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Teleonomic psychotherapy

In Philadelphia Russ and I talked about the contribution of our ideas to psychotherapy, trying to extend ground already surveyed by Leon Sloman et al. (1). We do not want to start another school, but feel our ideas may illuminate existing psychotherapies.

We talked about Interpersonal Psychotherapy (IPT, 2) and Cognitive-Analytic Therapy (CAT, 3) as being particularly consonant with our views, and Russ mentioned Harry Stack Sullivan's The Psychiatric Interview which I am determined to read. Our evolutionary biological approach sees the brain and all the behaviour it produces as evolved through natural selection, because these behaviours have been successful over hundreds of millions of years in the struggle for survival and in the contest of sexual selection. We are aware that what now exists may not be adaptations in the sense of George Williams, but it makes sense to us to regard them so for heuristic reasons; and therefore all psychopathology can be viewed as adaptive behaviour, or as exaggeration of adaptive behaviour, or as distortion of adaptive behaviour, possibly due to the mismatch of present times and the EEA. This latter possibility was particularly well illustrated by Kalman Glanz and John Pearce (4) together with the use of the conbcept in therapy.

The principles of our contribution to psychotherapy can be listed as follows:

1. Psychopathologies represent primitive strategies which are not under conscious/voluntary control, and can be replaced with voluntary strategies to achieve the same end in a more satisfactory way (5). Our analogies from other systems include the response to cold, in which the primitive, involuntary response of shivering can be replaced by the voluntary response of switching on the central heating; and the response to bright light, in which the primitive response of pupillary contraction (or blinking) can be replaced by the more recently evolved response of buying a pair of sunglasses.

In this vein we regard depression as a primitive form of submission, which can be replaced by voluntary submission (or other voluntary strategies for resolving conflict). Compulsive checking may be a primitive form of insurance, and compulsive cleaning a primitive form of microbe avoidance; although in these cases it appears more difficult to replace them with more rational strategies. Regression is a primitive strategy for eliciting more parental investment, and can be replaced by more mature care-eliciting behaviour such as arranging therapy to help one through a stressful period (6). Attacks of hyperventilation may represent the inappropriate triggering of a primitive response to impending suffocation (7).

2. We are impressed with the widespread occurrence of agonistic behaviour and hierarchy formation among vertebrates. We see humans as also having dispositions to the primitive behaviours evolved to manage social hierarchies, like behaviours to maintain both high and low rank, and behaviours for changing rank (8). These behaviours are discouraged in most cultures, but occur in places in which society has little influence, such as the school playground, the prison cell and the marital bedroom.

We note that very few animals can maintain cooperative relationships with same-sexed conspecifics of the same social rank, and that the human capacity to do so is a recent evolutionary development. Therefore we might expect problems in this area, and we can point to case reports from existing psychotherapies in which the task has been to enable patients to develop these symmetrical relationships.

3. We accept that much of the variation in relating and in relationships can be accounted for by two dimensions, those of upperness/lowerness and closeness/distance so lucidly described by John Birtchnell (9,10). The poles of these dimensions also reflect human needs, so that in assessing any patient, or any relationship, we should ask whether needs for upperness, lowerness, closeness and distance are being met, or whether there are any disagreements about these needs between the patient and those to whom he or she relates closely.

4. We go along with Michael Chance that any disagreement as to these dimensions may change the character of relating from hedonic to agonic, and this "agonic mode" may continue until processes of reconciliation have taken place (11). The agonic mode is one in which the participants are oriented towards fighting, and this not only distracts their attention from more useful pursuits, but also has psychophysiological effects which may be subsumed under "responses to stress". Moreover, the agonic mode is one in which the primitive response of the involuntary subordinate strategy (ISS) is likely to be triggered in one of the contestants (5).

So we can sum up our contribution as follows:

What is likely to be wrong? Some form of hierarchical stress, with conflict over a particular issue or over the matter of rank itself; or difficulty in establishing equal relationships. Or disagreement as to the "horizontal dimension" of closeness\distance (such as the recursive conflict between intrusiveness and withdrawal, the breach of agreed continuance by death or separation, and the breach of agreed exclusivity by infidelity).

What to do about it? Replace a primitive strategy with a rational one. Switch from the agonic to the hedonic mode (by reconciliation). Get the hierarchy sorted out so that everyone agrees with whatever asymmetry in social relationships, if any, is necessary for the dyad or group to function. Ensure needs for closeness and distance are satisfied.

After recovery from depression or whatever, strengthen the social base by extending interests and social network. Try to mend any existing feuds, and mobilise old friends who have lost touch.

These are not earth-shattering revelations. Some of our recommendations are included in the practice of much current psychotherapy. But they are not included in all psychotherapies, and in those that they are, they are not formulated as clearly as they might be. We hope that our approach will enable psychotherapists to take a systematic view of possible teleonomic problems, and have at their disposal the techniques of therapy which seem most logical from a teleonomic point of view. Having said that, we agreed that we should look at various psychotherapies, and identify those which already include the above principles, and also those that do not.

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