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Genes and the Unchangeable Core

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When Vin Rosenthal wrote me in eary September with the kind invitation to submit a manuscript for the "Unchangeable Core" issue, I at first replied that I had nothing new to say, and anyway I could hardly do even a short paper in time to meet his editorial deadline. But the idea had sort of grabbed me, and so I sent him another letter within 24 hours saying that I would try. I should share with you my reason for such un-Meehlian vacillation (I am one of the best "no"-sayers in the profession!) which may help defuse whatever anxiety or aggression my paper elicits, to wit, I detected within myself a wish to decline that involved an element of cowardice. The recent fracas among members of AAP (more clearly discernible in the *Newsletter* than in VOICES) in which we found ourselves polarized over questions of therapist aggression, spontaneity, self-revelation and the like seems to have simmered down somewhat, and I should be distressed if I inadvertently revived that controversy, which did not "go anywhere" much.

One has the impression, quite apart from AAP, that the polarization of "feeling" over against "thinking" that is part of the counter culture complaint against our society is fairly widespread among psychotherapists, in manifest or latent form, and whether or not they get excited enough to write frustrated, anxious or angry letters about the matter. I will lay my cards on the table and say that while I consider myself an intense feeler—a judgment I know that my family, colleagues, students and patients share—I am, if such a thing is not contradictory (and I think it is not) an even more intense thinker. Concepts, theories, clever experiments and novel arguments can turn me on as much as love making, music, booze or watching my cat (a favorite pastime).

All of us would probably object to the caricatured way in which our particular value system and personality syndrome is delineated by ex-Jesuit Malachi Martin in his fascinating *Three Popes and a Cardinal,*[6] but like most persons I don't find it difficult at least to sort myself under one of his rubrics; and in my case the rubric is the one he calls "intellecter." The aversion that anti-intellecters

and super-feelers have for that type is likely, I am afraid, to be maximally aroused by the kind of casual-theoretical content which I am going to present so briefly (and hence, perhaps a bit dogmatically) herein. And that's more than enough about Meehl.

Let me approach our topic of the unchangeable core by reiterating the familiar distinction between the therapist's cognitive events as they occur within himself, and the questions whether, when, and how he should convey these in words or gestures to the patient. (As we know, in psychoanalytic therapy the word 'interpretation' has been used both ways, which is confusing because that I discern some hidden meaning in the patient's material is neither necessary nor sufficient for communicating it to him.) As for the first: Perhaps one subscribes unreservedly to the idea (sentiment? attitude? feeling?) that however we may semi-cognize matters in words from moment to moment during the therapeutic session, our "main job" as helper is to provide a setting, an atmosphere, a human relationship with a loving and accepting listener, within which very broadly defined context it will be possible, "if the patient so wills," for him to grow and change in whichever way he wants, and at the moment is able, to do. Without entering the lists in the controversy that has continued in varying levels of intensity over that basic assumption about the function of the therapist as helper (at least since Carl Rogers' fundamental work in the early 1940's, which profoundly influenced the clinical psychology students of my generation whether we called ourselves "Rogerians" or not), it is a fact that many of us do not find this "official therapist position" completely effective in assuaging our professional anxieties when the relationship doesn't go well, or the patient gets worse, or we feel "I don't understand what the heck is going on with this person, and I don't have much confidence that I ever really will." I suspect that any reader who detects *none* of that kind of concern in himself as therapist could skip reading the rest of this paper, because I will simply not be speaking to his condition. As on the side of the psychotherapist doubts as to whether one is proceeding correctly are not, as I see it, childish or neurotic but realistic appraisals of our situation given the state of the science and art; similarly, I would reject the notion that every instance in which a discouraged patient says that he doesn't see why despite 100 hours of psychotherapy he feels as anxious in such and such situations as he ever did, or that he doesn't understand why he can't get turned on by his work the way his peers do, or that despite his objective evidence of "success" socially and sexually and vocationally, he feels like some kind of fraud or failure—I do not believe that all such complaints should be automatically classified as some kind of petulant demand or the persistence of a "magic helper" fantasy, despite the correctness of the psychoanalytic tradition in emphasizing that the latter element is to some degree present in all of us.

Given that the psychotherapist is at times troubled in a mainly non-neurotic, realistic way about the indifferent success of some of his efforts, I offer a thesis and, associated with it, I propound a technical query. *Thesis:* There are limits to the efficacy of psychological intervention, sometimes rather mild constraints but other times quantitatively tight and, humanly speaking, deadly serious, which are set by the patient's *genetic endowment,* and which will in some cases leave

him, despite his and our best efforts, permanently more vulnerable to anxiety, depression, boredom, resentment, impairment of cognitive and executive ego functions, etc., than is to be found in numerous other "healthier" persons who may never have had so much as an hour of psychotherapy. *Technical query:* if the preceding thesis is substantially correct and quantitatively important, under what circumstances, if any, and how, should such genetic limitation become the labeled subject matter of therapist-patient conversation?

Obviously it would be silly to try to "document" the thesis, in the sense of summarizing the evidence and presenting the inductive arguments thereon, in a brief communication like the present one. If there are any readers to whom the genetic thesis comes as earth shaking news this late in the day, I can get them started on the intellectual search by citing the excellent book by David Rosenthal,[12] the collections by Hirsch,[4] Manosevitz, Lindzey and Thiessen,[5] and Vandenberg.[13] See also a miscellany of relevant citations in footnote 16 (p. 393) of my paper on nuisance variables.[7] See also my "Specific genetic etiology, psychodynamics, and therapeutic nihilism" [8] and my afterword to Gottesman and Shields' magnum opus [9] where I try to show how even a strong genetic emphasis as to specific etiology leaves quite unimpaired whatever valid knowledge we possess about the psychodynamics and family (or other sociopathology) of behavioral aberration and psychological suffering. But I confess my own views go considerably beyond the present state of the firm evidence (chiefly twin and foster child studies) showing strongly genetic influences in the major functional psychoses (manic depressive disease, schizophrenia, and the unipolar depressions).

I conjecture (and am frank to admit, as practitioner, I *believe*—everybody is of course betting on a horse, so I feel free to bet on mine!) that in the nonpsychotic realm of psychological disturbance that we put under such arbitrary (and nontaxonomic?) rubrics as neurotic depressive reaction, anxiety neurosis, transient adult situational maladjustment, marital problem, etc., there is frequently—I do not say always— operative in the complex skein of causality which brings the patient to us, one or more (typically, I think one should assume more) hereditary variables of polygenic kind that represent not pathological entities such as Huntington's disease or schizophrenia but what may be called "normal individual difference variables" of temperament. Among these I would list such factors as anxiety proneness, energy level, the heritable component of the so-called general intelligence factor (which I am old-fashioned enough to persist in believing), social dominance, some components of so-called introversion, sexual drive, frustration tolerance, orality, rage-readiness, and the like. I think it difficult to set any strong limits on which aspects of socially learned behavior may involve acquisition-parameters that are in some degree genetically determined, given the growing body of evidence that there is a heritable component in a number of characteristics which might not antecedently have been expected to have anything to do with one's genes (e.g., social dominance in the mouse, introversion in the human, and I think particularly of some surprising studies indicating a heritable component even for vocational interests!) Genetic influences are currently unpopular among American psychologists, but the evidence is accumulating very rapidly; and I detect, especially among recent crops of clinical psychology students, a greater readiness to allow for the possibility of heritable contributors to behavior disorder than was true even 10 years ago. Of course when human family or physiological and biochemical data are skimpy or lacking, one who feels impelled to arrive, however tentatively, at reasonable conjectures about these matters will use whatever "personalistic probabilities" he can lay hold of.

In my subjective Bayesian appraisal of the situation, I freely admit that extrapolation from the animal data is part of my total body of evidence. It seems that almost every behavioral characteristic that we investigate in infrahuman animals turns out, if carefully enough studied, to have at least some genetic component to it. I have elsewhere [8] hazarded a prediction that when the design is adequate in terms of measures used and sample size, the proper inference will be that substantially all individual differences in any aspect of behavior, temperament, emotion, cognition, activity and the like in humans or infrahuman species has at least some heritable component. In addition to the aversive variables that came into attention with the rise of psychoanalysis and its emphasis on defense, there are probably sizable "normal range" individual differences on the appetitive side. One of these I think important—but this is based almost wholly upon clinical impressions and not upon research, except extrapolated—is basic hedonic capacity or, if we talk more behavioristically (why?) the generalized positive reinforcement parameters of a person's brain. I present some of the reasons why this strikes me as a theoretically interesting and clinically important possibility in a forthcoming paper.[11]

In what follows, I am going to presuppose the substantial correctness of the genetic thesis in discussing my query about tactics, concerning which I have much less stabilized convictions.

Thirty years ago, when I was an advanced doctoral candidate at Minnesota, I would have been tongue-tied had a psychologically sophisticated patient asked me bluntly in an interview, "My brother thinks that I am a schizophrenic; do you think I am?" (I cannot resist the impulse to mention in passing that psychotherapists of strong "feeling" orientation who combine it with an emphasis upon therapist spontaneity in expressing moment to moment experiences during the session, might not find complete candor at this point much to their liking—although I suspect that question doesn't arise often because therapists of that genre are, by and large, not overly fond of nosological nomenclature anyway!) I don't mean to suggest that over the thirty years ensuing I have come to find that a comfortable question to handle, although in recent years I have had several occasions when I had to handle it, as I daresay is true of many readers too. Let me bypass the stock response, which is also mine, of throwing the ball back in some such form as, "I am wondering why you asked that just now?" or "What would it mean to you to 'be a schizophrenic'?" or "Why do you think he says that?" and the like. As is true of other questions patients ask, throwing this one back does not invariably defuse the anxiety attached nor stop a persistent patient from pursuing his aim of finding out what one thinks.

I choose this example first because it is the touchiest due to the increased frequency with which educated persons know the word 'schizophrenia' and the combination of "crazy" and "pessimistic" flavors that the label has come to have. There is also the well known fact that insincerity and double talk, almost always undesirable in psychotherapy, are especially bad when relating to a schizotype. I do not claim to have an answer to my technical query, and it is a genuine query, not rhetorical. All I can report is that I have, after the usual tactics of reflecting concern and asking for clarification of what the question means and why he thinks it's important to answer it, and then a further preliminary defusing of semantic anxiety by saying that I do not know just how much hinges upon such labels anyway (I never say that I don't think *anything* hinges upon them, for the simple reason that I don't believe that) I have found myself willing to say some kinds of things which thirty years ago I wouldn't have found possible or held proper to do. Thus: "Well, from what you have told me and from the way you act in here, and from some of your test results, and reading what Dr. Fisbee says in his letter,

I think you may be one of those who is prone to get pretty mixed up in your thinking, unclear about what is reality, and scared or angry enough about other people that you have trouble relating to them; and these are things that we often label 'schizoid' or 'schizotypal'." I feel somewhat more comfortable about a patient who asks, "Do you think I'm a manic depressive, that's what another doctor told me?" partly because that label is less malignant and also, I suspect, because I am a cyclothymic personality myself. I do try to teach such patients to use the word 'mood swinger' or the word 'cyclothyme' instead of the word 'manic depressive.'

But let's take something that doesn't involve the formal nosological labels of DSM-II . Suppose, for instance, a patient complains of being "a terrible introvert," and expresses the fantasy that psychotherapy or joining the Toastmaster's Club or whatever will turn him into some kind of roaring free-wheeling extravert, and that if this doesn't happen the process will have dismally failed. Again, I do not by-pass the standard explorations of meaning and feeling as a first, and, I remain convinced, important step in catharsis and clarification. Furthermore, I believe that the human animal does a lot of self talk which involves eliciting the "emergency affects" (Rado) of fear and anger by certain words that have become conditioned elicitors of those states. And I believe that a process similar to, and perhaps actually consisting of, experimental extinction takes place when the patient says such charged words aloud in the presence of another speaking biped and finds that as a result he is not rejected or laughed at and does not fall out of the universe.

In the American culture, of course, the fear of being and, for many people, even more of *appearing* as "socially introverted" is quite common, although my impression is that this particular label is somewhat less used than it was when I began as fledgling psychotherapist in the 1940's. But I am convinced from the human research on twins, and admittedly extrapolated ideas from animal data, that certain forms of anxiety proneness, of social shyness, and below average social dominance are partly genetic in origin, and extreme amounts probably mainly so.

This carry over from research to clinical practice is supported by the fact that I have never treated a "severe introvert," nor met anybody of that sort, where the effect of otherwise successful psychotherapy was to move him five standard deviations along the introversion-extraversion dimension. And I would be amazed if any of my readers could present convincing clinical material to the contrary. I believe that garden variety social introversion (which I am distinguishing, of course, from schizotypy as well as from some other important variants that resemble it phenomenologically, such as class based social inferiorities and the like) is a fairly rock bottom, basic "temperamental" disposition. In terms of our issue's topic, it belongs to the unchangeable core of the adult acculturated personality make up, and I believe for either patient or therapist to entertain the idea that somehow that will be radically changed is unrealistic. One can help the person to cope with his tendency to experience more than an average amount of social fear, one can help him by interpretation and rational intervention and by other methods—not the least of which is experiencing of the therapeutic relationship itself as a loving, non-punishing, non-judgmental one—and can make helpful suggestions about kinds of social situations that he perhaps should steer clear of because they just aren't that positively rewarding anyway so why take the emo-

tional heat involved? In all these respects, the more pathological features and the subjective distress associated with "being an introvert" can be materially reduced psychotherapeutically. But I repeat that we are not likely to transform Mouse-in-Corner Mary into Elsa Maxwell by therapeutic conversation. This being so, I think it important to defuse the *word* 'introvert,' and to explore it with the person, which I do, once a good relationship is formed, in fairly aggressive and cognitively oriented ways, as by pushing the question, "Why does everybody have to be a roaring extravert?" The tactics here are probably closer to those of Albert Ellis than any other major therapeutic figure with whose views we are familiar from writings. And I do not hesitate, when this stage has been reached, in which the task is a mixed one of reducing semantic fear of self labels on the one hand and of "philosophical instruction" (I no longer have the reluctance I had in my youth to label it thus) to proceed by listing some of the numerous ways in which human beings differ on a combined genetic and early life history basis.

So I talk to the patient about the huge differences there are in energy levels and food intake and dominance and social hungers and sleep requirements and sex drives and aesthetic interests and need for activity and so on, constantly harping on the theme that I learned as an undergraduate from the late, great Professor Donald G. Paterson: *"The range of individual differences is tremendous."*[14]

I may say in passing that the notion that one is not really dealing with the person as an individual, or that somehow one is ignoring his human uniqueness if one permits himself as therapist to call to mind what he learned in preclinical courses about the science of psychology and related disciplines, seems to me quite wrong. Behavior genetics and differential psychology and personality theory leave plenty of "free space" for all of us to be our unique selves, and I have never felt that my or anybody else's unique personality was in the least ignored, or his human worth degraded, by the inference that he had more mechanical ability than verbal fluency or more "general intelligence" than athletic prowess or had inherited polygenes disposing to shyness.

It may be objected that these extrapolations from the preclinical sciences into the therapeutic hour are, even if done by a skilled, sensitive and tactful therapist, somewhat dangerous, both because of the terrible potency of labels in a speaking animal and because of reliance upon probabilistic extrapolations. No quarrel on that score. But since, as a quasi-determinist, I assume that when we enter into anything but the most trivial and superficial therapeutic relationship we are always playing with fire or dynamite, whether we know it or not, I do not find my professional conscience greatly disturbed by the truth of those two warnings. Of course, if we are going to play any such didactic role as this, engaging in cognitive causal discourse about the "unchangeable core," it is desirable for us to be as clear as the present state of the science permits about the character of these concepts. There is a great deal of dreadful nonsense written on the subject both ways, and I am inclined to believe that if one doesn't get past the undergraduate level of thinking about these matters it would probably be better for him not to deal with them at all in his capacity as therapist. For instance, if one thinks that allowing for a strong influence of genes on the major psychoses, or their pseudoneurotic phenotypic forms, would mean subscribing to some kind of silly idea, say, "Meehl and Co. want me to believe that you can inherit a schizophrenic delusion or a depressive self-image," that won't do at all. Genes do not determine any kind of behavior that has a learned social content. I can't

inherit delusions, any more than I can inherit a disposition to speak sentences in German or Swahili. In fact from either a behavioral or phenomenological viewpoint, what we inherit is dispositions of at least the second order [1] and I think, if the philosophical analysis is pressed sufficiently, it will usually turn out that we inherit dispositions of third or higher order.[8] And if the psychotherapist is going to make explicit cognitively oriented use of extrapolations from the preclinical sciences to his technical maneuvers during the hour, it is desirable for him to be fairly clear in the head himself about the conceptual network involved. Point: We don't have to "explain everything" we think we know to the client, but if our own belief system is a conceptual mish mash, (as is alas, true of quite a few people in the mind business) we are rather likely to bungle it. It goes without saying that one can have a pretty good theoretical understanding of things and be clumsy or otherwise inefficacious as a psychological helper. But I would *not* readily reverse this negation by saying that one can be an effective helper *using cognitions about the preclinical sciences* if his own ideas are woefully unclear or uninformed.

Discussions about the role of the therapist's purported "theoretical knowledge" in the helping process are reminiscent of somewhat heated debates among what we would now call "orthodox Freudian" analysts in the 1920's and 30's, between those who emphasized intuition and Freud's famous metaphor of the analyst's unconscious resonating like a telephone receiver to that of the analysand and more "conceptualizing" opponents (in the course of which I believe Wilhelm Reich, who at that time still considered himself an analyst, warned against permitting so-called "chaotic situations" to develop), with Otto Fenichel trying to steer a middle course between over intellectualizing on the one hand and simply "floating in the patient's material," fragmentarily communicating bits and pieces of interpretation as they bubble up in the listener's mind from time to time.[2] As I said above, if a reader does not experience any professional distress concerning the technical adequacy with which he performs his psychotherapeutic role, my remarks simply do not speak to his condition, although I will have a mild monitory qualification to make about this later. But if one does experience such doubts and concerns, and if one does believe (as I know some would deny, and I cannot definitively refute them) that there is and ought to be *some* sort of connection, however loose and probabilistic, between one's causal theory of the mind on the one hand and one's handling of the session on the other, then there immediately arises a kind of mixed scientific and moral question, to wit, "How is it possible for me to choose my words, including the choice of no words for the moment, on the basis of such a primitive and messy semi-science as psychology is presently?" For some general observations on this dilemma see the preface to my *Psychodiagnosis: Selected Papers* and elsewhere in that volume *passim*.[10]

For my part, I am prepared to accept the proposition that every psychotherapist, like everybody else engaged in the application of a field of knowledge, however artistic and intuitive in technique, and however controversial some theoretical issues in the field may be, will in fact be acting upon some kind of personalistic probabiltiy, in which both the Bayesian priors and the conditional probability are highly subjective. It involves acting as one thinks or feels best, and does in effect take a kind of professional responsibility for what happens even if the causal chains are obscure, and given a basic democratic commitment to the idea that ultimately the client is the one who chooses whether and where to move. Being an "intellecter," I naturally tend to think that part of the basis for such personalistic probabilities (upon which our "rational" hope for healing influence is based) lies in using whatever extra therapeutic information the sciences of psychology, sociology, physiology and genetics can provide. And while like most teachers of clinical psychology I am acutely aware of the tenuousness of connections between the so-called basic sciences and the moment to moment choices one makes in a therapeutic session, I do not agree with those who say that such con-

nections are non-existent, or so feeble as to be safely treated as such. I am firmly persuaded that a fair minded contemplation of what is presently known or reasonably evidenced in the fields of learning theory, psychometrics, descriptive clinical psychiatry, and, very importantly for the present paper, behavior genetics *do not leave me with complete freedom to believe anything that strikes my fancy on the basis of my work as a psychotherapist.* Being an intellecter, I rather like these scientific constraints; but I urge that it is not entirely responsible professional conduct in the present state of the evidence—especially the evidence in behavior genetics—for those with other interests, tastes, styles and preferences to treat all of these facts and theories as if they simply did not exist.

My monitory remark: If one says that he proposes to pay zero attention to any well documented facts about the genetics of behavior or about the statistical prognoses for suicide in manic depressives or unipolar depressions, I believe he has an obligation to explain why it is licit for him to take the responsibility for treating a person who in all likelihood exemplifies these scientific laws (whether nomological or stochastic) as if such did not exist. I do not maintain that the answer to this question is crystal clear; I *do* maintain that it is an important question demanding of scholarly, informed and ethically sensitive consideration.

The three commonest objections against explicit discussion of genetic factors as contributing to a relatively unchangeable core are all sound ones, in my opinion, although I believe that they are somewhat overdrawn. Like the qualitatively sound objections to other disputed therapeutic strategies and tactics (e.g., concurrent treatment of a husband and wife as mobilizing sibling rivalry and resultant counter-transference foul ups), they are not dispositive but must be weighed against the arguments pro. Since I take my task as being to apply an affirmative position on genetic aspects of the unchangeable core, space limitations prevent my discussing these three reasonable concerns in detail, so I trust that my absurdly brief replies will be seen as reflecting those spatial constraints rather than a dogmatism which I do not feel.

The first objection is that such discussion, like discussion of literature, politics, ethics, metaphysics, theology or "psychological theory" tempt to intellectualization. (Old-fashioned formula: Everything is a derivative and should be treated as such, i.e., by interpretation.) To the extent that the patient is an abuser of the intellect in the avoidance of feeling and in the service of defense, I think this concern may at times over-ride any plausible advantage. On the other hand, I am not persuaded that a person necessarily intellectualizes defensively just because he is persistently interested in some kind of causal-theoretical understanding of himself and the world.

Man is a cognizing animal, with a desire to comprehend "what is going on," especially in respect to his vital interests, interpersonal relations, and the functioning of his own mind and body. I believe that one of the most frightening and discouraging aspects of neurotic and psychotic phenomena is the realization "Something alien to my wants and baffling to my understanding is happening to me." (cf. the paranoid theme of "There are great vague forces at work.") Each case must be assessed on the merits. I remember that one time I commented to my second (Rado-trained) analyst that my first (Vienna-trained) analyst tended not to accept communications from me about my feelings which were expressed in psychoanalese, whereas the second one did not object. His answer was, "I have never noticed that you use the jargon defensively, for you it's so much a part of your whole way of thinking and talking that it carries the full emotional wallop." I believe he was entirely right in this clinical judgment.

Secondly, it is urged that emphasis upon genetic parameters may conduce to a certain therapeutic nihilism or pessimism.[8] "If I can't change my genes, then I'm a hopeless basket case, right?" All I can say is that it seems possible to introduce and develop this material didactically in such a way that my patients simply do not respond thus. It's not merely that I can "talk them out of it," rather that I almost never hear it in the first place. I permit myself the view that this is partly because I am myself sufficiently clear in the head cognitively, and articulate verbally, on the subject that I don't convey the usual sloppy implications. But even if the patient doesn't become pessimistically disturbed, I regularly buffer all such comments by slow and nontechnical analogies to more familiar contexts such as the fact that not everyone with innate musical talent has to be a violinist, that because one has a brain that is predisposed to seizures (I sometimes even mention the MZ twin data on the EEG vs clinical status in epileptics) it doesn't follow that he necessarily has to have fits; that a person may inherit a somewhat different metabolism or food utilization than others, but it doesn't follow that he must become obese or emaciated; that a person may be slightly more disposed to "temper" than another constitutionally calm individual, but it doesn't prove that he must walk around in a continual state of rage, and the like. But there is something further to be said about this that is psychologically more interesting, namely, that some patients experience a feeling of hopelessness or helplessness *without* any explicit genetic formulation about the limits of therapeutic change, because if there is *in fact,* as I firmly believe, a relatively "unchangeable core" (not, I repeat, of content but of parameters) this will be experienced by any but the most denial-defendant individual. So that the question is not really one of limitless change, which it takes a fool to believe in either as patient or therapist, but the causal explanation of already noticed limits upon psychotherapeutic intervention.

Thirdly, it may be thought too tempting for the patient to renounce responsibility, to get off the existential knife edge, to avoid efforts at constructive realistic problem solving, risk taking and change, by saying "Well, I can't do anything about it because I was just born this way." I agree that this is a danger that must be anticipated and, if it materializes, vigorously combatted. But I would point out that many of our patients (and perhaps most therapists?) are already tempted to do that within the dominant tradition of American environmentalism, that is by explanations in terms of the life history rather than inherited constitution. If a person wants to get off the hook of having to live and act and change and move and relearn and take risks and solve problems, it really doesn't matter too much whether he chooses to do it by saying, "My therapist thinks I have inherited a somewhat heightened anxiety tendency" or "My therapist thinks that my battle-axe mother screwed up my life."

And there is another side to this coin about refusing existential responsibility. We often see patients who have added to the usual assortment of guilts and self-hatreds a kind of second order one that involves feeling guilty or unworthy precisely *because* of suffering psychological malfunction, especially patients who have had considerable psychotherapy (whether from the current therapist or another) and with what was at the time, and for a subsequent interval, experienced as considerable improvement. We have all heard such persons say things like "I just don't know what's the matter with me, I must be a terrible mess basically;

because here I am after all this psychological help and time and money spent, and I thought I was doing okay, but look how I have slipped back—why can't I get hold of myself? I'm a real dope! What the devil is the matter with me anyway?" and so on. A very familiar story. Now again I don't reject some of the familiar therapist responses to this kind of "maladjustment-guilt (or shame, or both)." But I have found that in addition to employing them, I can add genetic explanations to which patients respond not with resignation and despair (as you might quite reasonably predict if you haven't tried it yourself) but with a relief of such "psychiatric guilt feelings." Thus, for instance, suppose the evidence rather strongly supports the existence of a cyclothymic temperament (I predict that within the next decade sub-clinical manic depression will come in for more attention and be recognized as almost as frequent and clinically important a syndrome as the compensated schizotypes and pseudo-neurotic schizophrenias that today are almost taken for granted).

One therapist response amounts in substance to, "Well, you see, there isn't necessarily any purely psychological explanation of why you, as you put it, have 'slipped back'—it may be that your mood swing gene or genes got turned on. We know that genes get turned on and off by other genes, and that the regulator genes that turn on and off the protein production control by structural genes are themselves influenced by environmental factors, which can range all the way from diet to psychological stress to intercurrent physical infectious disease or whatever. For all I know, sun spots might even influence a regulatory gene which would then switch on a structural gene that then produces a depressive spell. The fact of the matter is that sometimes we can trace out with considerable plausibility the precipitator of a mood swing; other times it is very difficult to do so and sounds a bit forced. I must tell you that from the statistics on precipitating factors, with the possible exception of a major loss of a love object like the death of a child or spouse, or the definitive liquidation of one's aspirations for some kind of achievement in work, it turns out to be remarkably hard to document the presence of such precipitators. But most of us believe that they exist, and it may be that in your case your current spell of depression was in part precipitated by . . ."

My experience has been that when this kind of thing is properly presented to a patient with whom one has a good relationship of emotional trust and intellectual respect, it is experienced by the patient with considerable relief of the second order psychiatric guilt feelings for "slipping back."

(As I was revising the penultimate draft of this paper, a mildly cyclothymic patient who has been taking several constructive steps in his social and professional life following 18 hours of work with me volunteered the comment that since he had been thinking over what I suggested about his mood-swinging temperament, he had found it easier by far to "quit hitting myself over the head all the time, and now when I'm 'up' I remind myself to watch it and not get over-committed; or if I have a little 'down,' I just tell myself that I'm having a down, it won't last, those genes will turn off, but meanwhile I can't expect as much of myself for a few days." Immersed in final draft of the paper, I allowed myself to say, "Well, that's fine; but you know there are some psychologists who think it's bad to tell a person he may have such and such genes, because it says he's a hopeless case." To which the patient replied, "That's hooey, it just doesn't work that way, for me anyway. I don't feel doomed or fated, like that; I feel sort of exonerated, but also I think I am learning how to handle it, both up and down. There's nothing so terrible about it, it's a big load off my mind." Why, actually, should we psychotherapists find such a reaction surprising? It makes perfectly good human sense, does it not?)

Finally, there is a problem about the therapist's own authenticity in the relationship which can, I think, be rather tough to handle once the therapist has internally concluded on the basis of the published research, plus theory, plus his clinical experience that there does exist an unchangeable core of dispositional parameters that are partly or largely of genetic origin. While

I don't suppose very many of us hold that one should always say everything that occurs to him about any patient immediately (kind of an impossibility even if you believed in such an approach), all forms of affirmative and negative lying, even white lies with therapeutic intent, tend in my opinion to corrupt the integrity of the therapeutic relationship in some measure. If the thing is sufficiently peripheral (for example, you tell a person that you don't accept gifts, even though in fact on a few occasions you have thought it wise to do so) that's one thing. But if it's a fundamental matter, that's something else again. Assume I believe that a patient has inherited the schizogene or the cyclothymic gene or has been loaded with a heavy chance piling up of anxiety parameter polygenes. These beliefs I do not leave behind when I come out of the library or laboratory and enter the therapeutic setting (maybe I should try to do that, but I can't think how, and as an intellecter I really wouldn't want to). Then given the patient's repeated raising of questions in the general domain of the unchangeable core or the mystery of explaining *why* he feels, thinks, and acts as he does after considerable therapeutic intervention, to deal with this by sluffing it off or by saying nothing or, what is really a form of lying, saying that I don't know what I think or it's up to him to find out, when in fact I have a fairly strong and rationally based belief about genetic determinants seems to me to involve a pretty big kind of inauthenticity on my part. I need hardly add that this is a rather different matter from saying that the therapist may leave on the shelf his own political or philosophical or economic or ethical beliefs or value commitments, since here we deal with empirical and in fact increasingly strongly scientifically supported beliefs about the factors operative in the patient and about which the patient is inquiring.

Upon reading the draft of this paper, and then re-reading Freud's "Analysis Terminable and Interminable" [3] I am not at all sure that I have said anything new. □

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