Case Study

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

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

Personality Disorders (e.g., Horne, 1945; Murray, 1938) have sometimes classified interpersonal behaviors into three broad categories. This classification is generated by considering, first, whether the subject is (a) avoiding the other person in (b) getting involved with the other. If the latter, the behavior can be further classified into

(ba) behaviors expressing a positive involvement and
(bb) behaviors expressing a negative involvement.

The resulting three categories can be labeled (a) avoidance, (b) positive involvement, and (c) negative involvement. Horoway (1945) has called these three classes moving away from moving toward, and moving against the other person. Murray (1938) has written of absence, presence, and constraint with similar meaning.

Behaviors involving other people, both positively and negatively, are frequently examined in psychotherapy. These collecting positive involvement occur when a person attaches, collabo-

rates, or coexists with another person, completes and shares thoughts and feelings and is person, warm, and loving. Ethnologists (Hussein & Rosen-

weg, 1973, chap 28) have noted these positive behaviors, cohesive behavior, because they bring movements together. Since many cohesive behaviors begin with the letter c (cooperate, consent, comply), we shall call them Type C behaviors. In contrast, behaviors reflecting negative in-

volvement produce a psychological differentiation from the other person. They occur when a person

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studies another person, disregards with, distracts, or disapproves of the person; hales, criticizes or opposes the person. Psychologists have called these behaviors dispositional behaviors, since they (essentially and aggressively) drive personal attacks. Since many dispositional behaviors begin with the letter d (deceive, disagree, disapprove), we shall call them Type D behaviors. As psychologists have noted, C and D behaviors show a complex interplay throughout the phylogenetic scale, causing the survival of both the individual and the species.

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

Impulse Versus Behavior

To clarify properly controlled behaviors, let us begin with a basic postulate of psychosomatic (as well as other) therapies, namely that an impulse precedes any nonresponsive behavior. The distinction is analogous to the psychologist's distinction between the underlying abstract representation of a thought and the corresponding surface structure of verbal behavior. In an isolated personal event, proceeds the other, an observable phenomenon. The impulse, an abstract representation, becomes decoded through a grammar that involves appraisal and obligatory rules and transformation rules; the defense mechanisms would thus be viewed as a subset of transformations that occur during decoding (cf. Suppe & Wrenn, 1969).

Just as the correspondence between the deep surface structure of language is not necessarily im-

mune to the behavior; different relationships ties between them. Sometimes an impulse is directly expressed in behavior; at other times, behavior is simply inhibited and, at still other times, the behavior is partly camouflaged by another behavior derived from another impulse. Thus, if a behavior were to exhibit both A and D components, we would assume that two different impulses, an A and a D impulse, both exist. An affective pinch, according to the

woman, would result from simultaneous im-

pulses to hurt and to be close to the same person.

A psychological "problem" is experienced when people lack control in translating impulse into behavior. For example, they might want to ex-

press one impulse and yet find themselves ex-

pressing another conflicting impulse. That is, on the one hand, they might find themselves unable to express an intended behavior directly and com-

pletely, for example, that they cannot cooperate or cannot fight even though they want to. On the other hand, they might find themselves expres-

sing a behavior more intensely or more compul-

sively than they want to, complaining that they have to state intimacies or keep to doit even though, they do not want to, such behaviors would have an obligatory quality.

A successful therapy should help people gain control over each kind of behavior. They should acquire the capacity to experience and express more directly both C and D behaviors. One goal of the following studies is to objectively seek improve-ments and to examine the relationship be-

between them.

Observation 1: Two Concomitant Changes

Method

This set of studies was based on a psycho-

analytic case treated by a psychoanalyst who was not familiar with the views expressed here. Every session of the analysis was tape-recorded with the written consent of the patient. The analyst also took process notes during each hour describing the content of the hour. As the patient was talk-

ing, the analyst was writing. His notes, however, did not report any comments on clinical infer-

ence; they simply summarized the patient's talk and his own interventions. A group of clinical psychologists and psycho-

analysts met weekly to discuss the case. Drawing only on the process notes of the first 10 hours and information of the intake interview, they formulated the case and predicted a sequence of changes. The following case description sum-

marizes the main details of the case and the group's formulation and clinical prediction.

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

The term impulse is meant to be neutral theo-

retically in the way that the term underlying abstract representation is neutral. Thus, for example, no en-

ergetic connections are intended.
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[Text continues with case study description, discussing a patient's condition, behavior, and possible interventions.]
As the behavior became more explicit and direct, the scale value increased, 3 indicated that the feeling of closeness was expressed to a third party, and 4 indicated that it was expressed directly to the other sworn. Each rating was also increased by .5 if the event occurred in the present tense (after the treatment began). The possible ratings thus ranged from 1.0 to 4.5. These passages were also presented to a panel of four clinical psychologists who were naive about the case. Explicit scoring rules were developed for rating the passages, and the judges followed these rules to rate each behavior.

**Results**

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

The 100 sessions were then grouped into 10-segment blocks denoted I, II, III, . . . , X. The number of passages within each block were $I = 32; II = 14; III = 16; IV = 9; V = 15; VI = 11; VII = 13; VIII = 10; IX = 29; X = 19$. The ratings of passages within each block were averaged, and the means ranged from 2.62 to 3.83. These means are reported in Figure 1, which shows the development of Type D behavior across successive blocks of sessions.

To examine changes in Type D behaviors more closely, all passages rated alike were examined as a group. Because of the small frequencies in some categories, passages rated 2.0 and 2.5 were combined, as were passages rated 4.0 and 4.5. Also, to obtain more stable frequencies, the sessions were grouped into 10-segment blocks.

The relative frequency of each rating was computed for each block, and these relative frequencies are shown in Figure 2. The top two graphs show a monotonic decline for passages rated 1.0-2.5. Figure 2 also shows a decline in 3.0 (criticizing someone for a past event) but no increase in 3.5 (criticizing someone for a current event). Direct confrontations (4.0 and 4.5) also became more frequent throughout the treatment. The graphs are largely monotonic and characterize major changes that occurred in the patient's behavior during the treatment.

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*These graphs, of course, are not independent of one another. The overall impression from Figure 1 requires that the lower ratings generally decline over the 100 hours while the higher ratings generally increase.*
To compare the frequencies of past and present events, the relative frequencies of 3.0 and 3.5 were compared. There were 101 passages with these ratings. For each block of 20 sessions, the relative frequency of 3.5 (patients' case) was compared. For successive 10-minute blocks, the values were 6/24 (6.4 cases were in the past tense, 4 were in the present tense, 18 were in the past tense, 10 were in the past tense, 8/16 = .50, 15/26 = .58, 8/11 = .72, and 19/24 = .79). Thus, the patient increasingly came to realize what for events in her present life. It is assumed that events from the past tense were less threatening for her and provided a convenient starting point for the therapy, but as the session progressed, she shifted her focus to her current life. Thus, part of the increase in Figure 1 is due to the patient's shift in present tense events, and part is due to the decline in past tense events (primarily 1, 2, and 3).

Type C behavior. The reliability of the 106 Type C ratings was also assessed. The four judges' ratings for a given passage were averaged, and the reliability of the four judges' ratings was .83. The 100 sessions were grouped into 10 session blocks, with the following frequencies within each block: Block 1: 11; Block 2: 9; Block 3: 15; Block 4: 10; Block 5: 9; Block 6: 12; Block 7: 14; Block 8: 9; and Block 9: 12. The ratings of the passages within each block were then averaged, and the resulting means ranged from 2.57 to 3.75. Figure 1 shows the development of the Type C behaviors across successive blocks of sessions.
To examine the change in Type C behaviors more closely, passages within each rating category were examined separately. Since the frequencies were smaller than those concerning Type D behaviors, all of the ratings from 1.0 to 2.0 were pooled (these were the categories that had shown increasing relative frequencies in Type D behaviors). Likewise, all of the ratings from 3.5 to 4.5 were pooled. These were the categories that had shown increasing relative frequencies in Type D behaviors. Relative frequencies of occurrence were computed for each block of 20 sessions, as shown in Figure 3. One graph shows a progressive decline in the relative frequencies of the lower ratings, and the other graph shows a progressive increase in the relative frequencies of the higher ratings. The two graphs thus resemble those obtained for the Type E behaviors. Events in the last three were also examined, but their frequencies were too small (only 23 cases) to permit any inference.

Thus, it is clear that two types of changes occurred, but it still needed to be demonstrated that a change occurred in the patient's presenting complaint, sexual frigidity. Therefore, every reference to the patient's sexual behavior was noted throughout the 100 hours. There were 16 such references (comprising a subset of the 100 Type C passages) all occurring between Hour 28 and 100. Each passage contained the word intercourse except one, which contained the phrase sexual intercourse. Here are some examples: From Hour 33 (rated 4.5): "Sometimes when she is trying to make herself have intercourse with Bill, she feels as though she wants to hurt him. She just doesn't understand it. She'll go from feeling very warm to feeling nothing toward him suddenly." From Hour 67 (rated 4.5): "This weekend she and Bill had intercourse, and she was thinking how different it can be when she's thinking about him and feeling close to him and not all wrapped up to herself.

Seven passages occurred in the first 50 sessions, and 11 occurred in the last 50 sessions. The C rating assigned to each passage was noted. For those in the early block, 6 had ratings of 3.5 to 4.5, and 1 (in Hour 67) had a rating of 3.5 to 4.5. Of the 11 passages in the later block, 4 had ratings of 1.5 to 2.5, and 7 had ratings of 3.5 to 4.5. The 7 passages with high ratings were mainly simple direct statements that the patient had had sexual intercourse. A Fisher exact test was performed to test the significance of this difference; the chance probability of the observed number of passages in the same category is 0.02.

Observation 2: Relationship Between C and D Behaviors

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

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

Method, Results, and Discussion

In Figure 1 the C graph resembles the general form of the D graph. To examine the relationship between the graphs more closely, the post-
tions of greatest increase along each graph were noted. A "significant improvement" in either function is defined as an increase from Block 1 to Block 2 plus 1 that exceeded .25. Significant improvements in Type D behavior occurred three times—from Block IV to Block VII, from Block VIII to Block VII, and from Block II to Block IV. Furthermore, significant improvements in Type C behavior also occurred three times—from Block VI to Block VIII, from Block IV to Block VI, and from Block IV to Block VII. In each case, a significant improvement in Type C behavior followed a significant improvement in Type D behavior. An improvement in D preceded from II to VII, an improvement in C occurred from III to IV. The chance probability that the three Type C improvements would occur in these particular three positions is .052.

In addition, a "setback" in either function is defined as a decrement from Block 1 to Block 2 plus 1. A setback in the Type D behavior occurred three times—from Block I to Block II, from Block IV to Block V, and from Block VI to Block VII. A setback also occurred three times in the Type C behavior—from Block II to Block III, from Block V to Block VI, and from Block VII to Block VIII. Thus, a setback in Type C behavior always followed a setback in Type D behavior. In other words, the two graphs took very similar courses, with not displaced from the other by 1 block of sessions.

The data therefore suggest that the patient's progress in expressing Type C behaviors followed her progress in expressing Type D behaviors. As she became progressively able to criticize, oppose, and disagree with other people, she felt progressively less vulnerable, thereby allowing her to feel closer, more affectionate, and more compassionate toward other people. If the two graphs had simply extended in a manner to which other factors could account for their concomitant rise and fall, then their displacement in time suggests that as advance in one type of behavior may facilitate an advance in the other.

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

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

Finally, another kind of explanation might account for the observations in Figure 1. Suppose the direct expression of aggression is in some sense incompatible with the direct expression of intimacy, so that the reflexive prohibition of one word implies a relative decline in the other. Then, as one graph rose from Block I to Block II, the other graph would fall. For example, in Figure 1, from Block I to Block II, the C graph rises while the D graph falls, causing the graphs to cross. Then, proceeding to Block III, the C graph falls while the D graph rises, producing another crossing. Additional crossings occur as the graphs proceed to Blocks V, VI, VII, and VIII. This characterization of the data has the virtue of parsimony, but it does not explain why both graphs would show concomitant overall improvement. It also suggests that the frequency of Type D behaviors should be strongly and negatively related to the frequency of Type C behaviors. The correlation was negative, but it was not significant (r = -33, p > .05).

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

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

In the course of 100 hours of treatment, Mrs. C mentioned a large number of other problems...
that were not directly related to sexual frigidity but that clarified the nature of her distress. Many of these complaints were expressed in the form of "I can't do something," revealing inhibitions and complications. A large subset of these complaints could be classified according to the C and D categories, and it was hypothesized that many complaints would reflect general problems over C and D behaviors.

Two people reading the process notes independently identified 248 complaints involving "can't" (e.g., She can't praise her assistant) and 103 complaints involving "has to" (e.g., She has to fight against her handwriting). Making a total of 351 complaints. Nearly symptoms of can't and has to were also accepted.

The statements were presented to a group of 20 judges (11 graduate students and 10 clinicians). Each judge was asked to classify each problem behavior as to Type C, Type D, or neither. A statement was considered a Type C (or Type D) complaint if 14 or more judges so classified it. Using this 14-or-more criterion, 60 complaints were of Type C and 56 were of Type D.

The complaints of each type were then analyzed further to determine how many were of the can't form and how many were of the has to form. Of the 60 Type C complaints, 31 were of the can't form and 9 of the has to form. Of the 56 Type D complaints, the corresponding frequencies were 34 and 32. The chi-square computed for this 2 x 2 matrix was 20.7 (p < .001). Whereas Type C complaints were typically of the can't form, Type D complaints were more evenly divided between the two. The single highest frequency was for complaints of the form "can't C," a form that corresponds to the presenting complaint, sexual frigidity. The other complaints, involving aggression and assertiveness, reflected poor control both ways. Sometimes the patient could not express behaviors that she wanted to express, but at other times she could not restrain herself.

General Discussion

Semiological studies of psychotherapy outcome have been undertaken in recent years, as summarized in the recent review of Bergin and Berzonsky (1973). Most of these studies (e.g., Bergin, Redor, & Sewery, 1975; Slonze et al., 1972) have reported data about treatment outcome, though details of the therapeutic process remain generally unclear. The present set of studies, in contrast, focuses on the treatment process per se and assumes that therapeutic outcome is best evaluated in the light of one patient's needs and goals.

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

These results thus point out one feature of a therapeutic process that is often overlooked in treatments that set specific behavioral goals, namely, that an advance in one behavioral domain may be a prerequisite for an advance in another, quite different, domain. For a patient like Mrs. C, a gain in assertiveness may be necessary for a gain in intimacy. Occasional writers have implied such a relationship (e.g., Smith, 1971), but no systematic documentation or explanation of the relationship has previously been offered.

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

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* Three variables declined in frequency over the 100 hours. The relative frequencies occurring in consecutive 20-hour blocks were 26, 24, 17, 19, 15, X²(4) = 14.18, p < .01.

** Very few of these can't complaints were specifically sexual in content, however. They concerned various people—the patient's husband, therapist, psychiatrist, and various aspects of her relationship (e.g., feeling close to or related to a particular person, her view, developing her own teaching method), making demands on other people, situation with other people, and aggression (expressing anger, being nasty to people, criticizing other people, opposing other people).
of treatment; simply and in combination with the other kind of treatment.

One early theme is Mrs. C's therapy consisted of her criticizing people (e.g., her parents) for events of the past. This kind of theme often occurs early in treatment as the patient spontaneously produces data from the past. It is possible that Mrs. C used as one demand characteristic of therapy that she criticize her parents for events of the past. In my view, however, she was not only producing personal data but was also taking very specific therapeutic ends by beginning the treatment in this way. Her criticism showed her to observe the therapist's reaction to one very mild form of aggression and assure herself of the safety of similar undertakings in the future. This low-level criticism can be viewed as an early test of a therapist. Other evidence of such tests has been presented by Bauswitz, Samuel, Siegelman, Wolfson, and Weiss (1971).

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

References


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