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The Theory of Anxiety and the Nature of Psychotherapy†

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I AM GOING TO IMPOSE SHOCKINGLY on your good nature by presenting at the start a really very old paper. I am doing this because, as I have glanced over the audience, I see that there are but a very few who have previously heard this paper, and it has never been printed. The reason for my doing this is to offer a certain hurried outline as to the nature of psychiatric therapy—not including brain surgery, shock, and so on—as I saw it some time since. I will then quote to some extent from the theory of anxiety as it has been most recently formulated. And, with this rather heavy preliminary, I will attempt to take up what is implied as to the nature of psychotherapy by the theory of anxiety—which is now entertained quite seriously as a temporarily good expedient, on the basis of some 6 years' collaboration with the colleagues in the Washington School. After I have read you this paper—and you must realize that this will show certain dating and certain other indices of the events concerned—I will tell you its origin hoping that the old heads who recognize it will in the meanwhile keep it a secret.

This brings us immediately to condensation of the subject-matter of this paper —which was entitled "Therapy and Pseudotherapy in Psychiatry"— to the therapy of the functional disorders. But I would wish you to accept the functional disorders as types of mental disorder which each one of you—which every approximately normal person—could once have developed. Every one can and, at times, does show all the mechanisms that make up the functional psychoses. And, therefore, it is possible to make an outline on that basis of the processes which are therapeutic, and of processes which, while delightful to all concerned, are not in any sense constructive.

Mental disorder must be regarded as the result of the personality relating to the demands of the personal situation. Personality is the integrative product of experience on the basis of the innate limiting factors. It must be kept in mind that the experience of each individual differs from the experience of every other individual, both in that the events making up the experience are unique, and also in that the particular compound of innate possibilities of the soma, nervous system, and so on, are to some extent unique. The demands of the personal situation to which I have referred may be considered as *externally* and *internally* conditioned. The *externally* conditioned, however, is really an *internally* apprehended or perceived aspect of the situation. In other words, everything which makes up the personal situation has to be experienced by the person as an intelligible demand which is mediated by other people. These other people may be real or illusory. In fact, they are usually the latter. The demands of the personal situation are then always related to the experience of the person; that is, to what has happened to him up to the moment in which we find him. Therapy must seek to augment the satisfactions that the person is deriving from living or in living, of which we must presume some serious deficiency. In other words, if a person is getting sufficient satisfac-

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tion, there is no mental disorder and therapy would be fantastically irrelevant. Therapy seeks to improve the relation of the personality to and with the demands of the personal situation which is made up of other people and their representations. It seeks to effect changes in the personal situation and in the personality. Unhappily, this dichotomy of the personal situation and the personality is a figment of logical thinking. Both are parts of one thing, and, therefore, therapy must always effect changes in both parts—the person and his situation.

Now, as to an extremely brief outline of some of the things that are done in therapy:

First, the therapist may provide information. In this role the therapist is an educator; that is, he is an agent in the transmission of the culture in which the patient is living, must live, to which he must conform, and in which all his activities must be patterned and must be explicable. The educative process is that which occurs when you tell somebody something which the person understands. This educative process can function *only* on the basis of previous experience and in the absence of serious obstacles to the accumulation of the particular entities of culture, tradition, data, and so on, about which you may wish to inform. The informative role of the therapist is not usually a very large one. That, however, does not in any sense diminish the enormous importance of the information that the therapist can give to the patient. In a situation in which *no* information is communicated to the *average* patient I am rather inclined to think that little therapy will take place. Most unhappily few of us have been so emancipated from our early striving for omnipotence and omniscience that we take the trouble to verify what among our beliefs are valid bits of information, and what are aspects of our life situation—our own life situation, and our own life problems. Thus to those of you who have come to a firm conviction as to the organic basis, let us say, of schizophrenia, it would be rather absurd, first, for me to attempt to learn from you the information you have as to the organic basis of schizophrenia or, second, for me to give you information which would correct your *to me* erroneous beliefs. Those erroneous—to me—beliefs are very important in your living. Your life has been more or less structured around these doctrines, certainly your life as a therapist—God save the mark—of schizophrenia. Under those circumstances, even if there were some way in which to prove that my beliefs about schizophrenia are correct, it would be rather futile for me to attempt to 'cure' you of your peculiar disorder by telling you about them.

The next great thing that the therapist can do is to correct misinformation—of which I have given a sort of splendid example just now—this misinformation having functioned in the personality to blunt the growth of information. I don't think I need to discuss the nature of information, especially as time is growing shorter and shorter. In the correction of misinformation—the second task of the therapist—the therapist receives his most glaring evidence of the fact that time-experience is not static, not something poured into compartments which can be fished up whenever needed, and so on, but something which *dynamically* restricts the addition of correct data. The correction of misinformation, therefore, is not too readily achieved by pouring correct data into the person but instead has to be sought by studying the role in the personality of that which is intact and correct.

Thirdly, the therapist functions by rectifying impractical evaluational systems. Personal evaluations—those things that we call good and bad, right and wrong—do not exist as units here and there in the mind, or something of that kind. They are momentary manifestations in a given personal situation—momentary presenting features, if you please—of highly integrated, interpenetrative systems of evaluation. And, therefore, the therapist in attempting to alter the value that a patient puts upon a certain act, or a certain belief, is not dealing with a little atom but is actually undertaking to change a very large integrated system in the per-

son. These systems of evaluations, these very large integrations, all of which combine in various ways to form the personality itself are very intimately connected with what we may call the feeling of personal worth which the particular individual has. This feeling of personal worth is most intimately tied up with the evaluational systems which apply to one's acts and the acts of other people, and thereby forms the channels by which are expressed most of the positive movements of the personality and most of the negative, hostile, or destructive movements of the personality. I need not pause to indicate to you here that this evaluational aspect of therapy has to do with rationalizations, nor, I presume, stress the news that there may be in this view as to the treatment of rationalizations.

Fourth, the therapist may act by reducing or by augmenting what we call *personal distance.* Now personal distance is altogether too often supposed to be a specialty of the schizoid and detached person—a sort of disease that the therapist should attack. With therapists as almighty as they sometimes try to be, if they were able to divorce their patients from this social distance that holds other people off and insulates one from other people's wishes, beliefs, and so on, then these therapists would precipitate panic and violent anxiety attacks without end—suicides, doubtless homicides, and so on. In other words, social distance—the distance with which we wall ourselves around—is a very necessary thing, although it may be practically a disease in itself. The therapist, therefore, in attacking this scientifically must realize that he is dealing, again, with very powerful dynamic systems which can change but slowly if they are not to change disastrously.

Next, the therapist can act by reorganization of the effective potentialities of his patient. This is an exceedingly important part of the therapy of the functional conditions. It is the correction of the *parataxic* or *transference phenomena* —the distortions that are incurred in the development of personality—that come out of the past and that are effective in distorting the prehensions and perceptions of the person as to the situations in which he has existed. This thing of reorganizing the effective potentialities of a patient is close to the nucleus of the therapeutic achievements of psychoanalytic technique—close to the nucleus of our hopes for a future therapy that will be widely effective in reasonable time. The effective potentialities of each individual suffer distortion of necessity. Just as I said in my opening remarks, as we at various times in our development manifest clearly the possibility of having any type of symptom-complex that is described in dealing with the functional disorders, so also we are born with enormous capacities for attaching emotional signs to various types of interpersonal experience. And these tend to become fixed along the line of our development by more or less crisis situations through which we have passed. Therefore, as a result of the reduction of effective freedom, the inhibition of effective potentialities, we are distorted so strikingly that we lose our potentialities for being universal human beings and become, in many cases, so distorted and so limited in this field that we are recognized to suffer mental disorder.

Next, the therapist may function by reintegrating dissociated and suppressed experience-systems. By the release of the personal awareness from inhibitions, this work is accomplished. That which is dissociated ceases to be represented within the awareness of the person. He goes on living a part of his personality, integrating personal situations, functioning in these personal situations, and achieving satisfactions and pains exterior to his awareness. He cannot take time out of life to do this and, therefore, to everybody but himself the manifestations of these dissociated tendencies are peculiarities, eccentricities, symptoms, and the like. The therapist functions to remedy these so that the awareness of the patient as to the situation in which he is living becomes a better approximation to correct information.

Therapy works through or as a function of interpersonal communication.

Now, in interpersonal communication there are many degrees of reference. For example, if you ask me where the Maryland Club is, I can either tell you a fairly good way to get there or say that I don't know. But if you ask me what I think of the last election and its probable effects on me, then—as I say when in a hotel—is the time to call on room service. If now, however, you should ask me why I like a certain person, no facilities of the hotel, or the Maryland Club, or elsewhere, would be sufficient to assist me in communicating correct information to you. In other words, there are many things about which much is said and exceedingly little communicated. I think that that is very often the case in alleged therapeutic situations.

Let me say then—continuing my outline without illuminating examples—language processes, those concerned in the most obvious of interpersonal communications, are very intimately related to the so-called logical structure of conscious thought. And there is a vast deal of everybody's time spent in revery processes that are *not* logical communicative thoughts, and therefore, any therapeutic efforts that sharply restrict themselves to dealing with logical communicative thoughts will miss the larger part of the implicit activity of each one of you, and of all of your patients, throughout your life. In communicating, one must be in a universe of discourse. In other words, the fact that you tell a patient something—if there is to be communication—must imply that the words mean approximately the same thing to the patient that they do to you, that the topic under discussion is recognized in the same type of personal significance as you had in your mind. It is amazingly easy to violate this particular law of communicative speech. A vast number of things are told to patients which mean so very different things to the patient than they do to the communcator, *the alleged communicator*, that if you would give your patient plenty of time to talk—perhaps not all the opportunities of a psychoanalytic case—but at least if you would inquire now and then what the patient understood of what you have told him, you would become informed rapidly.

A great deal of the things which are communicated with *alleged* therapeutic purpose, and with even alleged therapeutic results, are illusions, fixed beliefs, traditions, false evaluations, and so on, which are fixed in the common traditions—the cultural milieu from which you, yourself, and your patients come. No amount of juggling with these things is going to remedy personality disorder. But any juggling with them is going to increase the mutual respect in which you and your patient hold each other. That, I believe, is sometimes conducive to a good practice but I think that it is relatively useless as therapy.

I wish finally to say one word about the role of *magic* in the development of personal stability. Were I *by some magic* to expose before you the proportion of your most serious thoughts and most serious communications to your patients which were to me sheer *magic*—just as magical as any operation of a three-year-old child—if I were, then, to expound in a particular case the *why* and *wherefore* of this particular magical belief, magical procedure, magical ritual, magical sentence, or word of power that had persisted all these years in you and had apparently done marvelous work in your patients, you would see that everything about you and everything that you see in your patients—all the personal situations that you pass through and that they pass through, and so on—are a series of dynamic systems interlocking, moving together one way or another. And you will begin to see what, I believe, is to be the fundamental idea of this little talk—namely, if there is a forward movement toward an expansion of the satisfactions of the patient, then therapy is in progress. If, on the other hand, there is no such movement, if instead just a new private world is being developed between you and the patient, then therapy is not in progress. The patient is not being released to a larger living—a deepening and widening of interest in life—but is, in fact, being tied to you by a particular kind of neurotic, or psychotic, or what-

ever you please, process which is perhaps more incurable than the condition which brought him to you.

I have always been mystified about this paper because it was well received at the 1938 meeting of the American Psychiatric Association which convened in San Francisco and which, I am quite sure, a large number of you did not attend. Now, that was the view then. It was never published because there was never time to revise it because the White Memorial Lecture, *Conceptions of Modern Psychiatry*,[1] had to be gotten out next. In the years that have passed, a great deal of work has been done to check over the hypotheses rather obscurely conveyed in the latter. And this work, finally, culminated no more distantly than, I believe, last year in a talk on "The Meaning of Anxiety in Psychiatry and in Life."[2] While I am sure that some of you have been so very kind as to read that paper—which is actually available—I want to get through with my part of this evening's talk on the theory of anxiety by quoting some excerpts from that paper as a preliminary to a very unfinished attempt to expose my topic.

In extreme abstract, the theory [of anxiety] holds that we come into being as [people] persons as a consequence of unnumbered interpersonal fields of force, and that we manifest intelligible human processes only in such interpersonal fields. Like any mammalian creature, man is endowed with the potentialities for undergoing *fear*, but in almost complete contradistinction to infrahuman creatures, man in the process of becoming a person always develops a great variety of processes directly related to the undergoing of *anxiety*.

As felt experience, marked fear and uncomplicated anxiety are identical; that is, there is nothing in one's awareness of the discomfort which distinguishes the one from the other. Fear, as a significant factor in any situation, is often unequivocal. Anxiety, on the other hand, in anything like the accustomed circumstances of one's life, is seldom clearly represented as such in awareness. Instances of fear in the course of accustomed peacetime living are not numerous while instances of—generally unrecognized—anxiety are very frequent in the waking life of a great many people.

The significant pattern of situations characterized by the tension of fear is not recondite and is roughly the same for all people, excepting for the effects of habituation. The significant pattern of situations which arouse anxiety is generally obscure; can be almost infinitely varied among people; and shows much less, and very much less obvious, effects of habituation.

Habituation is a function of observation and analysis, of information and understanding, of recall and foresight. While fear may impede these processes, anxiety invariably interferes with their effective application to the current situation. The felt component of any 'emotion,' if sufficiently intense, will interfere with the application of these abilities [observation, analysis, and so on] to the immediate situation, and action in discharge of the tension will become correspondingly undifferentiated and imprecise. Up to the point at which this interference appears, the tension is attended by increasing alertness to factors in the situation which are immediately relevant to the relief of the tension, however great the inattention to other factors may become. In the case of anxiety, diametrically opposite is the case. Anxiety from its mildest to its most extreme manifestation interferes with effective alertness to the factors in the current situation that are immediately relevant to its occurrence, and thus [interferes] with the refinement and precision of action related to its relief or reduction.

In the case of every other tension the relief of which is sought by overt and [or] covert activity, excepting only the tension of anxiety and its complex derivatives, energy is transformed in ways that can be said to achieve, approach, compromise, or suppress action towards the objective. Thus the tension of fear is commonly manifested in activity which removes [that is] (destroys) the provocative situational factors, escapes them, neutralizes their importance, or defers being afraid to the near future. The tension of anxiety and its congeries, on the other hand, does not ensue in energy transformations directed to its relief by the removal of the situational factors obviously concerned in its provocation. Actions towards avoiding or minimizing anxiety certainly occur, but anxiety combines with other tensions only in opposition. In vector terms the tension of anxiety is always at 180° to any other tension with which it coincides. Moreover, other tensions cannot suppress or defer activity resulting from anxiety.

[1] *Conceptions of Modern Psychiatry*. Republished by the William Alanson White Psychiatric Foundation, 1947.

[2] PSYCHIATRY (1948) 11:1-13; see p. 3-4. Also available in reprint form.

Material in brackets in the following excerpts did not appear in the original article but were interpolated by Dr. Sullivan in this presentation.

I feel at this time like referring to one of my experiences in the good old days when I was at Sheppard and Enoch Pratt Hospital to give you a notion of one of the extremely significant instances of the fundamental difference of anxiety and fear. At that time I was engaged in the study of disturbed schizophrenic patients. And we occasionally had some schizophrenic patients who were so thoroughly disturbed that my sojourn with them in the strong room was a very notable experience. By that time I, fortunately, had gotten some idea of what I was trying to do and had some notions about the type of contacts which patients might have with the single other person in the same room. And so these interviews went without unfortunate eventuality to me, and perhaps were somewhat profitable. But the part that I am leading up to—this is an instance of fear, the like of this cannot happen with anxiety—that when presently I left the strong room I often had to fall upon the bench immediately outside of the door because my legs started shaking so badly I could not stand. What I have just said is an instance of how fear can be deferred to a suitable occasion. It is exceedingly striking of anxiety that it can never be deferred, it immediately interferes—the most vivid, I think, differentiation of things which feel in consciousness just the same but have extremely different basis.

Continuing with another excerpt from "The Meaning of Anxiety in Psychiatry and in Life": [3]

> In the study of any anxiety-fraught experience one discovers that the particular pattern of the situation which provokes anxiety can be traced to a past relationship with particular significant people in the course of which [relationship] one experienced anxiety that was more or less clearly observed to relate to [the] particular interaction with them.
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> The complement of eidetic [or imaginary] people which each of us carries with us and lives with reaches back in every instance to the first pair of our personifications: the *good mother* associated with the relaxation of the tensions of recurrent needs, and the bad or *evil mother* associated with the undergoing of anxiety. [This refers to the start of anxiety in the empathic linkage between the infant and an anxious, or a complexly disturbed mother.]
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> The next link in the inevitable developmental chain is the triple personification of *Good Me, Bad Me,* and the always rather shadowy but dreadful *Not-Me.* Bad me is constructed from experience with anxiety-fraught situations *in which the anxiety was not severe enough to preclude observation and analysis.* [Not-me grows] out of [the] mostly retrospective analysis of observed precursors to the paralysis of referential proc esses which is always associated with sudden severe anxiety.
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> Anxiety as a functionally effective element in interpersonal relations has to be mild in degree or gradual in its increasing severity. Sudden severe anxiety, or anxiety which increases very swiftly in severity is undergone in later life as what I call *uncanny emotion,* chilly crawling sensations, and the like, often meant by the words 'awe,' 'dread,' 'loathing,' and 'horror.' Uncanny emotion is an all but functionally ineffective element in interpersonal relations; it arrests useful transformations of energy other than (1) certain obscure covert processes which, if they occur, may be called "adjustment to the uncanny" with escape into more refined and less paralyzing anxious states, (2) those which make up the schizophrenic disturbance of awareness with its varying influence of the Not-me components, or (3) apathy [and somnolent detachment]—which I shall not here discuss.
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> I shall conclude my remarks [on the theory of anxiety] with a consideration of the dynamic role of milder, often vestigial, tensions of anxiety. It is in this area that the concept of anxiety makes its great contribution to understanding the difficulties in living, and to developing the technology of therapy—[that is] procedures useful in inducing favorable change in interpersonal relations. Let me suggest that the concept of anxiety as here [outlined] is useful in explaining, for example, a great many instances of irritation, anger, and unpleasant misunderstanding; all more or less enduring hateful relationships; the welter of belittling, disparaging performances which seems to be almost a national—at least, a national psychiatric—characteristic; a world of unreasoning prejudices and preferences; the time-destroying more or less obsessional preoccupations which so frequently characterize the gifted; the sad way of the pathologically alcoholic; and a startlingly great proportion of the so-called sexual problems of our times. The self-system [that part of personality organized to avoid and minimize anxiety], in its control over one's awareness of resentment which would entail anxiety, is central in understanding the ever more widespread vicissitude

[3] Reference footnote 2; p. 10-11.

of peptic—and probably, duodenal—ulcer, and the symptom-picture related to it, as well as I know not what others of the so-called psychosomatic disorders.

I hope, though I know from experience that I hope forlornly, that these statements will not be taken to show that I am making anxiety the "explanation of everything" in difficulties in living. There are many other factors that are important—loneliness, envy, the effects of conventional prejudices about lustful sports, and doctrines of sin and atonement, to mention a few. I am committed tonight to discussing anxiety, and, even if anxiety is far from an adequate explanation of all our troubles with other people, there can be no doubt about its being an ever important and ever recurring complication in all efforts to help people out of their difficulties in living. The self-system [I repeat, that part of personality organized to avoid and minimize anxiety] from its very beginnings throughout its historic development tends always to resist significant change in the direction of living. The meaning of anxiety in day-to-day life is to be found by study of the self-system interventions which tend to keep us living in our accustomed [however disturbed] way.

Psychotherapy is the inducing by chiefly verbal interchange of changes in the patient's living with significant others. The changes induced may be relatively specific or very broad in their effects on the various aspects of the patient's performances. They may be essentially beneficial, or actually more disabling. They may be permanently or only transiently effective, although it must be realized that even a little well-directed help may initiate long-continuing favorable change in some instances. The induced changes —that is, the changes induced by psychotherapy—may be merely ameliorative or, on the other hand, so great and pervasive in effect that they can be called *fundamentally curative.* In the matter of cure —as I indicated as long ago as 1939— there is an important distinction to be kept in mind; namely, the difference between *psychiatric* and *social* cure. In fundamentally curative psychotherapy there has been achieved—this is quoted from the *Conceptions*[4]— . . . "an *expanding of the self* to such final effect that the patient as known to himself is much the same person as is the patient behaving with others . . . . There may remain a need for a great deal of experience and education before the psychiatric cure is a *social* cure, [that is, an interpersonal or realized cure] implying a more abundant life in the community. It may be impractical to achieve this more abundant life, the collaborative participation with others, in that particular community. A change of social setting may be mandatory but impractical, in which case adequate mediate relationships and clearly understood reformulations of some of one's interpersonal goals must fill the gaps. The possibility of achieving a social cure arises solely from the fact of psychiatric cure. The probability of its achievement is a matter of circumstances, limited chiefly by factors inhering in the culture-complex and selectively reflected in all the people available for interpersonal relations. Be social cure achieved or not, however, the person who knows himself has mental health. He is content with his utilization of the opportunities that come to him. He values himself as his conduct merits. He knows and mostly obtains the satisfactions that he needs, and he is greatly secure [in his dealings with others]."

As already stated, the induction of psychotherapeutic change of an ameliorative nature may be by way of actually increasing the patient's disability for living. This is represented by any successful effort to increase the power of the patient's self-system to interfere with some threatening change in the direction of his living. This sort of intervention may be entirely respectable at particular points in the course of intensive, presumptively curative, psychotherapy, if it is clearly recognized by the therapist as a tactical operation which is not to be permitted to interfere permanently with the strategy of achieving psychiatric cure. Psychotherapeutic increase of the power of the patient's self-system to interfere with the threatening change in the direction of his living does *not* mean increasing the patient's suffering from anxiety. It is not to be taken to be an instance of the generally damnable cliché to the effect that the patient *must become worse before he*

[4] Reference footnote 1; p. 117.

can become better—use of which cliché often means that the therapist is not adequate to the task that confronts him. The suppressive or supportive psychotherapy to which I am here referring is not respectable psychotherapy when it is attempted without reference to the probabilities about the patient, when it is an attempt to reassure, persuade, or advise the patient, or to prohibit the manifestation of some of his troubles before the so-called therapist has established any grasp on the meaning of the observable phenomena in the patient-physician relation. This does not mean that such pseudotherapy cannot have effects under these circumstances. So far as the reassurance, persuasion, advice, or prohibition is congruous with common elements in the personal history of physician and patient, it may be effective for a while. The *while* is often as brief as 15 minutes after leaving the physician, but may last for days, weeks, or months, up to the time of the next really stressful event. When the effect wears off, the patient begins to suffer increased anxiety which may be rationalized as: "lest the doctor be wrong"; or "lest the doctor overvalued my willpower"; or for one or another different rationalization of the fact that the patient has not derived any *real* benefit but has, instead been deceived and beguiled into showing how really inadequate he must be.

Another of the psychotherapeutically ameliorative procedures which, too, can be highly respectable is the one that we may call *opening the mind.* It is a maneuver for overcoming some important instance of selective inattention so that the patient is able to see, to observe, some previously unnoted facts of his troublesome behavior, and infer from the new clarity something reassuring about his personal worth and probable adequacy for life among others. This procedure is used repeatedly in the earlier phases of prolonged intensive psychotherapy. Used in a subtle way, this can do much in establishing any doctor-patient relationship. Used crudely, especially when the doctor has no reasonably probable personification of the patient, it becomes absurd pseudotherapy and contributes less than nothing useful.

Here is another of the psychotherapeutically ameliorative procedures—"taking sides with" the patient. The same considerations apply here. If the physician does this brashly without adequate exploration of the patient's actual situation, he often does nothing more helpful than assist the patient to make a fool of himself and of the physician.

Finally, in this grossly incomplete list of ameliorative procedures which may have a respectable place in psychotherapy—but which often are merely pseudotherapy which damages the patient—I shall refer to the giving of tacit consent to dangerous beliefs expressed by the patient. This is a very broad topic, covering in a fashion events as dissimilar as expecting far-reaching benefit to result from the abreacting of a traumatic event and as the organizing of a paranoid world in which the elect are the physician and the patient. I would like to talk at considerable length on this particular maneuver of giving tacit consent to dangerous beliefs, but [because of considerations of time] I shall forego this unless it is insisted on in the discussion.

What, now, are we to assume from the theory of anxiety that the nature of psychotherapy must be? Psychotherapy must from this standpoint be a process—and I am speaking now of scientific, curative psychotherapy, and not of the ameliorative, and the many very useful parataxic, procedures which are not scientific and cannot be formulated rigorously so that they have to be learned as an art, by apprenticeship, and so on. The thing that I am talking about now is supposed to be capable of rigorous formulation and communication in ordinary teaching situations. Psychotherapy must from this standpoint of the theory of anxiety be a process that reduces self-system interventions which now cripple the patient in his observing and analyzing of some of the actual events in his living; which events observed and analyzed, and thus once clearly understood, would permit his better foreseeing of interpersonal possibilities and thus the deriving of

more satisfaction from dealing with others with less cost to his self-esteem. It follows immediately that psychotherapy must deal with specific, relatively enduring patterns of recurring, inadequate and inappropriate actions in interpersonal situations which characterize the patient's living with significant others.

The first task of the psychiatrist as a real therapist, or as a scientific therapist, must be the identifying of at least *an* important unfortunate pattern of this kind —preferably *the* important pattern of this kind. But this latter desirable specificity may for various reasons be very difficult indeed at the start of the relationship. Discovery is a very different process from assuming. And truly therapeutic situations are not integrated between intelligent patients, and doctors who have to "know it all" on a minimum of data. Discovery proceeds by the observation and analysis of data. The analysis of data is a double process of producing hypotheses on the basis of one's previous experience and ingenuity, and testing their relevance to and their incompleteness for encompassing the observed data, with resulting improvement of the hypothesis of at least temporary choice.

As inadequate and inappropriate action is usually the outcome of imperfect foresight, which, in turn, reflects *both* ignorance and inexperience *and* anxiety—which doubtless has interfered for a long time with some field of observation, analysis, and learning—the therapist can be aided in his task of participant observation with the patient by inquiring into matters which seem to entail mere misinformation or ignorance, and in the acute observation of the topical setting in which signs of anxiety are manifested in the patient. This latter mapping of anxiety-fraught areas in the patient's dealings with the physician is, again, no place for easy assumptions. It never hurts to confirm a hunch by presently returning to the topic along some other tangent. No physician can know *a priori* the significant patterns of accessible interpretations and misinterpretations of anxiety-productive people in any patient's past. He cannot, therefore, know *a priori* just how to reduce the force of anxiety concerned in any particular observed situation involving him and the patient. It takes a good deal of data of astute observation to put him in a position where it is safe for him to say, "You seem to become anxious whenever we touch on so and so. Is that the case?" Whether the answer be *yes, no,* or *what,* one hopes that after such an interpretative inquiry the physician will encourage the patient to talk freely, *if only* in order that the physician may discover the inadequacy of his own grasp on the meaning of the physician's "so and so" to the patient.

In the mapping of anxiety-fraught areas in the patient's dealings with the physician, one sometimes encounters strong or rapidly increasing anxiety. Realizing that anxiety is always a disjunctive force in interpersonal relations, one knows that these eventualities must be met if the doctor-patient relationship is not now to be attentuated or destroyed. The procedure in dealing with these emergencies calls for real grasp on the theory of anxiety. One has become involved in a parataxic distortion on the basis of some surviving figure in the patient's past. If this distortion is permitted to continue, psychotherapy in this area is made vastly difficult, if not impossible, with this particular physician. The use of a clumsy appeal to what I have called *abrupt transition* in the psychiatric interview may take the patient away from the dangerous area. But what of the tacit consent which is thus entailed? If you sweep a patient away from an area, a topic on which anxiety is mounting very rapidly—and if that is all you do—the patient is very apt to feel that that is a topic that you do not wish him to develop further. In other words, you have given tacit consent to this being an excellent topic to avoid. The technical procedure that works takes the two steps, which may be smoothly combined, of denying tacit consent to the parataxic distortion, and [making] abrupt transition to another important field of inquiry. It can be as simple as a faintly surprised comment: "You seem to be getting uncomfortable. We do not have to

understand this today. Tell me more about the relationship with Ida"—that presumably being a quite harmless person. The denial of tacit consent lies in the vocal—but not verbal—hint of the physician's puzzlement and the verbal implication "we do not . . . understand." This will have to suffice as a text for my final remarks of tonight. .

I wish now to discuss the *expert role* of the psychotherapeutic psychiatrist which is implied in the theory of anxiety. The fact that no psychiatrist is expert enough to deal with some problems, and that no psychiatrist is apt to be particularly expert in *all* his dealings with any one patient, in no way reduces the cogency of the consideration which I am now laying before you: The expertness of the psychiatrist refers to his skill in *participant observation of* in contrast to *mere participating in* the unfortunate patterns of his own and the patient's living. *This* is the thought to the exposition of which I wish that the diligent and scholarly would devote their teaching gifts for the next 6 years. Let me repeat: *The expertness of the psychiatrist refers to his skill in participant observation of the unfortunate patterns of his own and the patient's living, in contrast to merely participating in such unfortunate patterns with the patient.*

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