ASCAP NEWSLETTER

Across-Species Comparisons And Psychiatry Newsletter
Volume 4, No. 5, 15 May 1991

"...Dietrich von Hoist and we both were rather impressed that you [John Price] as a psychiatrist see much more clearly the relationships between evolution, social structure, socialisation, behavioural strategy and stress than most ethologists and behavioural physiologists." Sachser[1]

(c/o Russell Gardner, 1.200 Graves Building(D29), University of Texas Medical Branch, Galveston, TX 77550)[2]

For the philosophy guiding this newsletter, predicated upon combinations of top-down and bottom-up analyses, see footnote on p11

Newsletter aims; 1. A free exchange of letters, notes, articles, essays or ideas in whatever brief format.
2. Elaboration of others' ideas.
3. Keeping up with productions, events, and other news.
4. Proposals for new initiatives, joint research endeavors, etc.

Basic Plan Group Meets 7 & 8 July at the home of John Price in Sussex

The plans are sett core members of the basic plan group are coming as well as others less familiar. This issue provides supplemental agenda items (implicitly rather than explicitly stated) to the ones listed in the April issue of ASCAP. (Specific instructions for the meeting are going directly to the participants so far signed up).

Four countries are represented. The group at this time is a manageable work group size, but please let us know soon if you desire to join us; there's room for still more.

Announcement: The 14th meeting of the European Sociobiological Society will be held Aug 30-Sep 1, 1991, in Liblice Castle, Czechoslovakia (near Prague). The theme is "Sociobiology and Ethics." Deadline for abstracts: 15 June 1991. All inquiries to:

Dr. Valentina Leonovicova
Laboratory of Evolutionary Biology
Na Folimance 11
PRAHA 2
CS 120 00
Czechoslovakia
(tel:+42-2-257993)

Letters: • *April 16, 1991*

My colleague at Dartmouth, Jim Barrett, loaned me many back issues of the Newsletter. It deals with just the questions and problems I am primarily interested in. I would be very happy if I could subscribe from now on and get back issues he probably misplaced....

For years I've been convinced that depression, is among other things, the appeasement posture of humans that can efficiently assuage rage. I'd like to be directed to any research or writing about this. Possibly Roger Masters developed some of his interests years ago during conversations we had. But he's not as impressed as I am about how development of criminal justice and public protection have made an atavism of what once had true survival value in what were commonplace agonistic encounters. HE Payson, Norwich, VT

Feel free to write an essay fleshing out your views *vis* a *vis* those of Dr. Masters. Also feel invited to respond to other topics as you have much in common with ASCAP readers.

Letters (cont): *23-4-91*

Many thanks for your letter of March 19, and the excellent news that you are coming to England in July ... if more than ten people come we will have to farm them out in local pubs [ten can stay at my house in Sussex].

I enclose a "further reply to Leon"...[expanding] the point I made in the November ASCAP...In going on...about this business of "levels" I am not sure whether I am grinding an axe, flogging a dead horse, chasing a wild goose, or possibly just building castles in the air. I am still concerned that we have not got the terminology right, even if the underlying ideas are sound. I don't like "voluntary" because it is an attribution about behaviour made by fellow actors rather than by scientific observers (like "consciousness"). Do you prefer "higher level", "rational", "sentient", or something else? Also should we call it, say "sentient yielding", implying long duration, to distinguish it from acute submissive acts? Also do we go for "depressive yielding", "yielding subroutine", "insentient yielding" or something else?

I cannot think of a closer analogy than temperature control. Avoidance of glare by gaze aversion as opposed to pupillary constriction is a similar model. The balance of voluntary and involuntary components in reactions like swallowing, defeacation and breathing seem rather different. Do you have any suggestions? The occurrence of shivering during fever (and in the absence of cold) might be a model for endogenous depression, but I think to add that to the "reply" would complicate and confuse things (even more!).

The same two level model applies to acute agonistic encounters too, e.g., football hooligans exhibit autonomic fear: "The fear is experienced at a very basic and physiological level - we have seen many fans exhibiting the classical fear symptoms of turning pale, sweating, hair erection and so on when coping with serious conflict encounters."[4] This lower level response is relatively independent of their two higher level types of yielding which are running away and submission (which involves being silent and looking at the ground). Probably the fans know that the sweating, etc., is due to fear; but if in some culture these symptoms were interpreted as an incipient heart attack, and the St. John's Ambulance was called, the fan would then have made an exit from the arena using the metaphor of sickness, rather like what happens when depressive illness is interpreted as physical illness.

I am really amazed and delighted that so many people have taken the trouble to reply to the "metaphor" essay. Perhaps it is time now to wind the discussion up. If I send you a final comment, perhaps you could print it alongside an editorial comment. And when you come to England, we can sort out the problems of terminology, derive some testable predictions, and have a good time.

John Price, Milton Keynes, Engl

Price-Gilbert exchange. Conspecific competition as a model for the biological infrastructure of depression; Problems with "do depressives get their own way" by Paul Gilbert

John Price is both a friend and mentor. He has had a profound influence on my thinking and has been enormous support. So when Russell asked me to comment on his paper I was pleased to do so. However John and I do have some differences of view, eg, to

raise the issue of whether depressed people get their own way places the cart before the horse. Much depends on the definition of 'own way' since in many minds this can be associated with something positive. Second, the tactics of coping with depression should be separated from etiology. Third, in my view, his paper took us too quickly into a subtle complexity of the consequences of some depressive behaviour before a fuller understanding and articulation of the basic axioms of depression as an evolved potential psychobiological pattern (basic plan) of defeat/inferiority and/or helplessness.

Elsewhere, I have argued that depression is not a care eliciting tactic although care eliciting may be used as a strategy to overcome depression . Such concerns take us in the heart of the complexities of the social support literature. Fourth, I am unhappy with concepts like 'depression in the hedonic mode'. Unlike the agonic mode (whose definition rests on a clear understanding of the role of threat and aggression as tactics of social power), the hedonic mode is more complex. Its definition is vague and refers to an orientation for affiliative behaviour. There are at least three mentalities involved; care eliciting, care giving, and cooperating. Individuals use various strategies to show readiness to invest in and support of others, as well as need for, investment in and support from others (similar to Kohut's concept of mirroring). The hedonic mode depends on a mutual display of positively reinforcing signals. Whether a depressed person is cared for depends on the orientation of the other in the relationship; this may depend on basic personality and history of previous interactions.

Because I think John's ASCAP paper runs the risk of clouding what is his major contribution to our conceptualisation of depression I will not focus on disagreement, which in the overall picture is slight, but rather offer what I see as the basic axioms of his theory. John importantly brings attention to the role of power in psychopathology. Although philosophers have for centuries seen the use and abuse of social power as one of the most central dynamics of social life, psychopathologists have not really articulated a theory of social power in psychopathology. While we often talk about a patient's sense of powerlessness, helplessness, inferiority self-perceptions, or the role of high expressed emotion and agonistic family structures, a basic theory still does not tell why and how these relate to pathophysiological change and psychopathology. Many studies are correlational only.

The evolutionary approach excites us because we perceive the potential for a genuine, testable theory of how basic gene-neural structures evolved, and are related to, social living. Vining[6] but more specifically Nesse[7] have pointed out that what evolution has achieved is an interface of affective control systems with social outcome. As Nesse points out, social success tends to go with positive affect (eg, gaining status and respect, controlling access to resources, finding a mate,- being accepted and forming alliances/friendships) while negative affect relates to failing to gain status and respect, lack of control over resources, being rejected by allies and friends etc. At a neurobehavioral level Gray[8] has suggested that the behavioural inhibition system can be activated by either cues signaling punishment or insufficient positive reinforcement. It takes little to suggest these two aspects, social success and internal inhibition control systems, are related. For example, it makes sense that an animal's behavior is inhibited such that it does not invest

great energies in the pursuit of poor quality reinforcers, which may have low social success pay offs or situations leading to punishment. These two aspects; the importance of social success as a modulator of affect and the role of internal inhibition, are crucial in understanding depression. John's theory helps us understand both these aspects.

At the core of social success was at one time reproductive success and gradually positive affect became co-assembled with the proximate events that might lead to it. Thus humans are now motivated to social success rather than reproductive success per se. But social success continues to depend on social power; the power to influence others. Therefore it is profitable to explore how this is done with the consequences of failing to influence others.

In the agonic situation influence comes via aggression and strength. Power arises from the ability to force compliance from conspecifics and to inhibit behaviour that challenges for resources. This is achieved in territorial species by forcing a competitor out of the territory. Depression may arise from blocked escape and entrapments. In group living animals this is via influencing their biological state such that subordinates have higher levels of various stress hormones, are not optimistic, are non-explorative and experience various forms of internal inhibition. In depression this state of internal inhibition and non-explorative style is fairly obvious and biologically recognizable .

The Psychological Theory. However John's theory is a psychological theory because he points out that fighting is often ritualised and that there have evolved internal algorithms for calculating whether one is inferior to a conspecific and therefore could not win in challenging or whether one is superior and could win. He calls this relative RHP and has made the important connection with the evolutionary concept of evolved strategy (fight if stronger; withdraw, submit if weaker). However, stimuli conveying information about whether an animal is stronger or weaker are complex and are not absolute but only comparative. For example, it is not the size of an animal that is threatening but its relative size. These innate algorithms for social comparison, automatically set the internal levels of internal inhibition and indicate degree of social success. In psychological terms this means that a most basic algorithm that controls much of our social behavior is social comparison . We tend to feel more inhibited in the presence of higher status figures, but free in the presence of lower status or less powerful figures or very affiliative figures. Early attachments relationships in humans probably help to set this internal system . We also now know that social comparison is an important judgment in self-esteem.

The research question of when subordinate states of inhibition tip into depression is as yet unanswered and in part this is a question of definition of pathological states. But there are various possibilities. One is in individuals who have always felt somewhat inferior to others, are relatively unassertive and become depressed when they can no longer maintain relationships with others who are more powerful and who protect(ed) or signaled investment in them. Another is a reversal of rank such that someone very up-hierarchy motivated experiences set-backs that block their progress or reveal to them that they have less than desired power to influence social outcomes. A third is via the internalisation of excessively high standards and ideals such that one constantly fails the challenge and falls short. We are cur-

rently investigating the idea that the first group are prone to various states of negative affectivity[11].

So what have we here? First we have the idea of internal algorithms that calculate relative power and set the inhibitory tone of the animals'/persons' social-biological systems. In Russell's terms these are basic plans. Many sources of data may enter this calculation (age, history of success, and in humans, internal models of self and others). Involuntary subordinate self-perception arises from making unfavourable social comparisons and there is now much evidence that depressives do make unfavourable social comparisons . Second, we have the idea that depression is in part the result of geneneural structures that facilitated the inhibitory processes in subordinates and/or the termination of agonistic behaviour following defeat, an "I'm-out-of-action signal." Hence, as part of this system we would expect depressed and highly subordinate animals to be less explorative, rarely initiate behaviours that could be construed by dominants as a claim on, or a demonstration of, dominance-confidence; memory for positive events would be inhibited (to stop plans for behaving confidently) and the future is associated with negative affect — again as part of the inhibition of challenging behavior. Self evaluations focus on personal inferiority (deficits) in contrast to the power and talents of others. In John's terms, an internal control system sets the animal in a state of living as a subordinate/loser. He calls this the internal referee.

This is helpful because it points to a basic brain architecture or set of basic plans that evolved from having to compete with conspecifics in group living situations. And we should not underestimate the role of negative and hostile interactions in the onset of depression. There is clear evidence now that depressives are often subject to hostile interactions, and relapse is strongly associated with spouse criticism. Still the role of aggressive power is only part of the story.

Two additions: We know that rank in humans is also achieved by the demonstration of attractiveness, that we attempt to elicit the investment of others by living positively in their minds . For various complex reasons (not discussed here), our basic capacity for social comparison is now oriented to out-attract each other; "Do you love me more than Fred; am I a better researcher/theorist than Joe?" To gain social success we have to influence others with how we appear and what we can do (or if you like, to demonstrate our "investment worthiness"). In this way we are accepted and have resources bestowed. If we lose a sense of being attractive to others then this may act as a signal of subordinate status and activate the depressive inhibitory system.

In this (the attractiveness) domain the depressed person is hampered again by negative social comparison. This often takes the form of shame, a sense of inferiority and a painful focus on personal deficits (unattractive qualities of the self) and lack of social power.

The second addition is that social comparison also serves to locate a person in a group. Here the analysis is same-different. One of the typical evaluations of depressives is that they feel different from others, not part of the group. They experience themselves as outsiders. This use of social comparison can result in paranoid feelings.

Therapy Issues 1. Social comparisons (inferior-superior & same-different). 2. The role of shame (self-dislike or blame), envy and needs for approval/reassurance. Both shame and envy depend critically on rank evalua-

tions. Few envy subordinates or those that have less than oneself.

3. Inferiority beliefs; origins and current maintaining influences/relationship/events.

4. Premorbid functioning; eg, as dominant and up-hierarchy oriented, or chronic submissiveness and/or fear of being outsider/abandoned (these are important because they indicate a person's basic tactics for gaining social success).

5. The nature of ideal self-future fantasies (power, success, love, sense of belonging or finding one's place).

6. The themes and roles of self-organisation; repetitive themes in fantasy, conflicting themes and their underlying affect, eg, for care, social control/power, fear of being an outsider). Unresolved early difficulties; are themes compensations? (eg, if I succeed everyone will love me and I will turn out good and be redeemed, etc).

7. The inhibition of explorative behaviour and assertiveness. What blocks free expression of self? Exploration is necessary for development and change and depressives are non-explorative.

8. Biological states of defeat (withdrawal) and submission. Does chronic submissiveness have different biological substrates than acute defeat states? Is there a need for drugs to change brain state? Type of illness (eg, bipolar?)

The importance of these issues varies with case. In one, it may be a marriage and chronic put-down by a partner. In another chronic inferiority beliefs may be associated with hostile early parenting or failing to live up to parental ideals. The above are only guides.

In my view, and I disagree with John here, the therapist always comes to the rescue of involuntary subordinate self perception. We make the assumption that this is an archetypal potential that evolved from conspecific competition to regulate behaviour and inhibit continuous fighting. While acceptance of depression as a sprained brain syndrome may be helpful I do not think one should focus on subordinate behaviour. Indeed one of the fascinations of this theory is that it resonates so well with Kohut's concepts of the need for mirroring, idealising and alterego self objects. Hence the therapy involves the therapist acting as positive self object for the patient and in these ways raise their sense of attractiveness and ability to elicit investment from another. It also involves the cognitive therapy aspects, identifying internal self downing and (the conscious awareness of internal inhibitory mechanisms or internal self-talk, - 'you are no good - you are useless' — Freud's superego), realignment of ideals to focus on successes rather than failures, and the focus on various form of entrapments. In short it involves empowering patients and teaching them that the self should avoid being caught in the grip of an archetypal (self evaluative) mechanism that tries to get them to live as an involuntary subordinate in defeat.

All these themes here are of course enormously complex and (excuse the plug) my new book which has just gone to press goes into them in much more detail. The basic theory of mentalities is given in my 1989 book, Human Nature and Suffering Hove: Lawrence Erlbaum. In my view we are on the brink of a new archetype theory of human psychopathology and can get back on track with an understanding and mapping of basic human dispositions. When we do this, much of the mass data-assortments that have been studiously gathered begin to make sense. The achievement of ASCAP is to bring us into an hedonic relationship with each other such that we can 'play with'the very

central ideas of our human mentalities and basic internal structures. In John's writing we see the beginning of a theory of the tactics of social control, the internal algorithms that facilitate its calculation, and we gain insight into the psychobiological consequences of having or losing social control .

Price-Frankel Exchange by FH Frankel

There appears to be little to gainsay in the notion that human depression and depressive behavior could have evolved from the yielding component of ritual agonistic behavior. The suggestion that there exist basic patterns or propensities for subsequent related behavior evolutionwise, is intuitively appealing; furthermore, believing that yielding is the prototype of the depressive posture, or even of depression, is intellectually tidy in that it provides a sense of order and progression.

We continue to discover, however, that relatively straightforward or simple explanations of human experience and behavior are usually limited, or found wanting. The ritualized posture tells us about the structure, but only very inadequately about the functions we believe to be essentially human, such as the urge or the learned obligation to improve on one's performance and one's virtues, and to behave morally. Regarding the first, a major part of what depressed patients talk about, in addition to loss or defeat at the hands of others, stems from self criticism and the need to do better, not only in competition, but also to satisfy themselves or to please their "gods" or to emulate them. This disappointment in the self, assumes several added dimensions of experience that might dwarf the agonic struggle, even if the posture and the appropriate chemical messengers are still at the heart of the structural picture.

Similarly, with regard to the second attribute, the learned obligation to be moral in one's dealings with others. The use of the hedonic mode to explain the attempt in other species to elicit nurturance, directs our attention to the difference between behavior in other species and that of humans. For example, hysteria and hysterical behavior, banished as workable entities from the recent version of the DSM, are in my view essentially human and the human paradigm for what is under consideration. The explicit and manipulative communication influenced by the interaction between patient and caretaker that is often at the heart of hysteria, is probably best viewed as a gloss added to another primary clinical disorder. Depressed patients seeking to manipulate their environment are probably a long leap from the animal defeated in the agonic struggle and eliciting mercy. The mercy if it is forthcoming will spare the creature further punishment or death. Any fundamental similarity to the manipulative behavior that I prefer to define in hysterical terms must also acknowledge the distance between being allowed to survive in the pack, and enjoying special favors or privileges because one is disabled. Here again I can see the perpetuation of the basic pattern in the structure, but there are additional dimensions of human experience that contribute to a more complex situation. My view here is strengthened by my impression that in the animal world disabled progeny are at times in fact neglected, or extruded from the pack or the nest, the more rapidly to perish, rather than receiving special favors.

At times, angrily demanding depressed patients are driven, in my view, by other motives, some characterological in nature. But linking such human behavior to the plea for nurturance in the hedonic mode might

be stretching it.

From the clinician's standpoint I welcome explanations that help in the understanding and handling of human problems. These views expressed by Dr. Price and those flowing from across-species comparisons are in fact illuminating and a call to greater clarity in our concepts. They affirm for me that, in addition to the basic patterns or propensities for subsequent related behavior, there are essential differences between human and other species that are both qualitative and quantitative. This all strengthens the view that there is a cost to abandoning concepts that acknowledge the motivation and meaning behind human behavior, elements extremely difficult to validate and measure in scientifically acceptable ways. In the subject under discussion, I believe we are dealing with behaviors described as hysteria or hysterical. These are essentially human, and although in part driven by the need for nurturance in the interactive process, considerably more elaborate than survival behavior. The explicit communication in hysteria is also dramatically influenced by suggestive cues and imagination, perhaps present in other species, but highly developed in the human.

Price-Sloman Exchange; Psychotherapy with depressed patients; an evolutionary model by Leon Sloman

Recently you mentioned that it had been suggested that a model is required that is both clinically relevant and counter-intuitive. In order to continue our dialogue I provide a clinical vignette and then discuss how an intervention was shaped by an evolutionary paradigm.

A family sought help because of the ten year old son's severe behaviour problems and the extreme sibling rivalry between him and his eight year old brother. The mother described herself as chronically depressed and as subservient to her husband who was disinvolved with the children, but was also, at times, explosive with them. After a few sessions, the mother came alone, as father "could not make the appointment". The mother recognised her subservience, but saw it as independent of her depression.

The therapist pointed out that there were various degrees of submissiveness. A mild degree of submissiveness could be culturally determined. Extreme submissiveness, or "hypersubmissiveness", is characterised by feelings of inadequacy, inferiority, helplessness and hopelessness, and this could be experienced as feeling depressed. He explained that these feelings had a valuable function, because being an integral part of yielding or submission they served to prevent conflict from getting out of hand. He speculated that the mother must have had good reason for deciding to be submissive and wondered whether this was her way of trying to keep her marriage stable. The therapist explored with the mother how she felt she might respond if she were to decide to begin to give up being quite so submissive. He wondered how she felt others might respond if she were to become more self-assertive and self-confident. The therapist suggested that she must have had good reason for not being self-assertive.

She responded that after she got mad with people she always felt "she had acted like a bitch." When the therapist expressed interest in how she had come to feel that way, she described her childhood living with an autocratic father where she had learned to be obedient and not talk back. She later claimed that she was self-assertive with her children, because she often screamed at them. The therapist disagreed arguing that by her description her screaming

reflected helplessness rather than strength. Towards the latter part of the session, the therapist asked the mother if she were to decide to become more self-assertive could she think of any situations where she might respond differently. The mother was able to come up with a number of different ideas, which included her insisting that her husband attend the next session.

A few weeks later, she informed the therapist that her husband had agreed to come in with her and that she was feeling less depressed. One could speculate that mother's increasing self-confidence and positive mood could have the affect of destabilizing her marriage, or could lead to a more productive and meaningful relationship. It certainly had the effect of enabling the mother to handle her son's aggressive behaviour more effectively and also to show her children more affection. It should be noted the thrust of the intervention was not merely that she should assert herself. It was rather to help her become less submissive in order to help her feel better about herself so that she could express herself in a more open and direct manner.

The above interventions were based on an ethological mode. The interactions between the members of a family group are largely shaped by a combination of bonding and agonistic behaviours. When these agonistic mechanisms function smoothly, we can assert or express ourselves in an open, direct fashion and also, either avoid getting into conflicts, or readily concede defeat. When problems arise one often observes the following scenario. A fear of losing prevents the individual from being self-assertive, because that would increase the danger of defeat. The same fear also makes it harder to accept losing. As a result, the individual is torn between the need to assert himself and the need to yield with the result that he can do neither. If the conflict becomes more intense the individual may feel more pressure to do battle, but the countervailing pressure to yield may result in him or her behaving in a non-yielding hypersubmissive way, which can culminate in a depressed mood and perhaps in clinical depression.

The basic premises are as follows. First, yielding and dominance are deeply ingrained patterns of response. Second, many patients including those who have either Axis I or Axis II disorders, demonstrate inefficient functioning of these mechanisms. Both mechanisms often act synchronously with the result that each blocks the effective action of the other. The individual is therefore unable to yield and end the conflict.

This may be observed in individuals engaged in dysfunctional power struggles. They are often terrified of losing, which inhibits their ability to confront opponents in an open direct fashion. Because they fear defeat, they avoid open confrontation. This fear of losing also inhibits them from submitting so they avoid admitting they are wrong. This means they have difficulty either asserting themselves or submitting.

Their submissiveness manifests itself by an expression of helplessness, inadequacy or victimization. However, it is apparent that their submissiveness is a defence against underlying hostility so that they exhibit both fighting and submissive tendencies. This person may react with more extreme submissiveness (that we label "hypersubmissiveness") when the conflict escalates, and this can culminate in depression. On the other hand, the individual who experiences this conflict may demonstrate out of control dominant behaviour that escalates into mania.

The therapeutic aim is to promote smoother and more efficient functioning of these agonistic mechanisms.

This entails helping the patient to yield when it is appropriate. For true yielding to occur, a direct confrontation must be a viable option. Therefore, in order for the hypersubmissive client to feel comfortable about yielding, he must first end hypersubmissive responses and be able to respond in a self-assertive fashion. Many depressed patients continue to cling grimly to unachievable goals, which would indicate that they have irreconcilable dominant and hypersubmissive responses.

This evolutionary paradigm can be readily integrated into various models of therapy including the psychodynamic and cognitive models and reality therapy. The original adaptive function of these agonistic mechanisms represents a cornerstone of this approach by enabling the therapist to reframe feelings of inadequacy, inferiority and helplessness as playing useful roles in maintaining group cohesion. This reframing is based on the therapist's notions about these mechanisms' evolutionary function. Individuals with more conscious awareness of their own mechanisms might find it easier to decide whether to fight or to yield. The task of the therapist is to help patients now not aware to become mindful of options available to them.

The approach probably approximates the cognitive model more than any other. Because I am interested in his response, I hope that Aaron Beck, the founder of cognitive therapy, will not object if I draw a distinction between what I think he might say and how one might approach the same situation using this paradigm. Aaron Beck might say to a patient "when you were not able to respond to that challenge it must have left you feeling helpless and hopeless." Using this model one might say to a patient "you preferred to submit rather than cause conflict and disharmony and upset other people." One makes a special effort to connote the submissive behaviour positively with the aim of putting the patient into a therapeutic "double-bind." If the patient accepts the intervention, this leaves him/her feeling less inadequate. If the patient does not accept intervention, he or she must become self assertive in order to disagree with the therapist. There is a similarity between how the therapist utilizes the evolutionary adaptive function of the yielding mechanism and the way that family therapists utilize the systemic function of a negative behaviour to positively connote that behaviour.

The above model is oversimplified, and requires more than one vignette and a more detailed discussion to do justice to the complexity of the topic (which we have already begun to address)[12]. J Price has done pioneering work in this field and successfully applied these principles in his clinical work; I look forward to exchanging ideas with him soon.

Michael McGuire described how, when someone refused to press an elevator button for him, he asked why the refusal; the answer was: "I decided to refuse because I am now in an assertiveness training group." This probably illustrates an unsuccessful effort on the part of a submissive individual to act in a self-assertive manner. Being self-assertive involves being open, direct and self-confident and not being submissive. The individual that Michael encountered would appear to have been trying to compensate for feelings of inadequacy by acting in a superficially self-assertive manner. The submissive individual who tries to act in a self-assertive fashion is more likely to elicit a negative reaction than a person who is truly self-assertive. It therefore follows that when trying to help clients be more self-assertive, one should aim at helping them give up their submissive patterns.

1. Letter to John Price, 7 Jan 1991, from Norbert Sachser, Lehrstuhl fur Tierphysiologie, Universitat Bayreuth.

2. For ASCAP Newsletter Volume 4 (Jan through Dec, 1991) please send $18 (or equivalent) for the 12 issues. Make checks or money orders out to "Department of Psychiatry and Behavioral Sciences, UTMB."

3. ASCAP philosophy and goal. High scientific importance rests on comparing animal behaviors across-species to understand better human behavior, knowing as we do so that evolutionary factors must be considered for understanding properly such behaviors. To accomplish these comparisons, very different new ways of viewing psychological and behavioral phenomena are required. This in turn explains why we need new words to define and illustrate new dimensions of comparisons across species. We expect that work in natural history biology combined with cellular-molecular biologic research will emerge as a comprehensive biologic basic science of psychiatry. Both top-down and bottom-up analyses are needed. Indeed, this must happen if we are to explain psychiatric illnesses as deviations from normal processes, something not possible now. Compare to pathogenesis in diseases of internal medicine.

4. from P. Marsh et al.: The Rules of Disorder London, Rout ledge and Kegan Paul, 1978

5. Gilbert, P. (1991 in press) Depression: Types Concepts and Theories: An Evolutionary Synthesis on the Themes of Power and Belonging. London: Lawrence Erlbaum. And New York: Guilford.

6. Vining DR Jr: Social success versus reproductive success: The central theoretical problem for sociobiology (plus peer commentary). Behavioral and Brain Sciences 1986;9:167-216.

7. Nesse, R.M.: Evolutionary explanations of emotions. Human Nature 1990;1:261-289.

8. Gray, J.A. (1982) The Neuropsychology of Anxiety Oxford: Oxford University Press.

9. Henry JP: The relation of social to biological process in disease Social Science Medicine 1982;16:369-380.

10. Swallow SR, Kuiper NA: Social comparison and negative self-evaluation: An application to depression Clinical Psychology Review 1988;8:55-76.

11. a. Watson D, Clark LA: Positive and negative affectivity and their relation to anxiety and depressive disorders Journal of Abnormal Psychology 1988;97:346-353.

b. Watson D, Clark LA: Negative affectivity: The disposition of experience aversive emotional states Psychological Bulletin 1984;96:465-490.

12. a. Sloman L, Gardner R, Price JS: The biology of family systems and mood disorders. Family Process 1989;28:387-398.

b. Sloman L, Price JS: Losing behaviour (yielding subroutine) and human depression. Proximate and selective mechanisms. Ethology and Sociobiology 1987;8:67S-77S.