California Christian University

affective balance therapy

(Terapia do Equilíbrio Afectivo)

by

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CLINICAL PSYCHOLOGY

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AFFECTS AND THEIR ORIGIN

At least, in higher primates, the full range of emotional responses which the organism may one day be able to display sometimes elicited by specific stimuli (Rosenblum, 1978) is not present at birth.

Depending upon the species, and the nature of social structure and childrearing practices, the mother is the one who is the fundamental element who guarantees the infant's survival throughout the maturation process of its own emotional response (Rosenblum, 1978).

As long as the primates grow up, mothers begin to break contact with their offspring and protect them from a distance, leaving them independent when the infants mature enough to have their own autonomous patterns of emotional and survival behavior (Rosenblum, 1978).

Emotional terms have been used to label conscious experience, less often to name physiological state or even as hypothetical constructs to explain covariation between incentive events and behavioral consequences (Kagan, 1978).

According to some psychologists (Kagan, 1978) the category of affective must gather the following dimensions:

a) change in feeling state that is derivative of internal physiological events;

b) produced by an immediate incentive event;

c) short duration;

d) linked to cognitive structures;

e) not related to physiological deprivation.

In the antiquity, passions were considered affects, and the degree of good and evil was inherent to it. In the Middle ages, emotions were linked to affects considering these, equivalent to motives and drives. Renaissance linked objective behavior to affects. During the 17th and 18th centuries, philosophers postulated that affects sustained thought and determined intelectual and moral character being the incentives for action. During the 19th century there are informations about the possibility of emotional states not attaining conscious experiences. At last, we can discuss now affects as a state of consciously perceived feeling changes (Kagan, 1978). External events that typically produce alerting, attention and sometimes inhibition, are called discrepant and require acquired knowledge for the change in state, being distinct from those, inately provocative of a change in the state, like light or sound.

When reflections on the past or antecipations on the future are the primary incentives, there are important differences in the physical quality of change in state (Kagan, 1978). As the child grows up, she recognizes many different kinds of incentives which are available initially from the deviation she might have in relation to others' behaviors and later from the infe-

rences she does about the psychological reactions of other people. Nevertheless, it is easier to alter the affects of young children than those of adults, because of the former's beliefs (Kagan, 1978).

According do Darwin (Lewis and Brooks, 1978) a happy face would be equivalent to a happy feeling thus linking the state and expression intimately, but experience shows that there is not any one-to-one correspondence between emotional states and its expression; one might laugh to a joke which is not particularly funny and another one might cry with satisfaction. Emotions are the conscious feelings of bodily changes either muscular or neurophysiological that follow directly the perception of the exciting fact and our feeling of the same changes as they occur (Lewis and Brooks, 1978) according to William James' and Bard's theories.

If the emotional experience is the consequence of an evaluation of some bodily change, Lewis and Brooks (1978) say that there will exist these two processes: the knowledge that the body change is uniquely different from other changes; the evaluation process itself which have similarities with other cognitive processes such as learning efficacy.

Notion of self is necessary for the organism to cause events occur and it involves the self as the defined, in relation to others and has two components which are knowledge and feeling (Lewis and Brooks, 1978).

The ontogenic changes in self-directed behavior, sug-

gest that the self is located inside, not outside, being this knowledge used to locate emotional states inside the body (Lewis and Brooks, 1978) which cannot be experienced without some knowledge of self.

According to Lewis' and Brooks' (1978) findings, the experience of emotional state is heavily dependent on self-awareness, on cognitive evaluation and heavily influenced by the interaction of the infant with the social world.

According to Izard (1978) emotions and the emotional system, develop in relation to the other personality subsystems, becoming organized and interacting harmoniously to produce integrated behavior which is influenced by conditioning and social learning.

Also emotions emerge as they become adaptive in the life of the infant (Izard, 1978) adding each one to the complexity of consciousness increasing the capacity for processing and responding to different types of information with a social aspect that helps to set the stage for a particular type of learning and development.

The emotions play a part in the development of self-recognition and self-concept, and self-related cognitions influence emotional responses and behavioral sequences (Izard, 1978). As an emotion reaches higher level of phonomenological organization, its experience becomes less dominant in consciousness and the resulting increase in freedom of operations in consci-

ousness, facilitate emotion-congition interaction and the development of affective-cognitive structures (Izard, 1978).

ORIGINS OF DISTRESS

Our assumption is that since birth the individual in constant interaction with the environment gets positive or negative reinforcement, which shapes his behavior either in a social acceptable manner or in a deviant form. As human beings, we feel and think commanding our actions at our will. But sometimes due to maladjustments of physiological or psychological functioning, we cannot command our acts according to our own will or according to the rules of the society. Having in mind that also the physiogenic maladjustments can be decreased only through operant conditioning, we think that for psychogenic difficulties something more is necessary specially to avoid symptom substitution. Dynamic understanding is essential to know or to investigate where the symptoms are rooted. Usually, much of them are learned in childhood and widened through the years.

Eysenck (1976) reffers to Napalkov's experiments with dogs which reacted with the rise in blood pressure to the firing of blank pistol shots; although the dogs reacted to this unconditioned stimulus in the first trials, they did not react any more from the 25th onwards. Other dogs were conditioned once to expect the shot by being touched on the ear with a feather. Without any other shot than the first one, the simple repetition of the feather touching, produced ever increasing amount of blood pressure. This seems to provoke or incubate

the rise of anxiety. When anxiety provoking situations are preceeded by short neutral stimuli, the ocurrance of these stimuli alone may produce the rise of anxiety eliciting avoidance responses which, when negatively reinforced, may produce abnormal types of behavior. The possibility of being more or less conditioned depends on the physiological and biochemical function of the brain (Eysenck, 1976).

As soon as one is more or less strongly conditioned to a neutral stimuls which provokes anxiety, he tries his best to avoid any abnormal behavior and to cope with the distress. Repression might be one of the defense mechanisms that one uses to maintain his EGO integrity; this may be a period of incubation during which the same initial stimulus will produce an increase of 20% in the anxiety provoking conditioned response (Eysenck, 1976) every time it is presented. Let us suppose that a shock produced 100 units of anxiety when at the first trial it was preceded by a neutral stimulus of a flickering light. On the second trial of the flickering light, the anxiety will rise to (100 + 20) 120 units and on the third trial to (120 + 24) 144 units; when the amount of increase is so high that the biological organism cannot bear such a heavy burden, then avoidance responses to get relief from anxiety are tried and a pattern of well established responses acquired, its strength depending on the nature of the negative reinforcement obtained from the situation. When this patterns of response are socially unacceptable or disturbing for the individual, they fall

into the so called abnormal behavior.

These abnormal behaviors rise in intensity with the increase of time and experiences, that is to say, with the increase of age in the human being. So, clues for anxiety provoking situations which do not provoke too much distress in childhood and are successfully repressed, with the increase in age in some individuals, become unbearable eliciting responses which are sometimes in the category of abnormals and considered as neurotic and out of control of the distressed person.

PSYCHOTHERAPIES IN GENERAL

Many forms of psychotherapy are available nowadays to clinical psychologists and psychotherapists or psychoanalyists, ranging from the orthodox psychoanalysis to the most behavioristic operant conditioning with primary reinforcement. Almost all of them claim successful outcomes in about 50 percent of its selected patients; for example, psychoanalytic psychotherapy is limited to people with some verbal capacity and ability to form relationships, besides a genuine curiosity about oneself and ability to tolerate frustration (Kovel, 1978).

According to Eysenck, there are differences in outcomes of psychoanalytic and behavioral therapies. While the proportion of cases improved by psychoanalysis ranged from 39 to 67 percent, the corresponding indices for the "ecletic" psychotherapy ranged from 40 to 77 percent (Garfield, 1975). Eysenck's findings, also show that neurotic patients treated by the behavioral approaches, based on learning theories, improve significantly more quickly than patients treated by conventional psychotherapy.

What happens to other people who do not get any kind of psychotherapy or even chemotherapy? How can we improve psychotherapeutic techniques to help indistinctly people with any kind of psychological disturbance? How can we diminish the lapse of psychotherapy's duration, increasing at the same time its efficiency? Behavior therapy has been touted for its po-

tential impact on manpower shortages by virtue of its efficiency (Davison and Neale, 1974), averaging about five times more clients than the traditional clinician working on individual therapy. Although having advantages, the shortages in manpower are yet very high and make the group therapy necessary. It was during the World War II that the group therapy had its great increment and showed its potential not only as an economic form of therapy but also as a new kind of therapeutic tool: the vicarious learning (Davison and Neale, 1974). All over the world we feel yet a great shortage of psychologists and psychotherapists besides techniques that will enable the experts to alleviate human psychological suffering in the shortest amount of time.

If the psychoanalytic approach gives some alleviation to the neurotic patient and the behavior therapy can treat some cases of psychotic disturbance, and if there is some danger of symptom substitution in the strict behavioral therapy, why will we not be able to understand the dynamics of the human psychology and try to treat the underlying causes in a behavioristic point of view, and try to apply the method to group therapy or group and individual therapy combined?

Garfield (1975) says that psychotherapy is an interpersonal process being the therapist's personality an integral part of therapeutic process involving much more than mere verbal knowledge and intelectual discussion. The ability to empathize is important not only in terms of understanding the patient but

also for communicating to the patient that the therapist really does understand him and is interested in helping him, interpreting not only the verbal communication but also his gestures and the like, which may communicate his feelings. This could be a different approach either from the psychoanalytic point of view or from the behavioral one.

Erickson and Rossi (1979) define psychotherapy just like hypnotherapy, as a process whereby we help people utilize their own mental associations, memories and life potentials, to achieve their own therapeutic goals, being also a technique that does not work with every patient and always in the same manner, but helping people to reassociate and reorganize the inner processes.

In any therapy just as Erickson and Rossi (1979) say, there must be a constant minimization of the therapist's role and a constant amplification of the subject's role.

Although many therapists be wary of a patient's negative affects, doubts and confusion, Erickson and Rossi (1979) state how they can be utilized to facilitate therapeutic change through the entire personality.

Reviewing the cerebral hemisphere functions, we see that usually the left dominant hemisphere is proficient in processing verbal communication of an abstract or intellectual nature, while the right one processes visuo-spatial, kinestetic, imagetic and mytho-poetic data (Erickson and Rossi, 1979), be-

sides being closely associated with emotional processes and body image and responsible for psychosomatic symptoms.

While the psychoanalytic conventional language approach is reality-oriented and linked to left hemisphere, the mytho--poetic, symbolic and body languages are directly associated to right hemisphere (Erickson and Rossi, 1979).

Any kind of therapy occurs within the patient and not between the patient and the therapist. The therapist usually helps the patient to search non threatening material thereby "warming up" to continue the search on other aspects of one's complexes which lower the individual's intelectual level (Erickson and Rossi, 1979).

Although some therapists believe that the patient should not be acquainted with painful aspects of his life, psychotherapy cannot be applied like a general routine or standardized procedure. It is not also a mere application of truths and principles supposedly discovered by academicians in laboratory controlled experiments (Erickson and Rossi, 1979). Each psychotherapeutic encounter is unique and requires a fresh creative effort either from the therapist or from the patient who shall be motivated to utilize to its full potential his whole reportory of experiential learning (Erickson and Rossi, 1979). The most important thing in therapy is to break up patient's rigid and limiting mental sets (Rossi, 1973).

Having these features in mind, we tried to design a different type of therapy based in a humanistic point of view

and with the psychoanalytic and behavior approaches as two valuable contributions.

Man is a biological entity which is in constant interaction with his surroundings, being modified in his psychological aspects at every moment. The reinforcement he receives makes him increase, decrease, extinguish or alter his behavior. His thoughts, feelings and emotions are impressed by this interaction and give clues for future actions. If one is happy and gets positive reinforcement, his life is almost "normal" but if he is submitted to constant distress and negative reinforcement and if the punishment is ever present giving no chance to avoid frustration, then, one goes somewhat "abnormal", learning behaviors to avoid frustrations or to be in permanent depression. Anyhow, an abnormal pattern of behavior is established and anxiety is present.

As we learn to avoid punishment with negative reinforcement, neurotic patterns of behavior may include phobias, obsessions, compulsions, depressions and psychosomatic symptoms. The neurotic individual is not able to feel happiness. His mood is very pessimistic and it is difficult for him to feel joy or happiness and satisfaction in many aspects of his life and environment. If we could change only his affects and his ways of feeling he would be able to cope alone with his own problems without much psychological distress.

We devised a different approach to psychotherapy in which the balance of positive and negative affects must be over-

weighting on the side of the positive ones to keep the individual in a good psychological state. The therapist should be skilled enough to elicit in the patient's mind his positive and favourable aspects of life diminishing his negative affects elicited by emotions of fear, anxiety, anger, grief and shame (Martin, 1973).

This affective balance therapy was devised to have an unique approach for all the cases and was experienced in private consulting practice, because there were no possibilities in practicing it in institutions with the help of other clinical psychologists.

With this approach more than 60 percent of patients improved and some 20 percent had complete relief of their neurotic symptoms. About 15 percent abandonned the therapy because they did not want to practice relaxation at home or had no money to pay the fees.

Patients were not selected. They asked for psychological treatment on their will in private practice. More than half of them had already two or more years of treatment in psychiatric hospitals or in private consultations with psychiatrists or psychologists.

It must be stressed that it is rather difficult in Portugal to have any kind of psychotherapy delivered by psychologists in hospitals or any other official institutions.

The 71 cases already studied are categorized as school difficulties, depressions, feelings of inferiority, obssesion-

-compulsions, phobias, behavior problems, tics and enuresis, according to the descriptive symptoms self-evaluated by the patient falling mainly in each of these categories.

The therapeutic approach has been always the same.

FOUNDAMENTALS OF THERAPY

When we are happy and with pleasant emotional reactions, we enjoy this state and spend time and effort to increase its intensity, duration and frequency (Martin, 1973). We also enjoy antecipating feelings of pleasantness. Joy, pleasure, and all other behaviors that give us pleasurable emotions and satisfaction of homeostatic drives such as eating, drinking and sex, make us happy and keep us in a state of well being which is considered to be "normal". But if we are constantly with anger, grief, shame and fear, our behavior is affected and we are not considered as "normals". Either we refer to statistics or consider a subjective distress or psychological handicap or undesirable social deviation, psychopathology is a gross handicap in psychological functioning which is distressing for the individual and socially not admitted, caused either by biological components or by psychological or environmental variables (Martin, 1973).

As soon as the individual is born, he is almost immediately subject to the stimulations of the environment and according to the balance of interaction individual-environment, one lives happy or distressed permanently or temporarily. The therapy is meant to the distressed individual and sometimes prophilactic measures can be learned out of therapeutic procedure to avoid even the temporary distress.

Specially in psychoanalytic therapy, symptoms are likely to be seen as reflecting some underlying process, such as repressed conflict, in the same sense as the symptom of fever is considered to reflect some underlying physical disease. This way of thinking about the disorders is frequently referred to as the medical model. The behavior therapist says that the symptom is the illness, and that the analogy of physical disease is misleading. This distinction between the symptom as the disorder approach, and the underlying cause as the medical or psychoanalytic approach, is not, however, sharp one. Most behavior therapists do in fact make inferences about influences beyond observable stimuli in the form of thoughts, images or drive states and use constructs such as anxiety in "explaining" avoidance responses (Martin, 1973).

Albert Ellis (1958) says that the human being possesses four basic processes: perception, movement, thinking and emotion, all integrally related. Each one may affect the other.

"Rational psychotherapy is based on the assumption that thought and emotion are not two entirely different processes, but that they significantly overlap in many respects and that, therefore discordered emotions can often (though not always) be ameliorated by changing one's thinking"

We call emotion to a certain kind of thinking usually of a biased or strongly evaluative kind. They differ mainly because thinking is a mode of descrimination more tranquil and less somatically involved and less active than emotion. Through

the process of social living and aculturation, thinking and emotion become closely interwind. The sentences that human beings keep telling themselves are or become their thoughts or emotions.

The therapist in addition to dealing specifically and concretely with the client's distorted and illogical thinking, should demonstrate to the client what, in general, are the main irrational ideas that human beings are prone to follow and what more rational philosophies of living may usually be substituted for them.

The therapist tends to function in two main ways. First he keeps pounding away at the illogical ideas and superstitions that lie at the basis of client's fears. For example: if an individual is fearful of being imperfect he must show in a variety of ways how such fears are irrational, for no one is perfect.

The therapist encourages and persuades the client to engage in activities that will act as counterforce to the ideas held by the client. If for example, the client believes that no one will go out with him, attempts will be made to actually secure experiences in life which counter this false belief. Ellis (1958) has listed a number of illogical ideas and also assignments and practical tasks are used in therapy as aid in overcoming the illogical beliefs and fears.

Lazarus (Davison and Neale, 1974) say that our review of the field has necessarily been fragmented because we have

dealt with separate techniques one at a time. In clinical practice, however, most behavior therapists employ several procedures at once or sequentially in an attempt to deal with all the important controlling variables; this approach is generally referred to as broad-spectrum behavior therapy.

To attend only to one's fear of leaving home, would be incomplete behavior therapy and might even lead to the replacement of the agoraphobia with another difficulty that would serve to keep one at home -a problem frequently called "symptom substitution".

Garfield (1975) says that Freud attempted to make clear that the views and practices of Adler and Jung were not to be considered psychoanalysis, and he welcomed their designation as individual psychology and analytical psychology, respectively, to indicate their separateness.

Probably, one of the main differences between Horney, Adler and many of the others referred to previously, is a greater emphasis on social and cultural influences on personality development and less of a stress on biological determinants. The libido theory of Freud and the emphasis on psychosexual development, is either not accepted or given a place of lesser importance. Adler for example, placed greater stress on the social and family structure within which the individual lived as well as the place of the person within the family. Early memories, feelings of inferiority, compensation and the strug-

gle for power were also concepts or attributes that receive considerable emphasis in individual psychology. Adler also emphasized the social nature of man, his own purposes, and the "style of life". The person normally desires social belongingness and displays an interest in others. At the same time each person tries to reach some goal of superiority and in this process develops his own life style. Initially, Adler focused on the person's feelings of inferiority and his compensatory strivings for superiority (Garfield, 1975). Thus, the person who fancied himself physically weak might be concerned or preocupied with attempts with building up his physique. Adler later, however, stressed more, the creative aspects of the individual in his adjustment to his social environment and the development of his life style.

In general (Garfield, 1975), Adler's later views departed rather markedly from those of Freud. He was more optimistic about the human condition than was Freud. He saw the person as having social interest and feeling and as having a need to belong to some social group. The importance given to psychosexual development and strivings in the Freudian scheme was not clearly aparent in Adler's view and was another important difference between the two theoretical orientations. The implications for practice would appear to be quite apparent from the differences in viewpoint (Garfield, 1975). There would be little concern with infantile psychosexual development, castration

anxiety and oedipial complex. Rather, the position of the individual in the family, particularly as related to his experiences as a child, would become a focus for investigating personality and some emphasis would be placed on the earliest memories and recollections which the individual can recall. Therapy, in addition, would attempt to assess the individual's goals and style of life and help him to understand himself to attain a more realistic and social view of his life.

Psychotherapy (Garfield, 1975) is not a medical treatment but an educational process. The person learns to understand himself and his life. Psychotherapy implies a change of concepts, a change in the modes of finding one's place, an increase in the feeling of belonging through the diminution of self-doubt and inferiority feelings. This is the basis of all correctional efforts: to overcome doubts about value and ability, and to develop a sufficient social interest to cope successfully with life and people.

In therapy, an attempt is made to study the individual's life style, his neurotic goals and gains, secured by the patient's symptoms, and the distortions utilized in the struggle for power. His symptoms are considered to serve the patient's own egoistic goals (Garfield, 1975). For example, a person may use his neurotic symptoms actually to dominate and control the life of another person.

Individual Psychology, therefore, also points to the importance of the individual's past life experiences in personality development, but does so in a manner that differs from that

of psychoanalysis. While many of the same techniques developped by Freud are used by Adlerians, they are used in somewhat different ways in terms of the different theoretical emphasis.

Dreams, memories and other material are interpreted in terms of the individual's life style, egoistic goals and so on, rather than in terms of the repressed conflicts, emphasized by the Freudians.

Early memories give the therapist some clue to the individual's personality structure and attitudes (Garfield, 1975).

The lenghth of treatment is usually shorter than that of psychoanalysis and more emphasis is placed on conscious material. Conscious and unconscious material are not seen as primarily opposite forces in the personality, but rather as different manifestations of the neurotic patient's struggle for power (Garfield, 1975).

According to Orgler (1974), Adler was never a Freudian analyst. He had not followed his classes nor been psychoanalysed himself. Adler emphasized the unity of body and mind. He did not think that heredity and environment determine the development of a human being, but that heredity gives certain potentialities and environment gives certain impressions. These potentialities and impressions are the bricks and individual uses in his own creative way to build up his life style.

The purpose of the dream is not that it shall be understood, but that it shall arouse feelings and emotions that cannot be aroused by logic or common sense, in order to give us mo-

re impetus to solve imediate problems (Orgler, 1974).

This inferiority feeling spurs him to activity and is a stimulus to every upward striving. In contrast, the inferiority complex acts as a restraint. Some organic inferiority only comes to light under the stress of mental tension. Whether somebody actually was neglected in early childhood or only thinks he was neglected, hated, unwanted or too ugly to be loved, all have the same harmful effects. The opinion one has of the facts, rather than the facts themselves, matters most. Spoiling means pampering a child so as to produce dependency (Orgler, 1974). Many spoilt people get on very well in life as long as their path is smooth. As soon as there is an obstacle they fail, because they have never learned to use their own abilities. They do not know that life involves the overcoming of difficulties. As they are not aware that they suffer only from a lack of training, they understandably believe in a lack of ability and dare not solve problems by themselves.

There are three possibilities with an inferiority complex according to Adler (Orgler, 1974):

1. one may overcome it by one's own efforts or by psychotherapy;
2. one may not overcome it but suffer from it throughout life and limit oneself;
3. one may not overcome it but hide it under a superiority complex.

A superiority complex can be manifested in the exagera-

ted demands an individual makes on himself and on others. For the most part, people with an inferiority complex only harm themselves, but most of those with a superiority complex are potentially harmful to others. Those who depreciate others to savour their own superiority, can even undermine the physical health of those they denigrate (Orgler, 1974). The strongest expression of a superiority complex is power striving. It is essential to see through power striving as it is harmful to the mental health of the power strivers and of the people affected by them. The deeply hidden doubts in their abilities, drives the power strivers on to prove always to themselves and others that they are superior and never allows them any rest. It is futile, therefore, to give them all they want in the hope that they will stop their demands. As they strive towards the goal of personal power and superiority over others, they can be satisfied. This is demonstrated in everyday life in all human relationships (Orgler, 1974).

The current general tendency is to blame parents for the children's difficulties. In contrast, Adlerian psychotherapy helps the patient to overcome his bitterness about this. After all, as nobody knows the future, one is bound to make mistakes, and as parents are only human, it is futile to expect their behavior to be perfect (Orgler, 1974).

Free from provoking or enlarging feelings of guilt which lower the self-evaluation, we stress that one can only go from a greater error to a smaller error and thus raise the patient's

self-esteem. He gets insight into the discrepancy between the facts and his erroneous self-evaluation by the therapist's stressing of his former or present achievements which show he has abilities. The patient gets insight into the meaning of his symptoms and towards what goal they are directed and the patient is considered cured only when besides loosing these symptoms, he strives towards a constructive goal, takes responsability, corageously solves his problems and acts as a fellow human being (Orgler, 1974).

A child with severe learning difficulties will reject the learning at once if it not given under optimal conditions. Just as there is no general rule that will guarantee successful feeding, there is no one particular teaching method that will assure successful learning. Specific learning blocks, mainly occur with blending and synthesizing sounds into a word or with phrasing. Skills can be acquired if they are systematically practiced (Caspari, 1974).

Eysenck (1977) states that children receiving psychotherapy required 21 sessions over 31 weeks before it was thought that treatment could be terminated, but those receiving behavior therapy required only 9 sessions during 18 weeks. He emphasizes that behavior therapy cured twice as many cases as did psychotherapy, and in less than the number of sessions.

In the psychotherapies, however, it is well nigh impossible to separate the personality of the therapist from the techniques and skills which are used in the work. The personality of the therapist is the skill (Cooper, 1974).

Rogers (Copper,1974) felt that the patient who was treated correctly should be able to take charge of his own affairs after six to fifteen contacts. If the maladjustment was not severe, and with a patient who was not deeply neurotic, two,four or six contacts were felt to be enough for the patient to find the help he needed.

No matter how "standard" technique might be, its application to an individual requires unique modifications. These modifications are made in accordance with experimental findings and the effects of "treatment" on the patient are likewise experimentally validated, according to Yates (Yule, 1974).

Barclay Martin (1973) says that some emotional reactions are pleasant and enjoyable, being smiling and laughter one example. Another example would be excitement, in the sense of pleasure associated with some antecipated events, or the exilaration associated with overcoming a certain amount of danger such as skying or riding a roller coaster. The ecstatic or mystical experiences reflect variants of positive emotional reactions which are undoubtedly real, but about which we know little. There are no sharp distinctions between pleasurable emotions and the pleasure associated with satisfaction of the homeostatic drives such as eating, drinking and sex. In concluding, it is important to reemphasize how unpleasant -almost unbearable- the extremes of negative affect can be. An awareness of this fact is crucial to an understanding of the persistence

and seeming irrationality of certain forms of psychopathology.

Martin (1973) proposes the use of positive affects to reduce negative affetcs. The effectiveness of this strategy is intuitively obvious. The young child who sucks his thumb or clings his "security blanket" when distressed exemplifies the basic principle. Variations of this strategy are limited only by the types of positive affect inducing procedures which are available to people.

The consumption of alcohol, taking drugs, tobacco smoking, sex and eating, can be used in this way. Clearly these activities can also be engaged in as ends in themselves. However they can -to some individuals and under some circumstances- serve the purpose of negative affect reduction. When one of these activities does not serve the purpose of reduction of rather strong negative affect, the activity takes on a "compulsive" quality, by which we mean highly persistent, even in the face of some secondary aversion consequences. Thus, a person may persist in "compulsive" masturbation even though he is subsequently feeling remorse, or in "compulsive" eating even though he is overweight, or in "compulsive" drinking even though he subsequently becomes physically ill or encounters social difficulties.

The phenomenon has been demonstrated experimentally by Ullman (1951). His study revealed that when rats learned to eat in association with electric shock, they subsequently displayed compulsive eating behavior, that is, even when satiated with

food they continued to eat when experiencing shocks. Presumably the rats found that eating reduced the discomfort associated with shock, and therefore, they continued to use the strategy of reducing the shock-induced negative affect, even when they had no psychological need for the food.

According to Yesudian and Haich (undated), Dr. Gates published the result of his research about some physiochemical results in normal breathing. Under normal conditions the rhodopsine iodide of the expiration breathing activity, received in a chilled glass does not keep any deposit. But only 5 minutes after the subject gets angry, the glass is filled with a brownish deposit indicating that a sudden emotional outburst had taken place. This deposit injected in animals or other human beings, produces great excitement. Emotion of grief caused by the death of a son, would occasionate a grey deposit.

Dr. Gates (Yesudian and Haich) says that he is convinced that emotional states occasioned by rage, grief and irritation elicit the formation of toxic and poisonous products in the organism, while the feelings of love, happiness, joy, contentment and the occurrance of good thoughts, provoke healing forces within the organism.

Despite all these findings, we try to educate children with fear. Usually the child obeys her mother because she admonishes her and warns that something bad will happen if she does not obey. Things that can happen are: father can spank the child; demon can come and take the child; the child can die;

God may know about the child's desobedience and punish. Even the catholic religion is full of demons and hell: always the elicitation of negative affects and the production of avoidance behavior to win negative reinforcement.

What about the positive reinforcement? We know in experimental psychology that positive reinforcement is much more efficient than the negative one, specially when the reinforcement is terminated . The learning initiated with positive reinforcement is maintained while the one with negative reinforcement drops very quickly.

We know also that many endocrine glands are trigered by emotional feedback. Some emotions elicit the production of hormones that are mainstreamed into the blood. The reaction of fight-or-flight (Harvey, 1978) is one example of feedback system between the external stimuli and physiochemical changes in the organism. These feedback changes in hormone and brain electrical activity can produce many changes in behavior. Studies by Seymour Levine (Thompson, 1975) indicate that ACTH and the hormones from the adrenal cortex can have wide-ranging and profound effects on behavior; for example, corticotrophine secreted by the hypothalamus can release the factor CRF into the blood vessels, that carry it directly to the anterior pituitary which, in turn, releases ACTH having actions in tissues both in body and brain and acting also specifically on the adrenal centre to stimulate the release of corticosteroid hormones, particularly hy-

drocortisone in humans. Constant release of cortison may be a response to stressful situations; it can be desproportionate and physiologically demaging and according to Maxwell Cade "can lead to permanent changes and maybe to disease" (Harvey, 1978).

Hypertension, insomnia, heart infarction, cholesterol, are some of the results acquired through constant fight or flight response (Benson, 1976), but the relaxation response is one of the antidotes which can be used purposefully to counter attack stress. This technique is useful and suitable not only for people who cannot bare the stress of modern life, but for those who are already disrupted or begin to be disrupted or disabled, without being able to cope with stress. Relaxation is the first step to initiate a more powerful therapy.

THE NEW PROPOSITION

Just as we learned to act in an abnormal way to avoid or to reduce anxiety, we can unlearn it or learn a pattern of different responses which give us possibility of having no anxiety.

Anxiety is a construct and is inferred from our behavior; it does not exist objectively; it is felt so by individuals without any reason for that. So, we have to obtain some indications from the covert processes of thinking and feeling.

The psychoanalytic method uses mostly free association to reach, within a lengthy period, the early traumas which being repressed most of the time, cause the actual symptoms, but flooding, based on the principles of dynamic psychology claims that people get well when they overcome anxiety after being subject to the flooding sessions. Having acquired knowledge of Adlerian therapy, we see that although analytic in origin, it tries to give support to the distressed individual making him conscious about his actual life and helping him to reorient his life style; but the therapy is not of short duration.

We see that thinking and feeling are basic processes that govern our life and depend on perception which might be impaired by anxiety states which in turn will affect our movements and actions. We saw also that positive affects give us possibility of having a sound life while negative affects will interfere in the individual's well being.

Controlling our affects we would be able to avoid distress in a great measure. For that, our perceptions should be clear and our thinking sound so that our feelings would not be distorted. Relaxation is one procedure which gives us relief over distress and prevention about it. But the one who is already distressed? And the other who is not able to learn or practice relaxation and is entering into distress? These individuals need psychological help and nowadays the rise of the standards of living often precede and may eventually lead to revolution in poor countries (Pines, 1974); similar conditions in more advanced western societies lead to a demand for psychotherapy; the hungry mind replaces the empty belly; the emotional sickness shows (Pines, 1974).

How will we get quicker, safer and easier types of psychotherapy?

We thought that the following assumption might work in most of the cases and give rapid and easy relief to most people.

- When one has a physiological constitution which cannot bear the stresses of his normal life, he will get distressed.
- When one is distressed his feelings are overweighting in negative affects.
- Making one learn to elicit positive affects, would be enough to give him the capacity of handling alone the situation.
- As sometimes it is difficult to a person to elicit positive affects without any help, the therapist is the

one who is intended to be the facilitator.

- When one is relaxed, positive affects are easy to be elicited, but when one is in anxiety almost every sensation is distorted by the perception and feeling of shame, anger, grief is everpresent.
- When one tries to remember old traumatic events, a sudden muscular contraction/relaxation, may elicit the association of even more early memories which were repressed.
- When these repressed memories are brought into the field of consciousness and discussed, one has the possibility to overcome anxiety learning new strategies.
- When this learning is completed, one feels able to cope with the strivings of his daily life and has experienced to elicit, in imagination, situations even worser than those which provoked the stress at the moment.

THE THERAPEUTIC PROCEDURE

We feel necessary to have first a good and well conducted interview; to have an appropriate personal history of the patient having in mind that the main purpose (Sullivan, 1953) either in terminating an interview or in interrupting it for any length of time, is the consolidation of what has been achieved in terms of some durable benefit for the interviewee.

Through the interview some of the deep hidden drives and motives are traced back until a reasonable distance by a skilled interviewer, who will know what is missing from the client's surface linguistic structure by comparing it to the deep structure from which he knows it is derived (Bandler and Grinder, 1974). This will be the process of reaching the dynamics of the psychological entity called patient.

William James (Feuerstein and Miller, 1971) said once "Practice may change our theoretical horizon, and this in a two-fold way: it may lead into new worlds and secure new powers". Western man loves to theorize and likes to withdraw from practice, but Kant, almost two hundred years ago, had shown by way of logic that the intellect is not capable of solving the deeper methaphysical problems, which are expanding more and more in the west.

In yoga, methaphysical questions play a minor role (Feuerstein and Miller, 1971). The yogin philosophy is never

the final object; his aim is to actually "experience" which for Kant was the everlasting object of human mind: the reality beyond the phonomenal world.

But six thousands years before Kant, Yogins, in the East, had recognized the insufficiency of the intelect with regard to the cognitions of final truth. They not overlook the fact in their statement of the problem of man's nature, but sought after a "faculty" in man which might break through the limits of the mind -the method of yoga.

Even being difficult for a westerner to follow yoga, a profound theoretical and practical would lead to discoveries particularly in the fields of psychology, depth psychology and parapsychology, which may well be called sciences of the future (Feuerstein and Miller, 1971).

Yoga if unlocked by personal practice, could prove to be of a far greater value towards a re-moulding of human personality and thus of our age, than any other science, religion or philosophy, for it opens to us a completly new aspect of existence - the realm of the self beyond personality and phonomenal world (Feuerstein and Miller, 1971).

Although we could use yoga as a therapeutic tool and even a profilactic one, it is difficult for man living and created in the western civilization to practice yoga. Even with this difficulty in mind, we can use some simple theoretical assumptions and practices to acquaint what is needed for a therapeutic setting: to breathe properly.

Yesudian and Haich say that the civilized man does not know to breathe and that our narrow emotional life and the continuous instability between fear and passion restrain our throath avoiding a free breathing. According to western medical science, says Yesudian and Haich, one who works seated at a desk breathes fifteen times per minute and in each inspiration inhales only half a litre of air. When the breathing is a little more profound, the amount of air that circulate through the lungs is one and a half litres, plus the same amount as "reserve" besides another litre and a half of "residual air". This means that we use only one tenth of the lungs' capacity to feed our organism with the nervous' cells special food: oxygen.

Having in mind the benefits of the practice of yoga, we would like to use only the easiest technique: breathe correctly. It is useful to the patient to sit or lie down calmly and to learn to breathe deeply making a pause when the lungs are full and when the lungs are empty.

After the mastery of this technique, one is able to intake the air and contract all the muscles while holding the breath untilthere is need of releasing suddenly both the muscles and the lungs.

As soon as the patient learns to be calm, he practices to elicit pleasant past memories. All these exercises can be done at home with little help of other people unless the therapist who will teach initially how to handle these procedures (Noronha, 1978).

After the mastery of these procedures, the patient will submitted to the essential therapeutic procedure by the therapist. The patient at the therapist's command will close his eyes and recall negative past memories associated negative affects, maintain them for one minute and then, breathing deeply at the therapist's order, will contract and release all the muscles, just as learned before, opening the eyes at the same moment. The therapist will ask him in what he is thinking at that moment.

Soon after this phase is overcome, the therapist will flood the patient verbally with the recall of past unpleasant memories, while the patient follows the same pattern of procedures described before. The therapist continues to ask what the patient is thinking of, soon after the release of muscle contraction and air expulsion.

The next procedure is to flood the patient with negative thoughts and memories, while he maintains the recall of positive or pleasant memories. This procedure is maintained until the patient is apt to hold the positive memories for 5 minutes while being flooded with negative memories by the therapist.

Soon after, the patient must be able to recall negative memories and to feel them during one minute and switch to positive memories at the therapist's order, maintaining them while being flooded with negative memories.

When this situation is attained, the therapist and the patient design future aversive situations and conduct the same procedure with future imaginary negative situations and former

positive memories.

When the patient is able to switch from negative to positive memories or facts within less than five seconds without the aid of muscular contraction or any other kind of relaxation, we think that most of the patient's problems are solved and he can consider himself well.

ASSESSMENT AND THERAPEUTIC OUTCOMES

Pre-treatment assessment is a procedure that was not used with reference to classical psychological testing. Some patients are tested because the psychiatrists or any other physicians required psychological testing to recommend psychological help or psychotherapy. Although, an evaluation of the problem was made and the diagnosis was based more on symptomatic and behavioristic criteria.

Nevertheless, disturbances reported by the patients are evaluated and its intensity is self-reported by the patient in a 11 point scale (Noronha, 1979a). The patient reported all his distressing symptoms and from the begining they were self--evaluated item by item every week.

The scale of eleven points was described more or l... in the following way:

	in portuguese
10 - maximum	(máximo)
9 - very much	(muitíssimo)
8 - much	(muito)
7 - higher	(bastante)
6 - medium high	(acima da média)
5 - medium	(Média)
4 - medium low	(abaixo do média)
3 - less	(pouco)
2 - very less	(pouquíssimo)
1.- insignificant	(insignificante)
0 - mínimum	(mínimo)

The patients who decreased 5 points in self-assessed symptoms were considered improved when they could maintain this performance during more than 4 weeks.

There were also considered improved patients who could maintain their symptoms at the point 3 or below for more than 4 weeks.

Only the patients who could maintain their symptoms at the point 1 or less during more than 3 weeks, were considered with their cases resolved.

Follow-up was done whenever possible.

Our survey on this matter gave us the following picture:

- People sometimes have difficulty in breathing and this therapy benefits them in this viewpoint.
- Some people have as little as one or two seconds of pleasant memories at the begining of the treatment and this is relate specially with depressives; this also is improved in these patients.
- People tend to take less time to elicit negative memories in the begining of treatment then in the final stage.
- Soon after relaxation procedure, at the end of recall of negative memories, people can remember more negative happenings in the initial stage of treatment than at the final stage. Sometimes even other repressed material come to consciousness (Noronha 1979b).
- On the first days the patient takes more time to relax after the elicitation of negative memories than in the last stages

of the treatment.

- To switch from negative memories to positive memories without relaxation, the patient takes more time at the begining than at the end of the therapy.

All the patients were treated in private consultation and so, bound to pay fees. It was difficult to evaluate their capacity and willingness to continue therapy beyond a certain point. Some of them dropped the therapy arguing about not willing to practice relaxation at home. Was it a real argument or was it a justification for not affording money for fees?

From all 71 patients treated with this method, either referred through a physician or in direct contact with the psychologist we can see the results obtained in the following case descriptions and tables.

CASE DESCRIPTION

CASE 76002

Male patient, 12 years old, student.

School and behavior difficulties.

These difficulties made him unacceptable in a normal class.

With normal inteligence, the boy failed in the year before, to pass the first grade of the junior high school.

This only child, used to be punished very severely by his father due to his misbehaviors and lack of study. The parents had been counseled by psychiatrists to make him porsue manual work.

His self-reported symptoms were:

- difficulty to pay attention to the teacher and books;
- difficulty to memorize lessons;
- lack of will to study.

This case was resolved in 12 sessions within 154 days, from 7 January 1976 until 10 June 1976.

Follow-up in the next 2 years did not show any relapse, but increase in scholastic achievement year after year. He is now a successful Senior high school student.

CASE 76004

Female patient, 15 years old, student.

Depression

The patient tried to commit suicide with LORENIN for the second time within two months.

She lived with her mother and 3 sisters having the mother abandoned her husband because he used to threat the wife with an axe which was kept under his sleeping pillow. The patient's father was an alcoholic and suffered from syphilis.

Mother was too strict in her child bearing practices and was in constant clash with the patient. She felt trapped and desperate when had to date a male friend.

Her self-reported symptoms were:

- difficulties in relationship with her mother;
- difficulties in relationship with her sisters;
- difficulties to see the bad relationship between her mother and sisters;
- need to walk very fast;
- excitement;
- need to be dependent on a certain female friend;
- need to get out of home;
- need to smoke heavily;
- need to work very hard.

This case was resolved in 10 sessions within 56 days, from 26 July 1976 until 20 September 1976.

Follow-up in the next 2 years did not show any relapse.

CASE 76007

Female patient, 40 years old, married, nurse.

Depression.

Married to an alcoholic addict, with no children, she was always afraid of being a widow. Her husband did not pay any attention to her although being very polite. Her husband feels persecuted everywhere and specially in his job.

Both had bad infancies and her father tried once to rape her.

Her self-reported symptoms were:

- anxiety;
- need to cry;
- difficulty in sexual intercourse;
- difficulty in sleeping;
- difficulty to pay attention to a conversation;
- difficulty to see the husband drunk;
- lack of good relationship with her sister.

This case was improved in 18 sessions within 245 days, from 6 September 1976 until 8 May 1977.

Follow-up in the next 2 years did not show any relapse or withdrawl of symptoms.

CASE 76009

Male patient, 26 years old, single, administrative clerk.

Inferiority feelings.

This boy tried to kill her girl-friend twice and was interned in a psychiatric hospital where he was diagnosed as psychopath. His behavior was unacceptable to his working fellows. Since childhood he had always tempertantrums and misbehavior in school and other settings. His parents were divorced and he was brought up by his grandmother. He was educated in a boarding school until his 14 years. Since then he began to work as an administrative clerk.

His self-reported symptoms were:

- difficulty to communicate with other persons;
- mistrust in relation to every people;
- selfishness;
- avarice;
- feeling that he was very ugly;
- difficulty to maintain conversation with his girl-friend;
- jealousy about his girl-friend.

This case was resolved in 19 sessions within 169 days, from 11 November 1976 until 28 March 1977.

Follow-up during the next 2 years did not show any relapse, but improvement.

CASE 77006

Male patient, 8 years old, student.

School difficulties.

This boy had difficulties to attend school and to speak properly. A sister was born some months before and the young parents used to pay much attention to this newborn baby. The grandparents were illiterate and were not able to help the child during the day after the school hours when the child was at their home. The child appeared to have feelings of inferiority.

His self-reported symptoms were:

- difficulty to speak;
- difficulty to memorize.

The case was improved in 11 sessions within 85 days, from 18 February 1977 until 13 May 1977.

Follow-up in the next 2 years did not show relapse of any symptom.

CASE 77008

Male patient, 9 years old, student.

School difficulties.

The boy began to have behavior problems at home and school and to decrease in academic achievement. He had a 2 years younger sister from whom he was jealous. His parents were in their thirties.

His self-reported symptoms were:

- bad behavior at home;
- lack of attention at school;
- difficulty in pronouncing words and constructing phrases.

The case was improved in 3 sessions within 106 days, from 15 March until 28 June 1977.

Follow-up in the next 2 years presented gradual withdrawl of symptoms and better school achievement.

CASE 77013

Male patient, 10 years old, student.

School difficulties.

The boy had some school difficulties in the classroom and also with school mates whom he feared.

He used to live and was educated only by his mother, his uncle and his grandmother, while his mother was having a half marital life with a man who did not use to live with them.

The boy began to have nightmares and fear of darkness. He asked for psychological help because he began to develop breathing difficulties and began to faint easily.

The patient had many traumatic experiences during the last 6 years

- his grandfather died;
- his father returned when the patient was four, and left home soon after, just as he did when the patient was two years old;
- he had to begin to attend school leaving his home against his will.

His self-reported symptoms were:

- fear of his uncle;
- fear of his school mates;
- worries about his mother's business outcome;
- worries about his mother's and grandmother's health.

The case was improved in 6 sessions within 36 days, from 10 June 1977 until 21 July 1977.

Follow-up in the next 2 years did not show relapse of any symptom.

CASE 77020

Female patient, 40 years old, married, administrative clerk.

Depression.

This woman was to be abandonned by her husband who began to have marital life with one of his female students. He left 6 children ranging from 20 to 10 years, to be raised by the patient who had to apply for a job to bare the financial burden.

The patient complained of the following self-evaluated symptoms:

- severe and constant migranes;
- constant nightmares where she felt that a man was attacking her;
- insomnia;
- dreams about being constantly persecuted by the sea and at the beach.

This case was improved with 6 sessions within 175 days, from 21 June 1977 until 12 December 1977.

Follow-up in the next 2 years did not show increase of symptoms. The patient remarried and has a more or less satisfactory life.

CASE 77021

Male patient, 31 years old, married, wall-painter.

Obcessions-compulsions.

The patient has a history of psychiatric treatment during two years before referred to the psychologist.

Born in a family with many children, elder and younger, the patient was brought up alone by his grandmother who died when he was 12. Since then, he was raised by his family where he always felt like a stranger. He tried to live as much as possible out of home and at 25, he married, beginning to have since then a well supported financial life. He always felt alone and despised by his parents or relatives.

His major symptoms began soon after the birth of his first son and increased during the last six years:

- compulsive need to check the doors, cooking gas, etc;
- compulsion to wake up the children twice at night, to see if they were still alive;
- cumpulsion to look behind himself to see if he was being pursuited by anyone;
- need to clean very well a place before keeping something over it, not to hurt any living creature;
- need to talk alone with himself;
- worries about everything;
- forgetfulness.

The patient also complained of dizziness when standing on a

stool or a staircase.

The case was improved in 5 sessions within 57 days, from 28 June 1977 until 23 August 1977.

Follow-up in the next 2 years did not show increase in the symtoms already mentioned. There was also no symptom substitution.

CASE 77023

Female patient, 15 years old, student.

Depression.

The patient lived until the age of 7 with her parents. From 7 to 13, she lived with her grandmother while her parents were in France as immigrants.

During her early years, she watched many discussions between her parents specially when her father was drunk. When the parents went to France she feared that her father would kill her mother. At 13, she did not want to live with her parents in France, returning to her village and grandmother. When sometimes contradicted by her peers, she used to have extreme withdrawl reactions.

Her self-reported symptoms were:

- need to stay isolated from everyone;
- need to stay quiet and do nothing.

This case was improved with 5 sessions within 29 days from 5 July 1977 until 2 August 1977.

Follow-up in the next 2 years did not show any symptom substitution or increase in the former ones.

CASE 77030

Male patient, 55 years old, divorced and remarried, topograph.

Phobias (multiple).

This patient is married by the second time with a woman who divorced her first husband. His first wife, divorced him to remarry.

During his infancy he felt some difficulties and jaelousy about his brother.

When child, he fainted once while playing football.

At the age of 7 he was locked for about 1 hour in a WC of a train.

At 32, he slipped away to a rocky cliff and had to catch hard not to fall down to the bottom.

At 35, he was locked in a lift which was imobilized for 2 hours.

Some time after, he was very frightened when a friend of him took him for a ride in an aeroplane and made some loopings.

His self-reported symptoms were:

- fear of using the lift (claustrophobia?);
- fear of driving the car alone;
- fear of walking alone in the street;
- fear of letting her wife be out of home alone;
- dizziness;
- fear of fainting;
- lack of self-confidence;
- irritability.

This case was improved in 16 sessions within 183 days, from 2

August 1977 until 31 January 1978.

This case began to improve as soon as the patient was able to remember his early repressed memories.

His parent's friends with two children aged about 1 and 6 years, travelled together with the patient for a little more than a week. As the elder child was willing to go for a movie with his parents, began to cry and make fuss because his parents could not allow him to do so in the steamer where they were travelling. The boy was warned by his father, that he would be thrown to the sea if he cried or behaved badly. The boy calmed at once and stopped crying. The parents went to the movie, having kept their children already slept in their beds. Suddenly, in the middle of the movie the younger child began to cry and the elder one felt in need to open the cabin little window and push the baby to the sea just as his father promised to do if he himself had cried. This was a traumatic event lived by the patient when he was very young, making him not confident in anyone and compelling him to fear everything.

Eight months after the end of the first part of therapy during which the patient improved very much, two more sessions were done on 5 and 12 September 1978.

Follow-up during the next year showed slight but constant improvement, with greater decrease in all the symptoms already mentioned.

CASE 77036

Female patient, 40 years old, nurse, married, with 2 children.

Depression.

The patient was raised by her father who was alcoholic; her mother had died early. She had a younger sister.

She was very much attached to her father and married a divorced man about 12 years older than her, with whom she maintains good interpersonal relations.

Her self-reported symptoms were:

- hate to another nurse;
- fear of her husband's death;
- irritability with the two sons;
- sorrow for not doing something valid;
- nead to rest unknown;
- difficulties in interpersonal relations.

This case was improved in two endowments, in a total of 11 sessions, within 195 days, from 31 August 1977 until 13 March 1978.

Folluw-up in the next 18 months, did not show any increase in symptoms or its substitution.

CASE 77038

Female patient, 17 years old, student.

Behavior problems.

The patient is the only daughter of a couple who used to have many discussions and misunderstandings.

Her father is neurotic and had troubles when adolescent.

The patient had some traumatic experiences in her childhood: her uncle exposed himself nude to her, soliciting from her erotic play she had to scream and shout to get rid of him.

Her self-reported symptoms were:

- gets nervous with her father;
- gets excited when at home;
- likes to contradict people;
- is stubborn in school;
- has difficulties in learning;
- has feelings of inferiority.

This case was improved in 8 sessions within 50 days, from 6 September 1977 until 25 October 1977.

Follow-up during the next 2 years did not show any increase or substitution in symptoms as stated in the last session.

CASE 77045

Male patient, 20 years old, student.

Depression.

The patient is the only son of a well established couple.

Since the age of 15 the patient had psychiatric problems and was always treated by psychiatrists.

The last problem which made him ask the help of a clinical psychologist was his second attempt of suicide within a period of 2 months.

The patient had mood swings very frequently and periods of sadness irratability, shiness and withdrawl were frequent and lenghthy.

His self-reported symptoms were:

- need to smoke too much;
- need to heavy alcoholic consumption;
- fear of his father;
- shiness in parties;
- fear of introducing himself to new acquaintances;
- worries about some insignificant things.

This case was resolved in 21 sessions within 513 days, from 26 September 1977 until 20 February 1979.

Follow-up in the next 9 months showed complete withdrawl of symptoms.

CASE 77046

Female patient, 40 years old, married.

Depression.

The patient has two daughters. The elder does not have good relationship with her mother and the younger seems to begin behaving in the same manner. Her husband is a hard working man but also with psychiatric problems.

She complains always of a hard life during her childhood and infancy.

During her courtship her boy-friend was father of a baby from another woman who accused the patient of having stollen her man.

Soon after marriage they had to live with her parents-in-law having had many difficulties and discussions with the family and having to stay sometimes all alone in a room.

A couple of years after marriage, she began to have sexual difficulties, remembering always her husband's first woman. Soon after, she began to have psychological disturbances with relevance to depressive events. Usually every two years she had a breakdown.

At the moment, she was in psychiatric treatment with diagnosis of manic-depressive psychosis.

Her self-reported symptoms were:

- excitability;
- difficulty in gathering a group of many people;
- difficulty in breathing;
- need to punish unnecessarily the younger daughter.

The patient reported improvement and did not want to continue the treatment because the relaxation procedure was very much boring to her.

At the time, the patient asked to leave the hospital on her will, where she stood less time than in the former years.

This case was improved but abandonned in 11 sessions within 77 days, from 27 September 1977 until 12 December 1977.

We had no possibilities of follow-up.

CASE 77047

Male patient, 17 years old, student.

Depression.

This patient was a son not desired by his father who proposed abortion. Patient's older brother did not agree with the proposal and the child was born without father's support.
Mother was much attached to this child specially because her husband began to drink much more heavily than before. The patient used to sleep in a separate bed with his very anxious and depressive mother.

Since the age of 12 he began to be assisted by a psychiatrist because of his nightmares. From 13 to 16 it was very difficult to the patient to sleep alone on his bed.
His intelectual level is good and all the academic years he had good results. At the age of 17 he dropped the school and did not want to continue studies to much concern of his mother.
He began to sleep by day and wake up by night either to listen music or to smoke heavily or to wander about the city. He began to smoke marijuana and take psychomimetic drugs.
He tried to commit suicide twice within a period of 3 months, once ingesting LORENIN and the second time cutting his wrist blood vessels.

When young, as soon as he began to sleep alone, he began to have sexual contact (petting and caressing) with children 4 to 6 years younger than him. He felt it pecaminous but nevertheless enga-

ged in such activities without mother's knowledge.

He used to masturbate constanly and spread the semen on books which he was reading.

This patient had a profound identity crisis and his self reported symptoms were vague and very much concerned with items like:

- who am I ?
- am I a child or an adult ?
- am I normal or abnormal ?
- why do I have sexual difficulties and cannot engage in normal sexual activity ?
- how can I approach a girl ?

Once he was absolutely marvelled with a colleague. He thought of her like an angel. He never had any sexual thoughts about her and felt that it could even be a sin. He used to talk to her very shily and admire her beautifulness in an attitude more of adoration than of any other kind.

When some months later he knew that the girl was pregnant of a school'mate he had a great shock and since then, he dropped school

This case was very much improved but the patient did not want to continue the treatment because he was encouraged by the psychologist either to study or to hold a job. He liked to continue at home doing nothing and supported by his mother whom he threatens when she cannot afford the money necessary to his needs.

During 227 days, 40 sessions were done, from 11 July 78 to 22 February 1979, without much collaboration of the patient. We can infer some motivation not to colaborate through the lapse

of time delay since his mother's referral on 27 September 1977 until the onset of therapy on 11 July 1978.

Follow-up of six months gave us an idea about new behaviors of drinking and withdrawl which are being built by mother's reinforcement.

Mother accomplishes all his wishes and gives him all the support he needs to maintain these abnormal patterns of behavior.

CASE 77050

Male patient, 45 years old, married.

Depression.

This patient complained about headaches since his 6 years of age. At the age of 9 he was submitted to tonsilectomy with anaesthesia. During the operation, he was very much frightened. In the later years he had many episodies of severe headaches.

Soon after his schooling, at the level of general school certificate, he was not able to find an appropriate job and felt inferior, having to hold a job as groom.

Changing from job to job, he married a nurse suffering from many phobias.

Some years later, after his wife's bad delivery of a second daughter and her later death, the patient began to consult psychiatrist after psychiatrist always complaining of cardiac arrythmy.

In the last 11 years away from his wife, he has been in psychiatric treatment and dismissed from his job as a sick person.

His self-reported symptoms were:

- hollowness in the head;
- confusion in the head;
- inability to listen to noises;
- buzzing in the ears;
- dizziness;
- proneness to faint;
- feelings of blows on the head;
- high pressure on the skull;

- tiredness after a conversation;
- high pulse rate.

This patient, even telling that he was willing to cooperate, tried always to be "out" of therapy, stating that he was a sick man and without cure.

This patient had little improvement.

After leaving the therapy twice, continues now in treatment in a different therapeutic approach.

This case was considered abandonned after 51 sessions within a period of 805 days, from 13 October 1977 until 31 December 1979. This case will be further reported in a different research project.

CASE 77053

Male patient, 43 years old, single, electrician.

Depression.

This patient was the youngest son in a family with other two 7 and 18 years male elder brothers.

His father's death when he was very young, made him very much dependent on his mother who treated him just like a girl. He used to sleep with his mother during his childhood. His studies were few and he dropped school to work as electrician. He continued to live with his mother while the elder brothers married and left his mother's home.

Since his adulthood, the patient had many episodies of fainting and depression but only in his thirties he began to need psychiatric ambulatory treatment.

His mother suffered three heart strokes and was imobilized in bed during her last three years of life and the patient was admitted as in-patient to a psychiatric hospital 2 years before, when his mother died, being discharged after 6 months of treatment.

Attending now a day-centre, the patient reported the following symptoms:

- feelings of inferiority in relation to others;
- thoughts that other people always tried to cheat him;
- feelings of inactivity;
- lack of self-confidence;
- lack of self-assertion;

- sexual difficulties.

This case was improved in 12 sessions within 96 days from 20 October 1977 until 27 July 1978.

Follow-up of 12 months showed greater improvement in relation to what was obtained at the end of therapy which was terminated because the patient was dismissed from the hospital setting with remission of psychiatric symptoms. The patient is holding now a better job, and feels more confident about the future and with less sexual difficulties.

CASE 77055

Male patient, 15 years old, student.

School difficulties.

This patient is the only son of a couple who live in constant stress and anxiety. His father has personality problems and the patient's intelectual level is under percentile 50.

He was referred to a psychologist because he had difficulty in scholastic achievement and behavior problems.

His self-reported symptoms were:

- irritability when his father refused him permission to play;
- father's constant opposition;
- difficulty in concentrating in classroom;
- difficulty in learning;
- shiness with certain teachers;
- difficulty in accepting a defeat;
- lack of constancy in will;
- need to bite the nails.

This case was improved in 40 sessions within 547 days, from 8 November 1977 until 8 May 1979.

Follow-up 6 months later presented the stabilization of symptoms.

CASE 77057

Male patient, 9 years old, student.

School difficulties.

The patient lives with his parents and father's mother.

When he was four, a sister was born and he was very jealous about the fact.

He was raised in a home where everyone used to quarrel with each other. His parents were always in dispute just like the mother with her mother-in-law.

The patient began to have some difficulties with his school teacher and at 7 he was assisted and treated by a psychiatrist because of lack of attention and motivation for academic studies.

The patient felt a little better although begining to increase the difficulties soon after.

His parents tried to live separately; both had constant signs of breakdown and depression.

Patient's self-reported symptoms were:

- lack of attention;
- lack of memory;
- nervousness.

This case was resolved and the patient passed the academic year.

The therapy consisted in 12 sessions within 162 days, from 8 November 1977 until 18 April 1978.

Follow-up of 18 months showed increased performance in school.

CASE 77053

Female patient, 52 years old, married, with one son.

Depression.

The patient had many difficulties with her son's academic achievement. His intelectual level was not high but the mother was very much worried about his future and about his constant failure in school duties and performances.

The interpersonal relations with her husband were very much impaired and she used to feel very much neglected by him and also by her son who was trying to identify himself with the father. Her sexual activity was almost negligible since she married and many breakdowns had taken place from 23 onwards. Psychiatric treatment was usually followed for about 3 to 4 months every 2 years, but in the last 2 years, the symptoms were so unbereable that she decided to consult a neurologist. The neurologist referred to a clinical psychologist.

Her self-reported symptoms were:

- worries about her son;
- irritability;
- sadness to know her son's underachievement.

This case was resolved in 21 sessions within 170 days, from 22 November 1977 until 6 June 1978.

Follow-up of 13 months showed complete relapse of symptoms and improvement in the whole family life.

CASE 77062

Male patient, 18 years old, manual worker.

Inferiority feelings.

This patient lost his father very early and being the eldest son in a family with 3 more siblings, had to work to support his relatives.

He accomplished the second year of junior high school and began to work as a non specialized worker among other people with less academic instruction. He would like to porsue studies but no opportunities were available.

Soon after he began to feel insecure at work and to suffer from permanente and severe headaches. He developped also fear of talking to other people and began to tremble when nervous or irritated.

During the year before this therapy, he was treated twice with chemotherapy by a psychiatrist with six months interval and during 15 days each time.

At this time, after the second relapse, the self-reported symptoms were:

- shiness to talk about certain things with other people;
- nervousness;
- feelings of tiredness.

This case was resolved in 9 sessions within 52 days, from 15 December 1977 to 4 February 1978.

Follow-up after 13 months did not show any relapse of symotoms as formerly and the patient reported as a well integrated worker besides happy and well adjusted in his social life.

CASE 77063

Female patient, 33 years old, married, housewife.

Depression.

This patient began to have many problems with her husband and her only daughter.

She referred constant distress.

Her self-evaluated symptoms were:

- fear of nightmares;
- nervousness;
- constant discussion with her daughter.

This case was improved after a light chemotherapy and 3 sessions within 13 days, from 19 December 1977 to 5 January 1978.

Follow-up 18 months later did not show increase of symptoms.

CASE 78001

Male patient, 14 years old, student.

School difficulties.

The patient had many school and behavior difficulties.

His parents reported about their only son, symptoms such as:

- scholastic underachievement;
- nocturnal enuresis;
- childish behavior;
- headaches after studying a while;
- excessive nervousness;
- excessive lack of attention.

His parents are two troubled peple who needed psychotherapy but would not admit so, specially the father.

Since his childhood he used to have nightmares.

When the parents, after 7 sessions, within 50 days, from 3 January 1978 to 21 February 1978, began to be warned that they should join the treatment, they did not want the boy to continue.

During this lapse of time, the boy's symptoms reported by the parents declined from 7.6 to 5.8 in the already mentioned self-evaluating scale.

The treatment was abandonned without possibilities of follow-up.

CASE 78003

Female patient, 45 years old, nurse, married.

Depression, with epilepsy.

This patient is a middle born child, in a family of 4 male siblings.

Her father died early and all members of the family are "nervous" and with behavior and intrapersonal disorders.

The patient was restricted to home until she married and alcoholi

Separated from her husband at the age of 28, she began to study nursing and to work and live upon herself. Her husband died in a car accident when she was 39, and at 43 she married again with a widowed.

Besides epilepsy, the patient complained of:

- need to talk alone;
- misunderstood by parents and relatives;
- criticized by relatives;
- feelings of nervousness;
- tiredness;
- lack of memory;
- difficulty in interacting with colleagues;
- sudden nervous jerks;
- headaches.

This patient was assisted by a psychiatrist on whom she was most dependent. Her collaboration, even during the treatment and relaxation sessions, was very bad and her personality was very much infantile.

This case was instructed to interrupt the therapy until chemo-

therapy was over.

After 32 sessions during 200 days, from 23 January 1978 until 10 August 1978, the case was considered abandonned.

Folluw-up 12 months later gave indications that the patient soon after the interruption of psychotherapy left the psychiatrist and began treatment with a neurologist, reporting improvement 6 months after the begining of this type of therapy.

CASE 78012

Male patient, 16 years old, student.

Behavior disorders at home.

The patient is a foster child and had little connection with his mother since the age of 7 months.

When the patient was ten, his "sister" married and had a child which was not well accepted by the little boy.

From the age of four, the patient had to be submitted to special education (phoniatrics). He failed 3 years in the Junior Secondary school and used to be assisted by a child psychiatrist.

This patient besides low level intelectual ability (IQ about 70 in Goodnough), had personality disorders showing a pattern of psychotic problems in the EPQ junior.

This patient improved and began to hold a job, in 13 sessions, within a period of 281 days, from 28 February 1978 until 5 December 1978.

Follow-up 12 months later show that he is still holding the job without much effort and that he is also trying to study by night, attending classes in the evening.

This case has to be treated in another psychological and therapeutic approach.

CASE 78016

Female patient, 36 years old, nurse, single.

Depression.

The patient began to suffer from headaches and nervousness about two years before and was treated by psychiatrists with chemotherapy. In the last 6 months she began to feel difficulty in maintaining any kind of interpersonal relations and began to feel distressed with constant suicidal impulses.

Her infancy was not very happy and her father began to drink 4 years before.

Her self-reported symptoms were:

- irritation with everything;
- irritability at work;
- inability to sleep;
- inability to unbosom herself;
- shiness;
- lack of interest in everything;
- lack of interest in living.

This case was improved in 11 sessions within 44 days, from 8 March 1978 until 17 April 1978.

Follow-up 18 months later presented withdrawl of symptoms and improvement of result attained at the end of treatment.

CASE 78018a

Male patient, 9 years old, student.

School difficulties.

This child was living with parents and grandparents who used to discuss constantly and depreciate his mother's opinions.

The child was getting more and more upset at home and restless in school, with associated attention difficulties. He was to fail because had no achievement at school in reading and mathematics.

This case was resolved in 16 sessions within 141 days, from 11 March 1978 until 29 June 1978.

Follow-up 12 months later, gave indications that scholastic achievement was fine, with improvement during this year.

CASE 78018b

Male patient, 8 years old, student.

Tics.

This patient had also his parents living together with grandparents, with whom they used to discuss all the time. His mother was constantly depreciated by the grandmother.

The child lived in permanent tension and suffered of tics (close the eyes, move the forehead and expel a charachteristic sound through the mouth and nose).

Besides it, father reported that the child was:

- unclean and untidy in dressing;
- irritative;
- unable to disclose from some toys;
- always interrupting parent's conversation.

This case was resolved in 10 sessions within 78 days, from 13 May 1978 to 29 July 1978.

Follow-up 12 months later, did not show any relapse of symptoms.

CASE 78023

Female patient, 9 years old, student.

Phobia.

This girl was referred by her teacher, because she had many difficulties in achieving good academic results.

Besides it, she had:

- fear of darkness;
- fear of crowded places like trains, buses, etc.;
- fear of fire;
- memory difficulties;
- attention difficulties;
- fear of reading a lesson in the classroom.

She began to have a strange behavior in the classroom and the teacher reported the case to the parents. After 6 months of cautious observation, the parents decided to consult a psychologist.

This case was resolved in 9 sessions within 141 days, from 4 April 1978 until 22 August 1978.

The follow-up 12 months later did not show any relapse but improvement in behavior and in academic achievement.

CASE 78025

Male patient, 15 years old, student.

Inferiority.

This patient began to have lack of confidence, of motivation to study and of self assertion, soon after the secondary school grade.

Referred to psychological help, his self-reported symptoms were:

- repulsion for study;
- difficulty to stay without friends;
- difficulty in interpersonal relationship;
- difficulty in attention;
- feelings of inferiority.

This patient had many traumatic experiences in childhood and was constantly feeling rejected by other people and even by relatives. His EEG showed a pattern of slow waves, probably related to imaturity.

This case improved but is still under treatment in a different therapeutic procedure; 44 sessions were done in 676 days, from 5 April 1978 until the end of 1979.

CASE 78028

Male patient, 47 years old, married, mechanic.

Inferiority.

This patient has a very rigid and authoritative father. When child, he was very shy and had no possibility in behaving like other children. His father did not allow him to stay out of home after 8 o'clock in the evening until he was sixteen.

His first sexual intercourse with a prostitute, was a failure and frustration.

Married at 26, he had a daughter, but his wife was dead 6 years later. He had to live with his parents and the daughter was raised by his parents in law until he married again at the age of 36. The girl presents some psychological difficulties besides learning ones.

From the second marriage with a nurse, he has two more children. His sexual relations were never satisfactory.

Since the age of 20, he began to consult medical specialists for many physical complaints. The patient feels great pain in the annal region, with itching.

Being referred to the psychologist by his wife, this very anxious patient collaborated very badly.

After 3 sessions within 28 days, from 18 April 1978 until 16 May 1978, he refused to accept that his "disease" could be "cured" or minimized without medicine and drug ingestion. He felt always inferior to other people, compensating this feeling with superiority and arrogant behavior. He abandonned the treatment, stating that no one could even alleviate his distress.

CASE 78031

Female patient, 28 years old, married, administrative clerk.

Inferiority.

The patient began to complain about emotional difficulties since very early age.

Since the age of 7, she remembers that used to feel uneasy at beach. Her parents used to have constant discussions with each other and she had bad relationship with mother.

At the age of 15 she failed in the senior high school and dropped studies, staying at home during the next 3 years and being assisted by a psychiatrist.

At the age of 18, she began to date, having married at 20. At the age of 22, after the birth of a daughter, she began to feel sick again. Emotional problems were constant and she began to be assisted since then by many psychiatrists. As soon as she thought her problems were worsening, she used to change from psychiatrist. She began to worsen her symptoms day by day and her husband began to have and to increase love affairs outside home.

Her self-reported symptoms were:

- fear of fainting;
- lack of self-assurance;
- anxiety;
- loss of notion about the actual place;
- unwillingness to work or do anything;
- dizziness;

- headaches;
- will to die;
- need of being alone at home;
- fear of staying alone or being alone in the street.

As soon as she married, her symptoms began to increase, specially after deliveries and her husband tried to arrange love affairs. The patient,as soon as some symptoms began to decrease (lack of self assurance, anxiety, fear of fainting) reported increase in the ocurrance of headaches and fear of coming alone to therapy. As soon as these self defenses were built and her husband could not bring her and wait until the end of the therapeutic session, she had to drop the therapy. Stating these justifications the therapy was ended after 3 sessions within 22 days, from 20 April 1978 until 11 May 1978.

Follow-up says that she continued during the next 18 months with the same symptoms, wandereing from psychiatrist to psychiatrist.

CASE 78038

Male patient, 19 years old, student.

Inferiority.

The patient is the eldest son in a family with four more siblings 1 boy and 3 girls.

The patient studied until the O level, or secondary school certificate, and soon after began to develop feelings of inferiority. He was not able to work, and used to be in constant stress and anxiety. He could not complain of specific symptoms but could indicate that felt constant distress and was in a prolongued and acute state of anxiety. He was in constant struggle with his mother who did not use to be in good relations with her husband. As soon as the patient began to feel a little better after 4 sessions, his mother tried to convince him that he was not getting sufficiently well and to drop the therapy, which was conducted during 30 days, from 23 May 1978 until 17 June 1978.

Follow-up was not possible.

CASE 78041

Female patient, 25 years old, administrative clerk, married, but living alone with her little son.

Depression.

Since the age of 19, the patient used to faint and to loose conscience. She was the eldest sister in a family of 3 more female siblings, raised out of home by her aunt. Her academic level stands at pre-university level.

She felt very uneasy at home, during interpersonal relationsips with her son and at workplace.

Her self-reported symptoms were:

- inhibitions;
- worries about her son;
- disgust with her actual employment;
- difficulty in social interaction;
- difficulty in coordinating and executing any task;

At the third session she began to be able to remember her childhood and to understand the nature and origin of her actual feelings. The symptoms began to decrease and she commited herself to practice relaxation everyday at home.

This case was resolved in 6 sessions, within 58 days, from 7 June 1978 until 3 August 1978.

Follow-up 12 months later reported stability in the decrease of symptoms.

CASE 78042

Female patient, 37 years old, married, manual worker.

Depression.

Since her childhood the patient used to have headaches and to listen to some things getting out of the ears.

Her intelectual level is low and the academic record stays at primary school.

She married at the age of 23 and while pregnant, was abandonned by her husband.

At the age of 28 she remarried but her actual husband also has difficulties in interpersonal and sexual relationship.

The patient collaborated badly. It seemed to us that the status of sickness and disease, gave her some powerful secondary reinforcement from her daughter and husband.

After 6 sessions within 43 days, from 15 June 1978 to 27 July 1978, she abandonned the therapy stating that she had no availability in time to complete a whole therapeutic procedure during the next 6 months.

Follow-up 12 months later gave idea of no increase in original symptoms, which she could not indicate clearly.

CASE 78047

Female patient, 18 years old, student.

Depression.

This patient has a "normal" life in a "normal" home but there is something between the parents that does not go well. The father is much more concerned about his job work, and pays no attention to his home life. The mother feels alone and unsatisfied with the kind of life she lives. Her sexual life is not satisfactory. When the patient was 8 years old, another sister was born: it made her very jealous.

Her studies were regular but with hard work. The patient feels rejected by everyone and does not have any self-confidence.

Her self reported symotoms were:

- difficulty in paying attention to something;
- difficulty to establish any kind of communication;
- feeling of tension;
- difficulty to talk to her father.

This very tense, anxious and unassertive patient was improved in 23 sessions, within 212 days, from 4 July 1978 until January 1979.

Follow-up 9 months later did not show any relapse or increase in symptoms achieved during the last days of therapy.

CASE 78043

Male patient, 12 years old, student.

School difficulties.

This patient is the only child of a couple in their forties. The child does well in school but has difficulty in paying attention to any subject. His school marks are good but at examination he feels tense and usually fails to have good marks. The year before he went to a diagnostic centre where it was assured that he had no problems. Nevertheless he failed.

The child sleeps in the same bed with his mother and gets very frightened by night. Besides, being inattentive, the patient shows lack of self confidence and seems very dependent on his mother.

He abandonned the treatment when the psychologist told the mother that it would be much better for her to be submitted to treatment. Mother had interpersonal and sexual relation difficulties with the father and this was compensated through an excessive attachment to the son and its overprotection.

The case was abandonned after slightly improved in 5 sessions within 64 days, from 11 July 1978 until 12 September 1978. Follow-up was not possible.

CASE 78050

Male patient, 33 years old, single, dental prosthetic mechanic.

Inferiority feelings.

This patient is the eldest son.

His academic record is not good and he failed twice in the primary school.

Born in a poor family, he had to work soon. At the age of 13, he tried to have sexual relations with a girl of the same age but as she screamed, her mother knew all about and he was very much ashamed about it. Since then he began to have difficulties in talking to girls and dating.

This very anxious and inhibited man, was in trouble with her actual gir-friend and her relatives with whom she lived.

His self-evaluated symptoms were:

- feelings of inferiority;
- difficulty to talk to other people;
- feelings of inferiority in social gatherings.

Symptoms began to decrease in this case when the patient could remember clearly many of his past forgotten difficulties, specially in the primary school. He was then motivated to surpass actual difficulties just as he did formerly during most of his life.

This case was resolved in 12 sessions within 176 days, from 25 July 1978 until 16 January 1979.

Follow-up 9 months later indicated no relapse of sympyoms and a happy dating.

CASE 78053

Female patient, 40 years old, single.

Depression.

This patient called for help when she was afraid of commiting suicide.

Her childhood was very bad. Her mother lived alone and the child never knew her father. The mother has many physical handicaps. She did not like school and her mother did not pay any attention to her education or schooling.

Her uncle who lived with them, tried to rape her when she was 15. She was physically examined to see if there were any injuries, for legal purposes.

Soon after this traumatic experience, she ran away from home and began to work in a bar as attendant. She used sometimes to act as a call-girl.

Since the age of 18, she lived with a boy from whom she was afraid and since the age of 25 with a different one who left her some years after. Since then, she used to live alone and have a free but financially profitable sexual life.

She does not feel well and has no sexual enjoyment.

Besides a great depression and grief in which she was sinking, her self-reported symptoms were:

- difficulty to sleep (insomnia);
- difficulty and fear of leaving home;
- difficulty to maintain a boy-friend;
- nervousness;

- irritation;
- worries about other people.

She needed to interfere in other people's life and this was her first interpersonal relations impairment.

Even without much collaboration to make relaxation exercices, this case was greatly improved in 9 sessions within 73 days, from 22 August 1978 until 7 November 1978.

Follow-up 12 months later did not show relapse of symptoms and the patient is having a more enjoyable sexual life.

CASE 78061

Male patient, 13 years old, student.

School difficulties.

This patient was referred by a psychiatrist for IQ testing because of low scholastic achievement in June 1978.

One year later, his IQ decreased and he had dropped school.

His IQ in the WISC scale was under 85.

He began treatment and improved in 5 sessions within 28 days, from 25 July 1979 until 21 August 1979.

Follow-up of 3 months did not show any relapse and the boy began to work and live more satisfactorily eliminating destructive behaviors which he had before.

CASE 78063

Female patient, 14 years old, student.

Behavior problems.

This patient is the only daughter from a couple who does not interact very well. The father is very authoritharian and the mother very much submissive, to hold the marriage.

The patient does not like to play her feminine role and would be very much interested in being a boy even undergoing surgery.

Her academic achievement is good and has no difficulties, but her behavior in very much influenced by her prejudices.

Constant discussions with her father, are rooted essentially in desobedience.

Her self-reported symptoms were:

- nervousness;
- excessive sweating in the palm of hands;
- deslike of the actual high school she was attending;
- need to bite the nails.

This case was improved in 10 sessions within 71 days, from 3 October 1978 until 12 December 1978.

Follow-up of 12 months, did not show any relapse of symptoms which were very much decreased at the end of therapy.

CASE 78065

Male patient, 48 years old, engineer.

Depression.

This patient was one of many siblings, all of them well educated and with good achievement. His father was a very decent man with good academic background, sound principles and good social standing.

The patient was totally upset when a girl with whom he used to have marital life, married unadvertedly with another man. Since then, he began to feel nervous, depressed, irritable and very sad. He used to cry frequently and could not withold his tears. During the first three sessions he was not able to describe the symptoms or evaluate them. There was risk of attempting suicide.

This case was improved in 12 sessions, within 85 days, from 10 October 1978 until 2 January 1978.

Follow-up 9 months later, did not show any relapse but a decrease in grief, sadness and insomnia that the patient suffered from.

CASE 78067

Male patient, 9 years old, student.

School difficulties.

This child was referred to a psychologist because of his low academic cooperation and achievement and also for his disruption in behavior sometimes.

He has another brother, 5 years old.

After having been assisted by another psychologist and a psychiatrist during the two preceeding years, this child began therapy having his parents reported the following symptoms:

- difficulties in holding attention;
- desobedience;
- difficulty in staying quiet;
- unresponsibility;
- lack of interest for study;
- memory difficulties.

This case was resolved in 14 sessions within 169 days, from 17 October 1978 until 3 April 1979.

Follow-up 6 months later, showed the stabilization of total withdrawl of symptoms.

CASE 78072

Female patient, 28 years old, housewife;

Depression.

This patient began psychiatric treatment since the age of 20, without any lasting and stable improvement.

Referred to a psychologist, her self-reported symptoms were:

- need to beat her only son 3 years old;
- difficulty to sleep;
- need to burst with everyone;
- fear of night;
- rage of her husband;
- repulsion for her husband;
- unwillingness to speak to her husband.

After 3 sessions within 8 days, from 7 to 14 November 1978, she had to drop the treatment because her husband did not allow to continue psychotherapy, compelling her to search anly chemotherapy.

Follow-up 12 months later, gave an idea that the symptoms were remainning at the same level, without improvement.

CASE 78075

Female patient, 40 years old, married, administrative clerk.

Depression.

This patient had many marital and interpersonal difficulties and a constant depressive mood.

Her only daughter was always quarreling with her husband and sometimes had also bad relations with the patient.

Her self-reported symptoms were:

- feeling of tenseness;
- difficulty in accepting her husband's constant recrimination;
- difficulty in accepting her husband's callousness;
- difficulty in accepting her daughter's callousness.

This patient improved in 3 sessions within 16 days, from 21 November 1978 to 5 December 1978.

Follow-up 12 months later did not show increase of symptoms already withdrawled.

CASE 78076

Female patient, 10 years old, student.

School difficulties.

This patient began to have school difficulties and lapses of memory.

Asking for psychological help, her symptom was weak memory and some jealous behavior with her younger sister, 7 years old.

This case was improved with 5 sessions, in 36 days, from 25 November 1978 until 30 December 1978.

Follow-up 12 months later, indicated the stability of the improvement already achieved.

CASE 78077

Male patient, 9 years old, student.

Enuresis.

This boy after having been assisted by psychiatrists and psychologists was suffering from enuresis. His academic record was not good in the year before and his teacher was complaining about misbehavior.

His overprotective and authoritative mother indicated that his symptoms were:

- enuresis;
- restlessness;
- misbehavior;
- unwillingness to study.

This case was improved in 4 sessions within 29 days, from 5 December 1978 to 2 January 1979.

Follow-up 9 months later indicated no relapse of the symptoms and termination of enuresis.

CASE 79-001

Female patient, 47 years old, married.

Depression.

This patient asked for psychological treatment because she was in constant depression and in opposition to her only daughter, married at an early age with a boy whom the patient disliked. She was away from her husband who worked in another country as emigrant during the last 7 years.

After seeking chemotherapy and following it for years, without stable results in symptom removal, her self-reported symptoms were:

- feelings of dumbness;
- breathing difficulties;
- feelings of depression;
- sensation of nerve stretching at the left side of the neck;
- numbness at the left side of the mouth.

This case was improved in 29 sessions within 178 days, from 2 January 1979 until 23 June 1979.

Follow-up 6 months later did not show any relapse of symptoms.

CASE 78078

Male patient, 15 years old, student.

Tics (stammering)

This patient had a normal life during his childhood.

Since the age of 3 he began to stutter and perform some complicated tics with his eyes and head, and to emit some stereotyped sounds while talking.

This behavior increased with age and began to hinder his academic achievement.

He felt every time more and more insecure and less self confident, and self-assertive.

His self-reported symptoms were:

- need to make stereotyped movements (tics) with the head;
- feeling of nervousness among unknown **people;**
- **fear of attending telephone calls;**
- **fear of speaking in the classroom;**
- **fear of talking to unknown people.**

This case was improved in 18 sessions within 169 days, from 9 December 1978 until 26 May 1979.

Follow-up 6 months later, gave idea of improvement without any symptom substitution.

CASE 79004

Female patient,21 years old, student.

Depression.

This patient is the middle child in a family with other two siblings of whom the eldest is considered schizophrenic.

Her father is a troubled person and her mother abusing of alcohol, accuses the husband of marrying her more concerned about her money.

The patient tried suicide several times, dropped school and has been in psychiatric treatment in the last 6 years.

She used to sleep all the day and stay in her room all over.

Her father had a bad relationship with parents and his interpersonal relations with everyone at home are not much different.

Her self-reported symptoms were:

- listening to strange voices;
- inability to go around the streets crowded by many people;
- difficulty to close the eyes when at bed;
- need to crash the head rythmically against the cushion when at bed;
- inability to do something or to work;
- remorse of not doing something worthwhile;
- permanent nervousness;
- need to take excessive drugs to sleep;
- need to smoke marijuana;
- need to smoke usual cigarrettes haevily.

As soon as the patient began to remember repressed memories of her childhood, soon after the fourth session, symptoms began to decrease.

She remembered that her father desliked her and mother was in constant distress because of him. Her grandmother was ill treated by her father and at her death, she told the patient that she was suffering very much. The patient thought that her grandmother died with lack of medical care, but did not realize that she suffered from heart disease with probability of a heart stroke at any time.

When all these repressed memories were unburied and rationalized her symptoms began to decline very rapidly.

This case was improved in 14 sessions within 68 days, from 7 January 1979 to 11 March 1979.

Follow-up 9 months later indicated that the stabilization of symptoms already decreased, was good and that tha patient was working successfully in a shop.

CASE 79016

Male patient, 30 years old, single, administrative clerk.

Inferiority.

This patient complained about a depressive mood and feelings of inferiority at home and specially at work.

His self-reported symptoms were:

- shyness;
- anxiety;
- exaustion;
- nervousness;
- lack of self-assertion;
- difficulty in talking to people;
- difficulty in understanding;
- difficulty to learn;
- lack of self-control;
- headaches;
- tiredness in the head.

This patient improved in 3 sessions, within 50 days, from 30 January 1979 until 20 March 1979.

Follow-up 6 months later, gave indications of slow increase of early symptom withdrawl.

CASE 79017

Male patient, 15 years old, student.

School difficulties.

The patient is the younger son of a couple who live quarreling at every moment and has also another son, two years older than the patient.

The patient's relations with his father are not good and he feels also threatened in his security and self-assurance by his brother.

The patient in the year before began to have low academic achievement and for this reason, he was referred to a psychologist.

His self-reported symptoms were:

- unwillingness to study;
- repugnance to attend school;
- difficulty to understand his brother;
- difficulty in the interaction with father.

This case was improved in 14 sessions within 120 days, from 1 February 1979 until 31 May 1979.

Follow-up 6 months later indicated increase in the improvement already achieved.

CASE 79030

Male patient, 17 years old, student.

Depression.

This patient had difficulties in behavior during the last 3 years having been assisted by a psychiatrist. His behavior was inhibited and without self-confidence.

His self-reported symptoms were:

- difficulty in maintaining and initiating a friendship;
- difficulty in leaving an apathetic behavior;
- difficulty to speak;
- difficulty to sleep without tranquilizers and hypnotics;
- difficulty in maintaining attention over something;
- difficulty in pronountiation of certain words;
- difficulty in behaving with calm.

This case improved in 28 sessions within 304 days, from 3 March 1979 until 31 December 1979, but will be submitted to another kind of treatment.

CASE 79031

Male patient, 13 years old, student.

School difficulties.

This patient asked for psychological help because his school achievement was not good. He has a 3 years old younger sister.

His self-reported and mother-reported symptoms were:

- lack of interest for studies;
- nervousness;
- untidiness;
- annoyance with relation to sister.

This case was improved in 10 sessions within 78 days, from 10 March 1979 until 26 May 1979.

Follow-up 6 months later did not indicate relapse of symptoms.

CASE 79035

Female patient, 7 years old, student.

School difficulties.

This patient is an only child.

She asked for psychological help because she used to have low academic achievement, besides excessive shyness and withdrawl from other classmates.

Her self-reported symptoms were:

- excessive shyness;
- excessive over-dependence on mother;
- very low reading ability;
- lack of self-confidence;
- lack of self-assertion.

This case was resolved in 25 sessions over a period of 234 days, from 14 March 1979 until 5 November 1979.

CASE 79041

Male patient, 17 years old, student.

School difficulties.

This patient is the only son.

His mother is overprotective and overdirective even at home with her husband. She is a primary school teacher.

The patient, in high school, reported as self-evaluated symptoms:

- unwillingness to study;
- irritational mood;
- overexcitement;
- laziness.

This case was improved with 7 sessions, within 87 days, from 22 March 1979 until 16 June 1979.

Follow-up 6 months later indicated the continuation of improvement.

CASE 79045

Male patient, 16 years old, student.

Depression.

This patient had difficulties in terpersonal relationship and constant ideas of suicide and of escape from home.

His self-reported symptoms were:

- boredom at school;
- fear of unknown;
- plea against society;
- nervousness;
- hate about school subjects and disciplines;
- lack of self-control;
- difficulties in attention span.

This case improved in 5 sessions within 42 days, from 4 April 1979 until 15 May 1979.

Follow-up 6 months later indicated the maintenance of improvement already achieved.

CASE 79047

Female patient, 20 years old, single.

Inferiority.

This patient was referred by a psychiatrist for psychotherapy. She had many interpersonal relations difficulties not only with her alcoholic father but also with other people and children she used to care of.

Her self-reported symptoms were:

- feelings of inferiority;
- nervousness;
- worries about her past errors;
- insecurity and lack of self-assertion.

This case improved with 3 sessions within a range of 15 days, from 5 April 1979 to 19 April 1979.

Follow-up of 6 months did not show any relapse of symptoms.

CASE 79049

Male patient, 15 years old, student.

School difficulties.

This patient asked for psychological help because failed to achieve academically.

His self-reported symptoms were:

- difficulty to study;
- difficulty in behaving properly;
- need to lie;
- need to have much money in the purse;
- need to swear;
- need to read infantile books;
- compulsion to close all the doors at home;
- lack of attention at school;
- need to bite the nails.

This case was improved in 10 sessions within 122 days, from 5 April 1979 until 4 August 1979.

Follow-up 3 months later indicated withdrawl of symptoms.

CASE 79050

Female patient, 14 years old, student.

Obcessions-compulsions.

This patient began to feel compulsion some 6 months before and her mother asked for psychological help when the patient initiated obcessive behaviors of washing her hands.

Her self-reported symptoms were:

- trembling of the wrist while writing;
- need to bite the nails;
- fear of dirt;
- difficulty in manual work;
- nervousness;
- difficulty to concentrate attention;
- compulsion to keep things in the right place;
- compulsion to wash the hands frequently.

This case was improved within 9 sessions in 122 days, from 5 April 1979 until 4 August 1979.

Follow-up 3 months later did not show relapse of symptoms or its substitution by other ones.

CASE 79051

Male patient, 12 years old, student.

School difficulties.

This patient asked for psychological help because of his low achievement in school.

His father married second time, having divorced the boy's mother for reason od adultery.

The coming of a new baby upset the patient who began to fail in school matters.

His symptomathology of inability to hold attention even over a short period of time, began to decrease and the case improved in 4 sessions, within 51 days, from 10 April 1979 until 30 May 1979. Follow-up 6 months later assured the withdrawl of symptoms and good scholastic achievement.

CASE 79053

Female patient, 29 years old, married, bank clerk.

Depression.

This patient, married to another bank clerk working in the same institution, began to feel depressed soon after the birth of her second child. Since then in the next 4 years, she had yearly depressions every winter.

Her parents lived with the couple for a time and her husband does not like to maintain interpersonal relations with them.

The patient on account of her very much stressed life, and the detachement she feels from her husband about her, began to have ciclic depressions. She used to feel a little better during summer and then, begin to worsen until winter, when she collapsed.

This case improved with 18 sessions within 296 days, from 10 April 1979 until 31 December 1979.

The patient will be treated now in a different therapeutic approach.

CASE 79058

Female patient, 10 years old, student.

School difficulties.

Her mother asked for psychological help because the patient, besides having school difficulties, tried once to flee from home after having stollen some money.

Her parents were quarreling always and her granmother used to depreciate her mother.

The patient reported the following symptoms:

- need to flee from home;
- lack of will to study;
- nervousness.

This case was improved in 9 sessions, within 64 days, from 21 April 1979 to 23 June 1979.

Follow-up 6 months later indicated improvement and complete withdrawl of symptoms.

CASE 79059

Female patient, 29 years old, married.

Depression.

This patient, since her chilhood, had very bad interpersonal relations with her father who did not allow her to porsue studies because they were poor. She married early and has a daughter. At the begining of married life, her husband was comissioned for a 2 years army post in another country. During this time she had to live with her mother-in-law who was divorced and living with another man, who tried once to assault and rape the patient. As soon as her husband was back home, they tried to house elsewher Now the patient feels anxious, very stern with her daughter and constantly depressed. She had psychiatric help in the last 2 years but had no withdrawl of the following self-reported symptoms

- feelings of compression in the throath;
- pain at the back of the neck;
- need to burst verbally;
- nervousness;
- feeling of life stopping;
- need of loneliness;
- disgust about the place where she lives;
- disgust in having to shop at the place where she lives;
- feeling of lack of communication with the husband.

This case was improved with 11 sessions in 99 days, from 24 April 1979 until 31 July 1979.

Follow-up 3 months later presented stabilization of symptoms

CASE 79061

Male patient, 7 years old, student.

School difficulties.

This only child from a very much nervous and emotionally tis-

turbed couple, began to have the following symptoms:

- reading difficulties;
- restlessness;
- behavior problems.

This case was improved in 8 sessions within 235 days, from 27 April 1979 until 17 December 1979.

CASE 79006

Female patient, 24 years old, single.

Depression.

This patient was a refugee, with many difficulties of addaptation and social interaction.

Having an affair with a married man, she never attained orgasm, and her sexual relations were painful. After 3 years of chemotherapy she asked for psychotherapy. Her self-reported symptoms were:

- nervousness;
- lack of sexual enjoyment;
- sorrow because her partner does not want to join her family;
- headaches.

This case was improved in 13 sessions during 105 days, from 15 May 1979 until 28 August 1979.

Follow-up 3 months later, indicated the stabilization of symptoms, with the improvement already achieved .

CASE 79070

Male patient, 9 years old, student.

Enuresis.

This little boy had other 3 youngster siblings.

His mother very much concerned about his bed-wetting, tried to seek psychological help, stating that the symptom, besides enuresis, was desobedience.

This case was improved and resolved in 9 sessions, within 184 days, from 17 May 1979 until 16 November 1979.

Follow-up indicated no relapse or substitution of symptoms.

CASE 79071

Male patient, 49 years old, collonial administrative officer.

Depression and insomnia.

This patient complained only that he could not sleep.

Besides it, his self-reported symptoms were:

- inability to sleep;
- inability to stay quiet and restlessness;
- anxiety;
- wind;
- fear of walking in the street;
- fear of everything;
- lack of apetite.

This case was referred to a gastroentherologist, soon after blood and urine examinations were concluded.

Improvement was attained in some of the symptoms, specially insomnia, after 8 sessions, during 33 days, from 17 May 1979 to 19 June 1979.

Follow-up 3 months later, indicated improvement acceleration after medical treatment for his digestive difficulties.

CASE 79073

Female patient, 20 years old, student.

Inferiority feelings.

This patient is the only child from a couple of manual workers. She had a "normal" childhood and infancy but his academic record was not good.

Since the age of 12 she began to suffer from epilepsy and sometimes misbehavior at home and school.

She asked for psychological help complaining about the following symptoms:

- not being understood by other people;
- feelings of inferiority; ugliness;
- feelings of unworthiness for everything;
- feelings that other people despised her;
- feelings of uneasiness with people of her age;
- feelings that other people teased her.

This case which was tackled by neurologists and psychiatrists in the 2 years before, was resolved in 15 sessions within 211 days, from 24 May 1979 until 20 December 1979.

CASE 79076

Male patient, 13 years old, student.

School difficulties.

This patient had difficulties in scholastic achievement in the senior secondary school, soon after his parents divorced to build new homes.

His blood sister lived with his father with a daughter from his new wife.

The patient lived with his mother, who had another son from her new husband.

His self-reported symptoms were:

- need to stay near his sister;
- lack of attention in classroom;
- lack of memory for school duties;
- grief about parent's divorce.

During the school year he used to be absent from class, staying with his sister all the day who attended school in the evening. His abcenses to class were sufficient enough to make him fail the year.

This case improved in 20 sessions within 154 days, from 29 May 1979 until 31 October 1979.

TABLES

Therapeutic resumes are shown in tables

The following abbreviations are used

A = age

D = Number of days during which the therapy was conducted

Dates = date of begining and of end of the therapy

F-up = number of follow-up months

S = sex

T = number of therapeutic sessions, of more or less 50 minutes

In the therapeutic outcomes:

A = abandonned

I = Improved

R = Resolved

TABLE I (1)

	Case	S	A	Difficulty	T	D	Outcome	Dates	F-up
1.	76-002	M	12	School	12	154	Resolved	7JAN76-10JUN76	24
2.	004	F	15	Depression	10	56	Resolved	26JUL76-20SEP76	24
3.	007	F	40	Depression	18	245	Improved	6SEP76- 8MAY77	24
4.	009	M	26	Inferiority	19	169	Resolved	11NOV76-28MAY77	24
5.	77-006	M	8	School	11	85	Improved	18FEB77-13MAY77	24
6.	008	M	9	School	3	106	Improved	15MAR77-28JUN77	24
7.	013	M	10	School	6	36	Improved	10JUN77-21JUL77	24
8.	020	F	40	Depression	6	175	Improved	21JUN77-12DEC77	24
9.	021	M	31	Obssession	5	57	Improved	28JUN77-23AGO77	24
10.	023	F	15	Depression	5	29	Improved	5JUL77- 2AGO77	24
11.	030	M	55	Phobia	16	183	Improved	2AGO77-31JAN78	18
12.	036	F	40	Depression	11	195	Improved	31AGO77-13MAR78	18
13.	038	F	17	Behavior	8	50	Improved	6SEP77-25OCT77	24
14.	045	M	20	Depression	21	513	Resolved	26SEP77-20FEB79	9
15.	046	F	40	Depression	11	77	Abandon.	27SEP77-12DEC77	-
16.	047	M	17	Depression	40	227	Improved	11JUL77-22FEB78	6
17.	050	M	45	Depression	51	805	Abandon.	18OCT77-31DEC79	-
18.	053	M	43	Depression	12	96	Improved	20OCT77-27JAN78	18
19.	055	M	15	School	40	547	Improved	8NOV77- 8MAY79	6
20.	057	M	9	School	12	162	Resolved	8NOV77-18APR78	18
21.	058	F	52	Depression	21	170	Resolved	22NOV77- 6JUN78	18
22.	062	M	18	Inferiority	9	52	Resolved	15DEC77- 4FEB78	18
23.	063	F	38	Depression	3	18	Improved	19DEC77- 5JAN78	18
24.	78-001	M	14	School	7	50	Abandon.	3JAN78-21FEB78	-
25.	003	F	45	Depression	32	200	Abandon.	23JAN78-10AGO78	12
26.	012	M	16	Behavior	13	281	Improved	28FEB78- 5DEC78	12
27.	016	F	36	Depression	11	44	Improved	8MAR78-17APR78	18
28.	018a	M	9	School	16	141	Resolved	11MAR78-29JUL78	12
29.	018b	M	8	Tics	10	78	Resolved	13MAY78-29JUL78	12
30.	023	F	9	Phobia	9	141	Resolved	4APR78-22AUG78	12
31.	025	M	15	Inferiority	44	676	Improved	5APR78-31DEC79	-
32.	028	M	47	Inferiority	3	28	Abandon.	18APR78-16MAY78	-
33.	031	F	28	Inferiority	3	22	Abandon.	20APR78-11MAY78	-
34.	038	M	19	Inferiority	4	30	Abandon.	23MAY78-17JUN78	-
35.	041	F	25	Depression	6	58	Resolved	7JUN78- 3AUG78	12

TABLE I (2)

	Case	S	A	Difficulty	T	D	Outcome	Dates	F-up
36.	78-042	F	37	Depression	6	43	Abandon.	15JUN78-27JUL78	12
37.	047	F	18	Depression	23	212	Improved	4JUL78-16JAN79	9
38.	048	M	12	School	5	64	Abandon.	11JUL78-12SEP78	-
39.	050	M	33	Inferiority	12	176	Resolved	25JUL78-16JAN79	9
40.	053	F	40	Depression	9	78	Improved	22AUG78- 7NOV78	12
41.	061	M	13	School	5	28	Improved	25JUL79-21AUG79	3
42.	063	F	14	Behavior	10	71	Improved	30CT78-12DEC78	12
43.	065	M	48	Depression	12	85	Improved	100CT78- 2JAN79	9
44.	067	M	9	School	14	169	Resolved	170CT78- 3APR79	6
45.	072	F	28	Depression	3	8	Abandon.	7NOV78-14NOV78	12
46.	075	F	40	Depression	3	16	Improved	21NOV78- 5DEC78	12
47.	076	F	10	School	5	36	Improved	25NOV78-30DEC78	12
48.	077	M	9	Enuresis	4	29	Improved	5DEC78- 2JAN79	9
49.	078	M	15	Tics	18	169	Improved	9DEC78-26MAY79	6
50.	79-001	F	47	Depression	29	179	Improved	2JAN79-28JUN79	6
51.	004	F	21	Depression	14	68	Improved	7JAN79-11MAR79	9
52.	016	M	30	Inferiority	3	50	Improved	30JAN79-20MAR79	6
53.	017	M	15	School	14	120	Improved	1FEB79-31MAY79	6
54.	030	M	17	Depression	28	304	Improved	3MAR79-31DEC79	-
55.	031	M	13	School	10	78	Improved	10MAR79-26MAY79	6
56.	035	F	7	School	25	234	Resolved	14MAR79- 5NOV79	-
57.	041	M	17	School	7	87	Improved	22MAR79-16JUN79	6
58.	045	M	16	Depression	5	42	Improved	4APR79-15MAY79	6
59.	047	F	20	Inferiority	3	15	Improved	5APR79-19APR79	6
60.	049	M	15	School	10	122	Improved	5APR79- 4AUG79	3
61.	050	F	14	Obssession	9	122	Improved	5APR79- 4AUG79	3
62.	051	M	12	School	4	51	Improved	10APR79-30MAY79	6
63.	053	F	29	Depression	18	296	Improved	10APR79-31DEC79	-
64.	058	F	10	School	9	64	Improved	21APR79-23JUN79	6
65.	059	F	29	Depression	11	99	Improved	24APR79-31JUL79	3
66.	061	M	7	School	8	235	Improved	27APR79-17DEC79	-
67.	066	F	24	Depression	13	105	Improved	15MAY79-28AUG79	3
68.	070	M	9	Enuresis	9	184	Resolved	17MAY79-16NOV79	-
69.	071	M	49	Depression	8	33	Improved	17MAY79-19JUN79	3
70.	073	F	20	Inferiority	15	211	Resolved	24MAY79-20DEC79	-
71.	076	M	13	School	20	154	Improved	29MAY79-31OCT79	-

TABLE II (a)

School difficulties

	Case	S	A	Outcome	T	D
1.	76-002	M	12	R	12	154
2.	006	M	8	I	11	85
3.	008	M	9	I	3	106
4.	013	M	10	I	6	36
5.	055	M	15	I	40	547
6.	057	M	9	R	12	162
7.	78-001	M	14	A	7	50
8.	018a	M	9	R	16	141
9.	048	M	12	A	5	64
10.	061	M	13	I	5	28
11.	067	M	9	R	14	169
12.	076	F	10	I	5	36
13.	79-017	M	15	I	14	120
14.	031	M	13	I	10	78
15.	035	F	7	R	25	234
16.	041	M	17	I	7	87
17.	049	M	15	I	10	122
18.	051	M	12	I	4	51
19.	058	F	10	I	9	64
20.	061	M	7	I	8	235
21.	076	M	13	I	20	154

Male= 18

Female = 3

Mean age = 11,38

Resolved = 5

Improved = 14

Abandonned = 2

Mean nº sessions = 12,15

Mean nº of days= 129,66

In TABLE II the following abbreviations are used for the outcomes:

R = resolved case

I = case improved

A = case abandonned by the patient

TABLE II (b)

Depression

	Case	S	A	Outcome	T	D
1.	76-004	F	15	R	10	56
2.	007	F	40	I	18	245
3.	77-020	F	40	I	6	175
4.	023	F	15	I	5	29
5.	036	F	40	I	11	195
6.	045	M	20	R	21	513
7.	046	F	40	A	11	77
8.	047	M	17	I	40	227
9.	050	M	45	A	51	805
10.	053	M	43	I	12	96
11.	058	F	52	R	21	170
12.	063	F	38	I	3	18
13.	78-003	F	45	A	32	200
14.	016	F	36	I	11	44
15.	041	F	25	R	6	58
16.	042	F	37	A	6	43
17.	047	F	18	I	23	212
18.	053	F	40	I	9	78
19.	065	M	48	I	12	85
20.	072	F	28	A	3	8
21.	075	F	40	I	3	16
22.	79-001	F	47	I	29	179
23.	004	F	21	I	14	68
24.	030	M	17	I	28	304
25.	045	M	16	I	5	42
26.	053	F	29	I	18	296
27.	059	F	29	I	11	99
28.	066	F	24	I	13	105
29.	071	M	49	I	8	33

Male= 8

Female = 21

Mean age= 32.89

Resolved = 4

Improved = 20

Abandonned = 5

Mean nº of sessions = 14,04

Mean nº of days = 117.62

TABLE II (c)

Inferiority feelings

	Case	S	A	Outcome	T	D
1.	76-009	M	26	R	19	169
2.	77-062	M	18	R	9	52
3.	78-025	M	15	I	44	676
4.	-028	M	47	A	3	28
5.	031	F	28	A	3	22
6.	038	M	19	A	4	30
7.	050	M	32	R	12	176
8.	79-016	M	30	I	3	50
9.	047	F	20	I	3	15
10.	073	F	20	R	15	211

Male= 7
Female = 3
Mean age = 26.6
Resolved = 4
Improved = 3
Abandonned = 3
Mean nº sessions = 15.o
Mean nº of days = 192.71

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TABLE II (d)

Obssession-compulsion

	Case	S	A	Outcome	T	D
1.	77-021	M	31	I	5	57
2.	79-050	F	14	I	9	122

Male= 1
Female = 1
Mean age = 22.5
Resolved = 0
Improved = 2
Abandonned = 0
Mean nº sessions = 7
Mean nº of days = 89.5

TABLE II (e)

Phobias

	Case	S	A	Outcome	T	D
1.	77-030	M	55	I	16	183
2.	78-023	F	9	R	9	141

Male = 1
Female = 1
Mean age = 32.0
Resolved = 1
Improved = 1
Abandonned = 0
Mean nº sessions = 12,5
Mean nº of days = 162

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TABLE II (f)

Behavior problems

	Case	S	A	Outcome	T	D
1.	77-038	F	17	I	8	50
2.	78-012	M	16	I	13	281
3.	063	F	14	I	10	71

Male= 1
Female = 2
Mean age = 15.6
Resolved = 0
Improved = 3
Abandonned = 0
Mean nº sessions = 10.3
Mean nº of days = 134.0

TABLE II (g)

Tics

	Case	S	A	Outcome	T	D
1.	78-018b	M	8	R	10	78
2.	078	M	15	I	18	169

Male= 2
Female = 0
Mean age = 11.5
Resolved = 1
Improved = 1
Abandonned = 0
Mean nº sessions = 14
Mean nº of days = 123.5

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TABLE II (h)

Enuresis

	Case	S	A	Outcome	T	D
1.	78-077	M	9	I	4	29
2.	79-070	M	9	R	9	184

Male = 2
Female = 0
Mean age = 9.0
Resolved = 1
Improved = 1
Abandonned = 0
Mean nº sessions = 6.5
Mean nº of days = 106.5

TABLE III

resume of therapeutic approach

	School difficulties	Depression	Inferiority feelings	Obsession-compulsion	Phobias	Behavior problems	Tics	Enuresis
Total nº of cases	21	29	10	2	2	3	2	2
Male percentage	86	28	70	50	50	67	100	100
Female percentage	14	72	30	50	50	33	0	0
Mean age	11	33	27	23	32	16	12	9
Resolved cases %	24	14	40	0	50	0	50	50
Improved cases %	67	69	30	100	50	100	50	50
Abandonned cases %	9	17	30	0	0	0	0	0
Mean nº of sessions	12	14	15	7	13	10	14	7
Mean nº of days	129	118	193	90	162	134	124	107

TABLE IV

Resume of outcome percentages

	Resolved			Improved			Abandon.			TOTAL		
	M	%	F	M	%	F	M	%	F	%	M	F
School	4	24	1	12	67	2	2	9	0	29	18	3
Depression	1	14	3	6	69	14	1	17	4	41	8	21
Inferiority	3	40	1	2	30	1	2	30	1	14	7	3
Obsession	0	0	0	1	100	1	0	0	0	3	1	1
Phobia	0	50	1	1	50	0	0	0	0	3	1	1
Behavior	0	0	0	1	100	2	0	0	0	4	1	2
Tics	1	50	0	1	50	0	0	0	0	3	2	0
Enuresis	1	50	0	1	50	0	0	0	0	3	2	0
Male/female	10		6	25		20	5		5		40	31
% and total		16 23			45 63			10 14		100		
% M/F	62		38	56		44	50		50		56	44

TABLE V

Comparative table of

resolved, improved and abandoned cases

		School	Depression	Inferiority	Obssesion	Phobia	Behavior	Tics	Enuresis
Nº of cases		21	29	10	2	2	3	2	2
Percentage		29	41	14	3	3	4	3	3
Resolved	Sessions	15,8	14,5	13,8	0	9	0	10	9
	days	172	196	152	0	141	0	78	184
	age	9,2	28,o	24,o	0	9,o	0	8,o	9,o
	cases	5	4	4	0	1	0	1	1
	M/F	4/1	1/3	3/1	0/0	0/1	0/0	1/0	1/0
Improved	Sessions	10,8	14,o	16,7	7,o	16,o	10,3	18,o	4,0
	days	125	132	247	90	183	134	169	29
	age	11,9	32,4	21,7	22,5	55,o	15,7	15,o	9,o
	cases	14	20	3	2	1	3	1	1
	M/F	12/2	6/14	2/1	1/1	1/0	1/2	1/0	1/0
Abandonned	Sessions	6	20,6	3,3	0	0	0	0	0
	days	57	227	27	0	0	0	0	0
	age	13,6	39,o	31,3	0	0	0	0	0
	cases	2	5	3	0	0	0	0	0
	M/F	2/0	1/4	2/1	0/0	0/0	0/0	0/0	0/0

TABLE VI

		Resolved	Improved	Abandonned	
Nº of cases		16	45	10	
Nº of sessions	minimum	6	3	3	
	mean	13.8	12.5	12.5	
	maximum	25	44	51	
Nº of days	minimum	52	15	8	
	mean	167	133	133	
	maximum	513	676	805	
AGE	minimum	7	7	12	
	mean	17.5	23.3	31.5	
	maximum	52	55	47	
SEX	male	10	25	5	40
	female	6	20	5	31
	percentage	23	63	14	100

ONE TYPICAL CASE

Case 76009. Male patient, administrative clerk. On the 11th November 1976, he was 26 years old.

This patient discussed with his girl-friend and tried to strangle her after a discussion (Noronha, 1979b). As soon as he saw her fainting, he fainted too and both were carried to hospital urgency service, where he was hept under medical observation and treatment in a psychiatric ward.

On 11th November he was interviewed by the psychologist. This patient had tried earlier twice to kill his girl-friend.

His father was epileptic and soon after the patient's birth, he was admitted into a psychiatric hospital.

His mother divorced and married another man with whom she lives and with two more children. The patient was raised by his grandmother to whom he is very much attached. From 8 to 15, he was educated in a boarding school where he was not able to make friends.

From 16 onwards, the patient began to work as administrative clerk and from 21 onwards he served in the Army being detached during two years in Mozambique. As soon as he returned to Portugal, he joined his former civil service.

He began dating a girl at the age of 18 and continued to maintain with her sexual relations until the date of the interview.

He did not like his school years and as he joined the Army, everything learned at the High School seemed to him crazy.

He loved to be in the military service and declared that many new and valuable things were learned during that time.

As soon as the therapy began, he was trained to elicit positive affects associated with:

- military service at Mozambique;
- holidays , movies and conversation with his fiancé;
- ability to overpass most of his problems.

As ansiogenic scenes to elicit negative affects, we used

- discussions with a medical student, his relative;
- failure in a foot-ball game;
- depreciation of a photograph, by his grandmother;
- fear of psychological assessment done when he was very young in order to decide about electroconvulsive treatment;
- girl-friend being flattered by other young man;
- insults and inferiorizations;
- playground or recess at the school where he was educated;
- girl-friend in the arms of a lover.

The patient was initially trained to relax after being able to breathe properly. Then he learned to elicit positive affects and after to elicit negative affects.

In the initial sessions, the patient used to remember unpleasant memories after having elicited negative affects for one minute and did the contraction/release of muscles; but as the time went on, the memories faded away and were substituted by other kind of memories either neutral or pleasant.

In the middle of the 6th sessions, after the elicitation of negative affects and muscular contraction/release, the patien

claimed that he had a violent headache. Trying to relax him even more, he could remember a repressed memory about his total rejection at the school where he was educated. No one would like to play with him and he had as his only friend a little dog

Soon after he could remember about his grief for not having a mother or father who could visit him at school and feel what he used to feel when he was young and almost abandonned by his family, he began to relax more and more. He was treated as feebleminded and ultimately labeled as psychopath during the last two years before this incident, and treated psychiatrically as so.

The case began to evolve favourably and in 19 weeks his self-evaluated symptoms dropped from 8 to 1 and stood even lower during the following 24 months of follow-up.

His relations with other people began to improve and his girl-friend was not so frightened about him.

He is now trying to maintain good relations with his father who is in a Institution for the elderly, never having seen his son since he was 2 years old.

The following graphic indicates his symptoms mentioned in the case description, at the page 47. The vertical lines indicate the week in which the self-evaluation was done. The left line indicates the week 0 and each vertical trace to the right indicates one week. The horizontal lines indicate the values of the eleven point scale used in this study.

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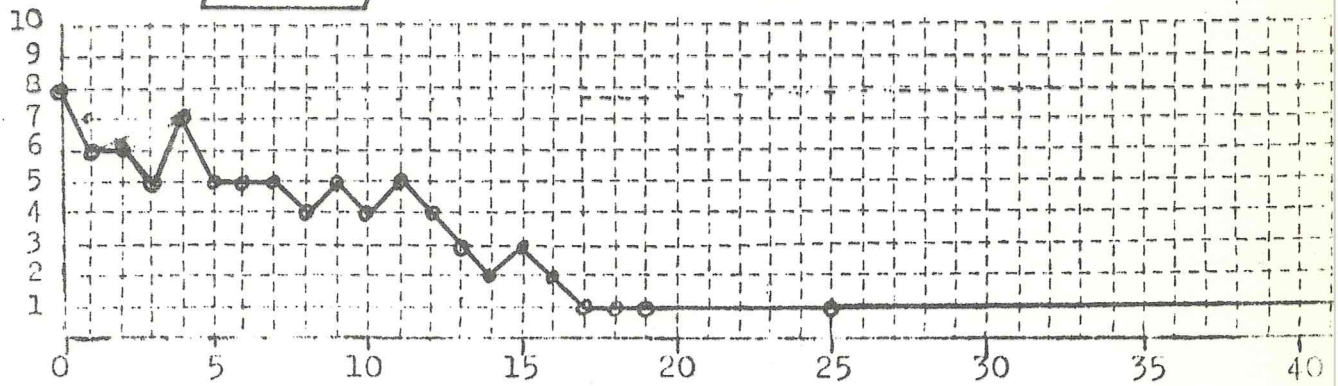
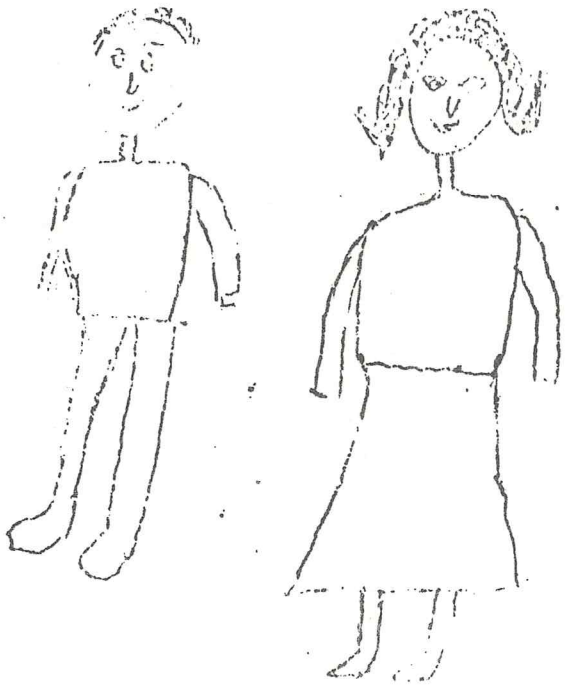


Patient's drawings: left side on 11 November 1976
right side on 9 March 1979



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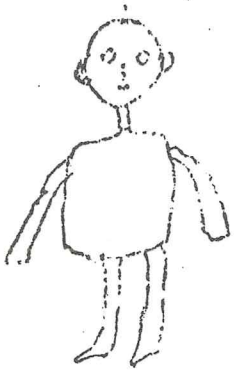

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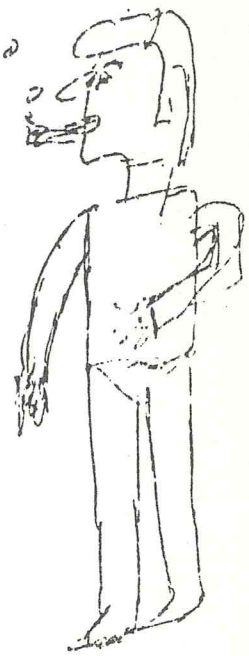

Lisboa, 11 de Novembro de 1976

CONCLUSION

Examining the tables we can see that there are more patients considered depressives than of any other type. Also their age is the highest.

In second place, we have school difficulties with patients of the lowest age.

In third place, we see feelings of inferiority with mean age between these two types.

Trying to conclude something from these findings can we say that children who begin to have school difficulties, sometimes without intelectual impairement, and who cannot afford to get therapeutic help may become adolescents with inferiority problems? Can we further hypothesize that some who advance hardly through their academic years and adolescence, as soon as reach the professional world and adulthood feel unfulfilled and depressed?

In this study all patients who asked for help were admitted without any kind of selection as happens in psychoanalysis and many other psychotherapies. Our foundamental aim was to test the therapeutic approach and its strength to deal undescriminately with any case in any moment of life. We think that we could fulfill this goal.

Comparing the dropouts, inferiority feelings had more dropouts than depression and school difficulties, but the resolved cases are higher in school difficulties than in depression.

In improvements, we see that depressed people as soon as improve, give up therapy; would they get secondary reinforcement within their environmental boundries?

Improvement for us is a very positive factor, because a mean of 15 sessions for difficult cases that had looked for psychiatrist's help and treatment during the former years without alleviation of their symptoms, is a very low number of sessions, when compared specially with the once a week treatment for several years which people used to have sometimes, with the adjunction of drug therapy.

The reabilitation of children's school problems is very scarce in Portugal, not to say inexisting. This might have widened the scope of adolescents and adults with problems of inferiority and depression, not being able to bear the frustration of life and not having a worthy image of themselves.

In therapy, we stressed the EGO strengthening and the unburial of pleasant memories for resolution of frustration and self-image worthiness.

We would like to stress also that if we could more easily tackle and resolve the school difficulties, the number of patients with feelings of inferiority and depression would diminish.

As school difficulties have been resolved with less patients than inferiority or depression, it would be less expensive. Since this action is oriented to a lower age, people would be able to have a wider scope of healthy years.

This would be a program to be established by schools:

have enough psychologists available to handle immediately children's problems to prevent the proliferation of adults with feelings of inferiority and depression.

The time consumed is not significantly different, but in an overall view, there are more dropouts among the depressives and people with inferiority feelings, than children.

With all the limitations that a private clinical practice may impose, we would like to diminish the rate of dropouts and increase the rate of resolved cases narrowing, if possible, the time consumed in therapy.

This would need a different approach: to motivate the patient to collaborate better in the therapy which, in turn, must be more effective.

Since our early investigations we tried always to motivate the patient in order to diminish the dropout either because of relaxation exercises required to be done at home, or because of the length of therapy which for some people has to be transformed in time and money.

Our first concern about time, has been now resolved with an hypnotherapeutic approach. Hypnosis can diminish the time consumed with relaxation and increase its effectiveness.

The concern about money has been also diminished because the speed in the therapeutic resolution will be translated into a less burdensome budget for the same results as the formor ones.

Besides it, patients who get tired with lengthy thera-

pies, will be satisfied with the new therapeutic approach that is being now developped with the aid of hypnosis.

Another economic measure which might be taken is to train subjects in groups to initiate relaxation or trance state. This would cut down therapist's time and probably be more effective with some patients who are more prone to vicarious reinforcement.

The other innovation which could be introduced in a future better designed and a more profound research, limited to fewer subjects, is the correlation of initial assessment -personality, motivation, inteligence, and sensitivity- with the final outcome -amount of symptom decrease and time consumed in therapy.

If a group of psychologists do so, a quicker and more expedite psychological therapy may be devised and improved in order to give the countries with shortages in manpower, means of alleviating the psychological ailments of their citizens.

Summarizing all the therapeutic procedures, we can delineate it as:

- learn to breathe slow and deeply, holding the breathe for a a while when the lungs are full and when they are empty;
- learn to elicit positive memories while the eyes are closed;
- learn to inhale thoroughly, hold the breath and contract totally all the muscles until there is need of expelling the air with the sudden release of muscles;
- if necessary the therapist will help the patient to elicit negative affects until they are completely overcomed by posi-

tive ones;

- when one has more positive than negative affects, his health is good and his psychological balance is sound.

We are expecting to have someday opportunity to gather in a whole wide frame of work all the knowledge and benefits that the behavior modification, personality assessment, intelectual evaluation, motivation, hypnosis, analytic theory and psychopathology can offer in order to alleviate human suffering and to improve the quality of life one has on the face of earth.

Only with a healthier humanity we will be able to avoid war, starvation, poverty and psychological maladjustment.

This is the heading we are trying now to maintain.

Portugal, MARCH 1980.

See references / bibliography

AFFECTIVE BALANCE THERAPY

Thesis dissertation for the degree of
Philosophy doctor in clinical psychology

CALIFORNIA CHRISTIAN UNIVERSITY - U.S.A.

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HUMAN RELATIONS

Whereas other animals cannot alter themselves except by changing their species, man can transform himself by transforming the world and can structure himself by constructing structures, and these structures are his own, for they are not eternally predestined either from within or from without (Piaget, 1972).

These individual structures of our own are in constant change, through the dynamic interaction with each other and with the milieu. So, instead of victims, we may become masters of our fate (Shotter, 1974) because, if the structures change at every time in a direction which is not predestined, it is reasonable that we have something to do with this direction which, in ultimate, will depend on the quality and quantity of interaction we are able to maintain. We can see therefore how the interaction is processed and what are the predictable results.

As the introspective method of Wundt and his successors (Guillaume, 1967) gave no possibilities in assigning the correct and objective report of events in the internal and external world, experiments had to take place and to fulfill the gap between the internal and external worlds and report of events.

As reasonable human beings, we all must be able to distinguish between that which we, as individual personalities, are responsible and that which merely happens, irrespective of our agency, stating a clear distinction between actions and events,

doings and happenings (Shotter, 1974).

Unlike actions, events just happen, they are no one's responsability; and they are not, of course, to be explained by seeking their reasons. As Popper (1972) has stated, there is a distinction between natural and cultural worlds and we would say that the natural world is a world almost made of events and the cultural world essentially made of actions. And man lives always in a cultural world which influences him althrough having been created by his action: art, religion, experimentations, observations, values, beliefs, etc..

To understand better and draw theories from experimental findings in social psychology -psychology of human interaction- the researchers tried the experimental method, but the gap between the laboratory and the real world seemed to be involving difficulties of conceptualizing, operationalizing and controlling variables (Rester and Walton, 1974). This theoretical problem is tried to solve actually creating artificial situations whereby phenomena like agression, are isolated and controlled concentrating on techniques which allow some rating measurements at individual level.

One of the most fascinating and also most controversial phenomenon in the social interaction is the conformism, well studied experimentally by Stanley Milgram (1975). According to him "first you keep your eyes open; then generalize on the basis of numerous specific incidents; try to determine wether particular incidents lead up to definable pattern; attempt to find an underlying coherence beneath the myriad surface phenomena in a par-

ticular city, generalize from your experience and make a hypothesis becoming systematic about it. You ask people what specific incidents seem to them to characterize a particular setting and you see wether any patterns or dimensions emerge".

Milgram (1975) says that psychologist also tries to measure features like pace, friendliness, diversity which correspond to one urban setting and differ from the next. He once stated that "I view man not as an isolated psychological entity but as an adaptive organism living in association with and reacting to his fellow men" and this view prevades his subsequent work on obedience.

We can rate obedience as simple compliance which makes an individual yield to group pressures at overt and public level but his original attitudes or desires are maintained (Worchel and Cooper, 1976). Although obedience can keep one out of deindividuation, a constant and almost continuous obedience may change one individual into a conformist. How is it possible to shape a conformist behavior?

One of the approaches is based on personality theories which state that certain types of personalities are likely and predictable to conform. Crutchfield (Worchel and Cooper, 1976) says that individuals who are less inteligent, with less leadership ability, feelings of inferiority, little ego strength, little ability to tolerate one's own impulses and ambiguity, little insight and willingness to accept responsability,less spontaneity and originality and more prejudiced authoritarian attitudes

are more prone to be conformists than others. Nevertheless, following studies have shown that all the conformists are not intelligent and maladjusted individuals and that personalities of conformists and non conformists are alike, making difficult a feasable predictability.

Other theories like group pressure, say that the group, besides the informational influence, has an additional pressure capacity to "persuade" the individual to conform with the positive expectations of another labeled as "normative social pressure" (Deutsch and Gerard, 1955). Anyone who wants to remain in a group, knows the anxiety aroused by the thought that the group might reject him and tries to avoid this painful situation conforming to the group norms. A handful of measures can be taken by the group members against a non conformist: denial of power to vote, physical or psychological abuse, unflattering names, etc. So the individual believing that deviancy from the group may lead to rejection, feels pressure to conform to the group model. We see how deviants are banned and how the once non conformists who begin to agree with the group norms and requirements, are praised and positively reinforced (Schacter, 1951).

From research done by Schacter, Milgram and other social scientists, we can draw the hypothesis that behavior conformity depends on three major factors:

a) individual's characteristics;

b) group's characteristics;

c) task's specific situation.

An individual with a certain type of characteristics, in a certain type of groups, can be predicted as having a specific conformist or non conformist behavior. Milgram (1974) also points out the four basic predictions which begin and alter the conformist behavior in his experiments:

1. Obedience decreases when the victim ~~when the victim~~ is in the same room as the teacher and decreases further, when the teacher has to touch the victim to administer the shock; impersonality without anyone ever seeing the victim —like dropping bombs or hurting someone manipulating a switch— heightens the odedient behavior.
2. Obedience drops sharply when the experimenter is absent while in his presence people feel the authority behind them to commit acts which are considered immoral.
3. Obedience drops when the subject is in a group of rebellious peers who give support for desobedience.
4. Obedience increases when the subject is merely an accessory to the crime and when one is not compelled to take action by himself.

While Milgram conducts experiments in finding why and how things happen as they do, Bandura, Ross and Ross (1961), try to find out how behaviors can be modified through imitation. Just as one's agressive behavior can be modelled by positive vicarious reinforcement (Bandura and Walters, 1963), the conformity behavior can also be modelled through the mediating condition of positive vicarious reinforcement films and other audio visual or in vivo

social means.

Milgram (1975) says, that embarassment often locks us into intolerable predicaments and that we are creatures entwined in a web of social restraints. Who establishes and maintains the social restraints? We will imediately answer: "they", "the social environment". But who are "they" when we are not the subject? Are we not forming sometimes the "they"? Just as Milgram (1975) and his students had difficulty in asking "Excuse me sir, may I have your seat?" the one who was seated should have similar difficulty in a similar situation. And just as the gentleman got up and gave the seat. Milgram and his students would probably do the same. We would like to reach the point where most of the behaviors that we are researching on other people, could be found on us if we hould have the capacity of a clear and unbiased or unprejudiced introspection.

Although many decisions in our lives are seemed to be fully conscious and without outer influences, most of them might be unconsciously influenced by models that we see in our everyday lives.

Lewin (1943), in his famous experiments in changing group norms regarding to consumable meat products, obtains evidence on how behaviors are changed in accordance with the experimenter's desires, with stronger changes when the subjects take part in discussions and decisions.

Although other people may have influence on our decisions according to social facilitation theory (Zajonc, 1965),

this effect might be either positive or negative. What will be the effect of all these influences in our behaviors which account for human relations?

We are born in a family which is based in a certain type of sub-culture from a broader culture. Our parents or parents surrogate might stay in the same place where we born. Our first socialization might take place either smoothly or in a broken family. All these factors will have its influence on the personality which is being formed.

Our education and culture, our physical build and our psychological make up, our environmental factors and our expectations, will all influence our behavior and make us conformists or deviants, happy or disatisfied with our own life, occupation, family and surroundings.

How do we relate to others? Human relation is essentially the relation that one individual maintains with other individuals. It refers to societal norms and deppends highly on approval or disapproval of behaviors by other members of the same society. Since birth, we learn through our parents and other relatives to relate with others. It is a permanent learning situation in which the learner goes on internalizing within his own psychological organization, the norms of the family structure. Later on, we learn to attribute to other people certain thoughts, feelings, intentions, beliefs, opinions and attitudes, evaluating its correctness, validity or properness, based on group of people with similar beliefs, opinions and attitudes (Festinger, 1954).

Based on these attributions and the reinforcements re-

ceived from the environment, initially from parents and later from siblings, peers, teachers and the rest of the society, we begin to build our moral code, according to how we feel integrated or segregated from the whole society, depending mostly on how mother's behavior acts on the socialization of the child, because long before words are available as means of interchange between mother and child, the mother will have begun, deliberately or quite unconsciously, to shape the baby's behavior in accordance with the expectations of their culture (Ferguson, 1970). The preschool years are significant in the development of interpersonal relations as well as the growth of motor, language and cognitive functions, but the development of social awareness and affiliation are aspects of utmost importance in this developmental stage.

Heathers (1955) makes differences between instrumental dependence and emotional one, which gives evidence that other people are satisfying and rewarding to us, subsuming acts as friendly approaches to others, wanting to be physically near or in contact with others, seeking attention, confort or approval from others, while being distressed by separation (Ferguson, 1970). Instrumental dependence means almost the opposite: lack of self sufficiency to accomplish the tasks and need of help to attain a goal, showing low competence. According to Stendler (Ferguson, 1970), mothers who tend to be inconsistent in their current handling of the child's dependency, presumably increase anxiety and tendency to seek reassurance through further dependent solicitations. The implication is that inconsistent nurturance wether

brought about through separation or through erratic maternal behavior, may lead to extreme emotional dependency and patterns of abnormal affiliative behavior.

Also the attachement system in these ages, is closely related to imitation and identification through which the child incorporates elements of his social environment into his own personality: -patterns of communication, moral standards, self control, sex typing and role identity. However, some of the social influences, both within and outside the family, are crucial in shapping interpersonal experience and behavior during the preschool years. Ordinal position of a child in the family, may give to the elder more motivation for academic achievement, anxiety, precocity in verbal development and incorporation of adult values, while the younger ones are less anxious and more prone to incorporate sibling and peer values.

Father's absence and mother's employment, are also two factors that influence the socialization process and personality development of the human being. Also the imitation of the social interaction can account for the establishment of patterns of behavior which will lead to a poor and unsatisfying interrelation. Bandura (Ferguson, 1970) demonstrated facilitating effects on agressive behavior when watching the agression of film-mediated or real life models. Such studies (Bandura and Walters, 1963) have been cited as evidence of harmful effects of television programs that expose children to violence and antisocial behavior. Here the main influence of the model seems to be to suggest that

agression, or other forms of behavior generally not socially sanctioned, may be permissible or even desirable. Although these facilitating effects can readily be shown to disappear if the model is punished for his agression or if he experiences undesirable consequences, like the films crime-does-not-pay.

Modelling may also be involved to a large extent in the transmission of deviant behavior (Ferguson, 1970), evidenced by the sympthomatic behavior of children referred to clinics who may be copying, quite exactly their parent's maladaptive patterns, of which they may be quite unaware. Sometimes parents even enhance this process by labelling similarities in behavior: a disgruntled mother when her son is being balky or difficult may exclaim "you're just as bad as your father", being this procedure very bad in child-rearing because focuses the child's attention on the undesirable actions, probably reinforcing them.

According to Sears and Lynn (Ferguson, 1970) it is primarily maternal variables, especially warmth and permissiveness that are related to conscience development. Boys who showed the most emotional upset had mothers who were both cold and restrictive, so that their sons had undoubtedly learned to fear possible rejection if they violated the mother's rather strict expectations. The little girls who became most upset, on the other hand, came from rather permissive families and had usually close, affectionate relationships with their fathers. Resistance to temptation seemed to form part of a more generalized syndrome of developing ability to behave in socially acceptable ways, and to control im-

pulses, especially agressive ones, leading these individual differences to the understanding of the development of self-control in preschoolers (Ferguson, 1970).

Children of both sexes tend to be self-reliant and self--controlled as long as they mature themselves, that means being able to direct one's own actions in terms of somewhat internalized set of standards for appropriate and acceptable behaviors.

Let us see also how, according to Piaget (1970), the human being goes on constructing his personality or his type of social interaction. Piaget's theory of human development unfolds in three following processes:

a) Adaptation of an organism to its environment during its growth together with the interactions and auto-regulations which characterize the development of the epigenetic system.
b) Adaptation of intelligence in the course of the construction of its own structures, which depends as much on progressive internal coordinations as on information acquired through experience.
c) Establishment of cognitive or more generally, epistemological relations, which consist in a set of structures progressively constructed by continuous interaction between the subject and the external world.

Piaget (1970) also states that knowledge, then at its origin, neither arises from objects nor from the subject, but from interactions —at first inextrincable— between the subject and the objects. And continues the Copernican revolution that babies accomplish in 12 to 18 months from considering themselves

the motionless centre of the universe to only one particular member of the set of the other mobile objects which compose his universe. From exercise games the child advances to symbolic games and then to rule games until there is no difference between play and spontaneous cognitive and instrumental activities.

Adams (1967) says that in general the needs of group members, or demand-input, increases as the size of the group increases and as the likelihood of immediate gratification of demand diminishes. It is not surprising that as the child moves out of the family setting (ordinarily a small group) and into nursery school groups, the immediate gratification of his needs and desires becomes less likely. He will encounter the necessity of subordinating some of his needs and desires to those of others and this process, not infrequently, produces conflict. There is ample evidence of aparently substantial need for social contact even among young children and is accepted that is desirable to cut the close ties to his mother and to broaden his base of interaction to include those outside the immediate family and while the process is often painful the child frequently seek suplementary forms of social stimulation. Amas and Learned (Adams, 1967) found that children in their first childhood used spontaneous fantasy play with imaginary companions, impersonation of animals or humans, animation or personalization of objects and general imaginative play. For some of them, the need for social contact produces interaction at the fantasy level if either the

peer companions are unavailable or the child feels too insecure in real peer interaction. Although closer friends are apt to spend far more time together than will more distant friends, with sustained interaction, the probability of situations involving mutually competitive needs increases. It is not surprising, therefore, that these close cooperative relations often involve conflict (Adams, 1967).

Early patterns of acquiescence to authority are established within the context of the family setting. Control of child's fate is at first entirely in the hands of the child's parents. As more time is spent outside the immediate confines of the home, in informal play groups or structured nursery schools, the external control over a child's behavior becomes more differentiated and the teacher assumes in school the type of control which previously had been rescricted to parents. Definite patterns of dominance-submission and leadership-followship evolve with the play groups of preschoolers. Such changes in the child's social relationship require him to structure his sources of authority. Compliance and obedience are the principal nature of the responses typically demanded from the child during these times.

Ascendancy, wether manifested in social acceptable or undesirable forms, refers to the tendency of a child to take the lead in determining the behavior of another person or the actions of a group. As such (Adams, 1967) ascendancy is closely related to the way that concept of leadership is frequently thought of in relation to adult behavior and at preschool level the complex in-

teraction of social skills and group situations necessary to the leadership process, are rarely present. Only with more than six months of difference in age between dyads, dominance-submission relations are established.

About behavior in groups we have also group identification about what Freud and Dann (Adams, 1967) state that while identification with the group is very high, the amount of status differentiation within the group is minimal. Although extreme group identification is unusual, this process, wether it results in the positive extension of interpersonal relationship or in restriction of individuality through conformity, requires acceptance of the purpose and values of a group as one's own. As the social structure of a group affects the nature of the interaction that occurs within that group, so do the social-structural attributes of the family affect the processes which occur within the family.

Considerable cross-situational fluctuation in the leadership status of individual children, depends, according to the group's task, wether it consists in competing an English lesson or planning a party (Hartup, 1970). Nevertheless, leadership has some degree of cross-situational stability being less stable when the peer group works on tasks assigned to it, than when it works on tasks of its own choosing. Adolescents also have the same problems and offer the same data as the preschool children. They agree among themselves in their rank-ordering of traits that characterize people who can get other people to do things for them.

The literature on relations about personality and behavior characteristics or academic achievement and the acceptance of an individual by the peer group, consists almost exclusively of correlational findings. Typical strategy has been to administer sociometric tests currently with tests of personality factors, intelectual capacity or academic achievement, correlating these two sets of measures, being thus the inferences very limited. One of these researches has been (Projecta e Noronha, 1973) the correlation between the achievement in a physical education class and the likelyhood or disgust of having the individual as group leader. Children who situated in the two tails of the frequency distribution curve (i.e. the best and the worst) of the physical education achievement test, were not chosen as group leaders while those who situated in the upper middle half of the curve, were chosen in first alternative. Could we infer from it that the best and the worst pupils in physical education are not well accepted by their peers? And also that children, to be well accepted leaders by their peers must be just like anyone else but in a little higher grade than the other one's? Through a clinical observation and rating by the experimenters (biased or not?) those who had the best and the worst achievement in physical education were classified as having inferiority complex, either with inhibitions or with overcompensations.

Other studies (Hartup, 1970) show that peer acceptance is directly associated with such characteristics as friendliness, sociability, social visibility and outgoingness, being these re-

sults more or less uniform across age levels from preschool to adolescence. In these studies, the non sociable child although not being popular, is not necessarily rejected by his peers. Data for young children are concordant with young adolescents. Peer acceptance, according to Marks (Hartup, 1970), between the ages 12 and 16 is positively associated with sociability: according to Rosen et al., with lack of desire to change the behavior of other members of the peer group; with being helpful, good-natured and the "life of the party", according to Elkins; with friendliness and enthusiasm, according to Gronlund and Anderson; being "good company" and participative in school activities, according to Feinberg, Smith and Schmidt.

Keislar (Hartup, 1970) reported positive correlations between sociability and both peer acceptance and prestige. However, for girls, sociability was more highly correlated with acceptance than it was with prestige, which was, on the other hand, more highly correlated, in both sexes, with marks, school effort ~~and other achievement~~ and other achievement-oriented behaviors than peer acceptance. Jones (Hartup, 1970) reported that high school students who were frequently mentioned in the school paper were more popular than those who were mentioned less often, and Marks found that popular adolescents were "more prominent" than less popular. In summary, it seems that social participation is positively related to peer acceptance.

Singer (1951) reported that acceptance by the peer group, is associated with the individual's acceptance of the group.

Another academic research (Noronha, 1974) gave some evidence about the possibilities of academic achievement when individuals who like to have group experiences study in groups; but when individuals who like to study independently, are forced by the circumstances to study in groups, their academic achievement lessens, giving us a hint about motivational factors within the individual. Another factor about group formation is that children with moderately high self-concepts are more accepted by their peers, than children with either low or very high self-concepts; but more studies are needed to determine the child's peer status through the role of self-attitudes.

Mead (1934), says that effective social relations are established only when one can distinguish oneself from others and take the role of the other. Social sensitivity, compliance and conformity (which involve recognition of others' needs), are positively associated with success in peer relations but the correlation between socio-empathy and peer acceptance remains in doubt. About social adjustment, findings show evidence that relative degree of maladjustment is inversely related with popularity in disturbed groups and there is some evidence that anxious children are less popular than non-anxious ones.

About personality and other characteristics, there are correlations between social power and IQ being these children also well liked and perceived as able in school and camp situations, competent in athletics and campcraft. In Michigan studies power-

ful children were generally more sociable and better adjusted than were children who did not possess the capacity to influence other children. The socially powerful child was likely to be realistic about his status in the peer group. High degree of association between self-ratings and other ratings of this attribute, are also found in the Michigan study. Also leadership is moderately correlated with "followership" but well correlated with suggestibility. Nevertheless, children possessing high social power tend to resist to the direct influence attempts of others, more frequently than nonpowerful children. Terman (Hartup, 1970) pictures the powerful child as intelectually able, actively and appropriately sociable and, among boys, assertive and agressive.

Schoeppe (Hartup, 1970) is a descriptive study of 30 adolescents found girls to be particularly concerned with "outer conformity" whereas the boys are oriented towards "autonomy or self-directiveness" while no differences were found in two studies of suggestibility. There are evidences that when the situation arouses motives which are particularly masculine, peer conformity in males is likely to exceed conformity in females; pre-school boys, showed more imitative agression following exposure to agressive peer models, than did girls. The bulk evidence suggests that when sex typed norms are not involved, females are more conforming than males. It may be argued that this difference reflects the greater strength of needs for social approval in girls than in boys in such area as dependency and motivational bases for achievement.

Patel and Gordon (Hartup, 1970) reported a general tendency for their high school subjects to be more influenced by high-prestige than by low-prestige peers, with more conformity on difficult than on easy tasks. Other studies suggest that attractiveness of the source may affect opinion change, wether attractiveness may be defined in terms of leadership or in terms of popularity. Also high prestige children are more socially active, more likely to initiate behavior contagion and more likely to exert direct influence on their peers than other members of the group. The prestige of the influence source also affected the success on the influence attempt, being high prestige children particularly successful as sources of behavior contagion with direct attempts to influence the behavior of their peers.

Lesser, Abelson and Wilson (Hartup, 1970) found that yielding was positively correlated with social isolation either in childhood or in adolescence. Thus, one who is not nominated either as "liked" or "disliked" on a sociometric test, conforms significantly less than the others and this happens with boys of middle social status. Another study by Harvey and Consalvi (Hartup, 1970) shows that in groups of delinquents, the second ranking in the group are more conforming than the leaders and the lowest ranking followers who have not yielding personalities and are more alike to each other than with the other members of the middle status, who are associated with maximum yielding to peer influences. High status children proved to be more resistant to direct influence than low status children. Resistance to conta-

gious influence is not consistently related to prestige while disturbed children are particularly open to such influence.

In studies oriented by naturalistic observations, we see that group's influence on an individual child varies according to the degree that group serves as a "reference function". Deviates have little influence in the group and are sometimes supported by other deviates who hold a kind of membership among them. Also a variety of incentive factors account for significant portions of the variance in children's tendencies to be influenced by their peers.

Peer values tend to be basically consonant with parental values and adolescence is not the period of cross-pressure and storm that tradition suggests. In a study by Stukát (Hartup, 1970) about responsiveness to peer influences, the factor labeled "primary suggestibility", the nature of the behavior responsive to adult's unobtrusive and monotonous verbal suggestion, is called "hypnotizability". Another factor labeled "secondary suggestibility" characterized by a tendency of the subject to yield to more obvious influence from the experimenter, cojudge or a peer group, is called "responsiviness to suggestion" or "conformity-proneness". Students who influence others, come from elements from important status in the comunity identified with social class, ethnicity, and religion and even friends are selected on a basis of consistency with parents' attitudes and when more important decisions are involved, most adolescents tend to seek advice and opinions from parents rather than from peers.

According to Lucas and Horrocks (Hartup, 1970), adolescents appear to desire harmonious relations with adults and most job aspirations appear to be concordantly influenced by peers and parents.

About the moral development, it seems that expression and inhibition of specific acts defined by socialization agents as good or bad and rewarded or punished accordingly, are the widest source of the personality development, according to social learning theory (Hoffman, 1970). With the further cognitive development, the child may reevaluate and shift his view of authority and rules so that they are no longer external, arbitrary and contrasting as they seemed in the early ages, but largely objective and moral. The interaction with authority figures who are rational in their demands, who use comprehensible inductions in terms of the child's own experience (not subjecting to excessive surveillance), is seen as a mediating agency basically sympathizing with the child's interests. Also the individual's own experience in taking role authority, participating in decisions about his behavior in home, about games and rules with peers, participation in the roles of authority and subordinate roles in organized groups and organizations, makes him develop soundly his moral judgement and aptitude for decision and leadership.

Reviewing all these findings and theories, we see that relations among human beings depend mostly on personality charachteristics and environmental factors, which in turn, depend on humans who inhabit a certain part of the world and influence a cer-

tain type of culture or subculture. On the other hand, personality characteristics are based mostly on inherited characters moulded widely by the culture and people who form that culture. We see that our ancestors shape our character and our forms or patterns of relations to other people. If this is true, we are shapping now the human relations and the cultures and societies of tomorrow.

Erikson (1969) assumes that today and tomorrow, adolescents are struggling to define new modes of conduct which are relevant to their lives within the context of two culture factors of moral temper: scepticism of all authority as a refusal to define natural authority and a cast of mind essentially anti-institutional and even antinomian. The extraordinary hedonism that the youth looks for, is the desacralization of life and an attitude that all experience is permissible and even desirable.

At the same time, society imposes new forms of specialization of extended training, of new hierarquies and organizations enhancing divorce between culture and society. With this hypothesis, the greatest strains will be on the youth who may come back to some form of accomodation with the society as it grows older and accepts positions within the society. The "cultural deposit" that the experiences have, is an irreversible cumulative consciousness that the next generation will use as starting position for a more advanced position of alienation and detachment.

According to Erikson (1969) the "younger generation"

will be devided more clearly into the older and the younger -young generation, where the older young will have to take over much of the direction of the conduct of the young.

Anyhow, the old will shape always the new, not in a total form of alienation but with clues which will be followed as landmarks for the guidance of the newest generations.

Human relations, by the same token, will be better understood and praticed by those who learn with the analysis of the mishaps and pitfalls of the older generations.

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TERM PAPER

COMMUNICATION

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COMMUNICATION

Information theory and communication networks have been long studied by engineers in the radiotelegraph and radiotelephone system (Delay et Pichot, 1969). In a transmission of this type, there is initially a certain information (words) called input which is coded in signals transmitted to a second device (telephone or telegraphic receiver), which decodifies the message transforming it in a new information named output and received by the adressee (Delay et Pichot, 1969).

During the coding and decoding operations and due to interference at the transmitter and receiver level, the message does not reach its destination as clear as it was transmitted. Noise is the phenomenon that provokes distortions in the original message called signal. Besides all these mechanisms we have also the feedback system, which gives to the transmitter the idea about how the message is received by the receiver (Anzieu et Martin, 1971).

In human societies, all social activities presume change of informations either among individuals or between an individual and a group or among groups. For the human being, communication is the totality of physical and psychological process through which is accomplished the operation of keeping in contact the transmitter -one or more persons- with the receiver -

-one or more persons- in order to attain certain goals with the exchange of information (Anzieu et Martin, 1971). The information is at the same time an operation and a content aiming to reduce a disorder. Through communication (Enriquez, 1962) we try to influence and to control and regulate other people's activities.

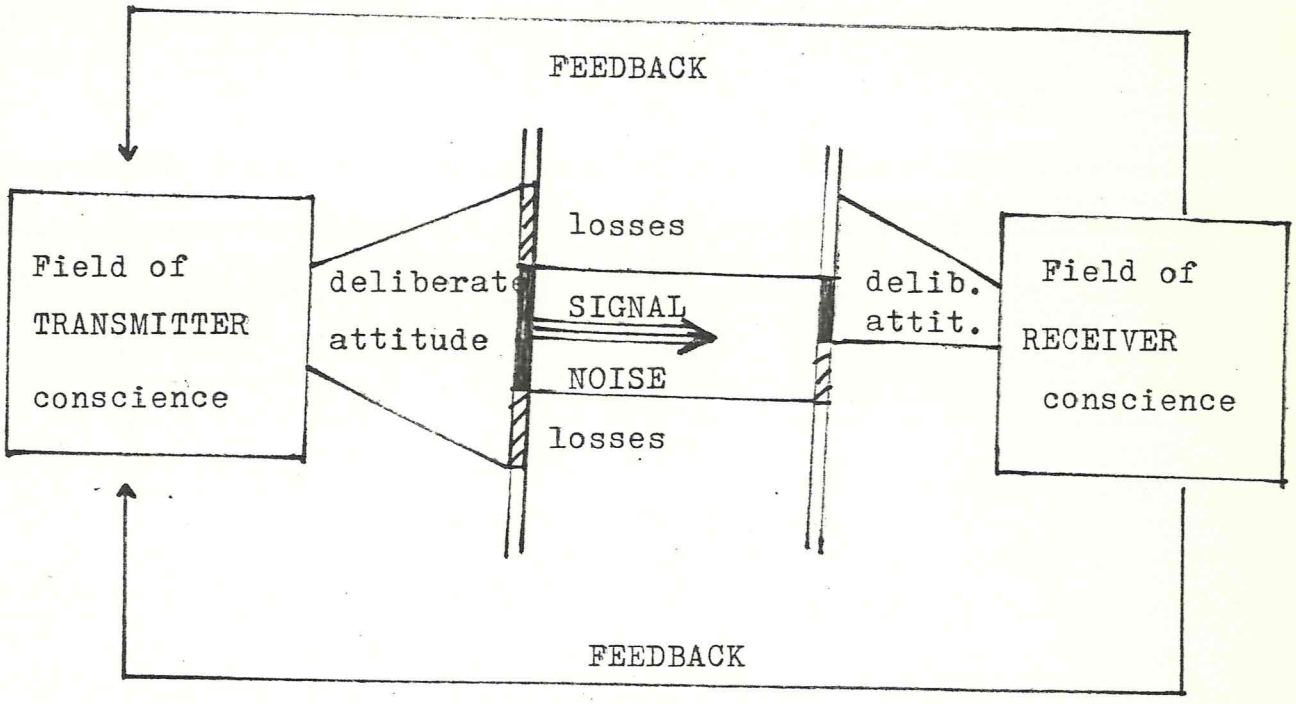
When an individual is kept in communication with another, we have two psychological entities, each of them with its psychological and inherited organism upon which the environmental factors made an almost constant and significant alteration.

Three basic elements must be taken in account when we deal with human communication (Anzieu et Martin, 1971):

- personalities with their personal history, motivational system, affectivity, intelectual and cultural level, frame of reference, social status and psychological roles;
- common situation, having in account the means to make the situation evolve, the aims of that communication (to yield, convince, modify an opinion, force to act, to take care, to express one's feelings, teach, act upon the emotional balance and physical health, induce feelings) and the nature of the situation which might create in two individuals a gerat need to communicate to each other or may provoke in both or in one of them the will to avoid such communication;
- significance, that means all the meaning attributed to the gestures, words, silences, etc., while the basic information is exchanged.

Basically, the transmitter has its field of conscience and deliberate attitude about this transmission. Nevertheless,

the whole information does not fit into the communication channel where the signal/noise ratio is established until the final stage where the message is received by the receiver through the deliberate attitude of his field of conscience that narrows the capacity of reception. According also to Anzieu et Martin (1971), the feedback either by direct answers from the receiver or by undirect clues perceived by the transmitter, the communication maintains a special course.



In this diagram, drawn according to Anzieu et Martin, we see that much of the information given does not reach the receiver because of the losses that it suffers. Although the symbols are widely common to most people, their meaning, the associations they elicit and the attributions they give rise, are not always the same in everyone and sometimes even in the same

individual in all conditions. People understand the meaning of a message (Anzieu et Martin, 1971), through:

- filter: system of values attached to a person at a level more unconscious than conscious, through which the individual drains all the inputs;
- halo: symbolic echo elicited in the receiver's mind by the meaning of the word, idea, comparison, tone of voice, etc., received through the communication.

Human communication established by needs, presuposes selective listening, either from a single source of information or from a number of sources. Moray (1972) advocates that there is tendency of modern society toward a reduced physical effort and increase in the rate of information transmission as basis of human being's interaction with their environment. How to listen one voice when many are being spoken at the same time? When two messages are resembled to each other, it is difficult to separate them and to descriminate each one (Moray, 1972) being the extreme case of close resemblance in the ordinary binaural reception of messages. The input of the same voice at the same loudness and with the same pitch and content, can be descriminated for its non resemblance for the minor effects of head shadow assymetries of non-linear distortions produced by the external and middle ears and by the fact of the rate of travel of sound at aproximately 30 contimetres per milisecond to the two cochleas. But in this case, these differences in the localization of the sound in auditory space, are treated by the nervous ststem as one fused coherent message.

According to Egan et al (Moray, 1972), dichotic presentation -one message to each ear- was markedly superior to monaural presentation -both messages to the same ear- being the improvement equivalent to the increase of the signal to noise ratio of the selected message up to 30 decibels. Also filtering of messages, either the selected one or the rejected, improves the inteligibility.

Tolhurst and Peters (Moray, 1972), present evidence that two messages presented binaurally with no instructions about which to select, brings the probability of selection of the louder message, and Egan et al (Moray, 1972) state that the voluntary attention is a psychological reality named selective attention and not only a subjective impression on the part of the listener.

The early structuralists tried to find evidences about the processes of attention but the introspective method of Wundt, Titchener and others, was a difficult approach and hard to replicate and furnish consistent data. In modern research, while Tolhurst and Peters say that listener's attention is "caught" by the louder message, Egan et al, show that attention can be voluntarily directed to the quieter of the two messages (Moray, 1972). It would seem to us that when a listener is asked to select one of a pair of dichotic messages he might "turn off" an ear and receive the selected message through the open ear. Triesman (Moray, 1972) says that the listener can select a male voice and ignore a female, when they are presented monaurally.

In Cherry's experiments (Moray, m972), when a listener

shadowed a message presented to one ear, while ignoring a different message to the opposite ear, he could say afterwards only that the rejected message was a speech or not and if it was a man's or a woman's voice without being able to mention its content and the language in which it was spoken; it seems that the shadowing locks the listener to the selected message. When messages are shadowed into prose, even the rejected message is heard in 30% of trials when prefixed by the listener's name. Also when a word is made "significant" by pairing it with electric shock, even not being heard, its ocurrence is obtained in the GSR (Moray, 1972). Anyhow, the listener's name seems to be previleged in any kind of list of words or prose eliciting K-complexes and GSR arousal in spleeping individuals at the sound of their names.

Howarth and Ellis (Moray, 1972) present the information that even non-attended signals arrive at high levels of the brain, probably at the cortex and that selection is not a peripheral mechanism. For shadowing purposes with the same message, we see that coherent prose must have a greater separation than a string of random digits, never being less than five seconds. According to Triesman, the selected message leaves its trace in the short term memory which is matched with the input from the both ears and eventually fades spontaneously or is erased by subsequent selected input and so desappears. Nevertheless, for several seconds, the nervous system will treat the two messages as identical with the resulting breakdown of attention. In dichotic inputs, a maximum delay of twenty milliseconds is permitted for a message to be heard as fused into a coherent one.

Broadbent (Moray, 1972) proposes that there is a short-term memory store at the end of the input lines, so that when two messages arrive simultaneously, one of them is transmitted instantly while the other is held in store until the line is free. During the storage time, the message may fade, decay or be interfered by other material. Models of communication by Triesman, Deutsch and Deutsch are discussed by Moray before his proposed split--span experiment which was partly successful and gave the following evidences (Moray, 1972):

- it is possible to alter the relative proportion of different kinds of errors by altering the payoff to the listener;
- when listeners are left to themselves they behave so as to minimize omissions;
- the effect of rate of presentation on recall is indirect, perhaps due to the fact that at fast rates there is less time for rehearsal and consolidation between items;
- listeners tend to recall at a fast rate when presentation is fast and at a slow rate, when presentation is slow;
- the question of practice is extremely important;
- recall of the lists, class by class, is as efficient as sequential, ear-by-ear recall.

The electrophysiology of the nervous system shows us in one study by Sharpless and Jaspers (Moray, 1972), that when cats listen to repeated clicks, the cortical response even after days, does not disappear and sometimes increases the evoked potential as the behavior response declines, indicating that high voltage cortical evoked responses, are not to be taken as indica-

ting behaviorally important events in the animal life but that probably, perceptually important events require the simultaneous interaction of many different parts of the brain, in particular, the cortex and the recticular system. Despite many experiments like this, we know very little at the physiological level in connection with selective listening.

Moray (1972), summarizes what is known about attention on the following way:

- the listener is able to exercise considerable voluntary control over what he will hear;
- the criteria on which selection can be made, include position, frequency spectra, loudness and semantic continuity and probably intersignal contingencies of rhythm;
- features which may be used voluntarily are also those which may over-ride voluntary selection and switching;
- voluntary attention, is a psychological and biological interdependent reality.

Leaving behind individual entities, let us see how communication processes among individuals living in groups and society. Murdock (1974), says that social psychology has concerned itself with the forms rather than the contents of social action and has concentrated an observable behavior to the neglect of subjective meanings being the psychologist more concerned about how people's actions looked to him more than the way they meant to the people themselves.

Persons' class situation as mediated through the kind of job they do and the sort of house and neighbourhood they live

in, intervenes decisively to determine not only their basic standard of living, but also to circumscribe the nature and range of their social relationship and their access to systems of meaning (Murdock, 1974). In our society, groups which occupy positions of the greatest power and prestige have greater access to means of communication and the mass media permeate our everyday life in two very important ways:

- provide dominant leisure activity;
- give informations and explanations of social and political processes, making sugestions about modes of self-presentation and general life styles.

The mass media, therefore, represent a key repository of available meanings which people can draw upon in their continuing attempts to make sense of their situation and find ways of acting within or against it, concerning specially general social and political processes which structure almost permanently inequalities in the distribution of wealth and power, in the name of the "national" interest against sectional and individual interests.

We receive information through all our sensory inputs, but our eyes and ears receive the widest impact of mass media in our modern society. Just as the radio and television broadcasts, newspapers are tied to time, having to reproduce themselves every twenty four hours, and this reason of immediacy of news coverage concentrates necessarily attention on the form of events, on what happened and who is involved rather than on underlying contents and causes. Newsmen face the problem of placing news within a

context that will render it meaningful to the majority of their audience. Specially in recent years, newspapers have found themselves competing for a declining readership against a background of spiraling costs. Mass media agents, have intensified the competition for viewers, readers and listeners, ensuing attempts to encapsulate the widest possible audience. Thus, the obligation to remain impartial is underscored being the probable truth and the reasonable solution somewhere in the space between the two accredited sides of the case, according to Hall (Murdock, 1974).

Tuchman says that the incessant pressures of time and the consequente problems of source allocation and work scheduling in news organizations can be reduced or alleviated by covering "pre-schedulled" events announced in advance by their convenors (Murdock, 1974). One of the consequences of adopting this solution, is to increase the extent of newsman dependence on news sources willing and able to pre-schedule their activities, increasing the reliance on élite sources such as official announcements, political speeches and diplomatical exchanges.

As Murdock (1974) continues to say, a symbiotic relationship arises between newsmen and the élites, specially the political, through which readily processable information is exchanged for publicity. This concentration on parliamentary events and political speeches is further reinforced by newsmen's conception of themselves as a "Fourth Estate", acting as an indespensable channel through which the decisions and doings of the political élites including their mistakes and miscalculations are made known to the people at large. Murdock (1974) continues, saying

that by making debates between legitimated power holders a major category of everyday coverage, news presentation serves not only to publicize the dominant definition of the situation, but also reinforce the key consensual notion that such conflicts as do exist, can be adequately accomodated within the existing representative machinery without altering the basic distribution of wealth and power.

In social psychological research from 1940 onwards, the question "what are the media doing to people?" has been substituted by another question "what are people getting out of the material they choose to consume?". British researchers on "uses-and-gratification", work on the premise that "social experience gives rise to certain needs, some of which are directed to the mass media of communication for satisfaction". Problems that arise, reffer to basic needs which supposedly underlie particular patterns of gratification which can only be inferred from individual's statements about gratifications themselves in a circular argument. Also as individual's needs are a product of specific social experiences, in the absence of a sufficient analysis of this experience or of an overall response to it, they are unable to provide a systematic explanation of the considerable variations in media uses, indicated by their own findings (Murdock, 1974).

Satisfactory account of relationship between people's mass-media involvements and their overall social situation and meaning system, needs to start from the social setting rather than from the individual, by introducing the concept of subcultu-

re with the replacement of the idea of personal "needs". Subcultures represent the accumulated meanings and means of expression through which groups in subordinate structural position have attempted to negotiate or oppose the dominant meaning system in particular parts of the social structure, in the course of their collective attempt to come to terms with the contradictions in their shared social situation. A situation is viewed as contradictory when elements in it are simultaneously affirmed and denied, taking the form of gaps between what is supposed to be happening and what is actually happening, between what has been promised and what is actually happening (Murdock, 1974). Also the demarcations and oppositions between different youth subcultures, may be seen as versions of the divisions and conflicts within the wider class structure transposed into the specific context of youth. It may happen that youth and adults do not communicate sometimes, properly due to these factors.

But according to Sartre (1940), man is not totally conditioned and constrained by the social situation in which he finds himself and can always make something out of what is made of him. We have thus, the communication in a different context: the interview. This is a structured or manipulated communication aiming the gathering of significant information or trying to alter the subjects overt or covert behavior or attitudes, befiefs and modes of thinking.

In the various therapeutic situations, interview is the most widely used form of therapeutic approach. Sullivan (1970)

divides the interview in four phases: formal inception, reconaissance, detailed inquiry and termination which means sometimes interruption. The formal inception of the interview, includes the reception of the interviewee and the overt establishment of the type of interpersonal situation that is expected to ensue. The way in which the interviewee is received, can greatly accelerate the achievement of the result desired or it can make the result practically unnatainable, because since the very moment that the interviewer and interviewee see each other, very important psychological processes are in progress (Sullivan, 1970). Thus, one must learn to devote an immense amount of alertness to the work at hand—a sort of watchful clarity as to what happens not to be afraid of the stranger who is in front, but to have o microscopically correct record of small events and engage congenially in all sorts of things that don't require any particular attention. Sullivan (1970) again says that the interviewer learns that there is communication from the first visual encounter with the stranger—not only communication by speech, but communication by gesture, broadly conceived an interchange by expressive movement other than speech.

The second phase, according to Sullivan (1970), is the reconnaissance during which many questions are made by the interviewer to obtain suplementary or complementary information about the personal history of the patient or interviewee. All the troubles the patient did announce in the first phase, are related temporally and spatially in the second phase and Sullivan recommends seven to fifteen hours of interviews before detailed psychothera-

py, ending this phase with a summary statement. This summary statement, is ammended by the interviewee after after having been in contact with it.

The phase of detailed inquiry, is meant to improve early approximations of understanding in which process a great change may occur in one's impressions about the patient. Thus, the detailed part of the interview (Sullivan, 1970) in order to be significant has to be exceedingly far from a conversation made up of simple correct answers to clear questions. The uncertainties of this part of the interview arise from the interviewee's feeling that what occurs to him isn't "good enough". The interviewer, according to Sullivan (1970), has to deal with anxiety almost eternally. Anyone who proceeds without consideration for the disjunctive power of anxiety in human relationships, will never learn interviewing. When there is no regard for anxiety (Sullivan, 1970), a true interview situation does not exist; instead, there may be just a person (the patient) trying to defend himself frantically from some kind of a devil (the therapist) who seems determined (as the patient experiences it) to prove that the person (the patient) is a double-dyed blankety-blank. This can be spectacular human performance but it does not yield psychological data relevant to therapeutic process.

The fourth phase in the interview (Sullivan, 1970), is the termination or interruption, depending on the possibility of not seeing the patient again or continuing to see the patient during another session. During this phase either giving some pres-

criptions for the next session or doing a final statement, the interviewer must consolidate what has been achieved in terms of some durable benefits for the interviewee.

With the interview, specially in psychology or psychotherapy, the therapist tries to change the interviewee's attitude. The unexperienced interviewer may fail to notice carefully and as completely as possible all of the context —operations, remarks and their patterns— which lead to distinct improvements in the situation. Sullivan (1970) says that if the interviewer knows how the situation came to be going so well, in the sense that he knows at which points of his operations the patient's communicability increased, he has quite valuable indices to the informant's covert security operations which are inferentially evident. The interviewer can find in the context that led to distinct improvements in the interviewee's freedom of communication, fairly clear grounds for inferring what sort of thing led him to suffer anxiety; improvement in the patient's communication at a particular time, implies that the patient at that time experienced relief from the feeling that he would make a bad impression, give away something disastrous or something of the sort that the interviewer did, that made the patient seem safe and go ahead leaving his precautions. Unless the interviewer pays close attention to the more or less episodic improvement in the interview that goes "wonderfully", he may miss a great deal of the data that might show what the patient would be like in a more difficult situation that didn't go smoothly.

When the communication evolves in the opposite direction, the patient being less communicative and acting as though he thought that the therapist is nothing but an expert, one must control

his own anxiety for the moment and try to study the deterioration in the relationship by retrospective survey specially of the moment when the deterioration began. It is good for the interviewer to review the factual basis for his more favourable appraisal of the situation and to learn wether anything discouraging as to the outcome of the interview has occurred. It is also good for the therapist, according to Sullivan (1970), to observe what relation the current situation has to his own attitude towards the patient. It is very important to the interviewer in all the phases, through the entire process, to covertly verify his observations in order to have a feedback about his behavior; he must not merely automatically react to the patient's expressed attitudes, wether by tone, by gesture or by words, but needs to have the understanding of the whole situation and the implications of his behavior—verbal, motor, attitudinal, emotional—on the psychological processes within the patient's mind.

Sullivan (1970) states that in situations integrated by any dynamism, the interpersonal process may have the following outcomes:

a) the situation is resolved;

b) the tension continues through covert processes;

c) there is increase in tension with suplementary processes leading to frustration;

d) there is frustration with desintegration or dissociation.

Sullivan (1970) says that the chief handicap to communication is anxiety, being the task of the interviewer, the avoidance of unnecessary anxiety: the therapist must be skilled enough to avoid and to restrain its development. Despite all

these problems brought about through interviewing procedures, let us see how secret voices can manipulate our behavior. Becker (1979 claims that his "little black box" functions like an electronic conscience. When a shoplifter takes something of the store, he feels a strong need of returning it into the counter. The equipment is basically a sound mixer like those used by disco deejays which mingles bland music with subliminal anti-theft messages like "I am honest, I will not steal" repeated rapidly about 9.000 times an hour at very low volume barely audible to shoppers and employees. Becker says that it works in the deep recess of the brain and aparently influences behavior. During a nine month trial one U.S. East Coast chain claims that saved about 600.000 dollars and cut down by 37% the number of thefts.

In the same weekly news, we learn that subliminal messages can manipulate or change our behavior for better or worse. Would it be good to conduct therapy through subliminal messages? And if the messages influences us to the worse?

For psychologists and specially for psychotherapists, communication is the most important tool to understand and modify the behavior of the patients who seek relief for their problems. How to use this precious tool? We can rather use it in a psychoanalitic context or in a brief psychotherapy. We can also use it in a client centered therapy, but also in behavior therapy, words have such a great impact that the behaviorists cannot deny its power. When we have different trainings and skills, the management of words and communication can shorten the therapeutic situation and even alleviate maladjustement symptoms in a very short

lapse of time.

We have suggestive therapies which work sometimes more powerfully than placebos. In suggestive therapy, communication is the basic form of interaction between patient and therapist. Cooke and Van Vogt (1965) say that in counselling or psychotherapy, words are the principal and frequently the only tools used. In both reading and listening, words are used to convey ideas. Each word carries some impact. Each word has an effect upon the nervous system. Each phrase or idea, possesses greater or lesser amount of "energy" depending upon the associations it arouses in a particular individual.

Let us imagine that we listen a couple of persons talking about us without knowing that they are being listened. We will already be tensing against the possibility of critical remarks fooling our conscious minds into believing that we don't really care, denying to ourselves that the words have any validity or casting doubt on the judgement of the person who utters them (Cooke and Van Vogt, 1965). Actually the "unconscious" mind will never forget anything that is said under the circumstances wether the words are favourable or unfavourable. While in the natural setting some words in some situations may provoke an unfavourable state of mind leading to maladjusted patterns of behavior, the therapist in another controlled setting called therapeutic situation, making use of words skillfully, tries to influence his state of mind in a predetermined direction in order to eusure a pattern of adapted and proper behaviors.

Cooke and Van Vogt (1965) consider also familiar advertisement situations always effective and useful for many different products. If we listen to a conversation which praises our qualities or our personalities, even if we consciously forget them, they always weigh on the positive side to our advantage and in hypnotherapy only positive and beneficial words should be used. In hypnosis, each word we hear has "energy" which can affect for good or ill depending on how one understands it or in what circumstances one receives it. Just as in a radio broadcast words are received at a determined energy and amplified through the stages of amplification making the output much greater, hypnosis is the amplifying circuit which may be added to any verbal therapy. Any word that can favourable affect a particular individual's nervous system, can be amplified by the technique of hypnosis to produce a much greater effect (Cooke and Van Vogt, 1965).

In ordinary life situations how the words affect us constantly? Let us take an example from Gindes (1976): "Tired from a busy day, we relax into easy chairs, click the knob of our radios and wait for our favourite comedian. Soft or stimulating music comes through the loudspeaker; the favourite comedian comes on, and soon is chuckling heartily. In the very middle of the relaxing chuckle we hear a jingle praising -for example- a soap. Quickly, before we can build up a healthy resistance to the sugestion, our comedian is back and we are laughing again. The chances are largely in favour of our buying that soap —not tomorrow not necessarily next week ... but eventually we shall try that

soap! Becker (1979) also says that subception is efficient in motivating people to act according to subliminal messages recorded in his little black box.

Changing over to the use of communication in groups, MeLeish, Matheson and Park (1973) say that the man-in-the-street has now access to therapy which some years ago was available only to the wealthy; the group is a substitute for the prohibitively expensive individual psychoanalysis. Besides the so called therapy, groups may also be used as means of developing communication skills of administrators, business managers and teachers-in-training and improving human relations. If we accept that communication is a primary process in the small group, a significant pointer to structure is the close study of patterns of interchange, according to McLeish, Matheson and Park (1973): Who speaks to whom? How often? In what terms? And how is the communication received? The patterns of communication differ enormously, depending more on both latent and manifest group processes at work than on the nature of the problem being discussed. The patterns of communication point to the power dynamic within the groups: emergence of power, withdrawl from power, elicitation of support and approval, isolation, power contest, modelling of behavior, dominance, submission and conformism.

Experiments carried on by McLeish, Matheson and Park (1973) with groups, seem to point to the conclusions that direct communication training is likely to be more beneficial as an aid to teacher-trainees than self analytic group treatment. It seems that the self analytic treatment groups are more interested in

observation without being able to learn virtually nothing about group dynamics having a very narrow percentage of participants suffered a slight change. On the other end, the participants and observers in the direct communications treatment made significant, systematic and predictable gains in the communication of empathy as well as in the understanding of group dynamics.

Although all the benefits we can receive from improved communication networks and skills through group practice, there is little opportunity within an educational institution for the cybernetic process of performance and feedback in relation to personal style communication. The feedback an individual normally receives in this setting, relates only to his intelectual performance or to a particular skill which is a minor aspect of an overall personal performance. Education is often directed to the head instead of to the whole person (McLeish, Matheson and Park, 1973) with little experiential emphasis in a learning environment often deliberately structured; sometimes the teacher's procedures can act to minimize participation and the open expression of negative feelings avoiding creativity and cooperativeness. The provision of a certain amount of feedback on other aspects of behavior besides intelectual performance, seems an acceptable and desirable improvement in educational emphasis specially when using the small group situation for such feedback. With an objective training of human relations, people become more sensitive to others as well as to their own behavior becoming part of the feedback process directed towards other participants and interpretation

of the impact of their behaviors on the self, besides the comparison of different behaviors observed around as well as their positive and negative effects.

After this review on human word communication, we can be sure about the effects and the impact that the word has on one another. Everyday we listen to many words from many types of human beings. Besides, it, we are bound to listen to mass media. Can we avoid or prevent the influence that others exert on us? Can we avoid to influence other people?

Certainly, if we have a good knowledge about how the communication works and if we get trained enough in communicating to other persons, we will be able to realize that influences pro and counter can be self-controlled almost at our will.

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ANALYSIS

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ANALYSIS

Man is a product of biological revolution which acted at the same time at the basis of its physiochemical structures and at its top, providing a peculiar and specific type of organization (Morin, 1973). The simple physiochemical structures do not produce living matter but living systems. Brillouin (Morin, 1973) gave us the explanation of on and off circuits between the principles of entropy and conterentropy. Using these principles and comparing an artificial machine with a living machine, we see that while the former can do nothing more but degenerate, the latter, while temporarily degenerating, will try to run orderly and regenerate without external help.

An automobile is constitued by highly verified spare parts, but the danger of malfunctioning as a whole, is as great as the danger of malfunctioning of each of its spare parts (carburetor, plugs, etc.) which have to be replaced or repaired by an external source. In a living machine the molecules which degrade are replaced by new molecules through a self regulating system which does not need external intervention. So this system can regenerate and reproduct the elements which are degraded (Morin, 1973), that is to say, has the property of self-repairment and self-reproduction.

Morover new ideas about the biological sciences stress

the interrelations between the living organisms and the environment not as closed but as open systems sharing each one some part of the other. The more a living system is autonomous, higher is its dependency on the ecostsyem; autonomy presuposes complexity which in turn presuposes richness of all kinds of relations with the environment, which ensure its independence to live autonomously (Morin, 1973).

The first ethological discoveries acquaint us with animal behavior which is organized and organizer. Just as ecology gives us a fresh notion of nature, ethology gives us a different idea about the animal. There are new discoveries about territoriality and communication ranging through a complex field of semiotics for a great variety of inter-individual relations: submission, rejection, choice, friendship, dominance, protection, etc..

With basis in communications, we see the building of groups and societies born through competition and solidarity among its members into hierarchical system. We can conceive that society is the most widespread self-organized system among all the living creatures. We see in the monkey world that most societies have their leaders, status, roles and even labour division and caste system (Morin, 1973). The relationship dominance/submission which rules the interrelations among "classes" and "individuals", is very complex and the one who maintains authority, is neither exclusively superior to others in intelligence, physical strength or sexual capacity, but a mixture of agressiveness

and exibitionism. The authority is maintained by his threat behavior which induces other members of the society to submission or withdrawl.

In such societies we see social inequality and mobility of people who want to climb and who sometimes are bound to discuss in the social hiearchy. The "power" offers to their holders all the liberties and specially a free personality development. The submissive role, and specially in the lowest strata, individuals suffer from constraints, frustration, prohibitions, inhibitions and perhaps "neurosis" (Morin, 1973). Social inequality is sometimes the meaning of lack of happiness. While in the animal world of primates there is a three class organization: masculine - feminine - juvenile, based on hierarchical inequality and group solidarity, in human society sometimes the youth does not have a distinct status and social role, bouncing between childhood and adulthood.

Morin (1973) says that since Neanderthal, the number of deaths, assassinations and slaughters has increased greatly. We can immagine that the demographic outburst of the species, multiplying the contacts and the ocurrence of rivalries among groups, has widespread the occasions of conflicts and fights; the need of hunting developed the inovation of weapons which allow war and consequent death. The generations of homo sapiens became more and more prone to onirism, eros, affectivity and violence. While in the neanderthal people onirism was restricted to sleep, in the newer generations it began to continue into

immagination, phantasy and ghostlike forms. The eros began to be unrestricted to the oestrus period and violence became not a form of deffense and of search for food, but a form of outburst without any meaningful reason. Affectivity became very unstable, intense, disordered and unpredictable (Morin, 1973). The kingdom of homo sapiens is linked to a massive introduction of disorder over the world, distinguishing him from other animals. According to Jouvet (Morin, 1973), 80% of cat's dreams are of predatory nature, 10% of defense against powerful enemies and 10% about feeding; but human dreams are complex, disordered and unpredictable.

With the development of the phylogenetic scale we see the first hominids moving themselves on only two lower limbs, keeping the two upper limbs free to any kind of work and since this movement the homo sapiens begins to foster its march to a different type of life. The cortex of 500 cc. in anthropoids widens to 600 cc. in the first hominids and enlarging further to 800 cc., in the early homo erectus is already spread to 1.100 cc.. With the first existence of hominoids, the homo sapiens begins to have 1.500 cc. in his cortical extension (Morin, 1973). Through the process of ontogeny and phylogeny the most primitive forms of life change into more complex forms and the society where they live changes also to more complicated patterns of interaction, acting in feedback, on the living creatures who inhabit the environment.

According to Morin (1973) at least 800.000 to 500.000 years before our days, the former paleo-societies began to need

some improvement in the forms of communication; it should be more rich, flexible and significant, passing from early gestalt premorphemes to more complex units called morphemes. Through language, much more meanings could be transmitted and much more doubts could be originated in the receiver. Messages could be clearly understood or misunderstood, eliciting some attitudes which might not be correct and proper for that occasion and matter.

Living in a society and being, specially in childhood, very much dependent on older people, we see that in constant interaction with the environment and other people, our words and motor behavior must be adequate to each occasion. We must act with older people whose attitudes and states of mind we must take in account to avoid deterrent actions on their behalf. Farrow (1967) remembers, during his self analysis, the blows and slaps given to him by his father. This happens usually in all societies and cultures, when children disturb adult people, and more in human than other animal societies. Although, Farrow (1967), states that undoubtedly is possibly very important for the child to be slapped, for if it were not for infant's doing something which offends any love feelings of the adult towards it, it migth be impossible for the adult to administer painful "corrective" physical punishments to the infant; he himself did not find any trace of trauma in the self analysis, due to parents' slaps.

Farrow (1967) explains that a) the pain may be administered by any ill-tempered adult towards whom the infant has never had love feelings in any case, so that there were no love

feelings to be frustrated; b) in the case of an adult towards whom the infant possibly had love feelings, its mind may possess some automatic repairing mechanism which completely heals, possibly within a short time any damage caused by this frustration so that no trace of any such effect appeared in the self analysis; or c) the infant under the age of two years may be entirely wrapped up in itself narcisistically, or even d) there might be a healing process by the infant's transferring its affection to some other adult who had not ill-treated it, or to a pet animal or even to its inanimate toy. Farrow (1967) seems to contradict the general psychoanalitc theory which emphasize that any infantile punishment leads to frustration and repression which are of primary importance in the psychoanalytic process. Any punishment can either provoke frustration or cessation of love on the part of the adult to the infant, caused by the infant's doing something which offends the "feelings" or opinions of the adult, or frustration of possible love feelings of the infant to the adult, or even neither of these two phenomena but only physical pain. Anyhow, at birth, and even before it, the brain begins to be impressed by all that goes in its surroundings.

Freeman (1967) counts her psychoanalytical process and stresses the importance of release of the repressed events which were very painful at the time. She became better when she could recall an event in which she thought her mother had forgotten her ony evening at school: one hour of waiting that made much difference for her emotional balance in all the future adult life.

Most people are punished when children but only few cannot overcome fairly the impact and damage that the punishment did in the emotional balance of the individual.

Attempts in systematic psychotherapy began about the turn of the century having been used before, such psychological techniques as persuasion, reassurance, etc.. In 1880, the interest was centered on problems of hysteria, assuming some physicians that organic symptoms were the causative factors and pointing others to psychological origins. Charcot, Bernheim and Janet in France and Breur and Freud in Vienna, were the first known to try a systematic study over these phenomena. Freud who worked with Charcot, Bernheim and Breuer, developed his own theoretical and therapeutical views called "psychoanalysis", giving rise to many more types of therapies either in an orthodox line or with many variations (Garfield, 1975).

According to Freud, the basic structure of personality consists of three major components: id, ego and superego. The id, is the primary and original system and source of psychological energy, instinctual strivings and tension, seeking release or discharge.. Closely related to id and derived from it, we have the ego with an integrating, executive and fulfilling function within the personality to satisfy the urges of the id. While the id operates primarily according to pleasure principle, seeking reduction of tension, the ego operates having in view the reality, according to the reality principle. The ego has to satisfy according to the realities of individual situation, and the

instictual urges of id. While in the first stages of life the id is the only component of the personality at work, as the individual grows and matures, ego processes and functions develop and serve as mediators between the instinctive demands of id as well as certain inputs from the superego. The ego has to integrate these conflicting demands within the resources of the individual and the environment, attempting some resolution or course of satisfactory action. The superego, is popularly equated to conscience (Garfield, 1975), and represents the internalization of the moral and ethical systems of the individual's culture as interpreted to him by parental figures besides their rewards and prohibitions with reference to specific modes of conduct. The child learns what is good or bad and gradually incorporates the whole value system which exerts influence on the individual's behavior, specifically on the ego, as it functions in relation to id impulses and realities of the environment.

Theoretically, an individual with strong sexual drives and fairly strong superego which prohibits the satisfaction of such drives, would be in a state of internal conflict and tension. In this dynamic conception of personality, neurotic symptoms or disturbed behaviors are viewed as the outcome of internalized or repressed conflicts. In a sense, symptoms are manifestations of internal conflicts, and in some dramatic instances, the specific symptom itself symbolizes the nature of the conflict. One must look beyond the symptom in order to discover the essential cau-

ses of disturbance.(Garfield, 1975).

Psychoanalysis is concerned in part in helping the individual gradually to trace back the relationship from the symp tom to the repressed conflict which underlies it. According to psychosexual development, one can go through all the stages of development or create a fixation to one stage and sometimes suffer from regression to an earlier stage of development. Besides conflict, anxiety is another construct within the psychoanalytical framework.

Defense mechanisms are constructs that mean the maneuvers that the ego can employ in warding of anxiety. Repression is one of them, besides, rationalization, displacement, projection, reaction formation, etc., which tend to become an habitual part of a person's pattern of normal response but whose excessive use or reliance upon, may impede the attainment of sound and mature patterns of behavior.

While the repressed material is insuficient to cause maladjustment, the psychological balance maintains well and the emotional health is not disturbed; but when the repressed material is suficiently large to menace the psychological balance, either the primary or the secondary processes take place (Freud, 1971). Lapsus linguae, parapraxis, dreams, are frequent means of maintenance of psychological health and balance and through their manifest or latent content, we can reach the origin of the repressed cause which produces the maladjustment To this process

of discovering the cause of the neurotic behavior we call analysis.

According to Freud (1971), the analytic process is based on the interpretations of the investment of libidinal force through the life. The free association method with interpretation of the material obtained during the analytic sessions, five times a week, during more than two years, is called orthodox psychoanalysis. All the dreams, parapraxis, slips of tongue, etc., from which the patient has notice are interpreted by the psychonalist.

On the other hand, Jung (Champernowne, 1974) delineates the Analytical Psychology in which he stresses the individuation, leaving behind the notions of libido and the sexual theory of repression. He admits that the individual has his own healing potential. For Jung, dream and art material are very important because they form the collective unconscious of a group or nation.

Adler, the other pupil of Freud (Orgler, 1974) disagreed with some Freud's ideas and founded his own type of Individual Psychology stressing the importance of the concept of inferiority which the child feels and has to overcome sometime during the development of the personality. Adler was not a Freudian analyst and was never psychoanalysed. For Adler (1970), the position of the child in the family and the relative position of the family in the social group, are the basic notions to be explored for the purpose of cure. The adlerian psychotherapy is a therapy based more on support of the EGO with four basic aspects (Orgler, 1974): establishing contact with te patient; elucidating his li-

fe-style; encouraging; developing social interest of the patient, always in a friendly attitude.

Freud's daughter, Anna Freud (Kreeger, 1974), with the publication of The Ego and the Mechanisms of Defence, in 1937, was largely responsible for the development of the school of Ego--Psychology in which the Ego and its correct balance is stressed during the whole therapeutic process, suplemented by educational measures (Rosenbluth, 1974). We see that this approach also does not stress too much the importance of sexual investment or libido but relies wore on educational measures.

The Kleinien approach to psychoanalysis (Hughes, 1974) was developed from the work of Freud and Karl Abraham. Her technique is based on children's play. While the child is playing she is projecting in her actions her deep feelings, needs and urges. Since the age of two, the child is able to be submitted to the Kleinien psychoanalysis because while she is playing, her emotional life is being discovered through interaction of the therapist. Melanie Klein considers that transference, while working with children, is present from the very begining of the analysis and that the child will express and experience towards the analyst feelings that related formerly to parental and other figures. In her approach (Hughes, 1974), the analyst takes comparatively an active part in interpreting and fostering the interchange between himself and the patient. Klein considers that mental process derives from instinctual needs having an idea of good or bad object part or whole. Kleinian framework consider that external events

can exacerbate or alleviate certain characteristics. If the environment is warm and loving, phantasies related to internal needs are invested with warmth and love. If the environment is cold and destructive, envious and destructive phantasies receive confirmation. If an infant has phantasies of destroying his object in hate and anger and a parent is ill or dies, then the illness or death serves to confirm his omnipotent destructive phantasy and he has an added task to distinguish his impulses from the external reality; on the other hand, if the object of his attacks not only remains alive and well, but also can tolerate his projections of hate and hostility without negating them, he is helped to accept his destructiveness as his own (Hughes, 1974). Just because birth frustrations are being helped to tolerate with moderate amounts of frustration over a period of time, that the infant develops a sense of reality as opposed to living in his phantasies.

Adler (1970) says that he insists in discovering the basis and establishing the causes of maladjusted patterns of actions. One needs to imagine what would happen in identical circmustances and usually arrives at the conclusion that a child feels the world sometimes threatening to her. If we try to understand the problem of the child our understanding increases and we can easily establish the connections of all the manifestations in accordance with the life-style of the child or even of an adult. When he describes the behavior of a little girl who every morning used to upset the whole family with worships and tears,

we see that her life-style was oriented to make other people care about her. Unconsciously, the little girl used to trouble the whole family but when this action was brought clearly to her consciousness, her tantrums and emotional outbursts faded away.

In part because of personality differences and also because of theoretical ones, more people who adhered earlier to Freudian theories, broke away and developed their own theoretical and practical orientations. After Jung and Adler, Otto Rank was one who drifted away from Freud. Also the movement designated by Ego-Psychology was an extension of Freudian theories, and Erikson, Hartman and Rapaport, are best known as its first followers (Garfield, 1975). Their primary contribution has been to emphasize more the antonomous functioning of the ego to which is accorded its own source of energy and is not seen as primarily dependent on energy sources arising from the id, with non-instinctual sources of motivation. More attention was paid to the coping mechanisms and the strengths and assets of the individual as well as to the situations that appear to arouse anxiety.

Karen Horney (Garfield, 1975) is labeled as "Neo-Freudian" because of the greater emphasis on social and cultural factors. Freud himself welcomed the designation of Adler's Individual Psychology and Jung's Analytical Psychology to differentiate from what he considered the only and authentic psychoanalysis. But Horney paid less attention to Freud's theories of libido, besides being critical about instinctive drives and Freud's view on the psychology of women. Unlike Adler she considered herself

psychoanalyst and conceived her own views as corrections to limitations in the scheme sketched out by Freud (Garfield, 1975), accepting the basic notions of unconscious motivation and psychic determinism. The notion of basic anxiety instituted by Horney, refers to the feelings a child has of being helpless and isolated in a world that is potentially hostile, being the most important influences the relationship between the child and her parents. Horney describes ten neurotic needs as strategies that neurotics have developed to cope with their anxiety and which will become over time rather stable personality patterns: need for power, need for prestige, need for perfection and neurotic need for affection, are some of them. Those needs tend to become insatiable and can never be fully satisfied enduring the development of conflicts which to be overcome, compel the individual to gain more realistic view of the self (Garfield, 1975). Later, Horney grouped these needs into three broader categories: moving towards people; moving away from people and moving against people. The handling of therapy has a psychoanalytical approach with more attention focused on the resolution of conflicts in the contemporary life situations.

Sullivan (1953) delineated the Interpersonal theory of psychiatry, stressing the importance of social setting on adult behavior. Sullivan's training, unlike Horney and Adler, was mostly influenced by W. White, M. Mead and A. Meyer (Garfield, 1975). He defines personality as "the relatively enduring patterns of recurrent interpersonal situations which characterize a human

life"(Sullivan, 1953), stressing in his theory two sets of basic drives: organic basic needs and needs for security, having both great association with interpersonal relationships. For Sullivan, the self-system develops out of the desire of the child to comfort himself interpersonally so as to receive tenderness and positive reinforcement from the mother, avoiding anxiety. In Sullivan's terms (1953), "we may expect, until well along in life, that the components of the self-system will exist and manifest functional activity in relation to every general need that a person has" and close relationship to anxiety has potentially negative consequences. Events or stimuli that threaten the self may tend to be dissociated from it with the self's tendency to limit the awareness and experiences of the person.

Sullivan (1953) borrowed for his theory, three principles from biology: principle of communal existence, principle of functional activity and principle of organization. The principle of communal existence refers to the fact that the living cannot live when separated from what may be described as their necessary environment, maintaining constant exchange through their bordering membranes with certain elements in the physiochemical universe around them. The principle of functional activity is a most common term for the processes which literally make up living. Organization is a principle which does not need to be explained and is constant in all types of forms of life. Sullivan (1953) also borrowed the ideas of absolute and limit from mathematics. Absolute is a construct used in two polar situations: euphoria

and tension. While absolute euphoria can be sbserved in a state of utter well-being, absolute tension might be defined as the maximum possible deviation from absolute euphoria, observed in a state of terror.

Sullivan (1953) also uses the term experience as a final analysis of tensions and energy transformations which occur in 3 modes: protaxic, parataxic and syntaxic. Tensions are those of general or zonal needs and of anxiety. The energy transformation may either occur covertly or overtly. The first successful activity in infants such as breathing, begins to define the nature of the need of oxygen, which before that is undifferentiated, and also begins to define the nature of extreme tension or almost complete absence of euphoria. Experiences in the syntaxic and parataxic modes are always interpenetrated by elements of the near past, sometimes even the distant past and by elements of the near future: antecipation, expectation and so on (Sullivan, 1953).

Sullivan (1953) puts his theorem in this way: "the observed activity of the infant arising from the tension of needs, induces tension in the mothering one, which tension is experienced as tenderness and as impulsion to activities toward the relief of infant's needs" and about the tension of anxiety, says that: "the tension of anxiety, when present in the mothering one, induces anxiety in the infant", stating that it is obscure how anxiety in the mother induces anxiety in the infant. Sullivan (1953) bridges the gap of this failure of reality referring to it as an not yet defined interpersonal process labeled as empathy.

For some people it is hard to accept the idea of empathy since it cannot be related to any sensory receptor. The tension of anxiety is early experienced in the protaxic mode differentiates from all other reductions in euphoria by the absence of any specific source of desequilibration such as the lack of oxygen, water or sugar, and consequent lack of differentiation in terms of the direction toward its relief by appropriate action.

Human beings manifest needs for sundry satisfactions (Sullivan, 1953). Converted into this language, the need for interpersonal security might be said to be the need to be rid of anxiety which in turn is not manageable and comes by induction from another person. The infant manipulates the other person calling out tenderness by manifesting needs. As anxiety is a tension in opposition to the tensions of needs and to actions appropriate to their relief, it interferes with the behavioral sequences. The differentiation of needs and the choosing of appropriate actions directed towards their relief, show the effect of the past and even at a very early stage, the element of antecipation of the near future. The capacity to experience anxiety is not an exclusively human capacity, but the role of anxiety in interpersonal relations is so profundly important that its differentiation from all other tensions is vital (Sullivan, 1953).

Mounier (1969) says that according to Nietzsche, the modern thought is full of phobias. He reminds the one who strolls by night and watches to its shadow: sometimes he fears it as it was another, but who is not another; something that it nothing,

but does not leave us alone. He says that the modern man fears to meet his shadow in the universe and to find with it an absolute solitude. Sartre says that when he stands before the being just as an observer, he sees the dialectic of plentifulness and of the inner mobility of the self (Mounier, 1969). In the plentifulness is nothing but massivity, the movement of the self, the immediate recall of experience, is not other thing than nothing, infiltration in the self of nothing which gives it an acceptable density. At the departure of all phylosophy and all existence we must place the original ontologic choice. We accept the self just as it is: as a self that must be discovered and accompanied and not as an object to be possessed. We are oriented through the avenues of our analysis to specify the notion of transcendence which plays such a role in all the existentialism that covers radically heterogeneous feelings.

Based on these views, existential analysis was practiced by Kirkegaard, Heidegger, Binswanger and Boss (Davison and Neale, 1974). Rollo May and Abraham Maslow, are the followers of this phylosophical point of view, besides being the leaders of the movement of humanistic psychology. According to Ford and Urban (Davison and Neale, 1974), the existential analysis presuposes that: "Man has the capacity of being aware of himself, of what he is doing and what is happening to him. As a consequence, he is capable of making decisions about these things and of taking responsability for himself. He can also become aware of a

possibility of becoming completely isolated and alone, that is, nothing, symbolized by the ultimate nothingness of death. This is innately feared. He is not a static entity but in a constant state of transition. He does not exist; he is not a being, rather he is coming into being, emerging, evolving towards something. His ways of behaving toward himself and other events are changing constantly. His significance lies not in what he has been in the past but in what he is now and the direction of his development which is toward the fulfillment of his innate potentiality."

Davison and Neale (1974) say that the existential therapist attempts to understand a person's problems through the subjective point of view of the patient, dealing with the reality not as it is perceived, but as it appears to the patient. This approach needs empathy that requires one human being to view things through the perspective of another. For this reason, existentialists are aware of the difficulties and recommend that the therapist understand his own feelings and biases so that he can hold them in abeyance while he attempts to place himself within the phonomenological world of the client. In existential therapy, the interpersonal relationship defines the identity and existence of the self who is threatened when isolated from others and deprived of open and frank relationships. As in the existentialist views, man can create his existence anew at each moment and the potential for disorder is ever-present and possible specially when one has not developed a strong sense of his own identity and worth as human being. The existential therapy makes the pa-

tient aware of his own potential for choice and growth being encouraged to accept responsability for his own existence and to realize that within certain limits, he can redefine himself at any moment and behave and feel differently within his own social environment (Davison and Neale, 1974).

Ronald Laing, a scottish psychiatrist uses most of the points of view of psychoanalysis but has some critics to this theory. He uses plain language and explains his point of view about psychosis, giving even to the layman a clear idea about his theoretical framework. Diverging also from the existentialists already mentioned, he presents a clear account of his caseworks specially with schizophrenics.

According to Laing (1974), the schizoid is not able to "feel with" other people and to be "as at home" in this world but feels withdrawn from other people and in complete isolation, almost divided, while the existentialist phenomenology tries to characterize the nature of experience, he tries to understand one's experience in a moment of the patient's life span. He imagines that there is an understandable transaction from the manner of being-in-the-world schizoid to the schizophrenic. In Laing's view (1974), we suppose that is made an attempt to understand when and how an individual slided from what we call normalcy to the state that we consider already abnormal. His therapy attempts to search all these clues in the family and social interaction along the total developmental span of the "sick" individual

(Laing, 1973). When one gets insight into his life and problems, tries to see the world more adequately and does not suffer too much from isolation begining no understand the problems of his fellow-men.

Humanistic point of view is also of Rogers' with his client-centered therapy which gives to the patient a great freedom of choice to modify his destiny. Free will is regarded as man's most important characteristic, offering not only fulfillment and pleasure but also threats of acute pain and suffering. Rogers (1974) make assumptions such as:

- man can be understood essentially from the point of view of his own feelings and perceptions and through the way he construes his world;
- man is innately good and effective but becomes ineffective and disturbed when faulty learning intervenes;
- a healthy person is aware of his behavior, being the therapy purposive and goal-directed requiring from the subject an active response and not passivity to the environment and inner drives;
- the therapist has to create conditions to facilitate the free and independent decision of the client without manipulating the events or the individual.

Rogers (1974), postulates an innate tendency to actualize or to realize one's potentialities. Men try to reduce the biological tensions from hunger, thirst and pain and seek to learn new things which enhance their lives; it is a search for pleasu-

rable tensions besides the urge to reduce unpleasurable ones. Thus our self-actualizing tendency elicits the production of behavior with positive consequences in relation to the goal and not to repeat behaviors with negative consequences. So when the self does not need to struggle and concern himself with approval from others, the most effective learning takes place (Rogers, 1974). When Rogers talks about the unconditional positive regard from the therapist, admits that in such moments one has the most valuable chances to evaluate himself, contributing to the enhancement of his own self-actualization.

The basic therapeutic tools—acceptance, recognition, clarification of feelings— are used within the context of a warm therapeutic relationship, competing to the therapist the duty of restating the emotional aspects rather than the content of what the client says, mirroring back to him his feelings about inadequacy. The honest talking of the client about himself, is largely responsible for the change of his behavior.

Psychotherapy with groups has evolved since the World War II as a mean of expediency. Large number of patients were referred to psychotherapy and the treatment of a single patient at a time was not in accordance with the number of experts available at that time. Since then, there have been innovations and modifications and actually there are many form of group psychotherapy available. The Rogerian approach is called group-centered therapy. In this therapeutic approach the situation brings into

focus the adequacy of interpersonal relationship and provides an immediate opportunity for discovering new and more satisfying ways of relating to people. The individual can come into closer contact with others and become gradually aware of those aspects of self which are important in his relations with others and can learn what it means to give and receive emotional support and understanding in a new and more mature way. In a group situation, people find it easy to express themselves much easier than in one-to-one relationship. But while the therapist does not impose his own set of values to the client, this one is exposed to the many value systems expressed by the group members being although free to appraise this material and still make the final choice for himself (Rogers, 1974).

Hobbs says that optimum groups consist of about six members plus the therapist, meeting twice a week and joining the group at the client's will. Nevertheless, an extremely hostile or agressive person will not be admitted into a group because he will interfere constantly with the athmosphere of acceptance and freedom from threat which the group-centered therapist tries to create. The group is free to bring forth and discuss any problems of significance to them and the therapist does not actively interpret material, limiting himself to accept the feelings of the group members, clarify the attitudes and feelings presented in the group and restate the content (Davison and Neale,1974). The great advantage of group therapy is that other members of the

group have a therapeutic role which is encouraged by the therapist who functions mostly as facilitator and not as a passive spectator or a guiding leader.

In the psychoanalytic group psychotherapy, Wender initially used the group interaction to allow the release of unconscious emotional difficulties and, according to him, the human individual is a "group animal" seeking a good place in the social environment; his difficulties are motivated by failure to adjust and to express his emotional troubles in the group and to find a place in it; this failure of adaptation produces neurosis or psycosis. In a small group, friendly to him, composed of other suffering beings, the patient becomes enabled to associate himself with them and release his agressive tendencies, hates, loves, wishes, without the sense of guilt. From a small group, the patient can be able to face a wider group in the daily life social situation (Garfield, 1975).

Wender points out the main factors he noted in group psychotherapy:

- there is intelectualization or insight;
- there is transference patient to patient;
- there is catharsis;
- there are phonomena such as group identification and sharing of common experience.(Garfield, 1975).

Schilder (Garfield, 1975) followed a more psychoanalytic pattern in group psychotherapy, using the method of free association. The patients were encouraged to write down teir fa-

mily relations and sexual development. Schilder tried to clarify certain basic attitudes or problems in order to help the person attain a better level of adjustment and worked on the "ideologies" during the group discussion: body and beauty; health, strength, efficiency, superiority and inferiority in a physical sense; aggressiveness and submission; masculinity and feminity; relation ship between love and sex; expectation of the future; meaning of death, with detailed outlines prepared for the interviews, some of them individual.

Slavson and Ackerman used psychoanalytically oriented group therapy with populations which ranged from pre-school children to adults. While he used play therapy -activity group therapy- with children, with adolescents his favourite method was "interview group therapy". Slavson used preferentially the interview method and selected his patients to the groups according to criteria such as interest in treatment, intelligence, intensity of individual disturbance, capacity for minimal primary selections, degree of sexual disturbance, minimal ego strength and minimal superego development. Slavson says that the chief value of the group is that it permits the acting out of instinctual drives stimulated by the interaction effect with other members who maintain an acceptance atmosphere, being always the individual and not the group that remains in the centre of the therapist's attention; the group is merely a mean of activating the individual and supplying the kind of experience that helps modify fee-

lings and attitudes (Garfield, 1975).

Ackerman has reported some success in an analytic group therapy with psychoneurotic adults. According to his point of view, conventional analysis has difficulty in the areas of social reality and interpersonal values, while in the group situation tangible social reality is ever present in the form of ideas, values, and interpersonal patterns of a group. According to Ackerman (Garfield, 1975), the therapeutic process moves back and forth between the social reality and the emotional life of each individual patient, being the group therapy a valuable support to those who completed successful psychoanalysis and have some difficulty in translating their analytic insigths into constructive form of social reaction. Ackerman believes that the therapist plays an active role in the group therapy and his evaluation about group and individual therapy, is stated in the following way: "group therapy, operating on an interpersonal level different from that in psychoanalysis yet gaining much from applying psychoanalytic insight to the dynamics of group living. On the whole, group therapy is a more real experience than is individual therapy. It is less bound to the irrationalities of the unconscious and is weighted on the side of social reality. Its greatest effectiveness seems to be in the area of reintegration of ego-adaptive patterns with resulting improvement of social functioning." (Garfield, 1975).

Activity group therapy developed by Slavson and colleagues, was applied to children mainly with charachter disorders and

behavior problems. Children with different clinical syndromes are assigned to the same group, believing that they can help each other in a permissive and unobtrusive atmosphere. The therapist without any kind of interpretations, let the members of the group -of almost the same age- grow free at their own pace.

Moreno idealized the psychodrama in which the patients take part in a dramatic production taking various scenes from past life. Trained personnel participate as "auxiliary egos", while the group members are encouraged to act out behaviorally their own role in relation to important problem areas. Sometimes the individual is asked to enact the role of an important figure in his own life and thus gain some understanding of the reactions of others to him. The most important feature of the psychodrama, is that participants actually engage in a dramatic sequence and thus specifically act out and experience some of their problems, much of them similar to those of real life situations. This technique is sometimes very useful even with "normals".

Besides these therapies which are used with both adults and children, there are analytic child therapies developed by Anna Freud. In this case, children are referred to treatment by adults and so they have no insight into their malady or voluntary decision and the will towards cure (Garfield, 1975). In this approach, the analyst takes the side of the child against others and even protects her from punishment. The child begins to depend on the analyst and enters into transference afterwhat the

real analytic work begins. The child's past history and other informations related to the maladjustment, are secured by the parents. Drawings are also used frequently as a mean of communication and play may be also used. Techniques of day dream and dream interpretations, are utilized as in analytic work with adults. While the child enters into a lively relation with the analyst and gives many evidences of transference relationship, she is not capable of forming a transference neurosis as is believed to happen in classical psychoanalysis. While the analyst shares the child's relationships and attitudes, there is no necessity for the child to give up the original relationships with the analyst who has a different type of behavior than in the adult analysis.

With this review on different forms of analytic therapy, we see that many psychotherapeutic approaches have claimed until now, the right to exist as valid and useful. We feel that most of them have worked at least on a basis higher than 50% of cures. Each therapist has his own framework and the divergences seem to be more on pheriferal aspects than on the core aspects of the therapy. It seems that there are not many different approaches in the analytical therapy, but approaches peculiar to each therapist or group of therapists which share a common type of work and style of language and scientific jargon.

We need that a therapist be skilled enough in his scientific approach, both theoretical and practical, to give relief to the suffering of human being. We would say that most of the

approaches , are essentially similar on their core theoretical framework but diverge essentially on some aspects of scientific jargon, which emphasizes points that are obscure and not highlighted in the other theory or therapeutic practice. As human beings are all different from each other and also similar in various aspects, it seems that in psychotherapy there is a great investment of the psychoterapist's personality in the therapeutic endeavour. In this case, the idiosyncratic language and intelectual outline will be overvalued and, in accordance, the whole therapeutic framework. We could obtain evidences trying to make an analysis with predictable outcomes correlated with the analytic theory and practice spoused by each of the different psychotherapists.

Would it be difficult to prove that any kind of psychotherapy is higly correlated to the psychotherapist's personality and that the outcomes obtained by him are essentially related to his skills?

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Course nº 751

MOTIVATION and EMOTIONS

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(Course nº 751)

MOTIVATION AND EMOTIONS

Motivation is the key principle of psychology, wether in the literature of learning or perceptual processes of human or animal behavior (Cofer and Appley, 1964), and motivational concepts are assigned a primary role, either in integrative personological or behavioral theories.

Scientific psychology studies behavior, and the why of the behavior is not directly observable in the individual's overt behavior but must be inferred tentatively and painstakingly from the observable and sometimes also measurable events.

In recent years many studies have been dedicated to study motivation and Bindra, Me Clelland, Adorno, Tolman, Woodworth, Berelson and Steiner, Spence, Troland and many others (Bindra and Stewart, 1973) have dedicated much time and effort to this problem which is stated in different forms of language and different concepts.

Nowadays the concept of motivation is emerging as a goal-directed action instigated by a central motivational state which is created by an interaction within the brain between the neural consequences of bodily organismic states called drives and neural consequences of environmental incentives called reinforcers (Bindra and Stewart, 1973).

Changes in behavior traditionally produced by manipulating "motivation" or "reinforcement" are the outcomes of influences from both the organismic states and environmental influences.

Motivation was first seen by the ancient, as instincts that instigated the actions of certain primitive animals, different from the voluntary and intelligent actions charachteristic of men. This primitive viewpoint sustained by Mc Dougall, Freud, Tinbergen and Lorenz, admitted the instinct as a psychophysiological entity consisting of energy-generating and direction-guiding process which produced all forms of primitive or intelligent behavior in men and animals (Bindra and Stewart, 1973). Today, Hinde and Beach try to alter this concept.

The concept of drive in motivation, was introduced by Woodworth from the observation that certain experimental manipulations such as food deprivation and induction of oestrus increased the level of general activity and facilitated the occurance of particular unlearned and learned responses such as eating, maze running, etc.. Carlson, Cannon, Richter, Warden in their investigations led to the conceptualization of drive as a specific biological state arising from the physiological consequences of change in a certain visceral function (Bindra and Stewart, 1973).

The notion of sensory feedback was used to interpret the drive but Lashley and Morgan taking it as invalid, emphasized central nervous mechanisms as basis of drive. According to

Bindra and Stewart (1973), Hull incorporated the biological view of drive into his theory, stating four primary drives: hunger, sex, thirst and pain, which are the main sources of actions, response reinforcement and acquisition of new or secondary drives. Dollard and Miller used the concept of secondary reinforcement and drive to designate human behavior. Still some shortcomings in this system had to keep some motivational phenomena out of homeostatic drives.

Reinforcement was correlated with motivation by Spencer saying that actions of animals and men, are influenced and modified by pleasure and pain. Thorndike's law of effect can be considered as statement of motivating and reinforcing conditions (Bindra and Stewart, 1973). Even contradicting Hull's idea about positive reinforcement being obtained by the reduction of drive, reinforcement became an important issue in motivation. Spence showed that learned motivational factors are generated by certain conditions of reinforcement and Bindra suggested that no motivational instigation can take place without the presence of reinforcing stimulus (Bindra and Stewart, 1973).

The nature of events and objects that have possibility of reinforcing responses led gradually to the idea that reinforcing stimuli might be the source of motivation. Certain stimuli and its configurations are intrinsically pleasurable or painful to individuals of certain species, and generate motivation instigating approach or withdrawl actions in relation to them (Bin-

dra and Stewart, 1973), the sensory processes arising from reinforcing stimuli, being the basis of motivation and not the response-reinforcing properties. Ethologists' recent work has contributed to analyse and specify stimulus configurations which are essential in making certain objects and events incentive stimuli, being this contribution very important for the acceptance of the point of view that incentive stimulation plays a role in motivation.

Electrical stimulation of certain parts of the brain, not only produce rewarding or response-reinforcing effects (Bindra and Stewart, 1973) but also can stimulate the animal to engage in action that lead to new stimulations. Electrical intracranial stimulation is fundamental to understand these phenomena, having the animal regulatory systems that have at least three types of components:

1. sensory mechanisms for monitoring conditions in the internal and external environment;
2. effector mechanisms for initiating behavioral or physiological control processes;
3. "set-point" mechanisms which generate values representing the balance to be maintained by the system in the face of internal or external fluctuations (Thompson, 1975).

The experimentations with electrical stimulation, led to the knowledge that the hypothalamus could be the facilitator of particular motivational actions such as eating, drinking, co-

pulating, thus being a possible centre of motivational processes, according to Stellar's theory (Bindra and Stewart, 1973). The concept of motivation began to be more clearly understood as a result of incentive stimulation on certain parts of the brain produced by electrical or chemical means, which elicit some consumatory or inhibitory actions, due to constant feedback of environmental factors on hypothalamic electrical or chemical stimulation.

Knowing that stimulations of hypothalaimc regions are responsible for the balance in the homeostasis of eating and drinking, we can easily understand that lesions in this part of the brain, disrupt eating and drinking, not only because they are separate and not unitary functions with the whole organism, but also because the regulator mechanism is upset (Thompson, 1975).

Thompson (1975) says that positive electrical self-stimulation of the brain, is a very powerful effect, particularly when delivered in the general region of the medial forebrain bundle-lateral hypothalamus, not different from basic properties from other types of reward or reinforcement.

Recent studies by Olds and associates, suggest that the hunger centre in the lateral hypothalamus, is separate and distinct from the self-stimulation zone. Being situated anatomically too close, only microelectrodes and weak currents can stimulate correctly separately each site at a time (Thompson, 1975).

Two major theoretical positions concern motivation and

reward: ethologists say that there is no general motivation or drive and that a given stimulus situation elicits specific food seeking and consuming responses. However, motivated behavior in higher animals, is not explained. The drive reduction theory says that motivation has general properties and that various needs contribute to the generalized drive level, being reward and reinforcement a result of drive reduction. While the drive reduction theory is supported by the only mechanism of reward and reinforcement, electrical self-stimulation does not reduce drive nor is part of any specific mechanism (Thompson, 1975).

Bindra (1973) poses a physiological theory assuming that the amount of motivated behavior is a function of the amount of activity in certain excitatory centres of the hypothalamus, being the level of activity of its critical centres, governed by the operation of four factors:

1. inhibitory centres in the hypothalamus depress directly the activity of the excitatory centres responsible for the production of satiation;
2. sensory stimuli set up afferent impulses which naturally contribute to the excitability of the hypothalamus if this is not done through a learning process;
3. changes in the internal environment exert both excitatory and inhibitory effects on hypothalamus;
4. cortical and thalamic activity, increase and decrease the excitability of hypothalamic centres.

Based on experimental evidence, Bindra (1973) says that:

a) there are different centres in the hypothalamus responsible for different basic motivations;

b) the hypothalamic centres' activity is partly controlled by excitatory effect of afferent impulses generated by internal and external stimuli;

c) for each kind of motivation there is one excitatory and one inhibitory centre;

d) all the roots of sensory stimulation, although differently stimulated, contribute to diverse hypothalamic activity;

e) the amount of motivation is determined by the amount of the total sum of afferent impulses;

f) a great variety of physical and chemical changes in the internal environment, influence the excitability of hypothalamic centres and contribute to the control of motivation;

g) for the temporal and spatial organization of motivated behavior, the cerebral cortex and thalamus, are directly intervening;

h) the control of motivation through excitatory or inhibitory influences on the hypothalamus, make different parts of the cortex and thalamus, operate separately, being the decortication or ablation of some of these parts an experimental proof confirming this statement;

i) control of motivation, probably through direct influence of hypothalamus, is exercised with many other factors besides

learning;

j) contribution of learning increases its influence as the animal is stimulated in a higher position of the phylogenetic scale. Cortical and thalamic damage, hypothalamic lesions, sensory deprivation experiments, give us evidence about this fact;

k) all factors adding the excitatory influences and subtracting their inhibitory ones, combine altogether their final intermingled variable at the hypothalamus. Experiences on sexual motivation, reduced by cortical lesions and restored by hormone therapy, are one example.

Let us return a bit to the view of motivation under the auspices of Freudian instinctual theory of psychoanalysis. Soon after the publication of Origin of the Species, by Darwin, and later Fechner's Elements of Psychophysics, Freud, attracted by the thinking of that time, began speculating about man and a scientific study about it. His training in medicine and neurology and his unwillingness to practice medicine, made him suitable to try to discover the mysteries of human life. Freud's early mentor, Brucke, was exposed to Helmholtz's influence and his ideas about energy conservation and exchange, provided Freud with a model for his theory of psychic energy and dynamic mental life (Cofer and Appley, 1964).

Taking the causality and determinism as a connerstone of his work, just as Helmholtz, Freud conceived that a careful analysis of the mental processes, beyond the conscious content, could reveal the links on the particular causal chains of events

in individual lives. Freud stated that individual organisms search satisfaction of its internal needs which give rise to tensions, arised by somatic demands on mental life (Freud).

Freud also says that internal body stimulation, wether produced as a result of chemical, mechanical or other changes, is represented in mental life by instinct arisen from the body itself in a constant stimulation to which the body cannot escape just as from the momentary external stimuli (Cofer and Appley, 1964). The amount of force is measured by the demand of energy which it represents. The aim of the instinct is to abolish the somatic stimulation from which they arose and this may be done through an object which may be the change (Cofer and Appley, 1964).

Instincts can be conservative and regressive, representing an inertial force and "organic elasticity" which keeps the organism resisting change. Traumatic episodes are "relived" in play experiences of children, in dreams and fantasies and in therapy (Cofer and Appley, 1964).

Basic instincts are derived from the body. Life instincts include reproduction and life maintenance. Death instincts are situated in the universal and phylosophic and scientific principle of entropy. The mental apparatus, according to Freud, is so composed: ID, EGO and SUPEREGO, being ID the most primitive, obscure and chaotic part of personality, functioning according to the pleasure principle and Nirvana principle and operating through the primary process. The EGO functions according to reality

principle, and operates through the secondary process with a continuous reality testing by comparison of memory images of previous satisfiers with those present in the environment, trying to maintain balance between ID and SUPEREGO impulses. The SUPEREGO, is built up through the EGO's contact with the outside world during the child's period of dependency on its parents, internalizing most of its patterns of behavior and those which reflect values, such as ethics, morals, ideals and taboos. The introjection of these values and mores, makes an individual capable of building his internal means of judging good from bad, awarding itself either self-esteem, shame or guilt (Cofer and Appley, 1964).

The effectiveness of action in the outside world, depends not only on physical reality but on the more arbitrary social reality of the culture in which the individual lives, being the EGO compelled to deal with this, to maintain a sound equilibrium between the ID and the SUPEREGO which present almost always conflicting tendencies that have to be soundly resolved. Identification, displacement, sublimation, anxiety, repression and defence are all constructs of psychoanalytic theory necessary for the functioning of the psychic apparatus.

New concepts about motivation, stress the following points (Cofer and Appley, 1964):

- psychological energy is dissociated from muscular energy assuming that biological substratum deriving from metabolic sources, is transformed through unknown mechanisms into forms of

usable psichological work;

- hunger thirst, sexual drive, etc. and all life drives make the motive forces, while anger and its concomitants, are a result of the inevitable frustrations and conflicts of early development;
- there are irrational primary processes and rational secondary processes of organized personality with motivational significance;
- instinctual motives and organized personality structural motives are intermingled;
- motivation results from the arousal of tensions and promotes organized behavior to reduce tension;
- EGO aparatuses mediate abilities and capacities as relatively independent from those involving defenses, modes and controls;
- anxiety stays as a link between biological energy and social behavior, allowing the hypothesis of tension-reduction for tension-increasing behavior; it gives an explanation to highly contrived behavior when assumed as an internal state of discomfort; it links present situation to the individual's past;
- conflict is the basic concept of the psychoanalytic theory opposing ID to SUPEREGO, actual to idealized self, modes of gratification, impulses or wishes to countercatexis, etc., being the personality a product of necessity born in conflict and guaranteed survival;
- early experience may be responsible for anxiety and for the later behavior development.

Having this psychoanalytic point of view about motivation, it is useful to establish a schematic division about motivation, designed by Berelson and Steiner. According to their idea of classification (Pereira, 1975), the motives are divided into three categories: primary, general and secondary or social.

Primary motives can be subdivided into positive (hunger, thirst, sleep) which try to reduce homeostatic needs in all the living organisms; the negative or avoidance motives try to keep the integrity of the organism avoiding harmful experiences or effects such as extreme heat, pain, etc.; motives of conservation include reproduction instinctual forces and need to search a better environment to continue life and the species, such as migration; these are life preservatory forces.

General motives affect either human or animal beings; these motives are neither totally learned nor instinctual: they are necessary for the organic and functional maturation of the nervous system. Piaget says that there is need of motivated behaviors to the equilibration between assimilation and accomodation. These general motives can be subdivided into exploratory drive, manipulation drive, affectivity drive, activity drive and competence drive (Pereira, 1975).

The third class of motives, is based on secondary motivation, learned through interaction with the environment. These motives are essentially learned in society and different from culture to culture. They can be: motive for power, affiliation,

security, status and need for achievement (Pereira, 1975).

With this classification of motives, we can use motivation to explain operationally some of the dynamic interactions which take place in human life, eliciting emotions that will be better understood and probably controlled when the stimulating motivation is carefully observed and measured.

There is a relationship between the autonomic nervous system and the endocrine system. To study emotional behavior in laboratorial experiments, we can use the following measures (Pereira, 1975):

- breathing rythm,
- heart rate,
- pulse rate,
- blood flow to the skin capilaries,
- skin colour and galvanic skin response,
- muscular electric potentials,
- cerebral electric potentials,
- retinian electric potentials,
- pupilary diametre,
- hormonal dosage in the blood, urine, etc..

Also according to Pereira (1975) the adaptation syndrome is constituted by:

- alarm reaction, with shock phase, and
  counter shock phase;
- stage of resistance;
- stage of exaustion.

In the shock phase, the nervous system is activated by the output of adrenaline elicited by a nervous mechanism through the afferent recticular substance, increasing the pulse rate and the quantity of glucose in the blood and decreasing the skin temperature through vasoconstriction.

The shock phase originates the countershock phase through hormonal feedback mechanisms; one hormone rises the blood pressure, while the other stimulates the adrenal glands originating the resistance stage.

Maintenance of this stage during a long period of time, may lead to the stage of exhaustion with the total collapse of organismic resistance and perhaps death.

Sudden emotions may elicit the alarm reaction with the startle pattern; there are many stereotyped modifications in the body position, lasting about 0.25 to 0.5 of a second; when lasting for a great period of time this pattern can lead to more dangerous reactions.

According to Mira y Lopez (Athayde, 1971), the emotion of fear has the following cycle of phases:

- fear threshold phase when the frightened individual tries to flee; the individual tries to be unnoticed;
- concentration phase, in which the individual has controlled movements, with fear of failure, trembling of the body and sharp attention;
- alarm phase, during which the individual presents lack of self confidence, failure in motor control, insecurity;

- phase of extremely high anxiety in which there is a functional disorganization of behavior patterns with discharges of the autonomous nervous system; one has anxiety and expectation of evil happenings;
- panic phase in which there is total absence of control on behavioral patterns; one might have an uncontrolled reaction of flight or an heroic action of attack; sometimes amnesia is a by-product of this situation;
- phase of terror, is the last one which can lead to complete inhibition of lower nervous centres, resulting in death by the paralization of nuclei in the brain stem.

This is the typical pattern of **fight-or-flight** reaction explained by Harvey (1978) in which the general changes are the increase of heart rate and blood flow to muscles, the decrease of blood flow to skin and organs to prevent hemorrages in case of wounds, the increase in oxygen consumption and cortisone output to provide blood clotting in case of **hemorrage**, the decrease in food and energy reserves and the increase in blood pressure and muscle tension to facilitate the flight in case of danger and fight in case of need.

Having studied the most primitive emotion -fear- we see that the determinants of emotional behaviors are (Pereira, 1975):

- state of activation with the consequent neuro-hormonal consequences;
- perception of the situation in its cognitive aspect.

Frustration, conflict and stress, can be considered

emotional states related to the interdiction of a motivated behavior. When a specific output or response is not obtained, these situations can lead to pathological conditions which may result in learning maladjusted patterns of behavior to cope with the situation (Pereira, 1975).

Barclay Martin (1973) discusses some emotional reactions specially those which are the charachteristic of neurotic disorders when extremely unpleasant: fear, grief, shame, anger.

According to Barclay Martin (1973) there can be a distinction between fear and anxiety, because fear is a response to a real danger whereas anxiety is not associated with any identifiable external events and is irrationally associated with situations that pose no real threat. Strong anxiety is likely to be reflected in psychological responses indicative of high arousal, behavioral disorganization and reported subjective feelings of tension, fright and aprehension.

Grief (Martin, 1973) is most commonly associated with the loss of important sources of need satisfaction or an abrupt decrease in levels of available reinforcement such as parents, spouse or child. Children separated from their parents due to extended periods of hospitalization or due to any hazard, become unresponsive and loose interest, after a period of "protest" during which the child cries and asks for parents, shows a restless activity and is easily angered. The facial muscles sag and the face presents accepted features of sadness and dejection. With

loud wailing and crying initially, it is later replaced by low intensity whimpering or sobbing and most children are likely to recover after several weeks from this depression withdrawl phase returning to a normal interest and responsiveness to their environment. Culture influences various learned inhibitions about grief expression, following the adult pattern. Some of the apathy and lack of responsiveness seen in the depression-withdrawl phase in humans are similar to learned helplessness demonstrated in experimental psychology with animals.

The other negative emotion is shame, behaviorally associated with hanging of the head and dropping the eyelids or averting the gaze. Shame is physiologically associated with blushing produced by the dilatation of the blood vessels in the skin and the charachteristic reddening. When we have a strong attraction and expect a disapproving reaction of others to its exposure, in the form of laughter or ridicule, we may be vulnerable to shame. The secretive enjoyment discovered by other people and exposed to ridicule, may produce the reaction of shame.

Anger is an emotion elicited by deprivation of sources of need satisfiers and is not highly unpleasant like fear, grief and shame. Rarely anger is experienced in isolation and mostly, affects such as grief , shame or agression, follow the shame reaction (Martin, 1973).

About positive emotions or those that elicit feelings of wellbeing and pleasure, man has a tendency to increase their

intensity, frequency and duration.

Love and satisfaction are two positive emotions that fulfil our lives. They are "energy mobilizers" according to Duffy (Cofer and Appley, 1964) and when permanently elicited and deepened, can lead to **ecstasy** and mystic experiences. Pleasure associated with eating, drinking, sex, sleeping and the other homeostatic drives can be considered to result in pleasurable emotions.

Just like anxiety is felt by babies which are permanently with anxious mothers, many emotions can be learned by people, from other people with whom they interact.

Rummerfield (1960) say you attract that which you want and by the same action repeat that which you don't want. The mood you are in when you make a decision or respond to another, along with the particular time this happens in relation to the other sequential instances to the day, determines the intensity of your feelings and how it all impresses you. Accordingly, you respond with actions and reactions.

Rummerfield (1960) also quotes some statements made by Anthony Barnett: "As for mental state it is well known that some illness, not caused by germs such as gastric ulcer, is associated with anxiety and suppressed emotional tension and that mental upset can cause symptoms of illness in any part of the body ... There is good evidence that psychological state is an important factor in a person's response to infection and this may be explanation for the aparently favourable effect of some anti-cold

vaccines: none of the vaccines so far used has proven effective under rigorous test".

Also Rummerfield (1960) says that for health and happiness, the human species must maintain a balance,and right attitudes help the body chemistry to maintain a physical balance.

There are usually two reasons why people want to be around you or associate with you:

1. you make the other person feel better, elevate his ego and self-respect because your personality suplements his; you add to one another and there is exchange of mutual respect; you recognize the other person as an individual who is worthy of respect, giving and receiving attention in a dignified manner; you bring out the better and nobler qualities in each other.
2. the other reason a person may want you around, is that he can dominate you because he feels he can dominate you and possess you and that you can't get along without him (Rummerfield, 1960).

Also Rummerfield (1960) says that you must accept your self and others in order to be well adjusted and happy. In these words we see that positive affects and their permanent elicitation and long duration, are one of the best strategies to cope with stress and disease or distress (Noronha, 1978, 1979a, 1979b). When one cannot help himself, the therapist is one who can and must be able to help people in distress or maladjustment (Diel, 1969).

Culture is a way of life and expression in a pattern demanded and allowed by a certain group (Rummerfield, 1960).

Therefore the individual matures as a composite of his culture, individual education and conditioning as directed by others or as discovered by himself. A new birth is required for his complete individualization for edifying expression (Rummerfield, 1960). Your happiness and security lie in your phylosophy of living.

Healing possibilities are within us. By repetitive response without self-condemnation, faith electrifies hope to assurance, bringing peace of mind by assuaging anxiety to accept that sought as now manifest or assured to come to pass in due time to prevent remorse (Rummerfield, 1960).

Positive thinking can change your life (Russell, 1978) and in this line of thinking co-counselling even with unskilled personnel is taking place in a do-it-yourself style (Callender, 1978). What is more important is to change substantially through environmental manipulation, our attitudes and our beliefs in order to alter our emotions through feedback mechanisms which will prevent us from entering in distress. Emotion is action plus cognition (Pereira, 1975) and if we think and act positively our emotional life will be full of assurance and confidence instilled to bring realization of at-one-moment with an ultimate and absolute power source (Rummerfield, 1960).

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