

LEARNED HELPLESSNESS AND LEARNED RESTLESSNESS

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ABSTRACT: Overgeneralization of the learned-helplessness model could encourage the assumption that instrumental coping behavior (voluntary escape/avoidance) is always the most adaptive response to threat. Clients in psychotherapy are often most threatened by their own unwanted responses, many of which normally elude voluntary self-control. Indeed, anxious efforts to avoid, escape, or otherwise control such responses sometimes have the self-defeating effect of producing them, as seen in such diverse conditions as stuttering, insomnia, sexual dysfunction, and even some depression. Such conditions have an experimental analogue in the persistence of punished escape/avoidance responses in vicious-circle learning. The persistence of instrumentally ineffective coping behavior is seen to be the converse of learned helplessness and is here termed "learned restlessness." In contrast to learned helplessness, learned restlessness calls for a paradoxical treatment strategy of response prevention or instructed helplessness, whereby the client is persuaded to give up any deliberate escape/avoidance efforts, risking or accepting the feared eventuality. Problems in diagnosing helplessness and restlessness, as well as possible sources of client and therapist resistance to a treatment strategy of giving up, are also considered briefly here.

The concept of "learned helplessness" is popular today in many circles, both clinical and experimental. The concept was first used to describe the failure of some laboratory animals to escape or avoid shock, when given the opportunity, after previous exposure to inescapable shock (Overmier & Seligman, 1967; Seligman & Maier, 1967). The term has since been applied to the failure of human beings to seek, utilize, or learn adaptive instrumental responses, as seen most dramatically in the depressed person who seems to have given up hope that effective voluntary control over important environmental events is possible

(Seligman, 1975). Some of the notion's current appeal lies precisely in the apparent clinical relevance of this experimentally derived paradigm.

The typical laboratory demonstration of learned helplessness has utilized an experimental design in which two of three groups of dogs (or other animals) are first exposed to a series of shocks while confined in a harness or hammock. Subjects in one of these groups are allowed to learn an instrumental escape response, while those in the second, yoked group have no instrumental control over the shock. Naive subjects in the third group receive no shock at this stage. When all animals are then given the opportunity to learn the usual escape/avoid response in a shuttle box, those in the naive and escape-conditioned groups readily learn to jump the barrier to safety, while many of those from the previous yoked condition fail to learn the available response. The latter, learned-helpless animals quickly cease running about in the new situation and simply lie passive, whining quietly, as they receive continued shocks. Even if they accidentally make an occasional escape response at first, they fail to repeat and learn this response.

This effect is by no means universal across all subjects or variations of procedure, but it does have some degree of generality across species and situations. With human subjects, exposure to aversive and uncontrollable noise has subsequently interfered with anagram solving, while experience with insoluble discrimination problems has likewise interfered with learning to control noise (Hiroto & Seligman, 1975).

Some naturally occurring forms of learned helplessness in humans could be of more direct clinical interest. Reactive depression, in particular, has recently been reinterpreted as the

outcome of a perception or belief that significant life events, both aversive and gratifying, are beyond the individual's control (Seligman, 1975). Hence the familiar pattern of "depressed" responding, of giving up even when adaptive responses would seem (to others) to be available. Of course, some giving-up reactions are not as global or generalized as in depression. Take, for example, children who react to failure in an academic or achievement context by giving up further effort, thus feeding a vicious circle of underachievement if not the broader pattern of depression (Dweck, 1975).

The therapeutic implications derived from the learned-helplessness model have thus far been less than dramatic. Predictions that time and ECT may both help in cases of learned helplessness or depression, though based on laboratory results, are not unique to the model (Seligman, 1973, 1975). Perhaps more specific to the model is the suggestion of forcibly exposing a victim of learned helplessness to successful control experiences, as when helpless dogs have been dragged across the shuttle box until they finally learn that they can escape shock on their own (Seligman, Maier, & Geer, 1968). The more general suggestion is being made that early experiences with effective voluntary control over events may help immunize humans, as well as other animals, against later learned helplessness when various trauma are encountered (Seligman & Maier, 1967; Seligman, Rosellini, & Kozak, 1975).

Also of some interest here is Dweck's (1975) reattribution training approach with learned-helpless school children. In persuading such children to attribute their failures to their own (correctable) lack of effort, Dweck was able to improve their overall performance by getting them to try harder. In contrast, a group of learned-helpless students who were simply given a steady diet of success still overreacted to later failure.

Neither a detailed review of the rapidly growing learned-helplessness literature nor a systematic critique of the concept will be attempted here. Critical examination of the model in terms of its learning rationale, the strength of its clinical/experimental parallels, and its therapeutic implications will no doubt be undertaken elsewhere. The present discussion focuses instead on but one area in which the

overgeneralization or overselling of this otherwise valuable notion could obscure some important clinical and experimental phenomena.

Already, the more general and popular statements of the learned-helplessness model (Seligman, 1973, 1975) have seemed to suggest that instrumental coping behavior is always the most adaptive response to threat. But adaptive escape/avoidance responses are not always available; for some kinds of aversive events, they may normally be unavailable. In the latter case, as in the inescapable-shock condition of learned-helplessness experiments, emotional passivity is in fact the most adaptive course. This point is acknowledged by Seligman (1975) and well stated by Kimmel (1971):

Since proprioceptive feedback from the fear reaction is itself aversive to the organism, the persistence of learned fear reactions in unavoidable-inescapable pain situations would be biologically wasteful, if not downright self-punitive . . . The only adaptive response option available to a dog which is forced to receive a series of signaled or unsignaled inescapable-unavoidable shocks is to *relax*, or to *inhibit* the aversive fear response. (pp. 167, 172; emphasis in the original)

Here, too, attempts to avoid or otherwise control the aversive event instrumentally would be useless, if not counterproductive.

Of course, human beings are generally more able to control external sources of threat than are dogs administered inescapable shock in the laboratory; at least we like to hope so. Individuals may also hope to exercise voluntary control over *their own* responses—physiological, emotional, cognitive, and behavioral—since these become sources of threat or gratification in their own right. Clients in psychotherapy, for example, often respond as much to their own unwanted responses as to external threats, and they seek to control and change themselves as much or more than external events, or as a means to achieve control over external events. However, it will be suggested here that voluntary self-controlling responses in particular are not always available or may have their own aversive consequences. The work of Seligman and his colleagues does not speak to this clinically salient possibility, partly because their work is based on laboratory studies of the response to externally administered stimuli.

If instrumentally effective coping responses are sometimes not available, especially for purposes of voluntary self-control, then learned

helplessness may indeed have its place as an adaptive reaction to uncontrollable events. It is thus clearly necessary to place the concept of learned helplessness in a broader context by clarifying the circumstances in which it is an adaptive condition, not a pathological state. But in such circumstances we also find a maladaptive condition that is more or less directly opposed to learned helplessness.

THE EXPERIMENTAL CONCEPT AND CLINICAL SIGNIFICANCE OF LEARNED RESTLESSNESS

It is certainly not the case that all clients in therapy present a pattern of learned helplessness. Many are actively casting about for effective coping responses to deal with external or internal events. Indeed, some clients seem to exhibit not a giving-up syndrome but a trying-too-hard syndrome, often in an effort to escape or avoid their own undesired reactions in certain situations.

There are many common clinical patterns of objectively unnecessary and maladaptive avoidance behavior. The classical phobias follow this pattern; so do some drug dependence and social withdrawal problems. Consider, for example, the male client who avoids urinating in public restrooms for fear of being seen if he fails to perform. Here, of course, as with most phobias, the avoidance behavior may be successful in minimizing embarrassment or anxiety. But this behavior is not only unnecessary, logically speaking, but also unpleasant or aversive in its own right.

In the case of chronic insomnia, on the other hand, the search for effective coping mechanisms may well continue even without notable success in escaping the feared event. Here the individual's anxiety persists and feeds a self-exacerbating condition, but the victim almost never gives up and relaxes (Storms & Nisbett, 1970). A similar "exacerbation cycle" plays a prominent role in many other psychosomatic conditions, from angina pectoris to gastric ulcer (Beck, 1972; Lachman, 1972). Stuttering provides another example where the victim's anxiety and even his very coping efforts maintain the speech difficulty (Bloodstein, 1958).

Do such examples point to a clinical converse of learned helplessness? If so, they should also prove to have their own experimental analogues, which could be directly contrasted

with the experimental paradigm of learned helplessness. Fortunately, such analogues can already be found in the conditioning literature.

The case of unnecessary avoidance responding in the laboratory is best known from demonstrations of the resistance of avoidance responding to normal extinction procedures (Solomon & Wynne, 1954). Just as the learned-helpless animal fails to learn that a coping response is now available, because it does not try hard enough to respond, the persistent avoider fails to learn that such a response is no longer necessary, for this animal never gives up responding or tries *not* responding. But this paradigm is too familiar to require further discussion here.

Less familiar but even more clearly opposed to the learned-helplessness model are studies in which animals learn some response to escape or avoid shock but are later exposed to shock contingent upon that same response. Here the original shock contingency is removed but coping responses are now punished instead. This is the paradigm of "vicious-circle learning," in which punished escape or avoidance responses are maintained by at least some subjects in a "superstitious" fashion long after they have become directly counterproductive (Brown, 1969; Fowler, 1971; Melvin, 1971; Migler, 1963; Mowrer, 1947; Solomon, Kamin, & Wynne, 1953). Here the animal gets the worst of both worlds; he not only suffers the primary, punishing stimulation (shock), but his emotional arousal (fear, frustration) is maintained as well, instead of being given up or inhibited as in learned helplessness. The animal in this position may even suffer pathological psychosomatic effects, such as ulcers, as a result (Weiss, 1971).

In any case, the unusual persistence of punished avoidance behavior looks as strange to the observer who does not know the animal's prior reinforcement history as does learned-helpless behavior. Bandura (1969) made the following observation regarding an unpublished study by Sandler and Quagliano in which monkeys first learned to avoid shock by lever pressing but were later punished with shock for doing so.

After the avoided shock was completely discontinued but lever-pressing responses (which had now become objectively functionless) still produced painful consequences, the animals continued to punish themselves

unnecessarily with shock intensities that they had previously worked hard to avoid. Anyone observing the needless self-injurious behavior of these animals without knowledge of their prior learning history would undoubtedly be baffled by their tenacious "masochism." (p. 297)

Kimmel (1971) has noted the parallel of vicious-circle learning with the learned-helplessness paradigm insofar as both involve trapping the animal in a change of environmental contingencies that is not discriminated by the victim. The animal that has learned helplessness fails to try when the situation now dictates that he should, and the animal that has learned to try often fails to give up when that becomes the more adaptive course.

The persistence of instrumentally ineffective coping behavior thus constitutes an experimental converse of learned helplessness and may perhaps be termed "learned restlessness." In these terms, a learned-restless individual is one who persists in futile if not self-defeating attempts to escape a feared event. Emotional arousal in the form of anxiety and/or frustration is naturally prominent in learned restlessness, just as low arousal and depression are emotional concomitants of learned helplessness. Literally, the victim of learned restlessness gets no rest, not even the rest of resignation.

The connotations of "learned restlessness" also fit the clinical picture of many clients who in different ways are trying too hard to escape or avoid some aversive condition through voluntary, instrumental behavior. In such cases, some degree of learned helplessness might actually prove more adaptive in the long run.

TREATMENT IMPLICATIONS: THE VIRTUES OF GIVING UP

Virtually every client comes to therapy seeking to escape or avoid some aversive condition. If the condition is not literally painful, as it is in many psychosomatic problems, it is psychologically distressing, as with anxiety problems, depression, insomnia, stuttering, sexual dysfunction, and many other difficulties. Occasionally, a presenting problem may be phrased in terms of positive goals to be achieved, though even here a formulation of escape from the present, undesired condition could equally well apply. The client may have come to feel more or less helpless insofar as he is now

unable to control the aversive situation. But chances are that he has previously tried several coping devices or responses, and seeking therapeutic help is another such response.

It seems unlikely that a professional helper would encourage this person to give up the search for help, or the search for an effective coping strategy. But if the therapist believed that a perfectly and permanently effective coping strategy of instrumental response was simply not available in this case, or that the problem was being maintained by the client's own emotional and instrumental reactions to the condition itself, then a strategy of encouraging the client to give up deliberate responding in this respect might seem more plausible.

Sternbach and Rusk (1973) have used an approach of this kind in their clinical work with psychosomatic pain patients. Sternbach and Rusk simply refused to focus their therapeutic efforts on pain complaints or pain relief per se, refocusing their patients' attention instead on formulating and working toward positive social, vocational, or avocational goals that did not in fact have to be contingent on prior pain relief. In a sense, this approach encouraged the patient to become less restless regarding his pain and less helpless regarding external sources of potential gratification.

This approach has much in common with Frankl's (1975) dereflection. Here too attention is refocused away from goals that often defy deliberate attainment, such as sexual fulfillment, in the belief that not trying so hard may be the surer path to such ends. Masters and Johnson's (1970) sensate focus exercise also encourages sexually dysfunctional couples to temporarily give up their efforts to achieve orgasmic success (or avoid failure) while focusing on other aspects of sexual pleasure instead.

This might be a fairly obvious clinical course when the client is escaping or seeking to escape a condition that is intrinsically not so aversive as the client believes it to be. Rational-emotive therapists (Ellis, 1962) often deal with exaggerated social fears by using logical argument to undercut or "decatrophize" them. Counterproductive efforts to avoid such experiences may then be given up. For example, the victim of "shy penis" may be convinced that failure to perform at a urinal will meet with no great aversive consequences and can thus be risked without the usual avoidance behavior.

Indeed, it might sometimes be appropriate to assure the client that he *will* experience the feared failure, at least for some time, and that he should learn to accept that eventuality with less anxiety or struggle. Reduced anticipatory anxiety may, of course, be a necessary step toward later being able to perform the desired response. A similar approach might be adopted toward insomnia and many other conditions where a giving up of all hope of voluntary control might undercut anticipatory anxiety and soon permit more normal, albeit "involuntary" functioning to occur. It is easy to see why explicit instruction in learned helplessness has rarely been attempted or even considered, but it would surely warrant further clinical test.

More commonly employed are various paradoxical techniques which actually prescribe the feared or unwanted condition. These include negative practice, paradoxical intention, implosion, flooding, and several others (Raskin & Klein, 1976). These techniques all have their own theoretical rationales, but they have one thing in common: They force the client to approach or produce the feared event, in fantasy or *in vivo*. As Haley (1963) has suggested, a paradoxical acceptance of symptoms may also occur, although less explicitly, in more conventional therapies, including psychoanalysis, client-centered therapy, and some directive approaches.

Perhaps the key element in all such paradoxical approaches is that the client may give up his previous, counterproductive struggle to escape the undesired condition. The effort to actually produce the feared event or fantasy, as in paradoxical intention or flooding, may not be the active ingredient in such treatments, except insofar as trying to approach is one way of giving up the counterproductive effort to avoid. But if this is true, simple "giving-up" approaches might prove to be as effective with some problems as prescriptive, "trying-the-opposite" methods. Such giving-up approaches would include Frankl's dereflection and the other previously mentioned strategies that divert the client's attention and effort from a feared or avoided event.

Whatever the specific approach, a voluntary choice to relinquish any deliberate escape/avoidance efforts and to produce or at least risk the aversive event instead may itself encourage a perception of the event as less catastrophic

than previously assumed: "I wouldn't choose to risk this event if it were really so terrible." After all, the opposite choice to avoid or escape a painful condition is likely to increase its perceived aversiveness: "I wouldn't choose to avoid this event if it weren't pretty terrible." Bandler, Madaras, and Bem (1968) and Corah and Boffa (1970) have actually confirmed experimentally that an aversive stimulus is perceived to be less unpleasant when it is voluntarily endured than when it is voluntarily terminated. Of course, direct experience with a previously avoided but now permitted event, if indeed it occurs, may further disconfirm any unduly catastrophic expectations regarding the consequences of accepting it.

The experimental analogue of this treatment approach in the case of a learned-restless animal would probably be forcible response prevention. Here again, the parallel contrast with learned helplessness is clear and illuminating. The learned-helpless animal is forcibly dragged to the safe side of a shuttle box until it finally learns to escape or avoid shock by responding on its own (Seligman, Maier, & Geer, 1968); the learned-restless animal may have to be restrained in the original shock compartment until it learns that avoidance responding is no longer functional (Solomon, Kamin, & Wynne, 1953).

DIAGNOSTIC IMPLICATIONS: DIFFERENTIATING HELPLESSNESS AND RESTLESSNESS

If diametrically opposed treatment approaches are appropriate for the two kinds of maladaptive behavior discussed here, the clinical diagnosis of any presented problem becomes critical in this respect. Has a given client given up where he should try, or is he trying too hard where he should give up? Giving up the anxious effort to sleep might be a solution for an insomniac, but giving up any hope of persuading a roommate to turn down the stereo after midnight might be part of a problem for an unassertive individual. So where *is* trying normally more adaptive than not trying, and vice versa?

The answer to this question is not easily established. A first approximation would be to follow traditional voluntary/involuntary or central/autonomic distinctions. Adaptive control of the external environment is most often

accomplished through muscular (skeletal) responses under voluntary control. On the other hand, many internal, autonomically mediated functions are generally not under voluntary control, certainly not under complete conscious or deliberate control. Thus, many emotional and psychophysiological problems, such as anxiety, depression, insomnia, tension headache, and sexual dysfunction, are aberrations of normally involuntary processes.

It might be argued that the solution to such problems lies in extending the individual's voluntary self-control to encompass them, using novel therapeutic means if necessary to do so. In many situations, deliberate relaxation is used as an antidote for anxiety, and thus an involuntary emotional reaction is supposedly displaced by voluntary physical responses. But then not all clients can relax in this manner, perhaps especially if they try anxiously to do so, as in the following example attributed to David L. Norris by Frankl (1975):

Steve S. was actively trying to relax. The electromyograph meter which I use in my research read constantly at a high level (50 micro-amperes) until I told him that he probably would never be able to learn to relax and should resign himself to the fact that he would always be tense. A few minutes later Steve S. stated, "Oh hell, I give up," at which time the meter reading immediately dropped to a low level (10 micro-amperes) with such speed that I thought the unit had become disconnected. For the succeeding sessions Steve S. was successful because he was *not* trying to relax. (p. 236; emphasis in the original)

Of course, methods such as Jacobson's (1938) progressive relaxation sometimes circumvent this problem by incorporating their own paradoxical elements: Relaxation is not achieved by simple command or direct effort, but by deliberately tensing muscle groups (an available voluntary response) and then "letting go" of that muscle tension.

Biofeedback is assumed to offer a further extension of voluntary self-control over normally involuntary responses, but here again overmotivated individuals are unlikely to learn how to reliably produce responses generally associated with a state of low effort or relaxation. It is not surprising, then, that even as subjects learn to deliberately increase their alpha levels over several feedback sessions, these alpha levels may remain below those recorded in rest periods between feedback sessions (Lynch, Paskewitz, & Orne, 1974).

But the important question in choosing a treatment strategy may not be whether a response can theoretically be brought under voluntary self-control, but whether it is normally under voluntary control. Falling asleep may sometimes be modified deliberately by the use of certain medications, but it is normally (and always to some extent) an involuntary response. When such responses go awry, the clinician must certainly consider whether deliberate coping efforts are really a long-term solution, or only part of the problem.

The trying-too-hard syndrome may also be found where complex motor coordination is required, as in athletic performance (Gallwey, 1974). This behavior is a mix of voluntary and involuntary responding; some degree of effort is naturally required. However, as the finely coordinated muscle responses demanded by the game are learned, they become less deliberate and increasingly automatic. Then, like other involuntary behaviors, performance may suffer if it is made overly self-conscious or deliberate (Kimble & Perlmutter, 1970). Thus, beginners may be more likely to suffer problems of giving up, while pros may be more vulnerable to trying too hard.

Of more clinical relevance is the case of stuttering. Adult speech is a complex but largely automatic behavior that is naturally disrupted by an excess of intention or deliberation. Most stuttering conforms quite clearly to the learned-restlessness model, even if some stutterers exhibit learned helplessness or depressive features in other areas of adjustment. Their continued struggle to speak fluently or to avoid dysfluency maintains the vicious circle of disordered speech (Bloodstein, 1958).

The pattern is not so clear in cognitive or academic achievement problems. It may be recalled that Dweck (1975) selected a group of young students identified as learned helpless, i.e., as prone to give up in the face of failure, and improved their performance by motivating them to try harder. Yet some students fail through trying too hard, as seen in many older students with test anxiety or study problems. A given student's achievement problem may actually prove to be a rather complex mix or vicious cycle of trying too hard and giving up, or it may move from a stage of anxiety and maladaptive effort to a later burned-out stage of exhaustion and depression (Thweatt, 1976).

These examples highlight the clinical care that may be necessary if learned-helpless reactions and learned-restless reactions are to be differentiated and diagnosed correctly. But this task may be the most difficult where one pattern is superimposed upon another in a compounding of ingrown, self-exacerbating reactions to the initial difficulty. Conditions such as anxiety and depression are commonly viewed as relatively simple and unitary reactions to external events. For example, depression follows from the perception or belief that significant environmental events are independent of voluntary control (Seligman, 1975). But as Seligman acknowledges in passing, depression itself is an aversive condition that the individual may (or may not) try to escape.

Theoretically, the experience of depression may become the stimulus for either helpless or restless reactions. If the otherwise helpless and depressed individual is greatly ashamed or afraid of his depression, he may indeed cast about anxiously for relief from that condition. This is consistent with the observation that depression and anxiety are often entangled to different degrees (Miller, Seligman, & Kurlander, 1975). On the other hand, a person could conceivably get (more) depressed that they are depressed or (more) anxious that they are anxious. Evans (1972) and Eysenck (1968) have both offered theoretical models of how the latter compounding of anxiety may occur.

Secondary reactions to the condition itself help to explain why many anxiety and depression states seem so loosely connected to precipitating or controlling environmental events. Indeed, such reactions may be of no less importance than the initial reaction, since they can maintain or compound an otherwise relatively benign condition. Furthermore, the nature of these secondary reactions may dictate the point and direction of maximum therapeutic leverage, at least initially.

Take, for example, an individual who is anxious that he is depressed. A simple treatment to alleviate the individual's depression would tend to confirm the person's learned-restless response to the depression *per se*. Perhaps more appropriate, at least at first, would be a paradoxical technique prescribing depression or otherwise undercutting the individual's anxious efforts to escape it. This strategy appears all the more reasonable if

indeed much reactive depression tends to lift simply with time—as long as secondary reactions do not perpetuate it. Thus, even some depressed patients might benefit from learning increased helplessness, at least with regard to their depression.

Sound treatment decisions therefore require careful clinical discrimination between helplessness and restlessness, and between situations where one or the other of these is the more adaptive or maladaptive response. But the therapist may also need to help some clients improve their own discrimination of these different kinds of reactions and situations. Otherwise, a successful experience with either reaction in one situation may encourage the client to generalize the response indiscriminately and inappropriately to other situations. Seligman (1975) has actually recommended maximum exposure to controllable events as a preventative measure to immunize individuals against later helplessness in different circumstances. This suggestion is clearly inappropriate if the individual does not also learn to distinguish circumstances where helplessness might be the more adaptive course.

CONCLUSION

The greatest value of the learned-helplessness model is not that it subsumes all of the most important clinical problems—it does not—but that its conceptual mapping of one area provides a figure illuminating the ground of other problem areas, where contrasting formulations are more appropriate and badly needed. The concept of learned restlessness should in turn help to set boundaries preventing the overextension of the earlier model. Together these two complementary notions should help to map a broad range of human behavior problems in theoretically, experimentally, and clinically useful terms.

The present discussion has probably raised and left unanswered many questions as to how therapeutic efforts should be guided in the case of learned restlessness. A detailed discussion of clinical practice in this area cannot be attempted here, though some suggestions follow directly from the diagnostic and treatment examples cited earlier. One thing is clear: Any therapeutic application of instructed helplessness as an antidote for learned restlessness will have a

paradoxical appearance, whatever specific form it takes.

Even where the clinical potential of giving up is apparent to the therapist in a given case, the biggest difficulty may lie in how to present this alternative to a client who is highly motivated to escape or otherwise control an unwanted condition. The clinician will certainly have to minimize the likelihood of the client angrily rejecting this course or, at the other extreme, overgeneralizing the hopelessness of the situation and giving in to a genuinely depressive reaction.

Here another decision is critical: Should giving up be presented as a course of genuine resignation or as a more subtle way to try to improve the situation? This is the difference between "giving up trying" and "trying giving up," and most paradoxical treatments may be presented to the client in either light. Of course, the second formulation would generally be more palatable to the restless client. On the other hand, this does not really break the pattern of restless responding, since even a response of passivity may be attempted actively and deliberately as a coping device. The learned-restlessness model would tend to suggest that genuine resignation may often be more helpful than feigned resignation. But this critical point certainly requires clinical and experimental test.

Of course, the treatment strategy outlined here might also prove unpalatable to most clinicians, at least at first glance. Clinicians prefer to see and present themselves as helpers of the helpless and are unlikely to countenance giving up, in themselves or their clients. But the temptation to always try to fulfill the client's search for an instrumental coping device is not only built into the clinician's helping role; it is also reinforced by the growing behavioral emphasis on self-control technologies and treatments, some of which seek to extend the individual's voluntary control over processes which are normally involuntary.

Sometimes this is clearly possible and even the best course. But the implicit or explicit assumption that this is always possible and always the best course grows less from sound clinical observation than from a broader clinical and cultural view of voluntary effort and control as the solution to human problems. It is this broader bias that makes more and better coping the appealing goal for clients and clinicians

alike and that also accounts, in part, for the immediate appeal of the learned-helplessness model and its therapeutic message that trying harder helps.

The learned-restlessness model, on the other hand, seems almost counterintuitive, at least to a work-oriented Western mind. In some Eastern traditions, especially Zen Buddhism, giving up is more readily recognized as an adaptive course in many situations (Watts, 1957). After all, even the ultimate "goal" of enlightenment is said to elude deliberate striving—or deliberate nonstriving. But hopefully some clients and clinicians could escape the trap of trying too hard, with regard to some of their personal and clinical objectives, by selectively and appropriately giving up.

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