ADVANCES IN PSYCHOTHERAPY TECHNIQUE - CRISIS MOBILIZATION THERAPY

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Crisis Mobilization Therapy, C.M.T., is a recently developed system of psychotherapy that claims to be basically different in its psychotherapeutic techniques and tactics from other modalities. Although unique in many important aspects of philosophy and technique, it is based upon and owes a great debt to other schools of psychotherapy, especially Psychoanalysis and Gestalt, and shares some basic assumptions with Existential philosophy. Unlike such currently popular approaches as Encounter, Transactional Analysis and Behavior Modification, it aims at changing basic personality patterns and is not satisfied with merely shifting defenses of the ego. C.M.T. also differs from Primal and other scream therapies and the various body manipulation approaches by its assigning full weight to ego psychology principles, and in fact the laying bare of secondary ego defenses assumes equal importance to reaching and working with unconscious and repressed material. C.M.T. incorporates, on the other hand, some of the techniques of Bio-energetic Analysis and the scream therapies and, like them, recognizes the importance of unlocking physically trapped pre-verbal feelings. In this sense, it sharply differs from the cerebral approach and the highly intellectualized techniques of Psychoanalysis. It differs from the direct body approaches in attaching proper significance to the working-through of physically incorporated feelings, once unlocked.

The need for developing yet another school of psychotherapy is derived from the fact that patients in present-day psychotherapy often improve, but only rarely is a real cure effected. The very existence of millions of uncured patients testifies to the sad fact that although the presenting symptoms often disappear,

the pathologic core is rarely treated and the illness commonly recurs, perhaps in a somewhat different form. Psychiatric intervention in the form of in-patient hospitalization, crisis intervention or short-term contact with a therapist, basically amounts to first-aid only. When a more serious attempt is undertaken to overcome the process of illness, therapy usually appears endless, and termination usually comes about as a result of attrition. Only rarely is termination a sign of completion. Progress is commonly measured by an individual's increased capacity to "function", rather than by objective and measurable observations of basic changes in one's personality and modes of being. Both proponents and opponents of psychoanalysis agree that it is more a method of research into the mental functioning of individuals than a psychotherapeutic modality. Freud (1) himself stated:

> "...the future will probably attribute far greater importance to psychoanalysis as the science of the unconscious than as a therapeutic procedure."

The splintering of the psychoanalytic movement from the very beginning, and the mushrooming and emergence of new psychotherapy approaches ever since strongly suggest that a valid psychotherapeutic method of therapy is still lacking. While radically changing the philosophic concept of Man, the insights of dynamic psychiatry have been applied with less success to the process of curing his emotional illnesses. The many patients who have been seen by psychotherapists of all persuasions since Freud's days have usually gotten much wiser, but they have not as commonly gotten well.

The disappointment in the results of psychotherapy has served as a plausible excuse for many psychiatrists not to subject themselves to the rigors of personal growth required for mastering the complex science and art of psychotherapy. Simpler, easier and seemingly more pragmatic approaches, such as drug and shock

therapy, behavior modification and environmental manipulation, have become popular and more prominent instead. Psychotherapy has failed to imbue most psychiatrists with much hope and enthusiasm. Administrative positions and research, teaching, social activism, consultation and other non-clinical activities have served as welcome refuges, since they offered more personal satisfaction. The daily disappointments involved in facing sick patients with a tool that even the therapists themselves often considered to be of questionable validity were thus avoided.

Crisis Mobilization Therapy is presented as a yet imperfect, but nonetheless integrated model of psychotherapy that holds promise of overcoming the widespread pessimism regarding the value of psychotherapy in general. Time and repeated objective observations by competent, neutral and sane professionals will eventually determine the validity of its claims. The following is an introduction to C.M.T. and to several of its techniques. A more detailed discussion of monograph length is in preparation.

Patient Suitability and Selection

Affective crises of great intensity are repeatedly mobilized in C.M.T., yet most patients including those with diagnoses of non-psychotic schizophrenia, borderline states and character disorder can benefit from it, as it is useful to those presenting with neurotic symptomatology. Brain defective and grossly psychotic patients are excluded, but since C.M.T. aims at repairing defects in the ego, those with weakened or defective ego structures are obviously not excluded. Patients are usually seen in combined individual and group psychotherapy, and more than a single therapist is often involved with each patient. One member of the co-therapy team serves as the main therapist and sees the patient individually, in sessions held once or twice weekly in addition to the group meetings. Although C.M.T. may be adaptive for use with children, it has so far proven useful only with young adults and

adults. Since its basic approach to patients holds them individually accountable for their lives, the youngest patients seen in C. M. T. were 17 or 18 years old. There is no upper age limit, but since the therapeutic work is prolonged, only a very few patients over the age 60 have ever been encouraged to begin this form of therapy.

The psychotherapist in C. M. T. must evaluate not only the extent of the lesion but also the general state of the patient's health as the decision about patient selection is made. Such a decision is basically different from the comparable one in psychoanalysis, by which a person's "analyzability" is determined, since the nature of therapeutic interventions in C. M. T. allow even non-psychologically minded patients with narcissistic and character defenses to become involved. The conscious and deliberate manipulation of the therapeutic relationship, the active and intrusive role played by the therapist, the combination of individual and group therapy as well as the presence of more than a single therapist enable many more patients to be reached than before.

Individual and Group Settings, Multiple Therapists

Patients are seen only individually at the onset of therapy. The duration of such an exclusive one-to-one relationship is dependent upon the nature and severity of the patient's ego defects and the difficulties they present to the formation of a solid therapeutic alliance. Although some patients join a group after only one or two individual sessions, those with moderately severe impairments in ego structure must sometimes remain in individual therapy alone for as long as several months or even a year. Only when at least a partially solid therapeutic alliance is established are patients permitted to become members of a psychotherapy group, in which the confrontation with one's defenses is usually experienced as more intense.

The psychotherapy group in C. M. T. is composed of eight to ten patients and meets for ninety minutes twice a week. As illustrated later in this article, the

group-as-a-whole is often experienced as a bad-mother, depriving and cold, who powerfully makes claims on the "good" therapist's time and attention. Individual sessions are generally felt as more gratifying, although the more intimate one-to-one setting may also be a cause of much anxiety, occasionally reaching panic proportions. Patients with diffuse ego boundaries sometimes feel safer in the relative anonymity that can be found in the group, at least for a while.

Twenty-eight hour long group marathon sessions are an integral part of the psychotherapeutic process of C.M.T., each patient participating in two or three such marathons a year. These marathons are similar only in name to marathons promoted by "growth centers" or itinerant therapists, in which instant intimacy, "feeling good" and promises of quick cures are often proffered. Being part of on-going, long-term therapy the marathon is used to help patients in different phases of therapy more fully integrate previously attained gains and further experiment with new modes of being. The extended time weakens resistances and allows the reaching of levels of affective involvement not easily attained in shorter sessions. Such peak experiences have no magical value, but they are most useful as high-water marks both for patients and their therapists, as they together plod through the tedious and difficult process of working-through.

Patients with ego defects and character defenses often find it easier to form a solid therapeutic alliance when the transference is split and involves two separate individuals. Quick shifts of the transference often take place in C.M.T. because of the active role of the therapists, and this can prove confusing when such intense transference feelings are concentrated on one single therapist. The dual therapist situation facilitates the development of a true transference neurosis, thus making therapeutic progress possible. While one therapist is experienced as threatening, engulfing or potentially even murderous,

the other can help the patient sort out such reactions and examine their origins and validity (2).

Transference splitting between two therapists no longer occurs as patients' integrative capacity improves and as they become less frightened and more able to experience and express powerful affects. The entire gamut of transferential and real feelings is eventually focused upon the main therapist, with whom a transference neurosis is formed and eventually resolved. The ancillary co-therapist remains in the picture throughout, sometimes as a minor and shadowy figure, at other times serving as the main focus of the patient's inner life. This complimentary coming-into and receding-from the central position in the transference allows patients with damaged egos to tolerate affective crises of great intensity without withdrawing temporarily or leaving therapy altogether.

Patients are actively helped in the formation of a viable therapeutic alliance by actively and repeatedly focusing upon the relationship with the therapists. This process is also helpful in recognizing early patients who have been so badly damaged in the past that they cannot form a lasting relationship at all, in which case they are unsuitable to become patients in C.M.T. This is an uncommon occurance. Such trial of therapy is of great significance, for even among those who seem to be too sick for any serious involvement in intensive therapy, many surprise themselves and their therapists with their hidden capacity to be and act sanely, once their life-long panic is brought under control, a task that is sometimes achievable with unexpected rapidity and ease. A basic island of healthy ego, like the fulcrum point of Archimendes, is an essential requirement for benefitting from this form of therapy, but it need not be as extensive as thought to be necessary in the past. A trial of therapy lasting two to three months is often most revealing. Here as elsewhere, the intuition, experience and skill of the therapist as well as the extent

and depth of the patient's fears determine the speed and the degree of success with which a therapeutic alliance between patient and therapist can be forged.

Psychotherapy as Medicine and as Surgery

While psychotherapy in general may properly be likened to medical intervention in the process of mental illness, C.M.T. has justifiably been likened to surgery for emotional cancer. Emotional difficulties that are of more than a transitory nature usually impose severe limitations on the functioning of individuals, causing discomfort, pain and suffering to a greater extent than those associated with most physical illnesses. The extent of such discomfort, pain and suffering are even greater if not only overt symptomatology but also the limitations on the exercise of a person's potential are considered. The severity of the impairment, which normally is life-long, calls for and justifies the taking of radical measurements for its correction.

The advent of anesthesia has basically changed the character of the surgical experience for patient and surgeon alike, and risks that were unreasonable before could safely to taken thereafter. Similarly, the new and different approaches to patient care of C.M.T. make it possible to attempt serious and reparative therapy with previously unworkable patients, and more importantly, the chances for success and the likelihood of achieving a cure for patients in general are markedly improved. Anesthesia freed the surgeon from the overwhelming pressure of speed in operating, and enabled him to successfully attempt increasingly more complex procedures. C.M.T. likewise frees the psychotherapist from the gnawing self-doubt regarding the effectiveness of his work that sometimes prompted the adoption of questionable practices, and enables him to get through the armor-suit of previously unpenetrable defenses, forming an alliance with islands of healthy ego that might have been too deeply burried and too well camouflaged.

The meaning of progress and the definition of the concept of "cure" in

psychotherapy deserve a separate discussion, for unless such terms are clearly defined in generally acceptable terms all claims and criticisms have no objective value. "Cure" in the sense it is used here refers to a condition in which an individual is not only basically symptom-free, but also to one in which he is reasonably capable of making real choices, not determined by compulsive needs to repeat early life patterns, nor overdetermined by irrational fears. Cure entails conscious living. It is a concept that is rarely used in psychiatry, perhaps because it seems unattainable with the present methods of psychotherapy, as it is obviously unattainable with drug, shock or other mechanistic therapy methods.

The Concept of Force in the Overcoming of Resistance

Present day psychotherapy and psychoanalysis are basically descriptive and analytic in nature. Hospital staff conferences and physicians' time are largely devoted to diagnostic determinations and to the understanding of underlying dynamics. Only relatively advanced seminars are designed to gain competence in treatment, and even these sometimes deteriorate and become forums for esoteric philosophising. 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 description and with the understanding of hidden dynamic aspects. The absence of a practical and specific system for treating psychological illnesses till now also accounts for such preoccupation. It was basically all that could be done.

Clinical observations strongly suggest, however, that what may perhaps have been true to some extent in Freud's Vienna no longer applies in an age that is psychologically sophisticated. Patients of today often understand basic psychologic configuration, and can often even apply them, correctly if incompletely, to their

own situations, and mouth them with varying degrees of confidence. Yet, such understanding is not usually helpful in the process of self-change and is often used, instead, in the service of resistance. More than an accurate description and understanding of unconscious self-destructive ways of an individual is needed to overcome life-long 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 pathologic part.

Psychotherapy as Trigonometry and as Physics

Psychotherapy as generally practiced may also be likened to trigonometry, the branch of mathematics that deals with the relations of sides and angles of closely related magnitudes, using the method of deducing from given parts other required parts. The end point of a trigonometric problem is the discovery of the missing entity, and elaborate, step-by-step progressions into the unknown lead to the finding of the desired solution.

C. M. T., on the other hand, more closely resembles physics, the science of matter and motion, in which the concepts of force and work are central. The magnitude of a force in physics is the produce of acceleration and mass of the body. The magnitude of the psychologic force used to move a patient in C. M. T. is the produce of mobilized anxiety* (acceleration), and of the relative strength of the healthy part of a patient's ego (mass). Normally encountered resistance in psychotherapy is often sufficient, or almost sufficient, to neutralize the minimal pressure that is spontaneously derived from therapeutic relationships, thus minimizing acceleration and real, rather than apparent, change in the direction of health. The provocative techniques used in C. M. T.

* To be distinguished from spontaneously occuring anxiety that must frequently first be attenuated.

to overcome resistance are designed to increase such acceleration, thus speeding up and intensifying patients' movement in therapy.

Work requires the exertion of strength for the accomplishment of a task, physical or intellectual efforts directed towards an end. Work is done when there is movement against a resisting force. The so-called "work" of therapy similarily requires the exertion of sufficient force on the part of the therapist to overcome the resistive forces against change in the patient. 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 "drive sane" in psychotherapy.

> Bill, a patient in his forties, is in the latter phase of therapy and seems to be stuck on a treadmill. Many aspects of his obsessive-compulsive personality have been worked-through during five years of therapy, including much of the underlying rage at an ineffective father and a cold, unreachable mother. He experienced his main therapist over the years basically as an idealized, warm and giving mother, while the group-as-a-whole was generally felt as a depriving and an unsympathetic one. (4) He tried repeatedly to leave the group, where he felt unloved and alone, but remained in therapy on the repeated recommendations of his therapist, whom he tried to please in almost every conceivable way. The idealized image of the therapist also began eventually to tarnish, as all of Bill's efforts to please him did not yield the desired approval. He again expressed his determination to leave the group, more strongly now than ever.
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> Using a specialized C.M.T. technique, "Dredging for Affect", the patient was offered a chance to go around the room, making eye contact with each person and repeating the sentence, "I am Bill. I feel very alone and very unloved by you." He refused. He tried to direct the course of events by becoming angry at his therapist, whom he accused of having been unfair to him when he was questioned about his reasons and motives for missing two group sessions. He was pouting, stating "I won't do it for you". He was cajoled. It is frightening, yet he is strong enough. He has walked out alive from all previous therapy sessions, and he is likely to walk out alive this time also. He was goaded. How old was he? How long was he in therapy? Would he want to hide under the apron of this therapist-mother?

> Bill protested, ridiculing the therapist as insane. But when he finally stood up, even as he was repeatedly reminded that it was his right to refuse and stop if he really wished to, the anger that filled his pale and tense face before was no longer evident. Deep sad lines appeared instead, his voice matching his words. Sobbing quietly, his body trembling, the hurt that was so deeply hidden slowly emerged. Tears rolled down his contorted features, and he was obviously experiencing intense pain, the very pain he devoted much of his life to not experiencing. Another episode in Bill's saga was just beginning to unfold.

When Bill's therapist was away for a couple of weeks, three years before, he felt so totally abandoned, afraid and confused that it was necessary to hospitalize him briefly. Every temporary separation since, in therapy and outside it, filled Bill with fear that at the beginning almost reached panic proportions. But he had survived all these separations, and he was becoming increasingly more conscious of the pattern of his reactions and of their genetic origins. He finally dared, albeit after much hesitation and still with much fear, to experience fully the same sense of loneliness that since early infancy was always likened to cold and black terror. He was willing to enter this forbidding region volitionally and voluntarily, but only after sufficient pressure and force succeeded in overcoming his understandable resistance to taking this chance. He could have consciously refused to continue at any point, had he really wanted to, in which case no further pressure would have been used, and Bill knew it. <u>There is no place for coercion in C. M. T.</u>

The Principle of Isolation of Action.

C. M. T. is designed to allow patients to experience all feelings most strongly and without holding them back, since feelings are not dangerous in themselves, regardless of intensity. Many psychotherapists share the apprehension of strong feelings that is common among non-professionals, and wittingly or unwittingly discourage patients from experiencing and expressing them. This is not true in C. M. T., in which affect

is mobilized to its tolerable levels. A basic pre-condition for reaching such a goal is a clear understanding and an unequivocal acceptance of the principle of "Isolation of Action" from feelings. This principle, not to be confused with isolation of affect, simply re-affirms the unacceptability of acting-out or acting-in in any form. All feelings may legitimately be experienced and verbally expressed, in relation to the therapists as well as all others, but no action whatsoever is ever to be taken on the basis of feelings alone. All actions, both active and passive, must first be cooly 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 the intensity of feelings can never be rationally cited as a justified cause for action. This appears to be a culturally determined basic defect in our society with far reaching and most damaging consequences in the lives of many individuals and of society as a whole. The firm establishment of the principle of Isolation of Action is a continuous task in C. M. T., for acting-out or acting-in, in its myriad disguised forms, is a repeatedly attempted route of escape for patients as they experience frightening or painful feelings.

Catharsis is similarly discouraged, and any form of physical activity has, therefore, no legitimate place in C. M. T., except for the purpose of eliciting affect. Touching, for instance, like screaming may sometimes serve to squelsh unwanted feelings but at other times it may be the most direct and strongest means for the elicitation of hidden affect, or for its intensification. Eating and drinking, on the other hand, as well as smoking, chewing or the engaging in automatic, repetitive mannerisms are all discouraged. So is impulsive walking out of therapy sessions before they are terminated, and the early or late payment of fees. Impulsive or spontaneous touching, hostile as well as loving, is strictly unaccepted. This, more so than anything else, enables patients to experience and express their feelings with the

greatest intensity yet without danger to themselves or others. Patients are repeatedly cautioned to consider all possible consequences of any action, as they are repeatedly shown the many masqueraded appearances that feelings can assume including the form of apparent rational thinking.

The successful completion of a course of therapy in C. M. T. usually requires five or more years, and it obviously is no short-cut. While the length of time required is similar to that of other modalities of intensive psychotherapy, C. M. T. claims that within this time span it uniquely reaches and modifies the pathologic core of many patients. Here as elsewhere, the length of required therapy is obviously a function of the skill, intuition and experience of the therapist, but more so it is dependent on the depth and extent of the patient's pathology, and on his anxiety threshold. Patients with low anxiety thresholds and tolerances will naturally require more time before they allow themselves to experience painful and difficult affects. Their internalized conflicts will, naturally, take longer to work-through.

Anxiety Threshold and Tolerance

The anxiety threshold and the anxiety tolerance of an individual are often accepted by psychotherapists as absolute givens, changeable only by outside chemical means. Advertisements for psychologically active drugs are largely based on the claim that they lower anxiety, so that "psychotherapy will become possible". Inexperienced therapists, likewise, often claim that a high level of anxiety in patients is responsible for the failure of their therapeutic efforts, not recognizing that such anxiety in itself is changeable through their efforts. Behavior therapy in particular, as well as several other therapeutic systems, have directly challenged these concepts, and have demonstrated beyond doubt that the anxiety threshold of a person is changeable through consistent psychotherapeutic efforts.

Neither the anxiety threshold nor the anxiety tolerance are considered as permanently fixed quantities in C. M. T. As each successive crisis is mobilized, patients tolerate increasingly greater degrees of anxiety, without escaping the situation by any of a variety of means. The process of desensitization in C. M. T. is philosophically similar to that of Behavior Therapy, but it is entirely different in mechanism and direction. No formal or repetitive desensitization occurs, even as patients are desensitized, as they also are in all forms of psychotherapy including psychoanalysis. And unlike Behavior Therapy, desensitization is not symptom-directed but global, thus changing the critical point of first experiencing pathologic anxiety and the over-all ability to tolerate it. Both the anxiety threshold and the anxiety tolerance are themselves considered in C. M. T. to be expressions of the patient's pathology, and not as determined by his physiology. They are treated, therefore, as alterable character defenses. The therapeutic alliance and the sensitivity and skill of the therapist are both put to an extreme test, as these seemingly unchangeable characteristics of an individual are subjected to scrutiny and close critical examination and even to sarcasm and ridicule, to help in making them ego alien.

> Mary, a young woman in her twenties with delicate features, came to her initial interview dressed in a most sloppy manner, hair unkept, teeth in bad repair and altogether giving a clear impression of chronic self-neglect. She was frightened, claimed she did not belong in such a nice office and tended to deprecate herself whenever an opportunity presented itself.
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> After several months of therapy, when the therapeutic alliance was clearly cemented with enough strength, her attention was repeatedly drawn to her drab appearance and her poor self care, but to no avail. She had different value systems, she claimed, women are not in the world just to look pretty or to please men. Even when it was pointed out to her that she was physically dirty it did not phase her. She was a human being, living in a free society, and it was her right to be dirty. All along she complained bitterly of her loneliness and about the empty life she was leading,

> Mary's appearance was now repeatedly described in grossly exaggerated terms. Sure, it was her right to be dirty, but she was so successful in her unique way of calling attention to herself that others might want to consider competing with her. One patient figured out the savings in his water bill if he showered only once a month. Mary was praised for having her own one-of-a-kind perfume. A dentist in the group joined in by describing the interesting microbe life within rotten teeth. Mary's facial expressions were grossly imitated, for herself and all to see.
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> She protested, refused to participate in such "hilarious stupidity", threatened to leave therapy, "and the hell with you all". But she stayed. What was ego syntonic slowly became ego alien. She eventually bought a lovely dress and made the first appointment to fix her teeth.

Responsibility for Oneself and for One's Fees

C. M. T. places the responsibility for the patient's life right where it belongs, namely on the patient himself. This is expressed from the very beginning by making even the initial appointment only at the patient's direct request and never at the request of anyone else on behalf of the patient. This prinicple holds true throughout. Payment for therapy, for instance, is generally not accepted from third-party payers, although patients are aided in collecting from government or private insurance companies such payments as they are entitled to. Insurance forms are filled out by the patients themselves and only signed by the therapists. Payments go to the subscribers, who then pay their therapists directly and personally. Checks that are mailed are frequently sent back, so that an actual financial exchange occurs within the therapeutic relationship. The established fees are sometimes altered, but only after negotiations that are initiated and followed through by the patient.

The cost of therapy in C. M. T., like that of any intensive and long-term therapy, varies but amounts to several thousand dollars a year, with a total cost of perhaps fifteen or twenty thousand dollars. This is an objectively huge amount, even if spread over a period of several years. Professionals in the field of mental health are

sometimes no less critical of the high cost of long-term therapy than are social planners and insurance companies who denounce it as socially indefensible. Such views fail to take into account the high costs that must be paid anyway in the form of direct losses from poor judgment and only partial use of earning potentials. Repeated hospitalizations, tardiness and absences from work, perpetuation of the illness in the next generation and in those around the patient must also be measured and expressed in economic terms, in addition to their cost in agony and pain. The cumulative cost of short-term, stop-gap measures is probably greater than that of even the most prolonged course of intensive psychotherapy, which is, however, justified only if it can really solve the problem permanently. Such cost often resembles that of a four year college education in a private school, and must be regarded as the price for a life-saving procedure. Help from third parties makes it obviously easier for patients to meet such costs, but individuals with limited means have made sacrifices and completed therapy without outside help. The willingness to make or not to make such sacrifices must in itself be scrutinized, for it is truly justified only if real personality change can objectively be demonstrated.

Two-Way Commitment To Therapy

Small amounts of tranquilizing medications are occasionally prescribed, but in general virtually no drugs are prescribed or taken. Patients have required hospitalization but only on very rare occasions, and for brief periods of a week or two only. Suicidal attempts and gestures are rare, and actual suicides even rarer. Such findings are explained by the fact that patients learn early that the commitment to therapy in C. M. T. is a two-way affair, both therapists and patients making conscious and volitional choices to work with each other. The patient pays the therapist for his or her time, yet the latter must decide which patients to work with and has to agree to invest of himself in each of his patients at least for the duration of therapy.

Such choices on the part of the therapist in C. M. T. are always conditional upon the patient's reciprocal commitment to treat himself and his life seriously and respectfully, and to assume full responsibility for his being. Patients soon understand that suicidal acts or gestures, just like other forms of regressive behavior, may necessitate their hospitalization and are likely causes for termination of therapy. This obviously applies only to actual behavior, not to the expression of any and all feelings, wishes and fears, specifically including those regarding suicide or other aggressive wishes directed at the self or at anyone else, such as therapists and fellow patients. Since patients frequently sense that the therapeutic milieu of C. M. T. provides them with a "place in the world" in which they can be heard and understood, a "home", they are not usually likely to give this up easily, mindlessly or frivolously. The wish to continue "belonging", which provides patients with a sense of security that many individuals have known only in earliest childhood or in utero is strong enough in most instances to overcome the impulse to act out. The resolution of such strong bonds at the time of termination obviously requires great efforts, since it involves the completion of mourning for one's childhood fantasies.

The Therapeutic Alliance

A uniquely strong therapeutic alliance is the cornerstone of C. M. T., and it is constantly being 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 conscious and deliberate attempts on the part of its therapists to couple deprivation of infantile needs with gratification of adult wishes. Patients who are either unwilling or unable to assume more complete responsibility for their lives are induced to do so, although not without much struggle, with the aid of this therapeutic alliance.

Much focus is directed on each and every session to the fluctuations of the patient's feelings. The minifest content of the verbal productions often takes second place to interpretations about facial musculature, quality and pitch of voice, body posture and other non-verbal communications of feelings, which are then traced to their immediate and genetic origins. As a result of repeated examinations of the relationship with the therapist, patients in C. M. T. begin to sense soon after the beginning of therapy whether the therapist is "with them" or not, and they are usually able to do so even at times when he is provocative or depriving or when he is experienced as attacking. The experience of being in a group allows patients to observe the therapist as he works with someone else than themselves, and to evaluate him or her in perspective. This enables even novices to distinguish an attack upon resistances and defenses from an attack upon the person, which is never justified under any circumstances. This sense of "being with" the patient is sometimes conveniently misunderstood as an implied promise that the therapist would be willing to assume the role of a guide or of a guardian. Such hopes are always frustrated, yet without the therapist ever withdrawing from the therapeutic relationship as a real and interested person.

The therapeutic split of the patient's ego is actively pursued in C. M. T. from the onset of therapy, so that a strong bond may be formed between the therapist and the healthy, adult part of the ego. This bond must be strong enough to sustain the repeated and direct assaults upon the other part of the patient's ego, the one that represents the pathologic characteristics of the patient. Such direct challenges by an intrusive therapist to life-long patterns of being are tolerated and not misinterpreted as sadistic attacks upon the person of the patient only after a basic trust has been established. The viability of such a therapeutic alliance also, explains the low suicide rate in C. M. T., and the willingness to remain in painful and often frightening therapy with little or no medication.

The Handling of Resistance

The framework of a reliable and dependable therapeutic alliance allows patients to take risks and to allow themselves to experience that which always was too frightening before. The provocative techniques of C. M. T. were developed to create situations in which patients will find the refusal to experiment with new ways of being as difficult as the experimentation itself. This puts the patient in a bind and is one way of applying pressure in the direction of change.

> George, a prominent and successful physician, came into therapy only when he had no other choice. He was encountering difficulties in sexual performance for years, and in spite of serious doubt about the efficacy of Psychiatry, he sought the consultation.
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> Only after much preparatory work did George agree to come to a group session. It was most difficult for him, as it often is for physicians, to accept being a patient. He attended the group sessions regularly and was obviously deeply moved on several occasions. But his verbal participation remained minimal.
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> On one occasion then he was asked whether he wished to be helped. It was suggested that he mention breifly the three most embarrassing subjects that he could think of. Blushing, he refused. It was then suggested to him that he go around the room saying to each person, "I'm George. I won't tell you anything for fear you'd laugh at me". A long silence followed, as perspiration beads appeared on his forehead. He finally refused again, and another patient began to speak.
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> It was in the next session that George spoke about his total blocking when faced with such an impossible dilemma. He spoke of his rage and of his fear. He had become a patient.

Although the techniques developed by C. M. T. for the handling of resistance are intrusive in character, a basic and ever present respect for the individuality of each patient dictates that the latter must give the therapist explicit license to be so intrusive. Patients similarly may rightfully refuse to subject themselves to direct questioning in areas that are highly charged and considered forbidden, as they are implicitly encouraged to protest when their questions go unanswered or when they are subjected to ridicule by imitation. The persistent and direct confrontation of

resistances is often experienced by patients as a direct attack upon their dignity and their person, and exquisite sensitivity and skill on the part of the therapist are required to clearly differentiate one from the other. Unless a patient is able to clearly see that the attack was directed at his pathology and not at himself as a person, further therapeutic work becomes impossible.

Under the pressure of repeated and unrelenting confrontations with one's self-destructive traits, each patient must eventually make a very difficult and painful choice: to continue holding on to pathological behavior that is experienced as being an essential part of the personality, thus risking further intrusive and painful interventions, or to experiment with slowly giving up some part of the self, frightening as such a move always is. The only way to really find out whether it is possible to exist without some part of the self that was always considered essential is by taking the difficult and courageous step of experimentally giving it up. This terror-producing decision can be attempted 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 can be experienced as a potential rescuer just as a supportive therapist can, as long as he really is "with" the patient in his or her travail.

Early in any surgical procedure, the surgeon must carefully separate the healthy from the diseased tissue, doing this with the aid of a blunt instrument or with his fingers, before any actual cutting is done. He must be extremely careful to include all the healthy tissue in that part that is to be left in, but to leave no trace of diseased tissue behind, if the patient is to recover completely. This preparatory task is also a requirement of good psychotherapy. Ego syntonic, life-long characteristics of an individual must first be made ego alien before any actual separation of the pathology from the person can occur. This is, in itself, a laborious, repetitious, and most difficult task, and yet one of extreme importance. Only if this task is meticulously

carried out and successfully completed can the therapeutic work proceed to a successful conclusion.

The Personality of the C.M.T. Therapist

The personality, experience and integrity of C.M.T. therapists are of the greatest importance, probably even more so than in other modalities, not only because they are intensely involved with their patients, but also because the intrusive and provocative tactics used could easily be abused by unscrupulous or unbalanced individuals. The damage that can be inflicted by an unqualified or an unethical surgeon is obviously greater than the damage that can be inflicted by physicians in more conservative specialties. The same holds true in psychotherapy. The C.M.T. therapist must continually scrutinize himself and check out his or her feelings about any one patient, a never ending process. The motives for any intervention must ideally always be clear, and their appropriateness and necessity to the situation must be carefully evaluated and judged completely acceptable, in spite of their unusual and unorthodox nature. Such careful scrutiny of motives must eventually become intuitive and automatic, or else interventions will be poorly timed, laborious and relatively ineffective. This presents the greatest challenge to the novice C.M.T. therapist, and it usually takes several years of full time active apprenticeship to reach therapeutic maturity. To the uninitiated and the uninformed, both the surgeon and the C.M.T. therapist may seem cruel and heartless, and perhaps even damaging. Primitive tribesmen in remote regions have been known to use all their force in fighting physicians and surgeons who risked their lives in an effort to bring them medical aid. Both surgery and C.M.T. are not to be undertaken lightly, and yet it is obviously indefensible to not employ either when it is medically indicated and clinically required.

The Goal of Separation - Individuation

True separation-individuation is the goal of Crisis Mobilization Therapy, the ability to exist without succumbing to the overwhelming need to attach oneself physically or emotionally to others. Incomplete psychologic weaning may well be at the root of all mental illnesses and, in any event, the state of separateness often gives rise to attacks of intense anxiety. Depression, especially masked, by far the commonest of all illnesses, can easily be explained as a life-long process of mourning for the perfect pre-birth mother, and therapy based on this formulation is often successful in lifting the heavy cloud. Much of psychiatric symptomatology is directly attributable to attempts aimed at overcoming such fears of being all alone in the world. And yet, only the freedom to live alone gives a person a true chance to voluntarily form lasting and meaningful relationships with others for mutual enjoyment and benefit. Such relationships are based neither on need nor on fear but, instead, on respect, appreciation and perhaps also on love. Such are the relationships of peers and equals, which have a better chance to survive without the development of hurt, bitterness or hate.

The achievement of real separation-individuation is obviously not a unique interest of C.M.T. alone. It is in fact the proclaimed goal of several other psychotherapeutic approaches also, and the theoretical differences between these and C.M.T. are significant but smaller than those in practice. Yet, by constantly working intrusively with character defenses and by consciously recognizing the importance of using force, as explained, within the therapeutic relationship, C.M.T. may have a unique contribution to offer in terms of actually helping patients to come closer to this widely acclaimed goal.

The active and intrusive role assumed by C.M.T. therapists assists patients in developing intense dependency relationships with their therapists, a very frightening

and misunderstood prospect for most individuals, in or out of therapy. The notion that even grown adults have realistic and non-realistic needs fulfillable by another person is often most terrifying, and many patients make repeated and persistent attempts to leave therapy before reaching this "most dangeous" point. Yet, only within the framework of a fully developed dependency relationship can the yearnings for an unreachable, unconditionally accepting mother be fully experienced and worked-through. The process of mourning is long and always painful and difficult, but only when these dependency needs have been fully experienced and finally resolved can the work of therapy be considered successfully finished. With a less viable therapeutic alliance the opportunities for a complete working-through of all the manifestations of patients' pre-verbal rage and hunger are more scarce. (5) A sub-clinical, attenuated but still troublesome chronic depression is often the unfortunate and point.

The Manipulation of the "Transference"

The therapeutic relationship in C.M.T. is consciously and intentionally manipulated to produce affective involvement and reactions that would fail to occur in many patients with character defenses. The spontaneously developed transference of such patients would be tenuous at best, just as many of their real-life relationships are. Such a transference is not really useful in any form of intensive psychotherapy and is almost totally useless in C.M.T. Patients of this type do not often come to therapy in the first place, or drop out soon after the beginning. Yet, the requirements of an actively manipulated relationship that intrusively focuses upon the interchange between patient and therapist renders characterologic withdrawal tactics relatively impotent.

Such manipulations of the relationship make the task of recognizing transference distortions more difficult than in more conservative forms of therapy, such as

psychoanalysis. The therapist must be reasonably free of a real bias and of unresolved related conflicts, and he or she must be alert and constantly conscious lest they mistake justified reactions to their manipulations for real transference manifestations. In a sense, the term "manipulation of the transference" is a misnomer used for brevity sake only. The therapeutic relationship is really the one that is manipulated, to produce strong reality reactions. This involvement with characterologically defended patients is intended to produce storms of affect of an intensity sufficient to penetrate the character armor. When this finally happens a primitive, early transference will emerge, often almost symbiotic in character. This is the true, pre-distortion transference, in the framework of which pre-verbal hunger and rage can be worked through.

The therapeutic interventions and tactics of C.M.T. would be expected to produce very strong reactions, and the demonstration of their absence or of their presence in attenuated form only often provides the first opportunity to make real contact with a patient. Other modifications of usual psychotherapeutic technique have similarly been found useful. For instance, consistency and constancy in the psychotherapy setting have always been held up as essentials to allow careful and objective scrutiny of patients' reactions. Such transference reactions would, according to these assumptions, reflect the pathological adaptational modes of the patient. As long as the therapist maintains the therapeutic neutrality in an unchanging manner, all changes within the patient can safely be attributed to him, clearly identified, analyzed and worked-through.

The validity of this approach has been questioned by many, and it is an unacceptable practice in C.M.T. The therapist who is invariably prompt and always exactly on time, for example, may unwittingly present a distorted picture of an idealized reality, as unreal as the patients' own distortions. Unfailing and ever present consistency on the part of the therapist allows patients to predict, often unconsciously, with a high degree

of accuracy his or her reactions to their defensive maneuvers. The ability to predict the responses of the therapist is useful in the service of resistance, and attempts are made in C.M.T. to consciously foil it. The ever present, ever patient, mildly interested, constantly prompt, even-tempered and ready mother-analyst does not conform to the reality of any mother-child relationship. Working-through based upon such a distorted picture often fails to resolve the original conflict.

C.M.T. is consistently inconsistent, except in relation to one basic and cardinal principle, namely that "reality comes first". To foil any attempt to imitate the therapists or to adopt any of their values, patiently are kept in the dark, as much as possible, as to their therapists'preferences. Patients are unable, by design, to guess the hidden wishes of the therapist, who makes conscious and repeated efforts to keep them unclear by being inconsistent and unpredictable.

> John, a compulsive computer-analyst in this thirties, was always deferential, most proper in behavior and dress, and usually five to ten minutes early to his appointments. His speech and thoughts were well organized and meticulous. Intellectualization and denial were elegantly and most expertly used, and repeated efforts to break into this system of defenses had basically been turned back. John succeeded in maintaining his usual cool composure in spite of all provocations.
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> The orderly calm that was the mark of his personality caused John to hypothesize many reality reasons to explain the unusual proceedings that he witnessed or was party to in group sessions. He was psychologically sophisticated, having been a psychoanalytic patient for several years before, and many of his explanations were correct. He was, however, unable to explain or to reason away the therapists' occasional latenesses in the beginning of sessions, and became obviously anxious and angered, both of which he attempted to deny, but only with partial success.
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> John was,as expected, always most prompt with the payment of his fees. When, on one occasion, his check was refused, without explanation, and he was asked to pay the following session instead, his composure was disturbed enough, and he spoke up vehemently against the unreasonableness of such an act, soon to catch himself and to continue in his reasoned manner. It was too late. What he denied as existing had just begun to emerge.

The Physiology of Psychology

Mobilized affective crises must eventually be of sufficient intensity to cause measurable changes in physiologic parameters such as blood pressure, body temperature, heart rate, breathing depth, muscle tone and others. Mobilized affective crises that fail to reach such levels of intensity must be regarded as only preparatory for more intense ones later in therapy. Repeated clinical observations lead us to conclude that the mobilization of affective crises that are close to the core of the internalized conflicts often produce storms of affect of such intensity. By remobilizing such crises again and again, previously established physiologic reaction patterns based on relative power positions of infancy are modified and eventually basically altered. Affective crises eventually lose their critical nature, and at last they begin to be handled in an appropriate, adult manner.

Crises are ideally mobilized exactly to that level of intensity that a patient is able to tolerate at any one point, a position that we have termed for convenience sake the Point of Tolerance. When an affective crisis is mobilized beyond the Point of Tolerance resistance takes over, patients refuse to continue working at that juncture, get confused by emotionally blocking out, physically walk out of a session (which is against the rules of the therapeutic contract) or leave therapy altogether. When an affective crisis is mobilized to an insufficient level of intensity, physiologic reactions fail to occur and resistance in the form of uninvolved boredom often takes over.

Both deductive reasoning and clinical observations strongly suggest that basic assumptions in the theory of personality change are in need of re-evaluation and change. Contrary to usual current practice, it appears that true and lasting personality change is not possible without specific modifications of physiologic patterns established in infancy in response to real or imagined physical or psychologic threats. Such

physiologic patterns become the characteristic and characterologic muscular and humoral responses of a person, mediated by his autonomic nervous system, thus determining the involuntary adult responses to psychologic or physical stimuli. The freedom to react behaviorally in basically different ways than in the past is achievable, therefore, not when just the cognitive or value systems of an individual change, but only when the basic physiologic patterns are concurrently also altered. The Bio-feedback approach, on the other hand, fails to recognize the symbolic connections of physiologic reactions to their psychologic stimuli, and like much of psychotherapy it attempts to alter only one half of the integrated circuit, the other half. <u>Psychologic reactions of an individual in psychotherapy must be intense enough to repeatedly produce physical reactions of a new and different character,</u> now possible because of the sense of safety of the therapeutic setting. This is not an easy task to achieve, but one that is absolutely needed if true personality change is to occur.

Since character formation occurs early in the development of the person, most reaction patterns are firmly established before the development of language. Incidents and settings that are most important in the shaping of one's character cannot, therefore, normally be recalled with the aid of this late-developing instrument. Physiologically mediated stimuli to the senses can recall such very early feelings, not words. Patients give clues as to what may have happened to them in their pre-verbal period by means of dreams and by changing physiologic parameters as certain situations or moods are somehow encountered, in the therapy setting or outside it, such as when reading or watching a movie. Conscious memory is, at best, vague and non-specific as it relates to such very early recollections. If it is true that early established physiologic patterns must be reversed for personality change to occur, then other means must be employed to discover the specific stimuli that would elicit them.

The Use of Language in C. M. T.

Psychoanalysis uses reconstruction by the analyst for putting together details of such an unknown past, an intuitively guided cognitive process. C. M. T. has developed various other techniques for this purpose, recognizing that it is both futile and unnecessary to connect such stimuli with specific words or images. In Dredging for Affect, a previously mentioned technique, a patient agrees to repeat a short sentence, usually spoken by him or her in the course of therapy and judged by the therapist as possibly being a direct expression of unconscious early affect. Verbal repetition of such a sentence often brings forth storms of very strong feelings, sometimes followed by a hazy reconstruction of early-life situations *by the patient himself*, a helpful but not an essential step. If the therapist's judgment and choice are correct, the dictionary meaning of such repeated words is soon lost, and they serve, instead, as a drill that reaches directly into pools of deeply buried and long forgotten feelings.

Language in C. M. T. is thus used in two ways, not only for the presentation of verbal material, but also for the elicitation of *specific* pre-verbal affect. The screaming techniques and bio-energetic analysis as well as similar approaches that aim at directly unlocking affect imprisoned in body tissues, are also capable of tapping early childhood feelings, but the lack of specificity in the stimuli used gives rise to global and non-specific reactions.

Conclusion

The therapeutic philosophy that underlies C. M. T. is based on an assumption that is repeatedly confirmed by clinical observations, that patients generally wish to be well and to *feel well*, but that they do not necessarily wish to *get well*. Getting well entails prolonged and painful efforts and, regardless of the reward, such efforts and pain are usually unwelcome, except when there is no other choice left. The goal

of becoming a separate, whole individual, capable of surviving without the aid of others, although not necessarily wishing to be alone, seems desirable and enticing in itself. "I Want To Be Me" is a title of a popular song, the slogan of many therapeutic fads, and the topic of many well-selling, self-help books. But, it entails the giving up of the dream of re-uniting with an ever-present, ever-loving, life-giving mother. To do so is painful and frightening, and requires enormous courage and perseverance. In spite of the popularity of the slogan, the weaning process is rarely completed, separation-individuation is infrequently achieved, and depression is the most common illness of our age.

The biologic hunger of the infant, expressed in adulthood as a multitude of demands for gratification of oral and other drives, cannot be directly satisfied, as hard as we might try. By steadfastly and repeatedly frustrating such demands, <u>in a setting that holds clear and close promise of gratifying adult needs</u>, such demands are turned first into dissatisfaction and eventually into rage, which is treatable.

But patients, quite understandably, wish to find solace and end their suffering and agony in a quicker and less painful way, especially since the existence of such ways is implied in the many promises made by the new therapies. In spite of repeated disappointments, an army of patients goes from one therapist to another in the vain hope of finding the unfindable.

> Glen, a schoolteacher in his thirties, was given up by his natural parents and adopted at age one. Several incidents during childhood made it clear to him that the children he was often playing with were his real siblings, who lived not far away. He was perpetually occupied with the question as to why he, alone of all his siblings, was given up for adoption, and he usually answered it by seeing himself as deprecated and worthless.
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> Glen's adopting parents were remembered as always being distant, drunk and preferring the one older child, their natural born son. Years of psychotherapy with several therapists had left Glen still withdrawn, very quiet, generally apprehensive and in an

ocean-deep depression. He was a grown up, untrusting orphan, with tangential relationships and much sadness.

After several years in C.M.T., Glen's therapy was nearing termination. Married now and a father of a little girl, more outgoing and less depressed, he was nonetheless, stuck on a plateau from which he seemed unable to move. Several dreams repeatedly suggested that he wished to stay put.

An unusual memory suddenly came to him one evening, after it was suggested to him that just as he was putting distance between himself and his therapist, so also he might have pushed his father away when the latter came to him. "I remember him now, he was actually very loving on occasion. He used to embrace and hug me from time to time, a big, strong hug, and I felt so safe. I don't remember mother touching me. One day he came home and approached me. He was about to hug me again, but I believed I was becoming too big of a boy for that , so I stretched out my hand and we shook hands, instead. We could never again get together. Even on his deathbed we remained strangers, neither of us could break the ice. He hesitated for a long while, and then slowly added: "One such mistake is enough. If I get well, I will lose you, too." Tears streamed down Glen's face as he shook with hurt and pain.

It took Glen several years to become emotionally involved, to get in. That was necessary for his overcoming a life-long conviction that the world consisted only of antagonists and rejectors. Now he had to begin getting out, a most painful process, yet just as necessary as getting in.

Glen, like all patients, was "driven crazy" by life's circumstances. In C.M.T., after granting his therapist permission to do so, the means now exist to help him get well by "driving him sane".