

CHAPTER 1

Common Sense and Beyond

Science is rooted in what I have just called the whole apparatus of common sense thought. That is the datum from which it starts, and to which it must recur. . . You may polish up common sense, you may contradict it in detail, you may surprise it. But ultimately your whole task is to satisfy it.—Alfred North Whitehead

THE PATIENT'S DILEMMA

Few areas of social concern have generated the kind of charged atmosphere that hovers over the field of psychological problems. The dearth of solid knowledge and of indisputable treatments has formed a vacuum that has drawn in an assortment of competing ideologies, movements, and fads.

The history of psychiatry shows that many ideas and concepts that once had attained the status of incontrovertible facts were later discarded as nothing more than

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myths or superstitions. We are forced to the realization that the study of the nature and treatment of the neuroses—or emotional disorders—does not rest on any proven theorems or generally shared assumptions. In the absence of any general consensus regarding the value of theories and therapies, there are no bounds to the extent of disagreement among the competing schools of thought.

The mental health field is dominated by a few durable establishments and clusters of smaller sects of more tenuous standing. The major schools within this domain share certain characteristics: a conviction of the ultimate truth of their own system, disdain for opposing theories, and a steadfast emphasis on purity of doctrine and technique. In many instances, the popularity of a particular system seems to depend more on the charisma and single-mindedness of its originator than on the soundness of its foundations.

When the authorities disagree among themselves regarding the correct approach to psychological problems, where does the troubled person turn for help? In view of the opposed and apparently irreconcilable views represented by the different schools, he faces a serious dilemma: He is trapped between choosing a therapist blindly and trusting to luck or trying to cope with his psychological difficulties by himself.

The solution to this dilemma may be found in an obvious, yet substantially neglected area: the rich data available in the person's conscious ideas and in his common-sense ways of defining and coping with his psychological problems.

Classical psychoanalysis regards conscious thoughts as a disguised representation of unconscious conflicts that are presumably causing the problem. The patient's own

explanations are regarded as spurious rationalizations, his coping mechanisms as defenses. Consequently, his conscious ideas, his reasoning and judgements, his practical solutions to problems are not taken at face value: they are treated as stepping-stones to deeper, concealed components of the mind.

The behavior therapists, similarly, have tended to downgrade the importance of thinking, but for completely different reasons. In their zeal to emulate the precision and theoretical elegance of the physical sciences, the original behaviorists rejected data and concepts derived from man's reflections on his conscious experiences. Only behavior that could be directly observed by an independent outsider was used in forming explanations. Hence, thoughts, feelings, and ideas, which, by definition, are accessible only to the person experiencing them, were not considered valid data. The patient's private world was not regarded as a useful area of inquiry (Watson, 1914; Skinner, 1971).

Traditional neuropsychiatry, like psychoanalysis and behavior therapy, also minimizes the importance of conscious ideation. The neuropsychiatrist, sometimes referred to as an "organicist," inquires about the patient's thoughts and feelings primarily as a basis for making a diagnosis. Abnormal ideation and feeling states are regarded simply as manifestations of an underlying physical process or as possible clues to a disturbance in neurochemistry; they are not explored to provide explanations for abnormal psychological states.

Proponents of the three major schools use therapies in keeping with their philosophical and theoretical origins. The Freudian, with his belief in depth psychology and symbolic meanings, attempts to cure the neurosis by

uncovering the hidden (that is, repressed) ideas and wishes and by translating the conscious thoughts and fantasies into their presumed symbolic meanings. The behavior therapist, with his faith in the determinative role of environmental (that is, observable) forces, attempts to enucleate the neurosis through external stimuli: administering rewards and punishments, exposing the patient by degrees to situations or objects that frighten him. The neuropsychiatrist, with his confidence in the role of biological causes, uses "somatic" treatments such as the administration of drugs or electroconvulsive therapy.

By glossing over the patient's attempts to define his problem in his own terms, and the efficacy of using his own rationality to solve his problems, the contemporary schools perpetuate a myth. The troubled person is led to believe that he can't help himself and must seek out a professional healer when confronted with distress related to everyday problems of living. His confidence in the "obvious" techniques he has customarily used in solving his problems is eroded because he accepts the view that emotional disturbances arise from forces beyond his grasp. He can't hope to understand himself through his own efforts because his own notions are dismissed as shallow and insubstantial. By debasing the value of common sense, this subtle indoctrination inhibits him from using his own judgment in analyzing and solving his problems. This pervasive attitude also deters the psychotherapist from helping the patient to draw on his own problem-solving apparatus.

Other writers have been concerned about the tendency to ignore the importance of common-sense psychology. Allport (1968) for example, once remarked,

"How in the helping professions—and here I include psychiatry, the ministry, social work, applied psychology, and education—can we recover some of the common sense that we seem to have lost along the way?" (p. 125). The professional's inattentiveness to the patient's conscious ideas and coping techniques has been appropriately captioned "blind to the obvious" by Icheiser (1970, p. 7).

CONSCIOUSNESS AND COMMON SENSE

When we consider the complexities and pressures of everyday life, we can only marvel that our fellow man is able to function as well as he does. He not only adapts to helter-skelter changes in his environment and difficult confrontations with other people, but he also manages to negotiate numerous compromises between his own wishes, hopes, and expectations, on the one hand, and external demands and constraints, on the other. Disappointments, frustrations, criticisms are absorbed without lasting damage.

Modern man is often forced to make extremely rapid life-and-death decisions (as when driving a car). He makes even more difficult judgments in distinguishing circumstances that actually are dangerous from those that simply *seem* dangerous (for example, distinguishing between a genuine threat and a bluff).

If it were not for man's ability to filter and attach appropriate labels to the blizzard of external stimuli so efficiently, his world would be chaotic and he would be bounced from one crisis to another. Moreover, if he were not able to monitor his highly developed imagination, he would be floating in and out of a twilight zone unable to

distinguish between the reality of a situation and the images and personal meanings that it triggers.

In his interpersonal relations, he is generally able to select the subtle cues that allow him to separate his adversaries from his friends. He makes the delicate adjustments in his own behavior that help him to maintain diplomatic relationships with people whom he dislikes or who dislike him. He is generally able to penetrate the social masks of other people, to differentiate sincere from insincere messages, to distinguish friendly mocking from veiled antagonism. He tunes into the significant communications in a vast babble of noises so that he can organize and modulate his own responses. These psychological operations seem to work automatically without evidence of much cognition, deliberation, or reflection.

These observations provide powerful evidence that, in the course of our development, we have acquired highly refined, sophisticated techniques for dealing with the intricacies of our animate and inanimate environment. Moreover, we have within the range of our awareness a vast reservoir of information, concepts, and formulas that enable us to deal with our familiar psychological problems. Of course, we make mistakes in appraising a situation and our own capabilities; we encounter many problems for which we have no ready-made solutions and are often required to make decisions without having been provided with adequate information. Nonetheless, we are able to use our psychological equipment to make split-second corrections, to judge, interpret, and predict. We can approach new problems in a systematic way, separate the various components, and consider alternative solutions.

In his approach to external problems, man is a practical scientist: He makes observations, sets up hypotheses, checks their validity, and eventually forms generalizations that will later serve as a guide for making rapid judgments of situations. Although much of his early learning is based on trial-and-error and inductive reasoning, he is able to accumulate an inventory of formulas, equations, and axioms that enable him to make rapid deductions when confronted with the same kinds of problems that he has already worked out. Throughout his development, man repeatedly uses the prototype of the experimental method—without recognizing it.

In the area of strictly psychological problems, a person acquires a host of techniques and generalizations that enable him to judge whether he is reacting realistically to situations, to resolve conflicts regarding alternative courses of actions, to deal with rejection, disappointment, and danger. In the course of development, his awareness of his own psychological experiences crystallizes into defined self-observations, which eventually expand into generalizations. As these improvised techniques stand the test of time, they provide the framework for genuine self-understanding and understanding of others. As we shall see, much of cognitive therapy places the patient in the role of the scientist and uses his already-available tools to approach problems that seemed insoluble to him.

Fortunately, each person does not have to start *de novo* in acquiring such understandings. Through the process of socialization he receives a rich infusion of folk wisdom: axioms of human behavior and homespun logic. By virtue of his personal experience, emulation of others,

and formal education, he learns how to use the tools of common sense: forming and testing hunches, making discriminations, and reasoning. The wise person is able to extract the sound principles from the thick brew of his cultural heritage and to ignore the residue of fallacious notions, myths, and superstitions.

The significance of common sense extends far beyond social learning. The importance of common sense in formal science, for example, has long been recognized by scientists and philosophers. The introductory quotation of Whitehead is echoed by J. Robert Oppenheimer (1956): "All sciences . . . arise as refinements, corrections, and adaptations of common sense" (p. 128).

Observations of *external* events—and common-sense laws based on these observations—were the starting point for physics and chemistry. The common-sense observation that unsupported bodies will fall was the necessary precursor to the laws of gravity; that water heated over a flame for a sufficient length of time will boil, to laws of heat and gases. Similarly, observations of consciousness—that is, of *internal* psychological events—provide the raw materials for the systematic study of human behavior.

The implications of common sense for the development of a scientific psychology have been extensively discussed by Heider (1958). As he indicates, the complexity of feelings and actions that can be understood at a glance is surprisingly great. "Intuitive" knowledge is remarkably penetrating and can go a long way toward the understanding of human behavior. Heider points out, "The ordinary person has a great and profound understanding of himself and of other people which, though unformulated or only vaguely conceived, enables him to

interact with others in more or less adaptive ways" (p. 2).

Common-sense psychology includes the psychological operations, reflections, observations, and introspections by which someone attempts to determine why he is upset, what is bothering him, and what he can do to relieve his distress. Through introspection, he can determine the main topic of his ideation and relate this to his unpleasant feelings (tension, sadness, irritation). The person also uses common-sense psychology when he attempts to identify the events or circumstances that have triggered his particular preoccupation, and consequently his distress. Moreover, he can then take measures to relieve his pain.

This kind of ordinary self-help is frequently applied to understanding and helping others; for example, encouraging them to focus on what is bothering them and then suggesting more sensible attitudes or more realistic solutions to problems. It is obvious that conveying commonplace understandings and giving practical advice does not always work, but it seems to help many, perhaps most, people to maintain their equilibrium most of the time. Furthermore, these common-sense insights and interpersonal strategies point the way to the development of a sophisticated, systematic psychotherapy.

WHEN COMMON SENSE FAILS

Despite the obvious value of common sense as a framework for understanding and changing attitudes and behavior, we are all familiar with its shortcomings: Common sense has failed to provide plausible and useful explanations for the puzzling emotional disorders.

Take, for example, the riddle of depression: A de-

pressed woman who always had a great zest for life, had felt a great deal of pride in herself and in her achievements, and had cared for her children with obvious love and tenderness, became morose and lost interest in everything that had previously excited her. She withdrew into a shell, neglected her children, and became preoccupied with self-criticisms and wishes to die. At one point, she formulated a plan to kill herself and her children, but was stopped before she could carry out the plan.

How can conventional folk wisdom explain this woman's remarkable change from her normal state? In common with other depressed patients, she appears to violate the most basic principles of human nature. Her suicidal wishes and her desire to kill her children defy the most hallowed "survival instinct" and "maternal instinct." Her withdrawal and self-debasements are clear-cut contradictions of another accepted canon of human behavior—the pleasure principle. Common sense is foiled in attempting to understand and to fit together the components of her depression. Sometimes the deep suffering and withdrawal of the patient is explained away by conventional notions such as, "He is just trying to get attention." The notion that a person tortures himself to the point of suicide for the dubious satisfaction of gaining attention greatly strains our credulity and actually runs counter to common sense.

In order to understand why the depressed mother would want to end her own life and that of her children, we need to get inside her conceptual system and see the world through her eyes. We cannot be bound by preconceptions that are applicable to people who are not depressed. Once we are familiar with the perspectives of the depressed patient, her behavior begins to make sense.

Through a process of empathy and identification with the patient, we can understand the meanings she attaches to her experiences. We can then offer explanations that are plausible—given her frame of reference.

Through interviewing this depressed mother, I discovered that her thinking was controlled by erroneous ideas about herself and her world. Despite contrary evidence, she believed she had been a failure as a mother. She viewed herself as too incompetent to provide even the minimum care and affection for her children. She believed that she could not change—but could only deteriorate. Since she could attribute her presumed failure and inadequacy only to herself, she tormented herself continuously with self-rebukes.

As this depressed woman visualized the future, she expected her children would feel as miserable as she. Casting about for solutions, she decided that since she could not change, the only answer was suicide. Yet, she was appalled at the notion that her children would be left without a mother, without the love and care she believed that only a mother could give. Consequently, she decided that in order to spare them the kind of misery she was experiencing, she must end their lives also. It is noteworthy that these self-deceptions dominated the patient's consciousness but were not elicited until she was carefully questioned about her thoughts and plans.

This kind of depressive thinking may strike us as highly irrational, but it makes sense within the patient's conceptual framework. If we grant her the basic (though erroneous) premise, namely that she and her children are irrevocably doomed as a result of her presumed deficiencies, it follows logically that the sooner the situation is

terminated the better for everyone. Her basic premise of being inadequate and incapable of doing anything accounts for her complete withdrawal and loss of motivation. Her feelings of overwhelming sadness stem inevitably from her continuous self-criticisms and her belief that her present and future are hopeless. Having pinpointed the exact content of the patient's erroneous beliefs, I was able to draw on a variety of methods to correct her misconceptions and to induce her to examine the unrealistic premises of her belief system.

This example demonstrates why common sense has failed to clarify emotional disorders such as depression. Crucial information (in this case, the patient's distorted view of herself, her world, and her future) is lacking. However, *once the missing data are supplied*, we can apply common-sense tools to solve the puzzle. As we fit the relevant material into place, a comprehensible, meaningful pattern emerges. In order to draw reliable generalizations from this finding, we check for the presence of this kind of pattern in other patients with the same emotional disorder. Then it is necessary to conduct a logical sequence of experimental procedures to consolidate the new framework for understanding the particular disorder. After the experimental findings have been checked, refined, and validated, we can test our formulation against Whitehead's ultimate requirement: Does it satisfy common sense?

Consider the case of the compulsive hand-washer. He spends inordinate amounts of time scrubbing his hands and other exposed parts of his body. When pressed for an explanation, he may state that he is concerned because he may have come into contact with germs that could produce a serious disease if he is not thoroughly

cleansed. He may even acknowledge that this fear is far-fetched, yet he continues with his handwashing even though it seriously interferes with his career, social relations, and recreation—even his sleeping and eating. The classical psychoanalytic explanation of this kind of behavior is that the patient has an anal fixation or that he is trying to wash away the guilt stemming from some forbidden, but unconscious, wish.

When the patient's thinking is thoroughly explored, however, the following facts are revealed: We learn that whenever he touches an object that might contain bacteria, he has the thought that he may contract a bad disease. At the same time, he has a *visual image* of himself in a hospital bed dying from this disease. The thought and visual fantasy produce anxiety. In order to counteract and dampen his fear, he rushes to the nearest washroom to start scrubbing himself.

In treating such cases, I have set up a procedure of inducing the patient to touch a dirty object in my presence, but—by prior agreement—I eliminate the opportunity for his washing his hands. Deprived of the mechanism for ridding himself of the supposed germ-laden dirt, he begins to visualize himself in the hospital bed, dying of the dread disease. This visual fantasy comes on spontaneously and is so vivid that the patient believes that he already has the disease: He starts to cough, feels feverish and weak, and experiences peculiar sensations throughout his body. By interrupting his visual fantasy, I can demonstrate to him that he is not sick: He still has his strength, does not have a fever, and can breathe without coughing. The sequence of interrupting his visual image and prodding him to make a realistic appraisal of his state of health relieves his fear of

having contracted a fatal disease and reduces his compulsion to wash his hands.

Having ferreted out the crucial information, namely that this patient experiences a fantasy and a physical experience of having a serious disease if prevented from cleansing himself, we find that his hand-washing compulsion is comprehensible. Furthermore, this information relieves us of the temptation to grasp for some esoteric interpretation that will not help the patient with his serious psychological problem. The compulsive hand-washer illustrates what a crucial role imaginal processes, including both visual fantasies and the accompanying physical sensations based on self-suggestion, play in certain disorders.

BEYOND COMMON SENSE: COGNITIVE THERAPY

The formulation of psychological problems in terms of incorrect premises and a proneness to distorted imaginal experiences represents a sharp deviation from generally accepted formulations of the psychological disorders. Freud assumed that peculiar behavior has its roots in the Unconscious, and that any irrationalities observed on the conscious level are only manifestations of the underlying unconscious drives. The presence of self-deception and distortions, however, does not require the postulation of the unconscious, as conceived by Freud. Irrationality can be understood in terms of inadequacies in organizing and interpreting reality.

Psychological problems are not necessarily the product of mysterious, impenetrable forces but may result from commonplace processes such as faulty learning, making incorrect inferences on the basis of

inadequate or incorrect information, and not distinguishing adequately between imagination and reality. Moreover, thinking can be unrealistic because it is derived from erroneous premises; behavior can be self-defeating because it is based on unreasonable attitudes.

Thus, psychological problems can be mastered by sharpening discriminations, correcting misconceptions, and learning more adaptive attitudes. Since introspection, insight, reality testing, and learning are basically cognitive processes, this approach to the neuroses has been labeled cognitive therapy (Beck, 1967, p. 318).

The cognitive therapist induces the patient to apply the same problem-solving techniques he has used throughout his life to correct his fallacious thinking. His problems are derived from certain distortions of reality based on erroneous premises and misconceptions. These distortions originated in defective learning during his development. The formula for treatment may be stated in simple terms: The therapist helps the patient to identify his warped thinking and to learn more realistic ways to formulate his experiences.

The cognitive approach brings the understanding and treatment of the neurotic disorders closer to everyday experience. Emotional disturbances can be related to the kinds of misunderstandings a person has experienced numerous times during his life. Since the psychiatric patient has generally had numerous previous successes in correcting his misinterpretations, the cognitive approach makes sense to him because it is in line with his previous learning experiences. By placing emotional disorders within the realm of everyday experience and suggesting familiar problem-solving techniques, the therapist can start to help the patient at the time of their first contact.

Recent developments within the major schools of psychology and psychotherapy attest to the importance of cognitive psychology in understanding and treating the neuroses. The growing confluence of tributaries from behavioral psychology and psychoanalysis has been charted by Robert Holt (1964). The behaviorists and psychoanalysts have become aware that there are legitimate and important problems left unsolved by their neglect of the cognitive realm. The psychoanalysts, who strove for depth, and the behaviorists, who prized objectivity above all else, have begun to realize that they do not have to betray their basic values to study these problems. Ego psychology began to emerge within psychoanalysis as a result of the stimulus of writers such as Hartmann (1964), Kris (1952), and Rapaport (1951). Attention was directed to the nature of reality and man's adaptation to it. Learning has always been a central concern of the behaviorists; gradually, they have shown an interest in thinking and thought processes, learning concepts as well as motor performances, learning words as well as nonsense syllables.

Despite their continued allegiance to their respective schools, many practitioners are increasingly using cognitive techniques in their treatment of patients. Much of behavior therapy, for instance, while ostensibly derived from laboratory experiments and from learning theory, is to a large degree an assortment of time-honored techniques used by people to deal with their psychological problems. Rehearsing frightening situations in fantasy in order to reduce fear of a relatively innocuous situation (the core of the behavioral technique of "systematic desensitization") and practicing self-assertion ("assertive training") have been independently improvised by

numerous people for ages. Similarly, many neuropsychiatrists, without abandoning their notion of physical causation, prescribe a variety of practical remedies for neurosis: re-education and explanation, encouragement, and environmental change.

The growth of this common ground may very well be enhanced by the spirited endeavors of humanistic psychologists and psychiatrists who have been dubbed "the third force" (Goble, 1970). This change of focus to a person's conscious thoughts, wishes, and ideals has been hailed by Allport (1968) as "a significant revolution." Referring to this approach as "attitudinal" therapy, he perceives points of congruence in the theories of such diverse writers as Adler, Erikson, Horney, Maslow, and Rogers. The work of Albert Ellis should be added to this list.

What is this middle ground that has been staked out by "third-force" humanists and that is gradually being watered by spillovers from psychoanalysis and behaviorism? Their approach consists of greater interest in, and willingness to accept at face value, conscious thoughts, goals, and attitudes. These theorists focus on the person's ideas—his introspections, his observations of himself, his plans for solving problems.

The crucial importance of cognitive psychology as a way of understanding human problems has been underscored by Arieti (1968), a psychoanalyst who has called cognition the "Cinderella" of the field of psychiatry. He emphasizes that, "A great deal of human life has to do with conceptual constructs. It is impossible to understand the human being without such important cognitive constructs as the self-image, self-esteem, self-identity, identification, hope, projection of the self into the future" (p. 1637).

Because cognitive phenomena are easily identified through introspection, they may be readily investigated. The accessibility of the patient's cognitions to systematic investigation has attracted many behaviorally trained writers (for example, Mahoney, 1974; Meichenbaum, 1974) to explore the role of cognitive processes in psychopathology and psychotherapy. Recent systematic studies have provided large areas of support for the principles of cognitive therapy. Finally, the increasing interest in this approach has led to a number of therapeutic trials that have indicated the efficacy of cognitive therapy.