Behavior Change – Insignificant and Significant, Apparent and Real

by REUVEN BAR-LEVAV, M.D.

Reprinted from WHAT MAKES BEHAVIOR CHANGE POSSIBLE?,
Edited by Arthur Burton, Brunner/Mazel, New York, 1976.

Behavior Change—Insignificant and Significant, Apparent and Real

by REUVEN BAR-LEVAV, M.D.

Individuals and societies may both not like the status quo in which they find themselves, yet they generally prefer it to change, since this always entails not only work but usually also the taking of frightening risks and the possible loss of the sense of security. Consider an individual struggling with his snooze-alarm clock very early in the morning, as he is rudely reminded every few minutes of the call of reality, yet wishing to enjoy a little more sleep and the cozy warmth of bed, rather than step into the cold of morning. Waking up is a gradual process extending over time, at first totally resisted. Only slowly and gradually does reality push itself, as it were, into consciousness. The temptation to turn the whole damned alarm clock off is usually resisted, as the guarding superego is nudging the slumbering and drifting ego to overcome the forces of impulse to remain undisturbed.

Repeated intrusions on the part of the alarm clock are necessary before behavior change occurs, especially when a person is very tired and experiences himself as lacking in energy, as is true in both physical and emotional exhaustion. The force necessary to overcome the status quo of the sleeping state is directly related to the strength of the wish to remain undisturbed. This is also true in a more general sense, and suggests how great and persistent the push to reverse basic character traits must be. Political apathy on the part of the population is an expression of the same principle in terms of mass psychology, since individuals in groups similarly tend to take action only when the discomfort of non-acting becomes greater than the effort of action. Politicians try, therefore, to whip up enthusiasm by making promises that each individual can translate into personally meaningful terms, exactly because of such considerations, thus hoping to activate the political process in their own favor.

These principles hold equally true in clinical settings. Patients generally do not really want to *get* well, they want to *feel* well. Getting well always entails prolonged and painful efforts, and regardless of the reward, such efforts and pain are usually not welcome, except when no other choice is left. The popularity of therapeutic fads such as T.A. (Transactional Analysis) or Encounter, or that of quick-help movements such as T.M. (Transcendental Meditation) and the various oriental "religions" and gurus, rests basically on the quest for easier choices. The goal of becoming a separate, whole individual, capable of surviving without totally depending on others, even if the company and closeness of other human beings is preferred to being all alone, seems desirable and enticing in itself. "I Want To Be Me" is the title of a popular song, the slogan of romantic posters, and the subject of many well-selling self-help books. But, it entails the giving up of the unconscious dream of reuniting with an ever-present, ever-loving, life-giving mother. To do so is painful and frightening and requires enormous courage and perseverance on the part of the patient, as well as exquisite intuition, skill, and competence on the part of the therapist. In spite of the popularity of the slogan, the weaning process is rarely completed, separation-individuation is infrequently achieved, and depression, clinical and subclinical, is by far the most common illness of our age.

The theory of behavior change is essentially the same for individuals and groups alike. Although observable behavior may seem to be the most important criterion for measuring behavior change, it is in fact one of the least important. Gross behavior changes are rapidly and easily achievable both in individuals and in groups when enough force is brought to bear upon a situation. Such changes are often superficial, however, short-lived and mean-

ingless in the long run. More subtle and seemingly insignificant changes in observable behavior, on the other hand, may be indicative of major internal shifts, both in society as well as in individuals. The trained eye may see in them the first signs of major and lasting behavioral changes. Consider the following clinical examples:

> A woman is brought to the office by her husband in obvious panic. Her associations are loose, her speech rapid, driven, and disorganized, and she is thrashing about in obvious fear. She is almost totally unreachable, not only because of her gross state of disorganization, but also because of a partial congenital hearing loss. Several years later she leaves therapy not only without her panic, which was brought under control without hospitalization within a month or two, but also basically without lifelong paranoid tendencies and with a markedly increased capacity to trust and love. More remarkable, however, is a significant and measurable improvement in her hearing capacity. As she no longer needed to block out so much, she could actually hear more and better. Although she always wore hearing aids, no one ever knew that a functional component also existed in her hearing loss.
>
> A psychiatrist in his fifties, suffering from a lifelong depression that inhibited him and limited his success as a physician, reports after two years of therapy that his gross earnings in the previous year have been $9,000 above those in any other year. His self-destructive and occasionally bizarre behavior has also practically disappeared, but his chronic overuse of alcohol persists.
>
> A depressed mother of two teenaged children, who never really accepted her role as mother and adult, had tried for twelve years to finish college, always without success. Her superior intelligence was no match for her mountainous anxiety, and she would start and stop and drop out before the end of semesters. As her lifelong depression began to lift, she was able to graduate and is now successful in graduate school.
>
> Diane comes from a very disturbed family. All her siblings have either committed suicide or are emotionally impaired in a serious way. Several times over a period of three years she has attempted to call for her first appointment only to hang the phone up in panic. It was long before she came to a group session, and for a full six months she uttered not a sound nor did she ever lift her eyes to look at another human being. She still lives by herself and still works in a job below her capacity, but her personal contacts have increased markedly and are much more trusting and loving even as fear still interferes after years of intensive therapy.
>
> Marty displayed bizarre behavior since he was a little boy, and had seen therapists off and on throughout life. He became more confused and withdrawn in his teens, and withdrew into the basement of his

parents' home, rocking himself in a semi-catatonic fashion. He would emerge from the basement from time to time to join a religious sect or a political cause, but would soon be disappointed and return to the basement where his mother catered to the whims of her sick "boy." He now works and pays for therapy from his earnings, lives in his own apartment, and is heterosexually involved. He also returned to school and is able to pursue his studies. His manner of speech, gait, and posture have all changed in ways noticeable to those who know him.

Behavior Change Defined

These short clinical vignettes amply clarify the need for defining what meaningful behavior change is, so that any discussion of it remains rational. It may denote dramatic changes in motor activity or such seemingly slight changes as an ability to look straight at another person with less fear. The philosophic orientation and expectations of those measuring behavior change obviously color the evaluation of such changes. As in psychotherapy in general so also in relation to behavior change, what appears as a satisfactory result to one may well be dismissed by others as a relatively minor matter. The ability to perform sexually by previously frigid or impotent individuals may be considered a significant mode of behavior change. If, on the other hand, such frigidity and impotence are considered to be no more than troublesome symptoms, a detail in a larger picture of rage at, or fear of others, then obviously the mechanical performance of the sexual act, although important in itself, does not yet signify behavior change of a magnitude that will enable the person to live "normally."

Ruth came to therapy in a psychotic state soon after delivering her first live child. She had had several miscarriages, and married relatively late since she was uncomfortable with men and avoided them socially and sexually. She was helped to overcome this fear in several months of counseling and hypnotherapy, but her disabling menstrual cramps continued to plague her even after marriage.

Ruth's frigidity was only symptomatic of a much more serious and disabling problem that probably was also responsible for her miscarriages. Although her behavior changed markedly as a result of her hypnotherapy, such change in observable behavior failed to recognize the continuing battle inside her, and a florid psychotic depression was the result.

In general then, real behavior change is defined in this chapter as representing only those new aspects of behavior that emanate from, and are the result of, shifts within the personality or character structure—the outside observable manifestations of new aspects of personality reorganization. Such changes are

termed "real" whether they are minor and insignificant in terms of observable behavior, or major and significant in such terms. Other changes which do not represent internal shifts within the personality are termed "apparent," even when they are major and significant in terms of observable behavior.

Acting-out as Behavior Change

Since behavior change, or at least the freedom to assume new behavior patterns, is the ultimate goal of all psychotherapeutic modalities, it is understandable why both therapists and patients are eager to find and proclaim signs of it, whether real or apparent, and why the distinction between the two is often overlooked. Therapists earn their livelihood from therapy and may have a need to validate their efforts in such terms. Patients, on the other hand, spend much time, effort and often a great deal of money on their therapy, and they have a vested interest in believing that such expenditures were justified in terms of the results.

Behavior change may also be a manifestation of resistance. Patients change to please their therapist in the hope of being loved and given some of his or her magically ascribed powers, or refuse to change out of conscious or unconscious disappointment or anger. Such resistance is also manifested when patients act outside the therapeutic setting to minimize their hurt, pain or fear.

Self-esteem of therapists which is dependent on patients' improvement is obviously endangered when they fail to make progress. Frustration, impatience, and anger are then bound to interfere with therapists' capacity to continue working with such patients. If improvements occur under such circumstances, their value must obviously be questioned, for these behavior changes may represent nothing more than accommodations for the therapists' sake. Behavior changes may thus be the result of direct pressure that some therapists knowingly or unknowingly subject patients to, perhaps with the best of rationalizations. The Jewish Rabbis of old, long before Freud, recognized the flimsy basis and the temporary nature of transference cures and of changes in behavior that result from outside pressure when they stated that "love which is dependent upon some external cause has no endurance nor a separate existence. With the passing away of that cause, the love, too, passes away. But love that is not dependent upon an external cause has a separate existence all its own, and shall never pass away" (1).

If behavior change is considered without its cause and, if the question of its persistence over time is ignored, both the achievement of such a change and its evaluation become markedly easier. Children are known to sometimes

carry out in their lives hidden wishes that seem unacceptable to a parent or are openly condemned. Repeated warnings against certain forms of behavior actually draw a child's attention to such manifestly unacceptable modes of behavior, and the child can both rebel against and secretly please a parent by carrying out such forbidden activities. This is also true in some therapeutic relationships where the morbid interest of therapists may in fact encourage patients to change and to engage in forms of behavior for such questionable reasons. When behavior change becomes the major yardstick of therapeutic success, such and similar manifestations of new behavior may be misinterpreted as real.

Some therapeutic modalities assign legitimacy to actual suggestions from therapists to patients as to acceptable and desirable modes of behavior. Even the very continuation of the therapeutic relationship sometimes hinges on patients carrying out the expressed wishes of the therapist, especially those that are labeled as "good," "healthy," "normal," and "indicative of progress." Such behavior changes may or may not have a salutary effect on patients, at least in the short run, but in any event, they must all be classified as apparent and not as real changes.

Individuals subjected to stimuli which eventually result in significant behavior modifications undergo processes that are similar and analogous to those experienced by whole societies undergoing major internal shifts. In general, both individual and societal behavior change can be classified as belonging in one of the following four groupings, each representing more intense, deeper, and more lasting behavior changes than the preceding one:

1. Simple behavior change.
2. Behavior change accompanied by fantasy changes.
3. Behavior change accompanied by physical or physiologic changes.
4. Behavior change representing personality change.

Simple Behavior Change

The application of enough pressure or force to both individuals and groups will cause them to act dramatically, suddenly, and unhesitatingly in totally new ways. "An offer he cannot refuse" made to a bank teller usually produces a willing handing over of previously guarded sums of money. Individuals will likewise accompany a stranger at the point of a gun. With Hitler's rise to power, tens of millions of Germans and eventually hundreds of millions of others altered their entire life-styles and behavior patterns, as respective countries were mobilized, invaded, bombed, and reconquered.

Highly cherished modes of behavior, encompassing important areas of life, are suddenly changed in compliance with the wishes of occupation forces, even though such invading armies are usually hated. But, since such forms of behavior change are dictated by outside forces and not accompanied by internal changes within individuals or society, previously established behavior patterns are resumed as soon as the outside pressure disappears.

Within hours after the German armies were driven out, behavior systems that had functioned successfully for several years came to a sudden halt, and a sharp behavior reversal took place. Similarly, in spite of real compliance at the point of a gun, an individual will revert back to his or her typical behavior the moment the threat is removed.

Behavior Change Accompanied by Fantasy Change

Sudden and dramatic behavior change can also be accomplished when new situations are established as a result of legal or contractual arrangements. For those still abiding by the old and established codes of personal behavior, entering a marriage is accompanied by new modes of previously unacceptable personal and sexual behavior, a new address, perhaps even a new name. Since such alterations in one's behavior are accompanied by parallel alterations in one's self-concept and self-image, these changes are more profound than those adopted in response to an outside force. Yet, the legendary strains of old-fashioned honeymoons suggest that, even though such behavior changes were accompanied by fantasy changes, further modifications were still required before such married individuals were able to comfortably live with each other.

The mass behavior of groups is also grossly and dramatically affected by changes in the legal system. Such was the case when in 1863 slavery was abolished in the United States. While the ownership and holding of slaves was no longer legally acceptable or tolerated, this major change in the economic and social life of the society was relatively sudden and not accompanied by corresponding changes in the fantasy lives of either blacks or whites. The slaves of yesterday continued to experience themselves more often than not as slaves, even after this status no longer had any legal existence, and similarly most whites did not suddenly begin to regard their black brothers as equal in their humanity to themselves. The actual freeing of the slaves in response to an emancipation proclamation from "above" must be regarded as no more than a simple behavior change at that point. The proclamation changed basically the status and the behavior of slaves and of slaveholders and abruptly forced them to act in totally unaccustomed ways. A fantasy change lag is common, and must always be expected, since

fantasy changes are never easily come by. They are, however, *always a necessary first step for real internal changes* within an individual or within a group.

A full hundred years had to elapse, in fact, before blacks really accepted, in fantasy as well as in fact, that "Black is Beautiful," and before most whites regarded Negroes as persons rather than as things. Many blacks have self-righteously exploited the guilt of many whites over the long overdue closing of this lag, as if it were one-sided and, in reacting to injustices of the past, have become tolerant of gross injustices in the present. Such gross distortions of reality in either direction are behavioral manifestations of the misguided expectation that fantasy may be changed suddenly even by most humane legislation or by political fiat.

Behavioral Change Accompanied by Physical or Physiologic Changes

Even though gross behavior may sometimes be modified in a lasting way when it is accompanied by fantasy change, such changes are limited in scope and in depth as long as previously established patterns of behavior are automatically repeated by an organism, be it an individual or a group. A compulsive individual in effective psychotherapy, for example, may engage in new modes of behavior in fantasy, and may eventually also experiment with new ways of being in reality. But in the presence of fear or rage such a person is likely to revert back automatically to old behavior patterns which were helpful in the past. Basic character traits must be thoroughly worked through over time before they are altered and become really different. Only then can it be claimed that real personality change has begun to occur. At such a point, a basic shift in the patient's defensive structure will also have occurred, and less physical and psychic energy will be spent in obsessive or compulsive preoccupations. The internal economy of the patient will have changed to permit him or her greater flexibility and more choices to pursue his or her real interests.

Meteoric political movements using personal terror as their chief tool, such as South Moluccans in Holland, the SLA in California, and others in the more distant past, have proven to be no more than short-lived flashes in the pan, since they usually lacked a wide enough economic and social base to sustain them. The same was true of the impressive power amassed by Senator Joseph McCarthy in the 1950's. It was based mostly on fear of Communism, and although formidable in its day, it passed overnight. It represented no new power alignments within society, no new economic interests nor social groupings reaching for new positions. Like similar movements throughout history, these too were basically expressions of protest or fear, rather than

integral expressions of genuine strain within the societies from which they sprang. Although occupying the headlines of the world and affecting the behavior of millions of people for a short while, such behavior alterations were in a real sense meaningless, except as bizarre historical episodes.

The miraculous revivals of both Germany and Japan after the Second World War, on the other hand, rising from the ashes of almost total destruction to occupy the peaks of world production, are examples of real behavior change based on definite and real internal transformations. As soon as war was over, the productive capacity of both these nations was shifted in a sharp behavioral about-face from an almost total wartime footing to reconstruction and the production of industrial as well as consumer goods.

The demographic presence of millions of highly-skilled Germans and Japanese who suddenly shifted the direction of their productive efforts was also instrumental in the emergence of new societies with new value systems and, in many cases, entirely new modes of individual and group behavior. Behavior change that is accompanied by internal physical or physiologic change is slower and less dramatic, usually requiring years of hard work to achieve, yet it is generally a more stable change and a more permanent one.

The Jews of old also offer a fascinating example of basic behavior change accompanied by basic internal changes within a society. The success of such adaptive changes is attested to by the fact that it helped the Jewish people to survive for almost two thousand years under very trying circumstances. When their land was overrun, their only Temple in Jerusalem destroyed, and their people driven away, they abruptly changed their territorially based religion and imbued it with universal values based on their specific history. These internal changes in their system helped them adopt new observable behavior patterns not possible before. Animal sacrifices, for instance, were replaced by prayer in a newly devised institution, the Synagogue, and while other ancient peoples perished, they survived. The decadent and pleasure-seeking society of old Rome, on the other hand, in so many frightening ways similar to our own modern Western societies, proved to be too rigid in its internal structure and therefore unable and unwilling to modify its modes of living in response to the new military and political pressures from the outside. Like the dinosaurs, and for the same reasons, old Rome with all its power and glory has disappeared from history's stage.

Physiologic changes, totally unrelated to conscious will, must similarly be altered within an individual as he or she undergoes psychotherapy with the aim of changing basic characteristics of the personality. When such changes take place, the behavior changes of such an individual are likely to encompass important aspects of the person's entire mode of adaptation to reality and

to its challenges. When no physiologic changes occur, the behavior changes are likely to remain encapsulated in their scope if lasting, or limited in their life span and life expectancy.

Once physiologic changes have begun to occur within an individual or physical changes within a society, an organic process with its own independent existence and pace has been initiated. This process eventually and inevitably leads to lasting personality or societal changes, unless stopped. The continued, independent existence of such a process does, however, require regular refueling from time to time, very much as the process of pregnancy has its own independent stages and rhythm, yet its continuation is dependent on the mother's life and well-being. Slow but steady and continuous changes occur under the visible surface when nations are being built or destroyed as well as in individuals when reconstructive psychotherapy is successful.

Behavior Change Representing Personality Change

Behavior changes based on parallel changes in the personality structure of an individual or of a group appear to be the most lasting and the most reliable of all. Such changes express facets of the changing core of one's whole being, and represent new adaptive modes to the challenge of existence in the universe. Mao's cultural revolution and the tight regimentation of both Chinese and Soviet societies are conscious, deliberate, but probably futile attempts to bring about such profound changes in their respective societies with enough continuous pressure over enough time. The leaders of these societies fail to understand what makes behavior change possible, and assume simply that pressure from the outside will somehow eventually initiate organic processes within their societies, even if willing cooperation and participation on the part of individuals does not exist.

Experience with brainwashing by means of extreme physical or psychologic deprivation may have misled some to believe that character traits can be changed by manipulating entire societies. Such assumptions confuse the sharply limited strength of any one individual with the enormous and limitless resources of the human spirit. Any one individual may be totally broken beyond repair. The spirit of man, like the legendary phoenix, is capable of rejuvenation and revitalization, at least as new generations are born, grow up, and come fresh into the arena to take up the struggle that may have been temporarily lost in the past.

The existence of typical national characteristics of Englishmen, Mexicans, the conservative Swiss, and others is sometimes used to demonstrate that some form of national character may evolve after all, if only sufficient time

is allowed for the process to get under way without disturbance. Linguistic peculiarities, temperament, and general social demeanor as well as typical common elements in posture and gait are all expressions of that which is common among people who share similar geographic, climatic, and political conditions. It proves again that character formation and behavior are largely functions of environment and time. Individuals emigrating to foreign and faraway countries do not suddenly lose their ethnic or national characteristics, and usually continue to follow old behavior patterns for a long time. Behavior change is gradual and slow, like character change.

Much more importantly, however, individual variations in character structure within any one national character group always encompass the whole range of possibilities, and they are far more significant than the common national traits. These characteristics, closer to the core of the personality and more intimately associated with basic fears of individuals, are even more resistant to change, and even more gradual and slower than ethnic ones. Real behavior change is always an end result of much effort over a long time.

In summary, behavior always expresses personality, unless some force interferes. By extension, it is reasonable to expect that real behavior change will similarly always express personality change. All other forms of behavior change must necessarily represent a response to external pressure. Such behavior changes are generally only apparent, for when the pressure is removed behavior is likely to revert back to its original form, with minor modifications at best.

Crisis as an Opportunity

Crisis Mobilization Therapy, C.M.T., is a recently developed, integrated system of psychotherapy which deliberately does not focus on behavior change, even though this is its ultimate goal. Behavior change in C.M.T. is considered significant only when it is real, as defined previously, and it is therefore always incidental to personality change. Profound behavior modifications are expected, and in fact the effectiveness of C.M.T. can only be judged by this yardstick, yet no deliberate attempts are made to modify behavior as such. In fact, unexpected changes in behavior of patients are generally looked upon with suspicion, for clinical experience has repeatedly demonstrated that such changes are often manifestations of a resistance. The giving up of personality traits that have always been considered essential for survival is a frightening and painful process, and patients frequently attempt to escape this self-imposed and yet difficult task (2) by behaving as if they had already undergone the personality change that would make such be-

havior change possible. If undetected, other undesirable personality traits or symptoms often become more prominent and troublesome instead. Manifestations of behavior change are naturally expected during therapy, but they are repeatedly challenged when they first appear to test whether they are real or not.

Crisis Mobilization Therapy, which is described here only to the extent required by a discussion on behavior change, should not be confused with any form of Crisis Intervention. It has, in fact, nothing in common with it except the use of the word crisis, which means different things in both instances. In C.M.T., crisis denotes a peak emotional reexperience of unresolved internalized conflicts, which can now be resolved in new ways, meaningfully different from past patterns. Patients are helped to reexperience all their feelings in a therapeutic setting, a frightening experience which does not develop spontaneously but must be evoked. Special techniques, provocative and other, were developed for this purpose in C.M.T. Such emotional storms are optimally experienced at a level of intensity just short of the point where anxiety would overcome the patient in the form of confusion or an outright refusal or inability to continue. Such peak emotional experiences require the active and willing participation of patients, although such participation and cooperation are always somewhat tentative and hesitant, considering the fear with which such experiences are often regarded as possibly endangering the very survival of those involved in them. Such crises of affect are usually mobilized or brought up in a group setting, but patients are also seen regularly in individual sessions, which are generally more supportive.

A therapeutic split of the ego must already have occurred before crises of affect can be mobilized. This allows therapists to encourage patients to take further risks, if they wish to do so, even as they are supported when they refuse to proceed. The patients in C.M.T. assume full responsibility to get themselves well or not to, even as it is the therapist's responsibility to make it as difficult as possible for a patient to not move in the direction of health. There is *no place for coercion of any kind in C.M.T.*

Patients are expected to clearly understand and unequivocally accept the principle of "isolation of action" from feelings, which should make it easier for them to take the risks involved in experiencing all their feelings. This principle simply reaffirms the unacceptability of any form of acting-out or acting-in, and should not be confused with isolation of affect. No action whatsoever is to be taken on the basis of feelings alone. All actions, both active and passive, must, instead, first be coolly considered and judged acceptable by the patient's cognitive process before they are carried out.

Most individuals in our society, in and out of therapy, fail to understand that intensity of feelings is never really a rational cause for action. This appears to be a culturally determined basic defect in our society with far-reaching and most damaging consequences to many individuals and to society as a whole. Firm establishment of the principle of isolation of action is a continuous task in C.M.T., for acting-out or acting-in comes in many disguised forms, and is a repeatedly attempted route of escape of patients when they are frightened, hurt, or they otherwise wish to escape a difficult confidential situation.

The Therapeutic Alliance as a Base for Behavior Change

A uniquely strong therapeutic alliance is the cornerstone of C.M.T., and it is regularly built up and strengthened, from a tentative and fragile relationship at first to one that can and should be able to withstand major tests. This alliance is stronger in C.M.T. than in other modes of psychotherapy, because of the active role assumed by the therapist and the central position that is consciously assigned to the interactions and relationship between patient and therapist. In addition, deliberate attempts are made by the therapist regularly to couple deprivation of infantile needs with occasional gratification of appropriate adult wishes. Patients who are either unwilling or claim to be unable to assume more complete responsibility for their lives are induced to do so, although not without a struggle, with the aid of this therapeutic alliance.

Patients in C.M.T. learn early that the commitment to therapy is a two-way affair, both therapists and patients making conscious and volitional choices to work with each other. Although the patients pay the therapists for their time, the latter must decide with which patients they choose to work and must be willing to invest of themselves in the patient. Such choices are always conditional in C.M.T. on the patients' reciprocal commitment to treat their lives respectfully, and to assume full responsibility for their being. Suicidal acts or gestures, just like other forms of regressive action, may be likely causes for termination of therapy.

Patients frequently experience the therapeutic milieu of C.M.T. as providing them with "a place in the world" in which they can be heard and understood, a "home," and they are therefore not usually likely to give this up easily, mindlessly, or frivolously. This sense of "belonging" often provides patients with a sense of basic security which many individuals have known only in earliest childhood or in utero. The wish to maintain this sense of security is strong enough a motive in most instances to overcome the im-

pulse to act-out. Even more so than in psychoanalysis, it is necessary in C.M.T. to construct a closed system in the confines of which pressure can be applied upon patients to facilitate characterologic and thus behavioral change in the direction of health. The strength of this closed system must be sufficient to withstand the pressure of patients against it as they wish to escape when pain and hurt seem to become intolerable.

The Concept of Force in Overcoming Resistance to Behavior Change

Present-day psychotherapy that is not directly involved in mechanistic behavior modification is basically descriptive and analytic in nature, as if this, in itself, would bring about behavior change. Much of physicians' time and the time of staff conferences is devoted to diagnostic determinations and to the understanding of underlying dynamics. Freud's unproven and probably mistaken notion that neurotic conflict is resolved by making repressed, unconscious material conscious and by removing the amnesias (3) is largely responsible for this preoccupation with finding and understanding hidden dynamic aspects.

What may perhaps have been true to some extent in Freud's Vienna hardly applies in this psychologically sophisticated age. Patients today often understand basic psychologic configurations, and can often even apply them, correctly if incompletely, to their own situations, and mouth them with varying degrees of confidence. Such understanding is not usually helpful in the process of self-change, and it is often used, instead, in the service of resistance. Additional dynamic interpretations are only useful in a setting in which the relationship itself is intensive enough to involve the patient emotionally in a meaningful way. More than an accurate description of unconscious self-destructive ways and even more than emotional recognition of such uncovered material by the patient are needed to overcome lifelong pathologic personality traits. What is needed is force, a pressure in the direction of health, *derived from the therapeutic alliance and applied with the explicit permission of the healthy part of the patient's ego* against his or her own pathologic part. *C.M.T., alone of all psychotherapeutic modalities, specifically acknowledges this need for force* and has developed special techniques for its exercise. As patients have been "driven crazy" in their formative years, so they must be "driven sane" in psychotherapy.

The Physiology of Psychological Responses

Mobilized affective crises are basically different from spontaneous eruptions of feeling storms as a controlled nuclear reaction is different from a destruc-

tive nuclear bomb. Since the therapeutic alliance is not very strong early in therapy, sufficiently intense affective crises cannot be mobilized until later in therapy, when enough reality-based trust has been established between therapist and patient. The mobilized crises must eventually be of an intensity sufficient to cause measurable changes in physiologic parameters such as blood pressure, body temperature, heart rate, breathing depth, muscle tone and others. Mobilized affective crises which fail to reach such levels of intensity must be regarded as only preparatory for more intense experiences later, but generally those close enough to the core of internalized conflicts bring forth affect of such an intensity. By the remobilization of such crises again and again, previously established physiologic reaction patterns based on the relative power positions of infancy are modified, and eventually basically altered. Affective crises lose their critical nature with time, and when they no longer have a crippling grip on the patient they can be handled more appropriately in an adult manner.

The Modification of Preverbal Hunger and Rage

When lifelong depressions are finally lifted, a task that often requires years of hard work and a great deal of patience, sensitivity, and courage, the organism is freed from leaden shackles that have burdened it up to then. Such release always frees much energy that was previously tied up in submerging frightening feelings. This new energy is now usable for living, and usually tips the internal balance between pathological and healthy tendencies so that real personality changes now occur in rapid succession. Objective determinations of changes in a person must necessarily be based upon records of observable behavior, even though other, often much more important but hidden, processes have occurred underneath the surface. What is actually observed may be essentially the same as that observable as a result of mechanistic behavior modifications, although the two are basically different, one representing modifications in depth, the other only superficial ones.

Lifelong depressions can be ameliorated with drugs and with various psychotherapeutic approaches as they can be suppressed with shock therapy. But such depressions will only really lift when the underlying hunger for good mothering has been sufficiently worked-through, and the enormous underlying rage experienced, expressed, and examined. The treatment of this preverbal hunger and rage is a special concern of C.M.T.

The yearning for the erstwhile Mother is expressed by patients as a wish to be given "more" in a variety of forms. Patients ask questions, wish advice, make themselves confused or stupid, develop psychosomatic symptoms, and

in general appear helpless and, therefore, in need of help. This multifaceted yearning for help and the desperate desire to be given, and to be taken care of, are openly recognized in C.M.T. as legitimate but are nonetheless repeatedly frustrated, except when the request for help represents appropriate adult needs.

Biologic hunger of the infant, expressed in adulthood as a multitude of demands for gratification of oral and other drives, cannot be directly satisfied no matter how hard we try. All such efforts are always doomed to failure. But, by steadfastly and repeatedly frustrating such demands, *in a setting that holds clear and close promise of gratifying appropriate adult needs,* such demands are turned first into dissatisfaction and eventually into rage. This rage in its myriad forms is treatable, and several unique techniques have been developed in C.M.T. for this purpose. The longing for reunion with a symbiotic mother can thus indirectly be resolved, and both separation and individuation more completely achieved. The repeated experiences of "loving" and "stroking" an adult patient as "corrective emotional experiences," so commonly the case in the newer modalities of psychotherapy, have obviously no relevance to such basic repair of the ego. In classical psychoanalysis, on the other hand, with its relatively tenuous therapeutic alliance, deprivation of infantile needs usually leads to subclinical depression, not to rage. The experience with a nongiving although benign "mother" usually results in frustration and bitterness, but not in true resolution.

Behavior Change as a Pressured Choice

C.M.T., unlike the various behavior therapy approaches and unlike T.A., Encounter, Rational-Emotive Therapy and others, does not aim at changing behavior through unlearning specific pieces of it which the patient consciously wishes to discard. Like psychoanalysis, C.M.T. recognizes the importance of unconscious factors in determining behavior, which is considered to be a function of the personality. Although it is no doubt entirely possible to overcome important segments of undesirable behavior in a mechanistic fashion, closer scrutiny shows that, contrary to popular expectations, much effort is often required to overcome even a single important symptom in direct attempts to modify behavior. The same work may yield greater benefits when aimed at personality change, thus undercutting many symptoms in a widespread area. If done properly this is the shortest and most efficient way in spite of its length.

These differences in approach are not only philosophical and technical, they also have an immediate practical importance for suffering individuals

who come for therapy. Attempts to directly modify pathologic behavior patterns not only appear to be much more economical and quicker but are also more in keeping and in step with the value systems of a society in which instant intimacy and immediate gratification are often expected and often promised. Narrow therapeutic contracts made to help an individual overcome a troubling symptom are popular and sought after, yet they are often followed by deep disappointment later on. Millions of ex-patients exist in this country, individuals who have gone from one therapist to another, improving each time so they "function" better, yet never getting well. The basic hopelessness which plagues many such individuals in the first place, and which is temporarily lifted from time to time, deepens and becomes more tenacious as one therapeutic disappointment follows another. When seen in the long perspective, these relatively short-term efforts are not only unkind by offering false hope but also are more expensive in terms of dollars and despair.

The individuality of each person dictates that the patient must grant the C.M.T. therapist explicit and repeated license to be intrusive before any such approach is attempted. The persistent and direct confrontation of resistances is often experienced by patients as a direct attack upon their dignity or even upon them as persons. Exquisite sensitivity and true respect for each patient are required from the therapist, if one is to be differentiated from the other. Patients must be able to clearly see, soon after every confrontation, that the attack was directed at their pathology and not at them. Further therapeutic work on a rational basis becomes impossible unless the situation is entirely clear to every patient after each time he or she is confronted.

Under the pressure of repeated and unrelenting confrontations with self-destructive traits, each patient must eventually make a very painful and difficult choice: to continue holding onto pathologic behavior that is experienced as being an essential part of the personality, thus risking further intrusions and painful interventions, or to experiment with possibly giving up a small part of the self, frightening as such a move must always be. The only way to really find out whether it is literally possible to exist without some part of the self which has always been considered to be vital is to actually take the difficult and courageous step of experimentally giving it up. This terror-producing decision can be attempted only when the therapeutic setting is experienced as being really safe in spite of confrontations, and only when the therapist is experienced by the patient as truly "being-there" to perform the rescue work that might be necessary. A provocative and confronting therapist may be so experienced no less than a supportive one, if he or she is willing and able to risk making real human contact with the patient and with the patient's travail.

Pressure to change is in fact applied by *all* psychotherapeutic systems, although psychoanalysts and several others would probably deny it. Direct observations of the therapeutic setting and of the interchanges between its participants strongly suggest that patients generally invest therapists with magical powers when they ascribe to them the role of healer. Even when the therapists are most careful not to impose themselves and their values on others, patients often act as if they do and "respond" to such imaginary suggestions or directions. The therapeutic setting in itself forces individuals to look at themselves, which makes it more difficult for them to act mindlessly, and it thus constitutes an indirect form of pressure. Some therapeutic systems even apply pressure by almost openly demanding change as a condition for the continuation of the relationship. The pressure in C.M.T. is not of this type. It consists of forcing the patient repeatedly into making the most difficult choice between consciously remaining in the morbid state, or consciously assuming responsibility for stepping away from it.

Consider the analogy of a person with several hot, swollen, and grossly inflamed abscesses. Behavior modifiers, under whatever labels they come, would basically attempt to reduce the tenderness, swelling, and pain of the one abscess that interferes most with the individual's functioning by applying ice or otherwise anaesthesizing the spot. They would also recommend bed rest and a high fluid intake to support the individual in general, expecting that the natural defenses of the body, aided by these measures, would eventually overcome the infections. The various psychoanalytic approaches, on the other hand, would wish to understand the underlying reasons for this condition, identify the organism that is involved and its sensitivity to antibiotics, and would then proceed to treat the individual systemically with antibiotics, in addition to the other supportive measures. They might perhaps also apply slight pressure near the abscesses in the hope that channels would spontaneously form for pus drainage.

C.M.T. would employ all the previous measures, but it would also introduce two additional techniques into the treatment plan:

1. It would apply heat to the area of the abscesses, thus increasing the pressure within each abscess and in the short run also increasing the pain, the temperature, and the swelling.

2. It would incise with a surgical scalpel into the ripe abscesses to create openings though which proper drainage of the pussy material could occur, using meticulous surgical technique to avoid secondary infections. The temperature, swelling, and pain can now all be expected to subside dramatically and without much delay.

The two additional modalities introduced by C.M.T. obviously require a

great deal of specialized skill and much forethought and care. Extreme measures can either benefit or hurt a patient, and they should never be attempted by anyone not carefully trained, nor with a patient whose general health has not been monitored and found to permit it. When the conditions are right, on the other hand, the use of such additional modalities may offer the patient a better chance for a complete recovery without recurrences.

The Critical Moment of Change

In physics, just exactly as in the lives of individuals or groups, minute increments of pressure cannot normally be observed by the naked eye, although they are the necessary components that lead to the eventual dramatic event which we call an explosion, a basic observable change from previous states of being. The temperature or pressure of gases within a boiler may slowly increase for a very long time before the critical moment arrives, when metal fatigue or the strength of other materials is no longer capable of withstanding the countervailing force. Although changes have been occurring slowly for a while, an outside observer can only see the explosion.

What is described as behavior change in individuals is likewise only the end point of a longer process. The relationship between President Ford and Secretary of Defense Schlesinger, for instance, was under increasing strain over a prolonged period, but only those very close to the scene were aware of it. Schlesinger's dramatic and seemingly sudden removal from his post was, in fact, only the natural and expected culmination of such tension and strain. The shifting of masses of icebergs, grinding imperceptibly against each other until one or both suddenly change position and roaringly move to new places, is a natural phenomenon with direct parallels in international relations. When, in 1947, the U.S. announced the "Truman doctrine," in effect guaranteeing the defense of Turkey and Greece, clear boundaries of global power spheres were established, and Soviet expansionism to the south was halted. The announcement itself was dramatically made one day, yet the basic change in the conduct of U.S. foreign policy was obviously no more than the culmination of a long series of complex deliberations.

Major and dramatic changes in behavior are usually preceded by a precipitous increase in tension, sometimes noticed as a sudden decrease in motoric activity, during which society or an individual regroups and reorganizes, gathering resources in preparation for the next stage of being. The first, tentative step or two in a young child's life, a major behavioral change from the crawling to the erect position, is always spoiled by a momentous fall, most hurtful physically and psychologically. This is likely to be followed

by the child's remaining on its knees for a while before the next steps are attempted. The more regressed position of crawling provides the young child with a sense of security and with an opportunity to regain self-confidence, a requirement for gaining mastery over the frightening sense of imbalance in the erect position.

Patients likewise often experience a recurrence of symptoms just prior to their changing in a major way, frequently becoming physically ill and regressing into a temporary state of complete bed rest, just like the one experienced in infancy. In general, major behavioral changes can be expected to be accompanied by major events in one's life, such as a temporary withdrawal from outside involvements into contemplative isolation. This period of relative or complete withdrawal, in many psychological and physical ways resembling the labor of childbirth, may last days, months and sometimes even years. The significance of such a period in the lives of individuals or societies is often appreciated only after it has passed by, when the fate of the involved organism has already been determined.

Conclusion

The basic concept of Democracy that all men (and women) are created equal is often misunderstood as meaning that all men (and women) are the same, which obviously is not so. Differentiation by role, position and power, age and gender are all questioned and under attack, as if what rightfully belongs to one must become the property of all. Public officials on all levels have catered to such unreasonable and absurd demands, allowing the legitimacy of even grossly bizarre ones, thus encouraging the most extreme and unreasonable voices to become spokesmen for the public.

Almost everything in this society is in a state of constant flux: morals and values, economic and sexual roles, rights and privileges, responsibilities and expectations. But all these changes essentially appear to involve no more than the loosening of internal controls, resulting in loss of a personal or public sense of balance. Recent behavior change in modern, industrial societies has always been in one direction only, that of gratifying more wishes, whether they make objective sense or not. History has repeatedly demonstrated that such a course of events invariably leads to complete destruction of a society or else to the assumption of power by a central, authoritarian figure using brute force to bring about simple behavior change and save his society for a while.

If our society is to escape the fate of other societies under similar circumstances, behavior patterns must be dramatically reversed to balance the one-

sided slide towards promising and *getting* ever more. This basic behavior change on the part of tens of millions of individuals entails *giving up* unsupportable and unrealistic privileges that have become expectations. Attempts to bring about such changes are always understandably resisted, in individual psychotherapy as in the political process.

Strong political leadership willing and able to exercise moral and actual force is an essential prerequisite for such changes to occur. Such a course of action has never before been followed in democratic societies, except in war or under conditions of siege by an outside enemy. The leader in such a society, entrusted to wield power and to use force, is in an analogous role to that of the psychotherapist. Both are freely granted the right to use pressure and force for a limited time and under certain conditions, even against those granting them that right. Extreme courage and true integrity are always required if either political leader or psychotherapist is to use such force against resistance, since his very position may be endangered by such use. Some of those resisting change, out of a wish to maintain old habits or old positions, will surely attempt to protect their interests by trying to remove such a leader or therapist, or at least by trying to strip him of his power to use force.

The common aversion in our society to the open use of force and the almost generalized suspicion cast upon those with power have deep roots in early family relations. Yet both the success of psychotherapy and the continued existence of Democracy may depend on not yielding to such aversion and suspicion. Psychotherapists and political leaders who refuse to exercise the power entrusted to them for reasons of personal survival obviously prostitute themselves and the processes in which they play such central roles.

Winston Churchill, in wishing to mobilize the British people in 1940, understood that real behavior change required basic changes in life-styles and the *giving up* of unrealistic wishes to have more and to be given more. "I have nothing to offer but blood, toil, tears and sweat" (4). John Kennedy similarly understood, at least in his public utterances, that the unrealistic but universal wish for reunion with an ever-present and ever-giving mother is incompatible with the continued existence of a society. "The New Frontier . . . is not a set of promises—it is a set of challenges. It sums up not what I intend to offer the American people, but what I intend to ask of them" (5).

In the absence of valid theories of behavior change, societies such as ours have in the past invariably disappeared from the face of the earth. If the theory of behavior change used as a basis for Crisis Mobilization Therapy proves to be valid, then there is no painless way to effect real behavior change

either in individuals or in society. Some form of force, physical or moral, is absolutely essential for overcoming the natural resistance to change. The sooner political leaders learn this simple truth, the better the chance this Republic will have of surviving, and this society of remaining intact and viable. The sooner psychotherapists learn this lesson, the better the chance patients will have of really being cured.

ADDENDUM QUERIES

I

DR. BURTON: The word crisis is a significant concept in your discussion of behavior change, and you make very close analogies to the crisis of a physical abscess which presumably contains bacteria, viruses, and so on. How does one define a crisis on a psychological level without taking refuge in clinical terms such as depression, which just as often mask as they scientifically clarify?

DR. BAR-LEVAV: Psychologically, a crisis is the point at which a person experiences a feeling with maximum tolerable intensity. When a feeling such as fear is experienced with an intensity beyond the crisis point, it will overwhelm the patient, and he or she may become temporarily confused or block it out altogether. Sometimes even more primitive defenses will take over. Fainting is to physical pain what psychotic-like symptomatology is to emotional pain. When the crisis point is exceeded, the healthy part of a person's ego is at least temporarily out of function and unable to participate in the tasks involved in the psychotherapeutic work. Such a situation has the effect of an increased resistance and is, therefore, counterproductive. It must be avoided whenever possible. Working below the crisis point is obviously wasteful, but this is nevertheless the place where most psychotherapy occurs, and remaining there is the aim of all resistances. Patients usually experience high intensity feeling-states as endangering their very existence, and understandably tend to avoid them. The concept of crisis in C.M.T. is similar in many ways to the point of impasse of Fritz Perls.

Anxiety threshold and anxiety tolerance are, therefore, intimately associated with the concept of psychological crisis. These two entities are theoretically considered in C.M.T. to often be manifestations of resistance in themselves, and quantitatively changeable by the psychotherapeutic process. In this sense, C.M.T. is closer to behavior therapy than it is to psychoanalysis, but it differs from behavior therapy in attempting to modify the anxiety threshold and

tolerance as character defenses, and not as they relate to any set of symptoms.

Patients usually and understandably behave as if the crisis point has been reached long before it is actually approached. This takes place in the unconscious service of resistance, to minimize pain and maximize comfort.

The abscess itself is not analogous to a crisis, it only contains the elements that may lead to one. A crisis is reached when the swelling, pain, and loss of function are maximal, at which point spontaneous or surgically induced lancing and drainage would produce the most dramatic effects. Physically and psychologically, a crisis is not only a moment of great danger but also the point at which opportunities for change are the greatest and the most promising.

II

DR. BURTON: My understanding of behavior change is the same as yours. Behavior itself can easily be altered by a variety of simple treatment techniques, but a basic change in personality or character structure is much more rare and difficult. Yet, cure or change in any sense of the word involves precisely this.

Your chapter is significant in that it does not reveal to what theory of personality you subscribe. Are you in fundamental sympathy with Freud's structural theory, Jung's archetypes, Adler's social inferiority views, Reich's body approach, some other?

DR. BAR-LEVAV: Crisis Mobilization Therapy is based on a theory of personality all its own, derived from, and in many aspects similar to, Freud's structural theory, yet with basic theoretical differences. The basic units of individual personality organization are id, ego, and superego, but the origin of internalized conflicts is usually dated as being much earlier than in psychoanalysis. Birth *as a separation* from an ever-present, protective, and nourishing mother (to be distinguished from the traumata of birth) is considered to be the basic traumatizing event. Consequently, a basic fear of non-being is regarded as motivating man to help himself survive as best he can.

Influenced by existential philosophy, universal anguish of nothingness is translated into terms of personal panic, against the experience of which individuals construct their entire life-styles. Symptom and character formation are thus seen as self-helpful measures based on the realities of early infancy and carried into adult life.

The basic problem underlying both neurotic and psychotic symptomatology is noncompletion of the process of separation-individuation, an adapta-

tion to very early infantile fears. Basically, psychotherapy is the process of working-through and resolving preverbal hunger and rage, without which true personality change is considered to be impossible and at best only apparent.

III

DR. BURTON: From your chapter I assume that you bring the crisis to a "boil" in the conventional ways that we have all been taught. Have you perhaps derived some unique, more efficient or safer procedures for focusing the crisis into choice and responsibility?

DR. BAR-LEVAV: As its name implies, C.M.T. makes a unique contribution to helping patients reexperience repressed conflicts at levels of highest tolerable intensity. The mobilized crises of C.M.T. do not take place in real-life situations but are only crises of feeling within the therapeutic setting. A variety of provocative and evocative techniques have been developed to bring them about. Language, for instance, is used not only for conveying thoughts and describing situations but also for direct elicitation of feelings, using a technique labeled "dredging for affect." Several other innovative techniques are also used for similar purposes in addition to such conventional methods as guided fantasies and occasionally a direct body approach.

In psychotherapy generally, crises are rarely brought to a boiling point. They are, instead, more often than not submerged with the aid of tranquilizing agents or otherwise. In C.M.T. specific affect is indeed repeatedly mobilized, and only when the "boiling point" has been passed does the task of integration begin.

Although the force of pressure to overcome resistance is specifically applied, the patient must consciously give the therapist explicit and repeated license to do so, and may withdraw such permission at any point. The twin elements of choice and responsibility are repeatedly stressed, and they are basic elements in the therapeutic contract of C.M.T.

IV

DR. BURTON: Various encounter groups, marathons, primal scream therapies, and so on seem to have similar goals to those of C.M.T. in the sense of seeking a quicker resolution of conflict, while the psychoanalytic psychotherapies are more paced and slow. Are you sympathetic to these approaches as blood brothers?

DR. BAR-LEVAV: This query provides me a most welcome opportunity to correct a basic misunderstanding that might otherwise not have been cor-

rected. The presentation itself apparently failed to clarify that C.M.T. is in no way a quick-cure method, and that it is basically different from encounter groups, one-shot marathons, primal scream therapy, and all other modalities that claim to bring about personality changes quickly or easily. Marathons, a few encounter techniques, and occasionally screaming are used, but they serve only as tools for the elicitation of strong affects and are considered of little value in themselves.

The completion of a course of therapy in C.M.T. usually requires no fewer than three, and often as many as six or seven years, just as in psychoanalytic therapies. Although the time span is similar, the personality changes in C.M.T. are claimed to be markedly more profound and more lasting. The quick-cure methods are not considered as blood brothers nor even as distant relatives. On the contrary, they are considered to make unfulfillable promises and to offer false hopes to individuals in distress and need. They may on occasion bring temporary relief, to be followed by greater disappointment than ever, and as such they are regarded as dangerously adding to the suffering of those who use them.

V

DR. BURTON: More than any other author in this symposium you make close and appropriate allusions to the social and cultural scene. What then is the relationship between the culture which is psychotherapy and the culture at large in which it is embedded? Is one a microcosm for the other, a refuge from it, a testing font of creativity, or what?

DR. BAR-LEVAV: The "culture of psychotherapy" is unfortunately a widespread phenomenon that stands as a living testimony to the failures of psychotherapy as a method of healing and cure. When separation-individuation is not completed, current and ex-patients become adherents to, and followers of a "psychotherapy cult" which serves as a security-giving mother substitute. The very existence of a "culture of psychotherapy," like the existence of many other social movements and groupings, is a second-rate and historically a temporary solution to Man's search for the security once experienced in utero.

Industrialization, urbanization, and the changing patterns within the modern family have all contributed to a sharp increase in anxiety of the separated, but not yet individuated, Man. This is culturally and sociologically described as anomie and alienation. Man has found economic and political struggles to occupy him, lay claim to his energies, and allow him to forget his anxieties. National and racial rivalries have similarly been used throughout

history as successful diversions from internal problems, internal within society and internal within each person. Class consciousness often replaced self consciousness.

The allusions to social and cultural events in this chapter were mainly to illustrate that behavior change within an individual is no less complex and difficult than it is within society. The nature of Man has basically remained the same, even as his societal organization has become more complex, more sophisticated, and sometimes even more just. The veneer of civilization is often frighteningly thin, as is seen when the social order breaks down at times of war or natural disaster.

True revolutions do not take place on barricades but in those very few consulting rooms in which good psychotherapy is being practiced. Man's fears are patiently dissolved there, as he finally achieves true freedom to be.

REFERENCES

1. PIRKE ABOTH: *Sayings of the Fathers*, Mishnat Chassidim, Chap. 5, V. 19.
2. BAR-LEVAV, R.: Do You Love Me, Yafah Booltiyanski? *Voices, J. of Am. Academy of Psychotherapists*, 1975, 41, 16-22.
3. FREUD, S.: On Psychotherapy. *Selected Papers on Hysteria and Other Psychoneuroses*, Authorized Translation, A. A. Brill. New York: J. Nervous and Mental Dis. Publishing Co., 1909.
4. CHURCHILL, W.: First Statement as Prime Minister, House of Commons, May 13, 1940.
5. KENNEDY, J.: Acceptance Speech, July 15, 1960.