (eg. work, interpersonal interaction). The individual is seen in psychotherapy primarily because of emotional complaints (eg. anxiety, depression, fear) which may surface independent of disrupted social performance, or in addition to it. Whether the evaluation is subjective or made by an external observer, the standards which govern the evaluation of subjective experience or social performance are derived from the group. The implication is that psychotherapy not only assists the individual actor but it also assists the group. On one hand, feeling better is defined subjectively as desirable, and on the other, performing better is defined collectively as desirable, in the sense that adequate social performance is necessary for a smoothly functioning society. Of course, subjective satisfaction may also result from better performance. The manifest benefits which may accrue for human beings from psychotherapy, however, mask the plausibility of explanation and intervention at the socio-structural level. The social order derives a latent benefit from the psychotherapeutic programme, namely, conformity to, as opposed to challenges to, social norms and rules.

The character of subjective satisfaction and adequate social performance is nebulous, which makes it difficult to distinguish clearly normal from abnormal behavior. Since all humans experience subjective distress and disruptions to social performance, the individual can never be certain that s/he is indeed normal. The result is that all social actors are potential candidates for psychotherapy. The success of an associative social control programme such as psychotherapy in attracting a clientele rests on the ambiguity of cultural definitions of normative experience and performance. The argument that psychotherapy is a form of associative social control is supported by this analysis. The goals of subjective satisfaction and improved social performance are perceived individually and collectively as desirable. It goes without saying that adequate social performance is a social necessity. Subjective satisfaction is also socially valued, but if it requires societal change to achieve it, then it becomes problematic in the in sense that the maintenance of social order is threatened. Society circumvents these threats by shaping the cognitive and affective processes through which subjective experience and social performance are evaluated.

The goals of psychotherapy are purported to be beneficial for the individual and the group. An exception this pattern is found in Halleck (1971), who suggests that if society is viewed as problematic, then an additional, or more appropriate goal for psychotherapy would be to foster frustration with the inadequacies of the system as opposed to simply helping people to feel and function better in the existing system. This is not to suggest that the goals of psychotherapy should be to maintain or encourage subjective distress and inadequate social

performance; rather Halleck (1971) questions the impications of helping people to feel and act better in the current established order. In short, an inadequate society may be maintained by the goals of conventional psychotherapy as well as the inability to distinguish normal from abnormal experience and performance. The goals of psychotherapy are framed in terms of the manifest benefits for the individual which obfuscate the latent socio-structural benefits; social order is maintained. Frustration with the existing system may facilitate change in that system such that all group members achieve subjective satisfaction and perform their roles well.

Subjective distress and inadequate social performance can be explained by using the individual, interpersonal interaction or the social structure as units of analysis, which indeed, all of the theoretical perspectives present and explicate. These frames of reference are used in differing contexts and with varying degrees of emphasis, but the conceptual parameters of psychotherapy are broad enough to incorporate the full range of issues, from the peculiarity of the individual to the objectionable aspects of society, within its explanatory domain. Although this continuum is formally included in psychotherapeutic theories of deviance, the theoretical application of the seminal theories indicates that individualized explanations inform clinical practise, except in the case of marital or family therapy. Upon closer examination of socio-structural explanations of deviance in conventional psychotherapeutic theory, their actual utility appears to be nominal. Consider again, Martin and Pears's (1978) discussion of the iatrogenic effects of avoidance conditioning, which they argue, pervades

the educational and legal systems. One can question why this strategy for ameliorating deviance is retained in practice when it is argued to have a deleterious effect on human behavior. Psychotherapeutic theory does not rely exclusively on internal subjective peculiarities to explain problematic experience and performance, but the theoretical formulation of practise does not reflect the integration of the entire range of explanatory concepts. Since the development of strategies to ameliorate deviance are structured by the unit of analysis that is used to explain it, in the final analysis, the inclusion of socio-structural issues in nominal to the extent that societal transformation is not integrated into mainstream clinical practice. Recall, Becker's contention that "what we call cause reflects our intention to act and the powers we dispose of ..." (1964:116). In psychotherapeutic theory, the incongruity between the explanation and amelioration of deviance suggests the opposite. That is, the prescribed action for ameliorating deviance reflects what is conceptualized as the cause of it, namely individual peculiarities and problematic interpersonal interaction.

The critical question for assessing the argument that psychotherapy serves to maintain social order is: how are deviant states or conditions best ameliorated? Again, ameliorative strategies are directly related to the unit of analysis that is used to explain deviance. If the individual, micro group, and the society itself can be viewed as appropriate units of analysis for explaining deviance, then it would best ameliorated by change at all three levels. Assuming that society structures individual and social life, then it can be identified, as perhaps, the most appropriate target at which to aim amelioration

efforts. In theory, conventional psychotherapy has formulated strategies for changing individuals, and in its broadest application, micro groups such as the family or marital relationship. If all three units of analysis are necessary for an adequate understanding of individual and social life, why is it that psychotherapy changes the individual, or the individuals that comprise micro groups? There is a distinct gap then, between the explanation and amelioration of deviance.

The three major schools of psychotherapy aim their efforts at changing the individual, although there are instances in which it is considered to be more appropriate to change social processes, or designate the micro group as the appropriate 'client' (eg. Laing, 1969; Fromm-Reichman, 1950; and Gottman and Leiblum, 1974), but none of the theories goes beyond the small group in defining who the client is. According to Becker (1964), this is a function of the powers the psychotherapist may dispose of. Social order would be threatened by attacks on the society and thus deviance is best ameliorated by change at the individual and micro levels of social life.

Subjective distress and inadequate social performance appear to be ameliorated in two fundamental ways. In the case of psychoanalysis, the cognitive and affective structures which are assumed to underlie problematic experience and performance are explored, interpreted and worked through so that the patient may achieve insight. The primary aim is to expand the individual's self-knowledge and change his/her emotional reactions that precipitate subjective distress or disrupt social performance. Similarly, client-centered psychotherapy focuses on the emotional dimension of the individual's difficulties, on the

assumption that with self-knowledge comes an understanding of the emotional factors which interfere with appropriate cognition and action.

The second way in which the goals of psychotherapy are achieved is by changing compartmentalized overt behavior. Behavior modification focuses primarily on manipulating the contingencies of reinforcement which create and sustain behavioral excesses, deficiencies or inappropriateness. Strategies are devised to promote adaptive and prosocial behavior and the process is virtually the same when covert behavior (eg. thoughts and feelings) is identified as problematic.

What is common to all three perspectives is that the focus is on changing the individual, despite the fact the interpersonal and socio-structural factors are also identified as plausible accounts of unacceptable subjective experience and social performance. The micro group may be identified as the appropriate target for change, but strategies for changing the social structure in which both the individual and micro group are shaped, are not integrated into psychotherapeutic practice (at least in theory). Rather, society is taken as given and the focus is on the promotion of subjective satisfaction and improved social performance within the confines of acceptable experience and conduct set out by the society.

The theoretical presentation of psychotherapeutic practice provides support for the argument that psychotherapy is a form of associative social control. By focusing on changing individual behavior and internal, subjective processes and not socio-structural arrangements, the social order is maintained. Halleck (1971) again represents an

exception to this pattern by addressing such issues as fostering the individual's awareness of and frustration with society's inadequacies. Moreover, he views it as appropriate for the psychotherapist to make an effort to motivate the individual to change the larger social system. Thus, although the seminal schools of psychotherapy raise socio-structural issues in the explanation of deviance, these issues are not translated into practice.

Insofar as psychotherapy individualizes clinical intervention, the role of the social structure in the etiology of problematic experience or behavior is obscured. Psychotherapy is indeed a "conceptual machinery of universe maintenance [which ensures] that actual or potential deviants stay within the institutionalized definitions of reality" (Berger and Luckmann, 1966:112-113). The nebulous character of normality, which renders every individual a potential candidate for psychotherapy, and the disparity between the explanation and amelioration of deviance supports the conclusion that psychotherapy is indeed a form of associative social control which not only maintains but also perpetuates a given social order. In short, the manner in which the goals of psychotherapy are achieved is an insidious use of power (Lukes, 1977) which sustains hegemonic control (Femia, 1975).

Awareness should be a particularly important outcome of psychotherapy, not only in the sense of being aware of one's internal dynamics or understanding of micro social processes, but more important, being aware of the interrelationships of the different parts of large social systems (Halleck, 1971). This awareness can be seen as necessary for the development of critical thinking, the suppression of which, some

would argue, begins very early in life (Fromm, 1941:216). Fromm contends:

> with regard to all basic questions of individual and social life, with regard to psychological, economic, political, and moral problems, a great sector of our culture has just one function -- to befog the issues. One kind of smokescreen is the assertion that the problems are too complicated for the average individual to grasp. On the contrary, it would seem that many of the basic issues of individual and social life are very simple, so simple, in fact, that everyone should be expected to understand them. To let them appear so enormously complicated that only a "specialist" can understand them...tends to discourage people from trusting their own capacity to think about those problems that really matter (1941:275-276).

It can be inferred from this that critical thinking is circumscribed by the social distribution of knowledge. Human existence is no doubt a complex phenomenon, but this complexity seems to have grown exponentially with the emergence of countless experts. As this excerpt suggests, the specialists, by delineating discrete areas of expertise, fail to integrate the fundamental questions that underlie individual and social life. Laing for example, argues that:

> the socio-economic factors of the larger community of which the patient's family is an integral part are not **directly** relevant to the subject matter that is our concern. This is not to say that such factors do not profoundly influence the nature of the family and hence the patient. But, just as the cytologist puts, **qua** cytologist, his knowledge of macroanatomy in parentheses in his description of cellular phenomena, while at the same time being in posession of this knowledge, so we put the larger sociological issues in parentheses as not of direct relevance to the understanding of how this girl became psychotic (1969:180, emphasis in original).

This enables the psychotherapist to avoid socio-structural issues in practice by suppressing the issues entirely or regarding the questions as outside his/her area of expertise.

The social distribution of knowledge is inevitable in the sense that society has become too complex for each individual to 'know' all there is to know. The basis for, and the nature of, this distribution is, however, a significant problem for study. The seminal schools of psychotherapy focus on self-knowledge, or the information that renders individual behavior controllable. If socio-structural factors can provide a plausible account of the development of subjective distress, then self-knowledge alone will not bridge the gap between internal dynamics and the social structure. Psychotherapy 'befogs' the socio-structural problems of individual and social life by designating the individual as the appropriate focus for change.

The question then is: what type of knowledge is imparted by the psychotherapist to the individual? An appropriate starting point for the consideration of this knowledge is to assess psychotherapy in practice. Psychotherapy promises to alleviate subjective distress and in so doing, or in addition, improves social performance. Theoretically, it views deviance as an individual, interpersonal and socio-structural phenomenon. In its presentation of practice ,however, it seems that, with the exception of micro social intervention, the individual is the problem that must be solved. Clearly, what is stated in theory may bear little or no relation to the content of practice. The problem then is to study psychotherapeutic dialogue to assess the type of, and the manner in which, knowledge is imparted. It is only in the social psychological/psychiatric perspective that alternative goals of psychotherapy are stated and presented as factors that may facilitate challenges to existing socio-structural arrangements. Again, there is an

awareness of the interrelationships of the parts of the larger social system; frustration with the inadequacies of this system; and the motivation to change it.

By far the most important task that lies ahead in this field of inquiry, then, is an analysis of actual psychotherapy in practice. Since this study did not attempt to analyze the content and process of psychotherapy as it happens, it is difficult to discern how the individual is actually changed, or, the steps in the process and the knowledge s/he acquires that produces such change. This was most clear in the case of client-centered psychotherapy which appears to be unique for each client. It is suggested that another way to assess the argument that psychotherapy is a form of social control is to analyze the process of psychotherapy from the initial interview to its termination with different clients and practitioners using different theoretical perspectives.

Appendix A

CORRESPONDENCE

Mary-Anne Kandrack
Department of Sociology
University of Manitoba.
Winnipeg, Manitoba.
R3T-2N2.
March 31, 1986.

Dear Professor

I am an M.A. student in Sociology and have reached the thesis stage in my program. I have proposed a content analysis of theories of psychotherapy with the aim of comparing different logics of clinical practice.

At this time, I am requesting your assistance in compiling a list of psychotherapy texts from which to draw a sample for content analysis. I would sincerely appreciate your cooperation in furnishing a list of five popular texts that are used in graduate courses in psychotherapy training.

Please find a form attached on which you can record the list. It can be returned to me at the Sociology department via campus mail, or I can be reached by telephone at 474-5555.

Since I intend to move on to a Ph.D. program this September, I would appreciate a response at your earliest convenience. If you have any questions about the proposed study please feel free to contact me, or my advisor, Dr. Stephen Brickey (945-3125).

Thank you for your consideration of this correspondence.

Yours truly,

Mary-Anne Kandrack

Appendix B

PSYCHOTHERAPY TEXTS

Psychoanalytic Texts

Balint, M., P.H. Ornstein and E. Balint.
Focal Therapy: An Example of Applied Psychoanalysis. Tairstock Publications Ltd., London: 1972.

Freud, Sigmund.
The Problem of Anxiety. W.W. Norton & Co. Inc. New York: 1936.

Fromm-Reichmann, F.
Principles of Intensive Psychotherapy. The University of Chicago Press, Chicago: 1950.

Behavior Modification Texts

Craighead, W.E., A.E. Kazdin, and Michael J. Mahoney.
Behavior Modification: Principles, Issues and Applications. Houghton Mifflin Company, Boston: 1981.

Gottman, John M. and Sandra R. Leiblum.
How To Do Psychotherapy And How To Evaluate It: A Manual For Beginners. Holt, Rinehart and Winston Inc., New York: 1974.

Martin, Garry and Joseph Pear.
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Experiential-Humanism Texts

Martin, David G.
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Rogers, Carl R.
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"A Theory of Psychotherapy, Personality, and Interpersonal Relationships, as Developed in the Client-Centred Framework". In Psychology: A Study of Science. S. Koch (ed.). McGraw-Hill Book Company Inc., New York: 1959: 184-256.

Social Psychological/Psychiatric Texts

Fromm, Erich.
Escape From Freedom. Avon Books, New York: 1941 (reprinted, 1965).

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

Laing, R.D.
The Divided Self. Penguin Books, Middlesex: 1969.

Appendix C

FACE SHEET

REFERENCE: _____ [8]

1. What is normal?

2. Unit of analysis in accounting for deviations from this ideal?

3. How to ameliorate these deviations

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[8] MEMO:

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