Journal of Consulting and Clinical Psychology
1978, Vol. 46, No. 3, 556–564

Case Study

Cohesive and Dispersal Behaviors: Two Classes of Concomitant Change in Psychotherapy

Leonard M. Horowitz
Stanford University

Harold Sampson and Ellen Y. Siegelman
Department of Psychiatry
Mt. Zion Hospital and Medical Center
San Francisco

Joseph Weiss
San Francisco Psychoanalytic Institute

Shirley Goodfriend
University of California, Berkeley

This article differentiates between two important classes of behavior that can be identified in any psychotherapy. One class concerns *cohesive* behaviors (Type C), which bring organisms together, and the other concerns *dispersal* behaviors (Type D), which drive organisms apart. This study examined changes in C and D behaviors that occurred during the first 100 hours of the psychoanalytic treatment of Mrs. C, a woman whose presenting complaint was sexual frigidity. The data showed improvement in both types of behaviors. In addition, progress in Type D behavior preceded progress in Type C behavior, a relationship that had been predicted by the case formulation. Then we identified approximately 350 complaints made by the patient during the treatment, complaints of the form "I can't (do something)" and "I have to (do something)." These complaints also declined in frequency during the treatment.

Personality theorists (e.g., Horney, 1945; Murray, 1938) have sometimes classified interpersonal behaviors into three broad categories. This classification is generated by considering, first, whether the subject is (a) avoiding the other person or (b) getting involved with the other person. If the latter, the behavior can be further classified into (b_1) behaviors expressing a positive involvement and (b_2) behaviors expressing a negative involvement. The resulting three categories can be labeled (a) *avoidance*, (b_1) *positive involvement*, and (b_2) *negative involvement*. Horney (1945) has called these three classes *moving away from, moving toward, and moving against* the other person. Murray (1938) has written of *abience, adience,* and *contrience* with similar meaning.

Behaviors involving other people, both positively and negatively, are frequently examined in psychotherapy. Those reflecting positive involvement occur when a person cooperates, collaborates, or concurs with another person, complies and shares thoughts and feelings and is intimate, warm, and loving. Ethologists (Mussen & Rosenzweig, 1973, chap. 28) have called these positive behaviors *cohesive* behaviors, since they bring organisms together. Since many cohesive behaviors begin with the letter *c* (cooperate, concur, comply), we shall call them Type C behaviors.

In contrast, behaviors reflecting negative involvement produce a psychological differentiation from the other person. They occur when a person

This study was supported in part by Grant MH 13914 of the National Institute of Mental Health. The authors would like to thank the many trainees and staff members of the Mt. Zion Psychiatric Clinic who generously supplied the clinical judgments and ratings.

Requests for reprints should be sent to Leonard M. Horowitz, Department of Psychology, Stanford University, Stanford, California 94305.

The results reported here are conceptualized in more strictly psychoanalytic terms in Bulletin No. 2 of the Psychotherapy Research Group, Mt. Zion Hospital and Medical Center, by Joseph Weiss and Harold Sampson. A copy of this bulletin can be obtained from Harold Sampson, Department of Psychiatry, Mt. Zion Hospital and Medical Center, P. O. Box 7921, San Francisco, California 94120.

defies another person, disagrees with, distrusts, or disapproves of the other person, hates, criticizes or opposes the other person. Ethologists have called these behaviors *dispersal* behaviors, since they (assertively and aggressively) drive organisms apart. Since many dispersal behaviors begin with the letter *d* (defy, disagree, disapprove), we shall call them Type D behaviors. As ethologists have noted, C and D behaviors show a complex interplay throughout the phylogenetic scale, promoting the survival of both the individual and the species.

Frequently during psychotherapy people complain of having poor control over C and D behaviors. Either they are unable to express the behavior comfortably or they are unable to modulate the behavior. In the case described below, for example, the woman sometimes wanted to be affectionate but found herself provoking. At other times she wanted to demur but found herself yielding. Her poor control was accompanied by psychological distress.

Impulse Versus Behavior

To clarify poorly controlled behaviors, let us begin with a basic postulate of psychoanalytic (as well as other) theories, namely that an impulse [1] precedes any nonreflexive behavior. The distinction is analogous to the psycholinguist's distinction between the underlying abstract representation of a thought and the corresponding surface structure of verbal behavior; one, an inferred private event, precedes the other, an observable surface phenomenon. The impulse, an encoded representation, becomes decoded through a grammar that involves optional and obligatory rules and transformations; the defense mechanisms would thus be viewed as a subset of transformations that occur during decoding (cf. Suppes & Warren, 1975).

Just as the correspondence between the deep and the surface structure of language is not necessarily 1:1, the impulse is not necessarily isomorphic to the behavior; different relationships can exist between them. Sometimes an impulse is directly expressed in behavior, at other times the behavior is simply inhibited, and at still other times, the behavior is partly camouflaged by another behavior derived from another impulse. Thus, if a behavior were to exhibit both a C and a D component, we would assume that two different impulses, a C and a D impulse, both existed. An affectionate pinch, according to the postulate, would result from simultaneous impulses to hurt and to be close to the same person.

A psychological "problem" is experienced when people lack control in translating impulse into behavior. For example, they might intend to express one impulse and yet find themselves expressing another coexisting impulse. That is, on the one hand, they might find themselves unable to express an intended behavior directly and complain, for example, that they cannot cooperate or cannot fight even though they want to. On the other hand, they might find themselves expressing a behavior more intensely or more compulsively than they want to, complaining that they *have* to share intimacies or *have* to defy even though they do not want to; such behaviors would have an obligatory quality.

A successful therapy should help people gain control over each kind of behavior. They should acquire the capacity to experience and express more directly both C and D behaviors. One goal of the following studies is to objectify such improvements and to examine the relationship between them.

Observation 1: Two Concomitant Changes

Method

This set of studies was based on a psychoanalytic case treated by a psychoanalyst who was not familiar with the views expressed here. Every session of the analysis was tape-recorded with the written consent of the patient. The analyst also took process notes during each hour describing the content of the hour. As the patient was talking, the analyst was writing. His notes, however, did not report any commentary or clinical inference; they only summarized the patient's talk and his own interventions.

A group of clinical psychologists and psychoanalysts met weekly to discuss the case. Drawing only on the process notes of the first 10 hours and information of the intake interview, they formulated the case and predicted a sequence of changes. The following case description summarizes the main details of the case and the group's formulation and clinical prediction.

Case description and formulation. The patient, Mrs. C, was a prim, married schoolteacher in her late 20s who came to treatment complaining of sexual frigidity, difficulty experiencing pleasurable feelings, and low self-esteem. Her father was a professional man, and her mother was a housewife. She was the second of four children

---

[1] The term *impulse* is meant to be neutral theoretically in the way that the term *underlying abstract representation* is neutral. Thus, for example, no energic connotations are intended.

(an older sister, a younger sister, and a much younger brother). When the treatment began, Mrs. C had been married for less than 2 years. She considered her marriage successful, though she felt that her sexual inadequacy created a major marital problem.

Mrs. C's parents were described as controlled people, undemonstrative of any affection. The mother, who was an organized and efficient woman, ran the house well. She was also very controlling, and Mrs. C felt in danger of being "owned" by her. On the other hand, the mother was not able to defend herself very well. Once, for example, the patient hit the mother in the stomach, and the mother could not defend herself or correct the patient except by retiring to her bedroom in obvious discomfort, leaving the patient to feel guilty, helpless, and frightened. The patient thus came to feel capable of hurting other people and guilty over aggression and assertiveness. Between the ages of 5 and 8, she had recurrent nightmares of something happening to her mother.

The father was also undemonstrative and easily embarrassed by other people's display of affection. Although he was generally controlled, he sometimes lost control of his anger and had temper tantrums that revealed murderous rage; at times Mrs. C felt that he was capable of killing her. The father was also upset by crying women and became angry over masochistic displays from the patient.

In the period before the analysis began, Mrs. C was feeling beleaguered and upset. In situations that called for intimacy, she experienced intense ambivalence, which left her feeling confused and in turmoil. The ambivalence resulted from numerous opposing tendencies: If she had an impulse to be sadistic, for example, she felt potentially guilty. Then, identifying with her mother, she would turn to masochistic feelings (feeling hurt, victimized, neglected, unfavored), which served to camouflage sadistic impulses. These feelings, however, were also unsatisfactory in that she felt that they would upset other people as they had upset her father, who sometimes lost control of his sadism. Thus, she could not express either sadistic or masochistic impulses comfortably and shifted between them, using each tendency to undo the other. The result was turmoil and confusion, and she was sometimes unable to focus her thoughts. She also felt vulnerable to criticism, since she was unable to defend herself against others.

Mrs. C's sexual frigidity may be related to her difficulties with aggression: Since she could not comfortably disengage herself from other people, sexual intimacy could be a problem in that she did not have the means of ending the closeness when she wanted to. Thus, an impairment in Type D behaviors could produce a corresponding impairment in Type C behaviors.

It was therefore hypothesized that during the treatment, Mrs. C first had to develop a better capacity to defend herself against other people (stubbornly resist other people without feeling guilty, disagree with other people, etc.) to allow herself to get closer to other people. It was hypothesized that as she acquired a better capacity for Type D behavior, she would feel less vulnerable in expressing Type C behavior and would therefore express Type C behaviors more freely.[2] The following procedure was designed to test these hypotheses.

Procedure. The first step was to examine Mrs. C's ability to express behaviors of Type D comfortably. A prominent subset of Type D behaviors contained instances in which she blamed, criticized, disagreed with, or opposed another person (the therapist or someone else). Three clinicians independently read the process notes of the first 100 hours in unsystematic order to avoid bias, looking for all passages in the notes that described such behaviors (in the present or in the past, toward the therapist or anyone else). Then the three clinicians together reviewed all of the passages that they had identified and retained the ones that they agreed were instances of blaming, criticizing, disagreeing, or opposing. Their resulting set contained 190 passages, involving both direct behaviors (e.g., criticizing the analyst) and self-reports of such behaviors.

Then a 4-point rating scale was developed to assess the directness of the behavior described in each passage. If the blame or criticism was only implied or if it was expressed tentatively with extreme discomfort, the scale value was 1; as the behavior became more explicit and direct, the scale value increased. A rating of 2 meant that a Type D behavior was expressed but immediately undone. Ratings of 3 and 4 meant that a Type D behavior was overtly expressed—3 by telling a third party about it, and 4 by directly

[2] It might be noted at this point that during the first 100 hours of treatment (covering a period of approximately 6 months), Mrs. C did achieve an increased, though limited, capacity to respond sexually. She also became more able to free associate easily, to reveal symptoms and preoccupations, and to think and work more productively. She became more able to express and tolerate strong feelings and found herself exercising a better-modulated discipline over the students in her class.

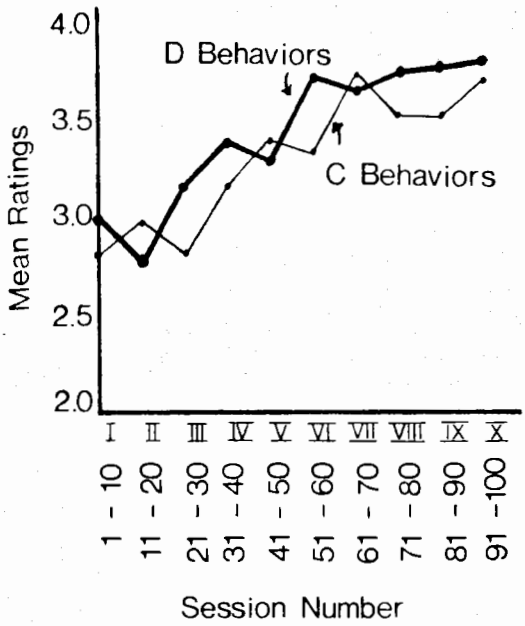

Figure 1. Mean rating of passages in each block of hours.

confronting the offending party. Each rating was also increased by .5 if the event occurred in the present tense (after the treatment began). Thus, the possible ratings were 1.0, 1.5, 2.0, . . . , 4.5.

The passages were divided into two subsets, and the passages of each subset were presented independently in random order to four clinical psychologists who were naïve about the case. Explicit scoring rules were developed for rating the passages, and the judges followed these rules in rating each behavior.

The second major step was to follow a similar procedure for identifying and rating the Type C behaviors. A prominent subset of these included behaviors in which the patient complimented someone, felt affection or compassion for someone, or wanted to be loved by someone. Two clinical psychologists read the process notes of the first 100 hours in unsystematic order looking for all passages in the notes that described such behaviors. As with the Type D passages, the clinicians reviewed the passages that they had identified and retained the ones that they agreed were instances of Type C behaviors. The resulting set contained 106 passages.

A 4-point rating scale was also developed to assess the directness of these behaviors. If the closeness was implied or expressed with extreme uncertainty, lack of clarity, or discomfort, the scale value was 1. A rating of 2 denoted an expression of closeness with immediate undoing. As the behavior became more explicit and direct, the scale value increased: 3 indicated that the feeling of closeness was expressed to a third party, and 4 indicated that it was expressed directly to the other person. Each rating was also increased by .5 if the event occurred in the present tense (after the treatment began). The possible ratings thus ranged from 1.0 to 4.5.

These passages were also presented to a panel of four clinical psychologists who were naive about the case. Explicit scoring rules were developed for rating the passages, and the judges followed these rules to rate each behavior.

Results

Type D behaviors. To assess the reliability of the judges' ratings, the four ratings for a given passage were averaged, and the reliability of the four judges' means was computed for each set through an analysis of variance. The reliability was .89 for one set, .90 for the other set.

The 100 sessions were then grouped into 10-session blocks denoted I, II, III, . . . , X. The number of passages within each block were I = 31; II = 13; III = 18; IV = 9; V = 35; VI = 13; VII = 13; VIII = 10; IX = 29; and X = 19. The ratings of passages within each block were averaged, and the means ranged from 2.62 to 3.81. These means are reported in Figure 1, which shows the development of Type D behavior across successive blocks of sessions.

To examine changes in Type D behaviors more closely, all passages rated alike were examined as a group. Because of the small frequencies in some categories, passages rated 2.0 and 2.5 were combined, as were passages rated 4.0 and 4.5. Also, to obtain more stable frequencies, the sessions were grouped into 20-session blocks.

The relative frequency of each rating was computed for each block, and these relative frequencies are shown in Figure 2. The top two graphs show a monotonic decline for passages rated 1.0–2.5. Figure 2 also shows a decline in 3.0s (criticizing someone for a past event) but an increase in 3.5s (criticizing someone for a current event). Direct confrontations (4.0 and 4.5) also became more frequent throughout the treatment. The graphs are largely monotonic and characterize major changes that occurred in the patient's behavior during the treatment.[3]

[3] These graphs, of course, are not independent of one another. The overall improvement in Figure 1 requires that the lower ratings generally decline over the 100 hours while the higher ratings generally increase.

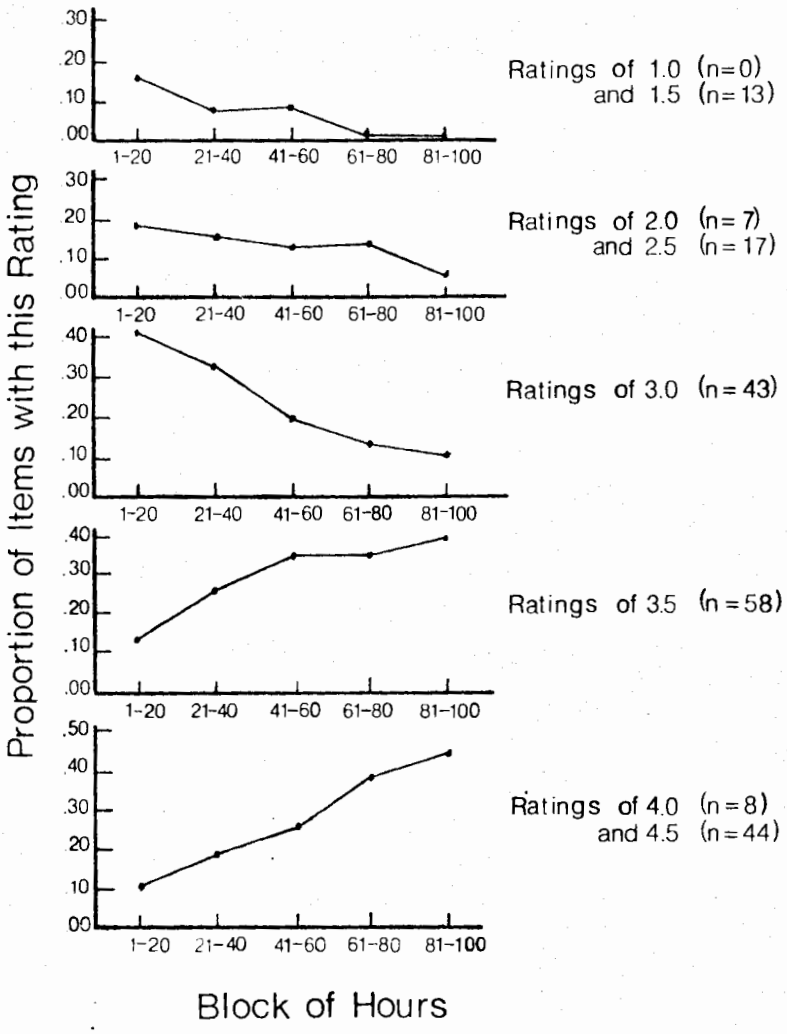

Figure 2. Relative frequency of passages in each rating category for successive blocks of hours (Type D).

To compare the frequencies of past and present events, the relative frequencies of 3.0s and 3.5s were compared. There were 101 passages with these ratings. For each block of 20 sessions, the relative frequency of 3.5s (present tense) was computed. For successive 20-session blocks, the values were 6/24 (i.e., 6 cases were in the present tense, 18 were in the past tense) = .25; 8/16 = .50; 17/26 = .65; 8/11 = .73; and 19/24 = .79. Thus, the patient increasingly came to criticize others for events in her current life. It is assumed that events from the past tense were less threatening for her and provided a convenient starting point for the therapy, but as the sessions progressed, she shifted her focus to her current life. Thus, *part* of the increment in Figure 1 is due to the patient's shift to present tense events, and *part* is due to the decline in lower ratings (primarily 1.5 and 2.5).

Type C behaviors. The reliability of the 106 Type C ratings was also assessed. The four judges' ratings for a given passage were averaged, and the reliability of the four judges' means was .83. The 100 sessions were grouped into 10-session blocks, with the following frequencies within each block: Block I = 11; II = 9; III = 15; IV = 10; V = 9; VI = 12; VII = 14; VIII = 9; IX = 5; X = 12. The ratings of the passages within each block were then averaged, and the resulting means ranged from 2.67 to 3.75. Figure 1 shows the development of the Type C behaviors across successive blocks of sessions.

To examine the change in Type C behaviors more closely, passages within each rating category were examined separately. Since the frequencies were smaller than those concerning Type D behaviors, all of the ratings from 1.0 to 3.0 were pooled (These were the categories that had shown declining relative frequencies in Type D behaviors.); likewise, all of the ratings from 3.5 to 4.5 were pooled. (These were the categories that had shown increasing relative frequencies in Type D behaviors.) Relative frequencies of occurrence were computed for each block of 20 sessions, as shown in Figure 3. One graph shows a progressive decline in the relative frequencies of the lower ratings, and the other graph shows a progressive increase in the relative frequencies of the higher ratings. The two graphs thus resemble those obtained for the Type D behaviors. Events in the past tense were also examined, but their frequencies were too small (only 23 cases) to permit any inference.

Thus, it is clear that two types of changes occurred, but it still needed to be demonstrated that a change occurred in the patient's presenting complaint, sexual frigidity. Therefore, every reference to the patient's sexual behavior was noted throughout the 100 hours. There were 18 such references (comprising a subset of the 106 Type C passages), all occurring between Hours 28 and 100. Each passage contained the word *intercourse* except one, which contained the phrase *sexual interest*. Here are some examples: From Hour 33 (rated 2.5): "Sometimes when she is trying to make herself have intercourse with Bill, she feels as though she wants to hurt him. She just doesn't understand it. She'll go from feeling very warm to feeling nothing toward him suddenly." From Hour 67 (rated 4.5): "This weekend she and Bill had intercourse, and she was thinking how different it can be when she's thinking about him and feeling close to him and not all wrapped up in herself."

Seven passages occurred in the first 50 sessions, and 11 occurred in the last 50 sessions. The C rating assigned to each passage was noted. For those in the early block, 6 had ratings of 1.5 to 2.5, and 1 (in Hour 43) had a rating of 3.5 to 4.5. Of the 11 passages in the later block, 4 had ratings of 1.5 to 2.5, and 7 had ratings of 3.5 to 4.5. The 7 passages with high ratings were mainly simple, direct statements that the patient had had sexual intercourse. A Fisher exact test was performed to test the significance of this difference; the chance probability of the observed pattern or a more extreme one is .022.

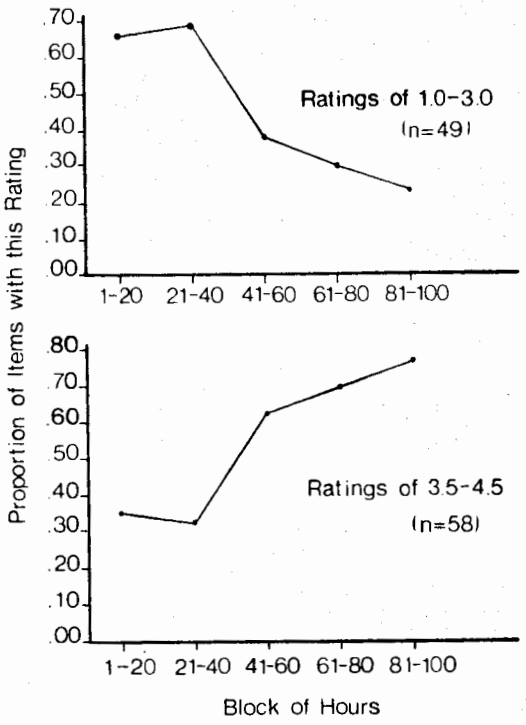

Figure 3. Relative frequency of passages in different rating categories for successive blocks of hours (Type C).

Observation 2: Relationship Between C and D Behaviors

The capacities to express C and D behaviors comfortably seem to be related, since a defect in D can produce a corresponding defect in C. That is, if a person did not have the capacity to disengage from the other person, intimacy would be unsafe, since the person would not be able to end the closeness and would run the danger of feeling oppressed or entrapped. On the other hand, once the person gained the capacity to express D behaviors comfortably, closeness would not be as threatening.

Thus, as Mrs. C gained the capacity to express Type D behaviors comfortably, it should become easier for her to express Type C behaviors. In any block of therapy sessions in which significant gains are observed in Type D behaviors, improvement should subsequently be observed in Type C behaviors. This hypothesis is examined below.

Method, Results, and Discussion

In Figure 1 the C graph resembles the general form of the D graph. To examine the relationship between the graphs more closely, the posi-

tions of greatest increase along each graph were noted. A "significant improvement" in either function is defined as an increment from Block i to Block $i+1$ that exceeded .25. Significant improvements in Type D behavior occurred three times—from Block II to Block III, from Block III to Block IV, and from Block V to Block VI. Furthermore, significant improvements in Type C behavior also occurred three times—from Block III to Block IV, from Block IV to Block V, and from Block VI to Block VII. In each case, a significant improvement in Type C behavior followed a significant improvement in Type D behavior: An improvement in D occurred from II to III, an improvement in C occurred from III to IV. The chance probability that the three Type C improvements would occur in these particular three positions is .012.

In addition, a "setback" in either function is defined as a decrement from Block i to Block $i+1$. A setback in the Type D behavior occurred three times—from Block I to Block II, from Block IV to Block V, and from Block VI to Block VII. A setback also occurred three times in the Type C behavior—from Block II to Block III, from Block V to Block VI, and from Block VII to Block VIII. Thus, a setback in Type C behavior always followed a setback in Type D behavior. In other words, the two graphs took very similar courses, with one displaced from the other by one block of sessions.

The data therefore suggest that the patient's progress in expressing Type C behaviors followed her progress in expressing Type D behaviors. As she became progressively able to criticize, oppose, and disagree with other people, she felt progressively less vulnerable; then, feeling less vulnerable, she could relax her defenses and permit herself to feel close, affectionate, and compassionate toward other people. If the two graphs had simply exhibited a correlation, other factors could account for their concomitant rise and fall. But their displacement in time suggests that an advance in one type of behavior may have facilitated an advance in the other.

This inference must be made with reservations for three reasons. First, the relationship may only describe an idiosyncrasy of one patient's progress and needs to be replicated with other cases. For example, Mrs. C's progress in part reflected a shift from past to present tense, and her proportions of present tense passages throughout the treatment, while similar for C and D behaviors, were not identical. It is possible that combining nonuniformities of this type could produce a lag between two graphs. Such issues would be best resolved by replicating the findings on another case.

Second, changes in Type C and Type D behaviors, as operationalized here, may be trivial. That is, they may reflect changes that occur in any developing human relationship in the way that the partners relate to each other (talking more directly, less cautiously, less formally) and are thus not necessarily to be traced to the therapy itself. It is possible that whenever Mrs. C entered a new relationship with someone, she would initially qualify with great caution any statements that she made so as to present a balanced view on any subject; such a tendency would involve statements that would get lower ratings. Then, as she came to know the other person better, she might drop this tendency and become more direct. If this interpretation were correct, though, C and D changes should occur simultaneously, rather than one consistently lagging behind the other.

Finally another kind of explanation might account for the observations in Figure 1. Suppose the direct expression of aggression is in some sense incompatible with the direct expression of intimacy, so that the relative prominence of one would imply a relative decline in the other. Then, as one graph rose from Block i to Block $i+1$, the other graph would fall. For example, in Figure 1, from Block I to Block II, the C graph rises while the D graph falls, causing the graphs to cross. Then, proceeding to Block III, the C graph falls while the D graph rises, producing another crossing. Additional crossings occur as the graphs proceed to Blocks V, VI, VII, and VIII. This characterization of the data has the virtue of parsimony, but it does not explain why both graphs would show concomitant overall improvement. It also suggests that the frequency of Type D behaviors should be strongly and negatively related to the frequency of Type C behaviors. The correlation was negative, but it was not significant ($r = -.33$, $p > .20$).

Thus, alternative hypotheses may account for some aspects of the data, and perhaps may even accurately account for aspects of the therapeutic process. However, they do not adequately explain the lag between graphs or the overall improvement in each type of behavior. For this reason, it is tentatively concluded that improvement in Type D behavior, at least in this patient, permitted subsequent improvement in Type C behavior.

Observation 3: The Nature of Mrs. C's Complaints

In the coures of 100 hours of treatment, Mrs. C mentioned a large number of other problems

that were not directly related to sexual frigidity but that clarify the nature of her distress. Many of these complaints were expressed in the form "I can't (do something)" or "I have to (do something)," revealing inhibitions and compulsions. A large subset of these complaints could be classified according to the C and D categories, and it was hypothesized that many complaints would reflect general problems over C and D behaviors.

Two people reading the process notes independently identified 248 complaints involving "can't" (e.g., She can't praise her assistant) and 103 complaints involving "has to" (e.g., She has to fight against her husband), making a total of 351 complaints.[4] Near symptoms of *can't* and *has to* were also accepted.

The statements were presented to a group of 20 judges (10 graduate students and 10 clinicians). Each judge was asked to classify each problem behavior as to Type C, Type D, or neither. A statement was considered a Type C (or Type D) complaint if 14 or more judges so classified it. Using this 14-or-more criterion, 60 complaints were of Type C and 56 were of Type D.

The complaints of each type were then examined further to determine how many were of the *can't* form and how many were of the *has to* form. Of the 60 Type C complaints, 51 were of the *can't* form and 9 of the *has to* form. Of the 56 Type D complaints, the corresponding frequencies were 24 and 32. The chi-square computed for this 2×2 matrix was 20.7 ($p < .001$). Whereas Type C complaints were typically of the *can't* form, Type D complaints were more evenly divided between the two. The single highest frequency was for complaints of the form *"can't C,"* a form that corresponds to the presenting complaint, sexual frigidity.[5] The other complaints, involving aggression and assertiveness, reflected poor control both ways: Sometimes the patient could not express behaviors that she wanted to express, but at other times she could not restrain herself.

General Discussion

Sophisticated studies of psychotherapy outcome have been undertaken in recent years, as summarized in the recent review of Bergin and Suinn (1975). Most of these studies (e.g., Berzins, Bednar, & Severy, 1975; Sloane et al., 1975) have reported data about treatment outcome, though details of the therapeutic *process* remain generally unclear. The present set of studies, in contrast, focuses on the treatment process per se and assumes that therapeutic outcome is best evaluated in the light of one patient's needs and goals.

The present article has examined several explicit propositions about the nature of Mrs. C's psychopathology and therapeutic progress. One major result showed that Mrs. C's difficulty in expressing Type C behavior was related to her difficulty in expressing Type D behavior; thus, the way to solve one specifiable set of problems involved the simultaneous treatment of another set. Throughout the treatment, progress on one set was a prerequisite for concomitant progress on the other.

These results thus point out one feature of a therapeutic process that is often overlooked in treatments that set more specific behavioral goals, namely, that an advance in one behavioral domain may be a prerequisite for an advance in another, quite different, domain. For a patient like Mrs. C, a gain in assertiveness may be necessary for a gain in intimacy. Occasional writers have implied such a relationship (e.g., Smith, 1975), but no systematic documentation or explanation of the relationship has previously been offered.

Furthermore, in Mrs. C's treatment, there were really *two* major therapeutic goals, but only one corresponded to her presenting complaint (sexual frigidity). It is possible, of course, that Mrs. C would have been helped more efficiently by a combination of assertiveness training and sexual therapy, but it is not necessarily the case that she perceived herself as needing to become more assertive. Indeed, a tabulation of her complaints throughout the first 100 hours showed that she often found herself too aggressive and oppositional, more than she wanted to be. Nonetheless, in principle, one could imagine a research design with patients like Mrs. C, comparing each kind

---

[4] These various complaints declined in frequency over the 100 hours. The relative frequencies occurring in successive 20-session blocks were .26, .24, .17, .19, .15; $\chi^2(4) = 15.48$, $p < .01$.

[5] Very few of these *can't C* complaints were specifically sexual in content, however. They concerned various people—the patient's husband, therapist, pupils, assistants—and they involved various forms of closeness—giving unilaterally to other people (praising, helping, reassuring, comforting, disclosing personal information), as well as exchanging (relating to other people, trusting, believing, returning love, feeling close to or relaxed with). The Type D problem behaviors were also heterogeneous, involving assertiveness (getting her own way, sticking to her views, developing her own teaching method, making demands on other people, disagreeing with other people) and aggression (expressing anger, being nasty to people, criticizing other people, opposing other people).

of treatment singly and in combination with the other kind of treatment.

One early theme in Mrs. C's therapy consisted of her criticizing people (e.g., her parents) for events of the past. This kind of theme often occurs early in a treatment as the patient spontaneously produces data from the past. It is possible that Mrs. C saw as one demand characteristic of therapy that she criticize her parents for events of the past. In our view, however, she was not only producing personal data but was also serving very specific therapeutic ends by beginning the treatment in this way. Her criticisms allowed her to observe the therapist's reaction to one very mild form of aggression and assure herself of the safety of similar undertakings in the future. This low-level criticizing can be viewed as an early test of a therapist. Other evidence of such tests has been presented by Horowitz, Sampson, Siegelman, Wolfson, and Weiss (1975).

Finally, the distinction between C and D behaviors emphasizes the *meaning* of the behavior in addition to its observable form. A given behavior may have multiple meanings for a particular person. For example, the very same behavior might be of Type D with respect to one person and of Type C with respect to another person. A criticism rated 3 in this study would be such a case; it was of Type D with respect to the criticized person and of Type C with respect to the therapist (since the patient is confiding in or confessing to the therapist). This form of closeness to the therapist was never tabulated among the Type C behaviors of this study, but it may comprise a significant aspect of the therapeutic process: The patient criticizes a third person, tentatively viewing the therapist as an ally; then, when the therapist permits the alliance, a closeness is established between them that neither party has directly solicited. Such aspects of the therapeutic process need to be examined further.

References

Bergin, A. E., & Suinn, R. M. Individual psychotherapy and behavior therapy. *Annual Review of Psychology*, 1975, *26*, 509–556.

Berzins, J. I., Bednar, R. L., & Severy, L. J. The problems of intersource consensus in measuring therapeutic outcomes: New data and multivariate perspectives. *Journal of Abnormal Psychology*, 1975, *84*, 10–19.

Horney, K. *Our inner conflicts*. New York: Norton, 1945.

Horowitz, L., Sampson, H., Siegelman, A., Wolfson, A., & Weiss, J. On the identification of warded off mental contents. *Journal of Abnormal Psychology*, 1975, *84*, 545–558.

Murray, H. A. *Explorations in personality*. New York: Oxford University Press, 1938.

Mussen, P., & Rosenzweig, M. R. *Psychology, an introduction*. Lexington, Mass.: Heath, 1973.

Sloane, R. B., et al. *Short-term analytically oriented psychotherapy vs. behavior therapy*. Cambridge, Mass.: Harvard University Press, 1975.

Smith, M. J. *When I say no, I feel guilty*. New York: Bantam Books, 1975.

Suppes, P., & Warren, H. On the generation and classification of defense mechanisms. *International Journal of Psychoanalysis*, 1975, *56*, 405–414.

Received July 22, 1977 ■