A Social Brain
Interpretation of Psychotherapy

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Sources for this Presentation

- Revised & updated © JO Beahrs, April 7, 2008
- Incorporates subsequent work:
  - Beahrs JO: The infrastructure of complex culture in humans, scientific article in advanced preparation
  - Beahrs JO: Psychotherapy and the Human Dilemma, book manuscript in advanced preparation
Introduction

• Mental dynamics vary with social milieu:
  – Permits therapeutic correction, if disordered,
  – by reframing their functions in the social milieu

• A “sociodynamics” concept
  – Causation proceeds from external → internal
  – Points to underappreciated research areas
  – Can guide more effective psychotherapy
Presentation will:

1. Address problems in traditional psychodynamics
2. Define constituents & rationale of sociodynamics
3. Review two underappreciated basic sciences
4. Show how a research-based conceptual framework aids treatment planning & practice.

Note: all psychiatric treatment interactions utilize social influence & sociodynamics
Organization of Presentation

1. Problems in traditional psychodynamics
2. Two underemphasized sciences
3. Constituents & rationale of sociodynamics
4. How does a research-based conceptual framework aid treatment planning/practice
Physics Metaphor in Psychotherapy

• Definition: Psychotherapy
  = technologies that improve disordered psychological realities via applied social skills

• Traditional psychodynamic theory interprets these through internal mental mechanisms
  – Mechanistic causation metaphor of classical physics
  – Sx’s social effects seen as “secondary” gains & costs
Problem with Physics Metaphor

• Psychotherapy’s proven efficacy & efficiency arise
  – Because patients’ “psychological realities” vary with their social context\(^1\)
  – Which can be reframed\(^2,3\)
  – This reframability contrasts with the context-independent “objectivity” of classical physics\(^4\)
  – Hence, \textit{different causal rules must apply}
Sociodynamics

- Sullivan, Berne, Erickson, Watzlawick et al.
- Sociodynamics focus on social influence
- Clinicians ask:
  - “What social payoffs do the symptoms provide?”
  - “What social reinforcers keep sx complex going?”
- External “interests” take priority over internal “drives” as causal forces
- Adaptive modules or life strategies replace defenses as modulators or determinants
Sociodynamics = Social Causation

• “Social brain” calculates/recalculates a person’s interests within his or her social milieu
  – Assesses one’s strategic armamentarium for strengths & weaknesses
  – Selects strategies most likely to win one’s interests
  – Largely outside conscious awareness (Unconscious)

• Sx’s social payoffs = primary, not $2^0$ gains $^6,^{10}$
  – Underlying “mental states” = secondary adaptations
  – Designed by brain in order to facilitate one’s strategy
Consciousness & Volition

- Are highly anomalous to classical mechanism
  - Further undermining the mechanistic metaphor
- Defined by contrast between polar opposites:
  - “Unconscious” awareness and “involuntary” action
- The opposing poles feel as if distinct, but
- Attempts to separate conscious from unconscious or voluntary from involuntary \( \Rightarrow \)
  - “A/not-A Absurdities”
  - In which one pole is shown to be “really” the other\(^4,11\)
Examples from Hypnosis Research

• Illusion of choice
  – Post-hypnotic suggestion may be
  – experienced & defended as if a free choice \(^{12}\)

• Hypnotic non-volition
  – May be constructed easily by voluntary actions \(^{1,13}\)

• Conclusion: A/not-A absurdities
  – Experienced volition is “really” involuntary
  – & Involuntary action is “really” voluntary \(^{14}\)
  – Same holds for conscious & unconscious
Paradox

- How do the dualities of consciousness & volition with their polar opposites, though illusory, remain ubiquitous & come to define human experience?
The Illusion of Conscious Will

- New data: subjective volition can be
  - Decoupled from skeletal muscle movement
  - *Does not cause our “voluntary” actions* \(^{12}\)
- “Volition” must serve other functions
- Such as regulation of social interaction \(^{12,14}\)
The fact that these data contrast so starkly with everyday experience suggests that a component of self-deception may contribute to the dynamics of our internal mental experience.
Sociodynamic Hypothesis

• **Human mentation = sociodynamic & complex**
  – (1) involves at least 2 primary interacting parties
  – (2) occurs concurrently on more than 1 level

• **Cultural transmission needs > 2 interactants**
  – Third parties mediate, legitimize & extend
  – All communicate concurrently on > 1 levels

• **“Mental states” ← tacit social agreements**
  – Added on after-the-fact, outside of awareness
  – Experienced as if substantive and causal
Levels of Interaction

- Berne: “overt” versus “covert” levels
  - roughly = “conscious” & “unconscious”
- Watzlawick et al: overt “content” & covert “relationship” levels
  - 1st = open information exchange, pastiming, & negotiation
  - 2nd a hidden web of mutual suggestion
    - Defines personal identities & relative social status
    - Generally ratified by 3rd party observers
Levels & Psychotherapy

• Incongruity between these levels
  → psychotherapeutic focal points

• Therapist strategy
  – Search patients’ social networks for self-reinforcing patterns of mutual suggestion
  – & how these patterns become pathogenic
  – Pursue ways to redefine & redirect them
    • Toward healthier patterns
    • That also become self-sustaining
Organization of Presentation

1. Problems in traditional psychodynamics
2. Two underemphasized basic sciences
3. Constituents & rationale of sociodynamics
4. How does a research-based conceptual framework aid treatment planning/practice
Underemphasized Essential Basic Sciences

1. Human evolutionary biology
   - How did natural selection shape the quirks and foibles of “human nature”?\(^\text{16}\)
   - Evolutionary biology clarifies the selective pressures that guided human evolution

2. Social influence research
   - How social milieus influence the form and direction of our evolved mental phenomena
Social Influence Research

- Studies\(^{17}\) of
  - Persuasion
  - Ideology
  - Socialization
  - Advertising

- Hypnosis = paradigmatic data set\(^{18}\)
Beahrs Articles

- Tacit contracting for reciprocal autonomy & shared self-deception
- Contributes to “unconscious” awareness & “involuntary” action\(^1\) to
  - “Psychological structures”\(^1\)\(^5\)
  - Social etiquette\(^2\)\(^1\)
  - Specific psychopathologies\(^2\)\(^2\)
  - Malleability of personal memories\(^2\)\(^3\)
Psychosocial Trauma as Illustration

• Effects of psychosocial trauma
  – Another set of specific scientific questions and treatment dilemmas

• Relates these 2 scientific data bases both
  – To one another
  – To neurobiology
Reciprocity

- *Homo sapiens* cooperates to a unique extent among complex species
  - cooperation must be achieved in the face of conflicting interests\(^8\)
- Reciprocity = bedrock of cooperation among unrelated people
  - One can benefit from doing a costly favor for another
  - Provided the favor is or will be returned\(^{19}\)
Reciprocity is Vulnerable to Defection & Deceit

- Discriminative skills (specific individuals and their behaviors)
- Episodic and semantic memory
- Police functions
- Social emotions
  - E.g., love
  - E.g., moralistic rage
Shared Self-Deception Hypothesis

• All parties want to pursue self-interest, beyond group norms & thus punishable

• By direct reciprocity, they grant one another wiggle room for self-interest:
  – Labeled as “freedom” & “autonomy”
  – Enhances common interest & social bonding

• Concealed by shared self-deception

• Enforced by threat of counter-betrayal
Illustrations of Tacit Contracts

• Shared social self-idealizations
  – E.g., “Sacred” or “politically correct”
  – Conceal sordid social reality that actually happens
  – Tacit social contract: aversion to whistleblowers

• Summary: one often detects others’ deceits
  – But tactfully acts deceived and respects the taboo
  – Often denies awareness even to the self

• “Conscious” parallels what’s open to discussion,
• “Unconscious” = what really happens & is taboo
Taboo Vs. Accurate Awareness

• Subtle & important point:
• Awareness remains, but
  is hidden even from its bearer
• This process predicts the anomalies of
  – An “unconscious” that’s “really” conscious
    • at another level, and vice versa
  – Sociodynamics that masquerade as psychodynamics
    • the illusion of conscious will
  – Equilibration through mutual suggestion
    • individuals’ “conscious” parallels social self-idealizations
    • “unconscious” parallels what really happens, but is taboo
Social Influence

- These sociodynamics pervade all human relationships
- They manifest themselves most dramatically in poorly-understood interactions that we call “hypnotic”\textsuperscript{15,18}
- Hypnotic-like phenomena and transactions pervade everyday living, so
- Hypnosis provides a research paradigm
Hypnotic Transactions Exemplify

- Hypnotists’ illusion of control
  - conceals dependency on subjects’ response for what to do next
- Subjects’ illusion of non-volition
  - conceals the fact that only they decide whether and how to respond
- These vividly-experienced illusions reinforce one another, like a *folie a deux*
3rd Parties → Social Reality

- Legitimization by 3rd parties → emergent “psychological reality”\(^{14,15}\)
- Social influence data\(^{17,18}\)
  - Show that hypnotic elements pervade all waking mentation & social intercourse\(^{1,4,11}\)
  - Hypnosis = non-hypnosis & vice versa
  - I.e., the A/not-A absurdities follow
Mutual Suggestion

• All communication carries elements of overt information exchange & covert mutual suggestion in tension⁴,⁶,⁷

• One can not avoid influencing and being influenced by mutual suggestion

• Any more than one can avoid communicating⁷
Psychosocial Entanglements

• Mutual suggestion creates entanglements
• These extend from dyadic interactions to determine an entire society’s mores
• Largely outside of awareness, individuals adjust personal beliefs to these mores
  – These social mores are coercive
  – Awareness of what is socially “taboo” tends to be suppressed in one’s “unconscious”\textsuperscript{8,14,15,21}
Psychodynamics Emerge

• What is inherently social and contractual becomes experienced as if it comes from within
  – as though it were internally driven
Psychodynamics = “Real”

• At an emergent “psychological” level
  – Through the vividness of experience
  – Extent to which they are shared
  – Intensity with which they are mutually legitimized and defended by all participants

• & gain further stability
  – From subsequent “commitment” processes
  – that make individuals more trustworthy
Psychodynamics = 2° Adaptations

• Not primary drivers,
  – e.g., “conscious will” = non-causal\textsuperscript{12}
• Secondary adaptations,
  – to primarily social pressures
  – which arise primarily from reciprocity & deceit
• Social functions
  – conscious will as “emotion of authorship”\textsuperscript{12}
  – convention for holding people responsible\textsuperscript{14}
Psychopathology

• People who fail to enact psychodynamics competently
  – do not adjust well, suffer,
  – & impose their suffering on others
  → psychopathology

• Many patients are inept at or violate reciprocity

• Anomalies described earlier arise from the necessary roles of deception and self-deception
Further Evolution of our Minds

• Once stabilized, yet-unidentified neurobiological mechanisms will have evolved to implement these processes

• “Consciousness” can then acquire new functions, such as long term planning\(^8\)

• “Volition” may then mark those behaviors for which we hold offenders culpable\(^{12,14}\)
Cultural Relativity of Psychodynamics

• All cultures develop their idiosyncratic psychodynamic models, whose specific content vary over a yet ill-defined range\textsuperscript{26}

  – Not as primary causal drivers, but as secondary adaptations to the pressures of reciprocity in human evolution
Narrative Summary I.

- The psychological anomalies described earlier arise from the necessary roles of deception and self-deception: what is inherently social and contractual becomes experienced as if internal drives. Psychodynamics thereby do become “real”, at an emergent “psychological” level, through the vividness with which they are experienced, the extent to which they are shared, and the intensity with which they are mutually defended by all participants.
• They are further stabilized by subsequent “commitment” processes that make successful individuals more trustworthy.25
• Once so stabilized, yet-unidentified neurobiological mechanisms will have evolved to implement these processes.
Trauma and Re-Enactment

• Psychological trauma intensifies and rigidifies these processes.
• Re-enactment evolved as a learned instinct?
• Promotes adaptive rehearsal for emergencies that recur episodically and occasionally, and
• Becomes pathological in rapidly changing milieus such as today’s advanced cultures\textsuperscript{27}
Neurobiology of Re-Enactment

- Re-enactment resembles chemical addiction, and
- may operate through opioid, dopaminergic and related systems activated by trauma
- Which thus serve to reinforce its effects.
Sociodynamics of Re-Enactment

- Trauma ↔ ruptured relationships
- Extends to others through “contagion.”\(^{28}\)
- Hypnotizability is enhanced,\(^{29}\) and
- Patterns of mutual suggestion are now driven by the coercive power of traumatic affect.
- We often feel drawn either to “validate” others’ traumas or to deny them, and either way,
- to denigrate those who do the opposite.\(^{30}\)
Trauma \(\rightarrow\) Intractable Conflict

- Competing groups reinforce themselves with hypnotic-like *folies a deux*, each strengthened by enmity with the other.
- Each increases the trauma: “ratifiers” fan the flame (positive reinforcement); “deniers” traumatize those who seek social validation.
- Intractable conflict may result
- Traumatic re-enactment is its fuel
- Without it, frontal lobes will learn to inhibit it\textsuperscript{31}
Some traumatized individuals adjust their projected self-image downward, thus assuring social dominants they’re no threat. Image is made congruent by self-deception, leading to a real posttraumatic disorder driven by traumatic affect & neural reinforcers, socially ratified by mutual suggestion.
Trauma ➔ Self-Deception II.

- Real illness & “illness role” often diverge.
- E.g., posttraumatic dissociative d/o’s.\(^\text{22}\)
- Here, therapists may do better
  - not to validate the illness role, but
  - challenge intact competencies.\(^\text{15,22,32}\)
  - within limits of safety
- in contrast to tx. of major mental illness
Psychotherapy: General Implications

- Most psychotherapies are sociodynamic.
- Whatever be their stated rationale.
- “Mental states” ← constitutional givens, neurobiology, experience, and social influence.
- As *per* Engel’s biopsychosocial model.\(^{33}\)
Sociodynamic Perspective I.

- Emphasizes the social pull more overtly
- Looks toward mutual suggestion for
  - sources of symptomatic behavior,
  - payoffs and reinforcers thereof, &
  - focal points for tx. intervention.
Sociodynamic Perspective II.

- Utilizes 3 anomalies of psychological reality:
  - 1\textsuperscript{st}: the evolved tension between our
    - sense of autonomous personhood &
    - hypnotic-like social entanglements
  - Here, psychotherapists
    - respect autonomy via informed consent & contract for tx. roles, goals, & behavioral safety
    - in a way that utilizes indirect suggestion to imply optimum mental health to begin with.\textsuperscript{34}
Sociodynamic Perspective III.

- 2nd: mental realities vary with the act of defining them → responsibility to reframe them toward positive change.
- 3rd: causation works in opposing directions
  - defying attempts to define the primary cause,
  - granting flexibility to intervene at “focal points” that are sometimes remote from the target of desired change.
- Breaking up self-reinforcing vicious circles = the key element
  - particularly relevant when traumatic reenactment is in play.
- Therapists challenge individual patients to
  - identify problem-maintaining reenactment behaviors,
  - voluntarily abstain from them, replacing them with coping skills
  - just as is done in the treatment of the addictions.
- Therapists support significant others in standing firm against patients’ passive control, thus further reinforcing health.
Relevant Initial Questions for Tx.

• What does this patient want therapist to believe?
• How does this symptom predictably affect others?
• What preferred strategies does this patient deploy?
• How do these cause problems in his/her current milieu?
• What principally reinforces one’s symptoms?
• How can the treatment redirect these reinforcers?
• How can one redefine this symptom complex
  -to increase the odds of + therapeutic change
  -occurring as if by itself, and safely?

→ To identify focal points for potent tx with enduring benefit
Utilizing significant others

- Assessing and utilizing patients’ immediate social context provides great instruction to the treater. I often invite new patients’ permission to bring a spouse or significant other to an early followup session, with explicit intent not to do couples therapy, but to hear how the patients are perceived by knowledgeable third parties, extending the assessment to other perspectives. Often the other’s report provides corroboration, but often not. When not, I now understand the context far more clearly, relatively soon, and interventions may become self-evident. Simply inviting the collateral visit respectfully implies an intention to keep the option open of viewing the problem from other perspectives than the presenting narrative only. This covert suggestion enhances therapeutic leverage for therapeutic change.
Intentionality of Patients’ Narratives

• Less the whole truth & nothing but; more
• *How patients want to be perceived.*
• Keeping this in mind helps us to shift
  - from problematic questions like truth,
  - to more productive questions, such as
• Identifying the patients’ social context, preferred strategies, and how these work or instead reinforce their problems
Passive Control Dynamics

- Therapists may identify “symptoms as power tactics,” bolster significant others’ ability to stand firm, thus putting the ball back in patients’ court.\(^\text{10}\)

- Referring families for support in standing firm:
  - of substance abusers to Al-Anon
  - of acting out pts to mental health centers to learn “tough love” and related strategies.

- Neutralizing problem-maintaining social reinforcers \(\rightarrow\) desirable therapeutic change

- Most patients welcome family involvement.
  - when not, many report what family would say,
  - enabling one still to address potential social payoffs
Implying Health and Competency

• “Treat another as he is, and he will remain as he is. If we treat him as what he ought to be and can be, then he will become what he ought to be and can be.” (attributed to Goethe).

• = indirect suggestion, the “relationship message” that pulls the person in the relevant direction.\(^7\)
  - parental approaches imply pts’ impairment, and invoke child-like mental states.\(^6\)

  - **providing informed consent** presumes their ability to make personal decisions, implying health & competency whatever the diagnosis.\(^34\)
Informed Consent as Therapy

• Far more than just a legal obligation, giving informed consent is a potent therapeutic technique that pulls patients toward the greater health that the process implies. This process illustrates how treatment can utilize the suggestive component of communication even while negotiating at the most overt conscious level. Milton H. Erickson utilized this type of indirect suggestion most explicitly, though he stated it was just “common sense psychology.”
Transference & Standing Firm I.

- Psychoanalysis is a sociodynamic tx.
- Concentrates interpersonal entanglement into a dyadic treatment relationship.
- “Transference” describes a hypnotic-like relationship in which patients re-enact symptomatic relational schemas.\(^{35}\)
- This process creates a focal point for a comprehensive “working through.”
Critical to its efficacy is that the analyst stand firm against reinforcing disordered schemata. This requires that patients use other tactics. In other words, the treatment interdicts and redirects vicious circles. Other techniques often accomplish this more efficiently, without the associated dependency.
Eric Berne provided a potent antithesis to “why don’t you, yes but” transactions, instead asking -“That’s an interesting problem; how are you going to solve it?”

Within this single communication, the therapist permits face saving, respects contrary motivations, speaks to more competent levels of function, declines to ratify a problem-maintaining behavior, asserts interpersonal boundaries and redirects responsibility onto the patient.
Tx. Boundary-Setting II.

- When declining to ratify perceived helplessness or to intrude on patients’ autonomous domain, treaters lessen the risk of regressive dependency, while enhancing their relational stimulus value.
- Paradoxically, by explicitly disavowing the role of essential change agent, treaters actually become potent stimuli for therapeutic change.
Strategic Self-Therapy\textsuperscript{32} I.

- This dynamic may be used as tx modality
- Useful for posttraumatic disorders with extreme tension between help-seeking and help-rejecting behavior, at high risk of malignant regression.
- = “strategic self-therapy”\textsuperscript{32} (SST)
  - patient = change agent
  - therapists = consultant only
  - independent system = crisis resource
Engagement phase: psychotherapists de-emphasize their role as primary change agents, turning responsibility back onto the patients.

SST Proper: patients challenged to define themselves: who they are, what they stand for, where they’re headed – their goals, perceived roadblocks and plan. The very act of defining their personal identity serves to redefine and thereby change it.

Utilizes the reframability of psychological reality.

Often proves safe & cost-effective for high-risk patients.
Reframing *per se*

- Strategic\(^2,10,32\) and cognitive\(^37\) therapies place more emphasis on utilizing reframability as a locus of change in its own right. Strategically, the treater gains rapport at hidden levels through relabeling a liability as an asset, a setback as an opportunity, or resistance as autonomy; casting character traits in more favorable light; and cautioning that any change should be well informed and not done too hastily.\(^2,3,4,10\)
Criteria for Reframing

• Although seemingly “paradoxical”, appropriate positive reframing is
  1. equally or even more true,
  2. feels better, and
  3. implies desirable behavior change.

• There can be no positive reframing for blatantly destructive and disrespectful behaviors.

• Here, one confronts and holds patients responsible for their behavior, while continuing to reframe basic personal attributes positively.
Training Recommendations I.

- Add **evolutionary biology** and **hypnosis** to psychiatry & psychology core curricula
- **Evolutionary biology**: I particularly recommend
  - Trivers & Alexander on reciprocity and deceit help to understand how anomalies of consciousness and volition evolved.\(^8,^{19,20}\)
  - McGuire & Troisi offer a broad evolutionary framework for general psychiatry.\(^{38}\)
Training Recommendations II.

- **Hypnosis**  It is equally essential that budding psychotherapists learn the core essentials of clinical and experimental hypnosis. They are thereby enabled to recognize and redirect hypnotic phenomena when they spontaneously occur, to master the therapeutic power and learn the limits of reframing within controlled settings, and to gain confidence in the full range of the applicability of this technique. Respected professional societies provide ongoing forums in all of these areas.
Summary I.

• “Sociodynamics” describes mental dynamics and psychotherapy more accurately than the traditional term, “psychodynamics”. Internal “mental states” arise from external social causes, more than vice versa.

• A person’s brain calculates that individual’s interests in relation to his or her social milieu, assesses the strategic armamentarium for strengths and weaknesses, selects strategies likely to improve the odds of success, then brings beliefs, desires and behaviors into congruence.

• All occurs largely outside of conscious awareness.

• Two lines of research data are particularly relevant to this process, evolutionary biology and social influence, both curiously underemphasized in current psychiatry.
Summary II.

- These data point toward the likelihood that consciousness and volition arise as shared self-deceptions that promote social cooperation where interests otherwise conflict.
- Shared self-deception hypothesis predicts the anomalous duality of consciousness and volition.
- Confirmatory data from reciprocity, hypnosis, and psychological trauma converge to show that mutual suggestion mediates the social and psychological domains.
Summary III.

• Most importantly, psychological realities vary with how they are socially framed. Psychotherapy is made possible by therapists’ resulting ability to reframe patients’ symptomatology in its social context. It may be rendered more effective and efficient by identifying social payoffs of patients’ symptoms, utilizing significant others, redefining patterns of mutual suggestion to imply optimum health, and identifying symptom-reinforcing behavioral complexes that can be modified at biopsychosocial focal points toward greater social functionality, behavioral safety, and personal wellbeing.
References I.

References III.

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