THE
TECHNIQUE OF
PSYCHOTHERAPY

Lewis R. Wolberg

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FOURTH EDITION

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Preface to the Fourth Edition

What inspired a fourth edition of this book were a number of important developments in mental health that are having an impact on contemporary psychotherapeutic practice. Among these are (1) the availability of new psychopharmacological agents that are singularly effective for symptoms of anxiety, panic, obsessive reactions, depression, mania and schizophrenia; (2) a greater use of short-term approaches not only because third party payers have placed limitations on the number of reimbursable sessions, but also because brief therapy has established its validity beyond traditional limited goals; (3) a shift toward the sicker end of the spectrum of patients seeking help in outpatient clinics and private practice due to the reduction of inpatient facilities, and emphasis on short-term hospitalization, deinstitutionalization, and many other factors; (4) the continuing development of creative symptom-oriented and problem-solving, supportive, behavioral, milieu and outreach approaches as well as family, marital, and group treatments; (5) greater efforts toward more scientific treatment planning with emphasis on differential therapeutics; (6) expanding experimentation in reconstructive therapy through methods oriented around object relations theory and self-psychology, which have led to changes in the way the more severe personality problems are being conceptualized.

While the field of psychotherapy is virtually bursting with luxuriant techniques and expanding dimensions of application, little attempt has been made to integrate the information that we have available today. This poses a problem for students learning ways of managing emotional illness. Added to their befuddlement is the persistent fervor of some established groups to maintain ideological purity. Sugary pieties about the need for unity have not succeeded in halting adversarial verbal dueling.

What we have come to realize more and more is that psychotherapy is not a homogeneous operation, being burdened by many contradictory variables. It is not only the actual interventions that determine the outcome, but also the degree to which the

patient accepts and utilizes them, the skill of the therapist, and the climate of the therapeutic alliance. Countless snags and resistances arise in treatment that can sabotage the efforts of the most dedicated therapists and best motivated patients. And many non-specific factors influence therapeutic results for the good and bad. Yet there is a possibility that all good therapists operate in somewhat similar ways if they are to achieve worthwhile results, and this is irrespective of the theories they espouse and the explanations they offer of what they do.

When the original edition of this book was published in 1954, partial solutions for some of the quandaries in psychotherapy were offered. I had acquired a bulk of data of how therapists with different orientations conducted psychotherapy that registered a positive effect on their patients. The locus of this information was a community health center in New York City, the Postgraduate Center for Mental Health, which my wife, a psychiatric social worker and clinical psychologist, and I founded in 1945 under the name The New York Consultation Center. The Center provided a laboratory for study, and the relatively large numbers of patients being treated served as a rich resource for empirical observations. Our case load in the early days consisted of a sizeable number of civilian patients as well as veterans of World War II who had come back from the European and Asian theaters and who were sent to us for treatment as a contract clinic of the Veterans Administration. In a short while we were deluged with veterans being discharged from the service, and to treat this mass of emotionally disturbed patients as well as our habitual caseload of civilians in need of help, we had to enlarge our staff greatly.

World War II having ended, the army medical officers with psychiatric training were going back into private practice. Drawing on this group, we developed a large staff of psychiatrists and a few clinical psychologists, all of whom had been trained in diverse methods of psychotherapy and belonged to practically every school of psychological thought existing at the time. Although their theoretical belief systems varied widely, and their focus on pathology differed, we soon discovered that there were those who obtained good results and those who did not. We tried to substantiate what it was that successful therapists did.

Our initial hypothesis was that good therapists, irrespective of discipline, established rapid rapport with their patients, displaying empathy in dealing with expressed emotion. They developed a theory about the patient's illness and around this formulated a treatment plan involving the patient in at least some of the decision making. They took the time to resolve unreasonable expectations and to enhance motivation for therapy. They adapted their techniques to the needs of each patient, e.g. utilization of structured approaches with confused and helpless patients and less structured ones with more highly organized individuals. They did not hesitate to employ confrontation with patients with whom they had a good relationship in order to create a better learning medium through affect arousal. They worked within the framework of the patient's belief systems where possible, but when these interfered with treatment they tactfully attempted to alter distorted cognitions. Analytically oriented therapists did not hesitate to work toward symptom alleviation where symptoms were self-defeating, diverting the patient from self-observation. Aware of transferential projections, they controlled their own untoward countertransferential feelings. The more intuitive therapists employed their personal feelings to divine what was on the patient's mind, conscious and unconscious. They aggressively dealt with evasions and resistances, recognizing the carry-over of defenses and value distortions from the past. They provided reinforcements for constructive behavior. Finally, where the goal was not personality reconstruction, which was most often the case, they terminated therapy at a point where the patient could reasonably manage on his or her own in order to avoid a therapeutic stalemate in dependency. All of these maneuvers were done irrespective of cherished theories.

As the Center expanded, it developed an organized interdisciplinary training program in psychotherapy and psychoanalysis, obtaining a charter for this from the Board of Regents of the State of New York. It became one of the largest outpatient continuous treatment centers in the country, servicing a steady caseload of over 1600 patients in its Adult Clinic, Clinic for Children and Adolescents, Social Rehabilitation Clinic, Group Therapy Clinic, Family Therapy Clinic and Clinic for Alcoholism. Its clinics were licensed by the New York State Department of Mental Hygiene and approved by the Joint Commission on Accreditation of Psychiatric Facilities of the AMA. Apart from the

Fellowship program in psychotherapy and psychoanalysis, training programs for qualified personnel were developed within each of the clinics in child psychiatry, analytic group therapy, family therapy, supervision of the therapeutic process, and alcoholism. The Department of Community Services and Education developed a counseling service and a training program in counseling for social workers, clergymen, teachers, rehabilitation workers, and other personnel dealing with problems encountered in their work. A two-year part-time mental health consultation course for certified psychotherapists enabled the servicing of over 600 agencies, institutions, and industrial groups in the community. As part of public education an ongoing lecture series was developed for the general public. Continuing education programs for mental health professionals rounded out the activities of the Center.

All of the foregoing activities enabled detailed observation of aspects related to the practice of psychotherapy and, coupled with studies of cases in my own private practice, inspired later editions of this book.

Because of the wide range of its coverage and step-by-step delineation of techniques, the book became known as the "cookbook of psychotherapy," and was also referred to as a treatment manual. However, it was never intended as either a "cookbook" or treatment manual with standard recipes of operation. Too many variables exist in the continuum of patient-therapist-environment to allow for universal formulas applicable for all patients and therapists under differing environmental circumstances. Although the methods described in the book have been tested, they are best utilized as guidelines to be altered to the needs of individual patients and the styles and personalities of practicing therapists.

Throughout the book allusions have been made to a dynamic way of thinking about what goes on in psychotherapy. The reason for this is that even though the methods employed by the therapist may be non-analytic, one sometimes cannot escape intrapsychic interferences such as those that issue out of the pool of early developmental conditionings. The form of these interferences are embodied in transferential corruptions and manifold resistances, identification of which would seem to fall within the premises of

psychoanalysis. Although in the past few decades we have witnessed the erosion of psychoanalysis as a preferred method of treatment, this has not lessened its value in understanding operative forces in psychotherapy. "Psychoanalytically oriented psychotherapy" accordingly has become the most common form of psychotherapy in use today.

The psychotherapist who has not been trained as an analyst may still be able to identify transference and resistance, and one may recognize some countertransferential responses within oneself. In utilizing psychoanalytic concepts in treatment, as in the identification and resolution of resistance, the therapist may still be effective even though not practicing formal psychoanalysis. Since over 90 percent of patients cannot afford, or tolerate, or constructively utilize intensive psychoanalysis, psychotherapy will constitute the best approach for most patients. Blending dynamics with a skilled use of techniques, the therapist may enable the patient, not only to achieve symptomatic relief, but also to gain sufficient self-understanding to effectuate some important reconstructive personality changes. The present volumes detail methods through which such changes may be accomplished.

Psychotherapy," to Thieme-Stratton "The Handbook of Short-Term Psychotherapy, to Grune & Stratton "Short-Term Psychotherapy" and "The Dynamics of Personality." Finally thanks are due my secretary, Jeannine Matthews, for her help with the physical preparation of the manuscript.

Part I. The Scope, Types, and General Principles of Psychotherapy

1
What Is Psychotherapy?

Few words in the lexicon of the mental health field are as ambiguous as the term *psychotherapy.* It is loosely employed to connote, among other meanings, helping, treating, advising, guiding, educating, and even influencing. Definitions of psychotherapy are often bridled to fields of disciplinary operation, e.g., psychiatry, psychology, casework, etc., sanctuaries for such characterizations being sought in specialized societies. DifFuseness, in definition, has converted the arena of psychotherapy into a swamp of murky ideas, fostering many divergent theories and techniques. Yet a brief and precise description of therapy is important if no more than to circumscribe boundaries of operation and for purposes of hypothetical construction and empirical study. A comprehensive working definition might be the following:

Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behavior, and (3) promoting positive personality growth and development.

This formulation requires additional elaboration.

Psychotherapy is the treatment. No matter how much we attempt to dilute what we do in psychotherapy, it constitutes a form of treatment. Such terms as *reeducation, helping process,* and *guidance* are merely descriptive of what happens in the course of treatment and do not really disguise the therapeutic nature of the process. Forms of intervention other than therapy do exist in the mental health field and will be described later.

Psychological means. Psychotherapy is a generic term covering the entire spectrum of psychological treatment methods. These range from designed maneuvers of the therapist-patient relationship to indoctrinations fashioned to change value systems, to

tactics aimed at intrapsychic processes, and to conditioning techniques that attempt to alter neural mechanisms. The repertoire of strategies is thus legion, and formats are varied, e.g., individuals, couples, and groups. They are all, nevertheless, dependent upon the establishment of adequate communication, verbal and nonverbal. Excluded are such modalities as somatic therapies (drugs, convulsive therapy, surgery, etc.) and "trial action" therapies such as occupational therapy, dance therapy, music therapy, psychodrama, etc. that, though psychotherapeutic in effect, are not, strictly speaking, forms of psychotherapy.

Problems of an emotional nature. Emotional problems are diverse, influencing every facet of human functioning. They are manifest in distortions in the individual's psychic, somatic, interpersonal, and community life. Manifestations of emotional illness are thus multiple, involving the total human being. In view of this totality of disturbance, it is arbitrary and unsound to dissociate psychic from interpersonal, social, and psycho-physiological difficulties, aspects of which are usually concurrent, though not always obvious.

A trained person. In search of relief, the individual is apt to involve oneself in a relationship with a friend or authority. The motivations that prompt such a relationship are disabling symptoms or a realization that one's happiness and productivity are being sabotaged by inner forces that one is neither able to understand nor to control. Sometimes the consequences of this relationship are registered in a restoration of homeostasis, a product of healing forces liberated by the helping process. At other times, particularly when attempts are made to handle the sufferer's emotional turmoil in depth, the relationship may become disastrous to both participants. Dealing most adequately with an emotional problem requires a high degree of skill that may best be acquired through extensive postgraduate training and experience.

Deliberately establishing a professional relationship. The relationship, the core of the therapeutic process, is deliberately planned and nurtured by the therapist. Unlike nonprofessional relationships, which are part of the social nature of man, the therapeutic

relationship is a collaborative undertaking, started and maintained on a professional level toward specific therapeutic objectives. More than one therapist (co-therapist, multiple therapists) may work together.

The patient. An individual in psychotherapy receiving treatment is best called a patient rather than some other designation such as a client. The therapist may relate capably to more than one patient during a session, as in marital or group therapy.

The object is removing existing symptoms. A prime goal in therapy is to eliminate the patient's suffering as well as to remove the handicaps imposed by symptoms.

Modifying existing symptoms. Despite our wish for complete relief, certain circumstances may militate against this objective. Chief deterrents are inadequate motivation, diminutive ego strength,[1] and limitations in the patient's available time or finances. These will impose restrictions on the extent of help that can be rendered and make for modification rather than cure of the patient's symptoms.

Retarding existing symptoms. There are some malignant forms of emotional illness, such as certain fulminating schizophrenic and organic brain disorders, in which psychotherapy, no matter how adroitly applied, serves merely to delay an inevitable deteriorative process. This palliative effect is eminently worthwhile, however, often helping to preserve the patient's contact with reality.

Mediating disturbed patterns of behavior. The recognition in recent years that many occupational, educational, marital, interpersonal, and social problems are emotionally inspired has extended the use of psychotherapy into fields hitherto considered provinces of the psychologist, teacher, sociologist, religious leader, and lawmaker. Realization that the character structure is involved in all emotional illness has broadened the objectives of psychotherapy from mere symptom relief or removal to correction of disturbed interpersonal patterns and relationships.

Promoting positive personality growth and development. The final use of

psychotherapy is as a vehicle for personality maturation. This has introduced a new dimension into the field of psychotherapy—a dimension that deals, on the one hand, with problems of immaturity of the so-called normal person and, on the other, with characterologic difficulties associated with inhibited growth previously considered inaccessible to treatment. Here psychotherapy aims at a resolution of blocks in psychosocial development in order that the individual may aspire to a more complete creative self-fulfillment, more productive attitudes toward life, and more gratifying relationships with people. The goals of psychotherapy thus extend from the limited objective of helping to control symptoms to the liberation of the rich resources of the human mind from neurotic obstructions that thwart its purpose and stunt its growth.

IS THE MEDICAL MODEL OUTMODED?

Therapists who venture into rendering essential human services in mental health will inevitably find that they must penetrate into zones alien to the medical model. Of necessity, they will have to adapt to concepts and interventions that are more related to the social than to the biological sciences. For example, if one seeks to engage in preventive work or in some forms of short-term therapy, it is necessary to become familiar with the dynamics of social systems and the world of learning and rehabilitative procedures. The information one already possesses of biological and psychological systems will, of course, be fed into these areas in a way that adapts one to the exigencies with which the therapist must deal. Unless the therapist is willing to restrict operations to the handling of a narrow band of problems, models of helping will have to be employed that go beyond training in traditional psychotherapeutic education.

Whether we need to call such types of helping psychotherapy is a moot question. Shall we restrict the word to the treatment of outright emotional illness, or shall we extend it to dealing with behavioral and adjustment problems that are not conspicuously pathological? A good deal of the confusion about psychotherapy stems from the fact that over the years psychological help has been extended to larger and larger groups of people with increasingly diverse complaints. These range from physiological disruptions of

anxiety involving almost any organ, to depressive manifestations, to phobias and compulsions, to psychotic dislocations, to habit disorders, to behavioral aberrations, to interpersonal difficulties, to marital and family disturbances, to educational and work blockages, to sexual malfunctions, to addictions, and to a host of other vexations that can plague human beings. The models most appropriate for the understanding of and the dealing with this plethora of troubles must be spread over a number of fields. Indeed, in the course of helping the same individual we may have to apply information from medical, sociological, educational, rehabilitative, and other sources.

In a way, the term psychotherapy is a limiting one because literally it means *treatment* of mental or nervous disorders. This suggests a restrictive medical model. To encompass all the troubles for which psychological help is sought under the term psychotherapy will necessitate a borrowing from theories and stratagems more appropriate to structures other than medical ones, such as sociological or rehabilitative and learning models. Functionally, this is what has happened over the years, often with protests from professionals in disciplines of sociology, anthropology, psychology, and education, who resent encroachment of their domains. Actually, psychotherapy should not be regarded as a cormorant intent on swallowing diverse disciplines. It is a *body of procedures* that overlap techniques used in counseling, social casework, education, and rehabilitation, even though its goals may be different.

There are advantages and disadvantages to the medical model per se; but, on the whole, it has a proven utility for a bulk of problems seen by the psychotherapist. It is possible that Third Force psychology embracing humanistic aims, as well as the human growth potential movement, may some day provide a viable alternative. As matters stand today, we have not yet achieved this goal. Substituting for the concept of "mental health-mental illness," "different modes of coping with life" does not necessarily lead to greater clarification of the many problems with which we have to deal in psychotherapy.

The fact that therapists work within the orbit of the medical model does not mean that they must propel themselves into an absurdly authoritative position, thus

perpetuating a parent-child relationship. Authoritativeness is more a product of the personality of the individual therapist than the model that an individual pursues in practice. Nor does it follow that patients need be depreciated by being labeled "sick" or "mentally ill," thus pinning on them awkward pathological labels. Nor, if we adopt the medical model, need they be deprived of their freedom or liberty, nor robbed of the option of deciding for themselves their suitability for therapy, nor forced to sacrifice responsibility for their own destiny and the right to their own sense of values, nor prevented from being active participants in their own treatment. The medical model does not necessarily have to restrict the focus purely on disease. Expanded psychological growth and development are within its purview, much as physical hygiene is within the scope of good medical practice.

Merely because our present nosological systems are not entirely satisfactory does not sanction the abandonment of diagnosis that is an essential aspect of the medical model. A proper diagnosis can be helpful to the institution of a rational therapeutic program. For example, violence may appear as a symptom of a variety of causes. It may be a simple behavior problem nurtured by situational dislocations. It may be a habitual ego-syntonic display in a psychopathic personality. It may be a manifestation of failing repressive control in a borderline patient. It may be the expression of a delusional system in a schizophrenic. Or it may be a symptom of the manic phase of a bipolar disorder. Unless a correct diagnosis is established, we may fail miserably in providing effective help. Thus, elimination of violence due to environmental difficulties can be helpful in simple behavioral problems, but it will usually be ineffective in the other conditions cited. Anyone who has witnessed the ameliorating effect of neuroleptic medication in schizophrenia and of lithium in manic disorders will attest to the value of a diagnostic survey. Violence in a borderline case will require special psychotherapeutic management that might not be applicable to other conditions. Diagnosis can be as important in psychological as in physical problems.

On the other hand, a disadvantage fostered by the medical model is that it concerns itself with techniques of therapeutic intervention that are sometimes dissociated from the

daily life of the individual. Diagnosis and pathology, legitimate as they may be in disease areas, are sometimes not applicable to certain behavioral zones. To classify these as normal and abnormal or as symptoms and defenses neglects considerations of background, culture, and life style, which require a different perspective. Moreover, while the medical model has in the past sponsored a limited training perspective, it has rarely equipped trainees to deal with many behavioral difficulties that are disruptive to the individual and the community.

It would seem appropriate then in a comprehensive training program to expand the education of psychotherapists toward a wider understanding of the behavioral sciences and toward the use of a broad range of techniques additional to the conventional psychotherapeutic procedures. Under these circumstances, the therapists would be better equipped to move beyond the boundaries of the medical model toward a more pragmatic commitment to the spectrum of problems challenging them in their practices.

PSYCHOTHERAPY VERSUS PSYCHOANALYSIS

According to Webster's New Universal Unabridged Dictionary psychotherapy connotes "the application of the various forms of mental treatment, as hypnosis, suggestion, psychoanalysis, etc., to nervous and mental disorders." This generic definition is, in mental health circles, supplemented by a more specific usage of the term in relation to goals and methods of treatment as contrasted with psychoanalysis.

Psychoanalysis aims at a systematic and total resolution of unconscious conflicts with structural alteration of defenses, and the character organization. Psychotherapy is less ambitious, reaching for the practical and less arduously achieved goals of resolving some conflicts, modifying others, and even retaining and strengthening certain neurotic defenses that permit individuals to contain their anxiety and to function. This does not necessarily make psychoanalysis a better kind of treatment than psychotherapy or vice versa. Some patients fail miserably at one and do quite well with the other. The key issue is the proper selection of cases for the two different techniques. Patients exposed to formal analysis, centered around evolvement of a transference neurosis and its resolution

through interpretation, will require so many qualifications in terms of personality characteristics, motivation, available time, finances, etc. that they are relatively few in number. Most patients, on the other hand, will qualify for psychotherapy.

Accepting the fact that psychoanalysis has provided us with concepts and techniques that can lead to the recognition and exposure of conflicts that operate beyond the zone of awareness, what is of concern to clinicians is how useful this information is in treating and resolving emotional problems. Most students are no longer willing to accept psychological theories on the basis of faith or literary elegance. Some are relatively unimpressed with both the pronouncements and achievements of psychoanalysis, moving toward psychotherapy with its active approaches directed at symptom relief and problem-solving. Among the expressed doubts are (1) that psychoanalysis is the best treatment for most problems of an emotional nature; (2) that unconscious conflict is necessarily at the root of all emotional difficulties; (3) that every communication of the patient to the therapist during a session has an unconscious meaning, and that through free association one eventually can reach this repudiated core; (4) that verbal unburdening has a greater impact on the individual than behavioral solutions to a problem; (5) that supportive and educational interventions are temporary and inevitably lead to greater avoidance and repression; (6) that an adequate cure of a neurosis necessitates its duplication in treatment through the relationship with the therapist (transference); (7) that psychoanalytic theories can be validated through either research or careful clinical inquiry; and (8) that psychoanalysis is the only method through which reconstructive change can be achieved.

The upshot of these questions is that students in progressively larger numbers are doubting the clinical usefulness of psychoanalysis and the need for personal training in psychoanalytic techniques, with the sacrifices of time, energy, and money that disciplined analytic studies would entail.

More insidiously dynamic theory, which is useful in understanding psychopathology, is downgraded and credited with little clinical utility and therefore considered not worthy

of study. This is unfortunate since insight into anachronistic coping patterns, so essential in reconstructive treatment, will draw upon certain psychoanalytic concepts such as unconscious ideation, repression, resistance, and the survival in the present of needs and defenses rooted in the development past.

Among some psychoanalysts, psychotherapy is sometimes employed to distinguish a wide variety of superficial supportive and reeducative procedures aimed at more conscious mental processes, from psychoanalysis that supports techniques of "depth therapy" focused on the unconscious. While utilizing methodologies for expediency's sake, which may be condoned under certain circumstances, they consider it a baser metal than the pure gold of analysis. The latter alone of all therapies is targeted at the surviving nucleus of emotional illness in the residual "infantile neurosis." Psychoanalysis, they say, offers itself as a technique that may, in the cases where it can be successfully employed, promote maturity by eliminating the infantile neurosis as a source of emotional pollution. Psychotherapy is more modest in its goals. It can help to strengthen the individual's defenses so as to prevent the infantile neurosis from interfering too much with a reality adaptation. It can also provide guidelines for more competent coping with everyday stress. In this way the individual is better able to live with the infantile neurosis and to make an adjustment that is no better or worse than the normal individual who possesses some neurotic defenses, but never sees the inside of a psychotherapist's office and still gets along satisfactorily with life and people.

Tarachow's (1963) differentiation of psychoanalysis from psychotherapy is still serviceable. He considers that in the former "transference, repression, other ego defenses, and resistances are all freely subjected to analysis and resolved," while "psychotherapy, on the other hand, is a selective, limited treatment in which a rearrangement rather than a resolution of these elements is aimed at." Furthermore, as more and more defections from Freudian theory have occurred, classical (orthodox) Freudians have tended to claim priority for the term psychoanalysis and to label any derivative neo-Freudian method as psychotherapy. Factional quarrels have accordingly developed.

Since psychoanalytic doctrines have permeated into the fiber of mental health practices and theories, the question of where psychoanalysis belongs is an arbitrary one. A well-trained psychotherapist is usually schooled in analytic doctrines and methods and is capable of applying these as part of the treatment program.

PSYCHOANALYSIS VERSUS PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPY

A good deal of the family strife among psychoanalysts who adhere to classical theory and those who have deviated in their ideas and methods centers around the word psychoanalysis. Classical analysts claim, with some justification, that the term is being watered down to include stratagems that are not even remotely related to psychoanalysis. They insist that psychoanalysis is restricted to a specific mode of treatment, focused on the unconscious, in which the uncovering of repressed childhood conflicts is achieved through the gradual resolution of resistance. This aim is accomplished through an intensive therapist-patient relationship, insured by frequent treatment sessions (preferably five times weekly) and the employment of the techniques of free association, dream analysis, and the evolvement and "working through" of a "transference neurosis." The latter embraces the projected distortions in the therapeutic relationship of traumatic experiences with early parental figures. The transferential development is guaranteed best by the employment of passive, neutral, anonymous, and nondirective attitudes on the part of the therapist. This tends to mobilize the most repressed components of conflict (the infantile neurosis) and to permit the patient to work through with a new parental image (as embodied in the therapist) more perspicacious attitudes toward authority, toward oneself, and toward one's own impulses. Resultant is a modification of the severity of the *superego,* a releasing of the strangulations that characterize the archaic defensive maneuvers of the *ego,* and a freeing of the constructive elements of the *id.*

Since there are patients whose problems, motivations, and life circumstances are such that they are unable to respond to the passive methods of psychoanalysis, and since there are therapists who are unable to function in an anonymous, nondirective, non-authoritative manner, dictated by classical technique, a number of modifications have

been devised. Because these serve some patients effectively, the revisions have been proposed as "refinements" and "improvements" over the orthodox procedures. The hard core of psychoanalysts connected with the Freudian school have challenged such modifications, considering them a reversion to preanalytic methods or a blocking of the true aims of psychoanalysis—which deals intensively with the unconscious and the *non-interfering* resolution of the transference neurosis.

When we examine the therapeutic tactics of the schools that advocate modifications, we do find a diversion from classical aims and techniques of psychoanalysis— such as the institution of activity in the relationship, a reduction in the number of weekly sessions, a substitution of the focused interview for free association, a consideration in the interview of the present rather than the past, the introduction of adjunctive devices, the proffering of suggestions and directives, coordinate interviews when necessary with other family members, and even the restraining of the development of a transference neurosis.

While Freudian analysts generally do not object to these innovations, and even admit that they may serve some patients better than formal psychoanalysis, they do object strenuously to the labeling of these newer techniques as psychoanalysis. Neo-Freudians, on the other hand, object to the narrow definition of psychoanalysis defined by the Freudians. After all, they insist Freud himself defined psychoanalysis as any method that dealt with resistance and transference. Why circumscribe it to a special kind of orientation?

Freud (1952) persistently contended that no person was a psychoanalyst who did not accept the foundations of the theory of psychoanalysis, namely the existence of unconscious mental processes, the recognition of the theory of repression and resistance, and the importance of sexuality and the Oedipus Complex.

Some authorities now employ the term "psychoanalytically oriented psychotherapy" or "dynamic psychotherapy" to those approaches that accept some, but not all of Freud's premises. Others consider a psychoanalytically oriented psychotherapy the modulated utilization of the techniques of psychoanalysis that circumvent or dilute a transference

neurosis, and that deal with the understanding in dynamic terms of a limited area of the pathology. However, because the word psychoanalysis carries with it connotations of "depth" and "thoroughness" and because there is still a status and economic advantage in some parts of the country in being known as a psychoanalyst and in doing psychoanalysis, therapists resist debasing their activities with a term that might be interpreted as second best.

Where psychoanalysis ends and psychoanalytically oriented psychotherapy begins has become a matter of opinion. One may remember the fruitless struggle of the American Psychoanalytic Association to establish, through its Committee on Evaluation of Psychoanalytic Therapy, a baseline from which to approach the contradistinction between psychoanalysis and psychoanalytic psychotherapy. The effort bogged down, and a report was issued to the effect that even investigation of possible differences mobilized resistance among the members of the Society (Rangell, 1954).

Orthodox Freudians insist that psychoanalysis presupposes an acceptance of the instinct theory (libido theory) and the primacy of early sexual conflicts. They contend that deviants of cultural or sociological theoretical persuasions are simply not doing psychoanalysis, even though there is an employment of free association and dreams, a delving into childhood conditionings, an uncovering and resolution of resistance, and a setting up and working through by means of interpretation of a transference neurosis. This position is gradually being softened with the current interest in cognition and "ego psychology," which considers behavior too complex to be accounted for solely by innate psychological events.

There is then a tendency to embrace as psychoanalysis only those treatment processes that (1) are executed by trained psychoanalysts, (2) have as their goal the overcoming of resistances to unconscious conflicts, whatever their nature may be, (3) deal with a continuity of experience back to early childhood, and (4) encourage the building up of a transference neurosis and its resolution through interpretation. Techniques that diverge from these methodologic objectives, and yet employ some of the uncovering

procedures for delving into the unconscious, such as dreams, free association, and analysis of resistance and transference (which is not to be confused with the more intense transference neurosis) are best classified as "psychoanalytically oriented psychotherapy," or "dynamic psychotherapy," or "exploratory psychotherapy."

OTHER DEFINITIONS OF PSYCHOTHERAPY

The comprehensive definition of psychotherapy given above has many advantages. However, other explanations of the meaning of psychotherapy exist that may be interesting to review.

The sundry published definitions of psychotherapy agree on one point— namely, that psychotherapy constitutes a form of approach to many problems of an emotional nature. They do not agree on other aspects, such as the techniques employed, the processes included, the goals approximated, or the personnel involved. Typical definitions are these:

1. "Psychotherapy is the formal treatment of patients using psychological rather than physical or chemical agents, principally verbal communication."

2. "Psychotherapy may be defined as the treatment of emotional and personality problems and disorders by psychological means."

3. ''We shall define psychotherapy as any type of professional interpersonal situation between a therapist and his patient designed to help the patient to resolve emotional problems."

4. "Psychotherapy is primarily a transaction between the patient and his therapist."

5. "Psychotherapy is ... a developing transaction between two people, one suffering from some type of distress or exhibiting disordered behavior, the other offering amelioration as part of his professional activity."

6. Psychotherapy consists of "techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the

intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviors judged to be maladaptive or maladjustive."

7. " For a very simple realistic definition, one could say that psychotherapy is the utilization of psychological measures in the treatment of sick people."

8. [Psychotherapy endeavors] "to alter the behavior and change the attitudes of a maladjusted person toward a more constructive outcome."

9. [Psychotherapy alludes] "to the entire collection of approaches attempting to influence or assist a patient toward more desirable ways of thinking, feeling, and behaving."

10. "By psychotherapy is meant the use of measures which it is believed will act upon the patient's mind and thereby promote his mental health and aid his adjustment to the particular problems which have disturbed his happiness or adaptation."

11. "Psychotherapy is a form of treatment in psychiatry in which the psychiatrist, by his scientific thinking and understanding, attempts to change the thinking and feeling of people who are suffering from distorted mental or emotional processes."

12. Psychotherapy "aims to help the impaired individual by influencing his emotional processes, his evaluation of himself and of others, his evaluation of and his manner of coping with the problems of life. It may also include changing his environment ... and simultaneously increasing his potentialities of mastery and integration."

13. "[Psychotherapy includes] a multitude of psychological methods, all having one thing in common—the intent to help a suffering individual through psychological means."

14. "Psychotherapy is a planned and systematic application of psychological facts and theories to the alleviation of a large variety of human ailments and disturbances, particularly those of psychogenic origin."

15. "In general, psychotherapy can be defined as the provision by the physician of new life-experiences which can influence the patient in the direction of health."

16. "Psychotherapy is the art of combating disease and promoting health by mental influences."

17. "[Psychotherapy] connotes the use of definitive psychological techniques designed to relieve demonstrable disturbances in psycho-social adjustment."

18. "Psychotherapy includes all kinds and ways of utilizing psychologic means to achieve beneficial psychobiologic changes."

19. "Psychotherapy consists of any considered and competent medical endeavor directed toward the improvement of the emotional health of the individual, based upon the understanding of the psychodynamics involved, and of the need of the individual under treatment."

20. [Psychotherapy is the] "treatment of mental or emotional disorder or of related bodily ills by psychological means."

21. [Psychotherapy is] "the use of any psychological technique in the treatment of mental disorder or maladjustment… . The term carries no implication about the seriousness of the disorder … the duration or intensity of treatment, or the theoretical orientation of the therapist."

22. [Psychotherapy is] "an emotional exchange [process] in an interpersonal relationship which accelerates the growth of one or both participants."

23. "Psychotherapy is … a cooperative enterprise for clarifying purposes and modifying attitudes in the direction of greater integrity of personality."

24. "Psychotherapy is a certain kind of social relationship between two persons who hold periodic conversations in pursuit of certain goals: namely, the lessening of emotional discomfort and the alteration of various other aspects of client behavior."

25. "Psychotherapy may be defined as the treatment of emotional and personality problems and disorders by psychological means… . Types of psychotherapy fall into two general groups. One may be described as genetic-dynamic, the other as supportive, suppressive, non-exploratory, or non-specific."

26. "Psychotherapy: The generic term for any type of treatment which is based primarily upon verbal or nonverbal communication with the patient, in

distinction to the use of drugs, surgery, or physical measures, such as electroshock or insulin shock, hydrotherapy, and others."

27. "Psychotherapy is a process in which changes in an individual's behavior are achieved as a result of experiences in a relationship with a person trained in understanding behavior."

28. "In its classic sense, psychotherapy is defined as the restructuring of the malfunctioning personality."

29. "... psychotherapy is a form of help-giving in which a trained, socially sanctioned healer tries to relieve a sufferer's distress by facilitating certain changes in his feelings, attitudes, and behavior, through the performance of certain activities with him, often with the participation of a group."

30. "Psychotherapy is a form of treatment of a client by a therapist for disorders of emotional adjustment, with the purpose of bringing about his readjustment so that he will become more comfortable in his emotions, thoughts, and attitudes, and so that his social relationship will be improved."

31. Psychotherapy is a "process recurring between two (or more) individuals in which one (the therapist), by virtue of his position and training, seeks systematically to apply psychological knowledge and interventions in an attempt to understand, influence, and ultimately modify the psychic experience, mental function and behavior of the other (the patient)."

32. [Psychotherapy is] "a procedural arrangement between a therapist and patient in which the therapist, by explicit or implicit contract, attempts to improve, by psychological means, conditions and behavior which interfere with the patient's well-being— and which are ascribed wholly or in part to psychological causes."

33. "Psychotherapy: The generic term for any type of treatment that is based primarily upon verbal or nonverbal communication with the patient as distinguished from the use of drugs, surgery, or physical measure such as electroconvulsive treatment."

34. "Psychotherapy in its broadest sense is the systematic effort of a person or group to relieve distress or disability by influencing the sufferer's mental state, attitudes and behavior."

35. [Psychotherapy is the] "use of psychological techniques in the treatment of mental disorders. Psychotherapeutic methods are employed by a trained psychotherapist who helps the patient by means of verbal and emotional communication."

36. "The science and art of influencing behavior so as to make it (a) more efficient and satisfactory to the individual and (b) more compatible with social norms."

37. Psychotherapy is "a process in which a person who wishes to relieve symptoms or resolve problems in living or seeking personal growth enters into an implicit or explicit contract to interact in a prescribed way with a psychotherapist."

38. "Psychotherapy is an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes, and behavior which have proven troublesome to the person seeking help from a trained professional."

39. "Psychotherapy is a confiding, emotionally charged relationship between a trained, socially sanctioned healer and a sufferer. The healer seems to relieve the patient's suffering and disability ... by a procedure often involving other patients or family members, that is organized in terms of a particular conceptual scheme."

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2
Varieties of Psychotherapy

An impartial observer of the contemporary psychotherapeutic scene would be forced to admit that present-day theories about how people become emotionally ill are exceeded in number only by the available remedies for making them well again. The individual seeking help for an emotional problem, the student in quest of training in psychotherapy, the investigator searching for answers to the puzzling problems of process and outcome research—all are confronted with an imponderable dilemma of choice. Indeed, the field of psychotherapy has become a vast supermarket where consumers may shop for stores of interventions that can satisfy the most capricious tastes. These range from mundane traditional interview methods to more exotic excursions into marathons, mantras, and massage.

There is no need to agonize over reasons for the predicament that psychotherapy finds itself in today. Empirical studies have shed little light on how treatment processes operate and when they are most effective. Emotional problems are difficult to treat. Well-trained therapists are hard to find. Good therapy is expensive and, even when implemented, encounters great resistance in some patients. Professionals are constantly devising unique approaches that coordinate with their personalities, philosophies, and styles of relating. Often they become so convinced of the virtues of their systems that they incorporate in it the entire world of psychopathology. Vast pockets of need remain unfulfilled and into these areas pour the less trained, less experienced practitioners, as well as a host of charlatans, drum beaters, and mental health evangelists whose enthusiasm for innovation is matched by their ignorance of things psychological. Lacking the discipline of experience, they promise rapid cures with a murky collage of half-truths, naive opinions, and outright distortions.

The average person is thus in a quandary when exploring the field in the hope of finding an adequate resource for personal emotional difficulties. Inquiries will generally

bring as many opinions about preferred courses of action as there are people to consult. The family physician may admonish to "slow down and relax," supplementing this advice with such medications as tranquilizers, vitamins, energizers, hypnotics, or placebos. A minister may enjoin more assiduous devotion to religion and faith that God will show the path to follow. A lawyer may counsel a long vacation in order to get away from the press of business responsibilities. Friends may urge one to leave a job, or to divorce a mate, or to find an absorbing hobby, or to take up meditation, or to see a chiropractor, or to read self-help books.

If the average person decides to get professional help, there will be no less confounding advice, particularly if a resident of a large city where there are many representative types of therapy. If such is the case, what should he or she do? Should he choose a therapist who practices psychoanalysis in spite of the current unfavorable publicity regarding its values? Should she go to a behavior therapist even though some of her friends have warned her that symptom alleviation will not get down to the bedrock of her troubles? What about group therapy, or marital therapy, or Scientology, or primal scream therapy, or transcendental meditation, or reality therapy, or any of the scores of other approaches that he or she has heard or read about? Perhaps his body needs balancing with psychotropic drugs, or maybe she can gain control over her physiological responses with biofeedback, or is hypnosis or strategic therapy the answer?

It is confusing, even for the average professional person, to view the multiform methods of treatment that are promulgated for emotional illness and to listen to the exaggerated claims of their devotees and the violent denunciations of their critics. Equally puzzling is the fact that published statistical data, tabulating percentages of cure and improvement and failure, reveal that results obtained by various methods of treatment are strikingly similar. Indeed, people seem to be benefited by all kinds of therapy—by those that have a scientific stamp of approval as well as those on the fringe of quackery.

How can we explain such inconsistencies? How can we, for instance, explain the failure of people to respond to years of intensive and skillful psychoanalysis who,

succumbing to the blandishments of untutored charlatans, lose their symptoms in a few weeks and take up life with renewed vigor? Are there differences in the quality of improvement with varied forms of treatment, or do certain kinds of problems respond better to specific types of treatment methods? Are there differences in the permanency of the results obtained by the respective procedures? Can we say that there is a "best" treatment for neurosis? Added to these confusing issues is the fact that in some instances an individual suffering from a severe emotional problem may experience considerable relief, and even a so-called cure, without the formality of having received any kind of treatment whatsoever. How much of a spontaneous reparative element, therefore, is present during the course of any therapy? Answers to these questions will be considered in the chapters that follow.

To describe the countless permutations of therapy that exist today would be an almost impossible task since all practitioners evolve a unique format influenced by their background and character structure. Corsini (1981) lists no less the 250 different kinds of psychotherapy, and Herink (1980) describes as many in his book. Nevertheless, there are identifiable pools within which practitioners flexibly float. It may be useful to classify the chief varieties of psychotherapy in relation, first, to the objectives they pursue (Table 2-1) and, second, to the fields from which they derive their substance (Table 2-2).

The varieties of psychotherapy may conveniently be divided into three main groupings: supportive therapy, reeducative therapy, and reconstructive therapy. The distinctions among these as they relate to objectives and the more common approaches are outlined in Table 2-1. The many psychotherapies in supportive, reeducative, and reconstructive categories become more diverse from year to year as an increasing numbers of professionals enter the psychotherapeutic field, introducing into it their unique technical modifications. Schools of psychotherapy have crystallized around the various approaches, each of which has its zealous disciples as well as its staunch critics. Each lays claims to multifarious successes and admits to some failures. Actually, radical divergencies in technique are more apparent than real, many distinctions vanishing as soon as semantic differences are resolved (Rosenzweig, 1936; Watson, 1940). Some

differences, however, do exist and will be considered in detail in the next chapters.

Schools of psychotherapy are characterized by the aggregation under one banner of a host of professionals, trained to respect one or another of the pioneers in the biological, psychological, social, and philosophic fields and espousing, often fanatically, a general point of view and basic postulates, which, upon close examination, reflect wide personal differences in interpretation and application. Indeed, the variations and shades of divergence between members of the same school are often greater than between members of rival schools.

Professionals develop individual styles of doing psychotherapy, as artists evolve unique ways of painting. They then become wedded to these styles, perfect them, find them effective to their satisfaction, and then sometimes promote them as the best of all treatments. A general theory is fabricated sooner or later to provide a rationale which, more or less, draws from their personal lives and intrapsychic experiences. If they are sufficiently persuasive, they may attract a host of followers who are searching for answers to the dilemmas of treatment. And if they possess an abundance of charisma, they may even initiate a revolution in the form of a new school, which lasts for a period until sufficient failures in therapy accumulate to convince therapists that the psychiatric messiah has not yet arrived. When we distill out the important essences of all of the existing therapies, the differences are not as profound as they seem on the surface, although several classes of therapies do exist with distinctive goals and operational modes.

While all schools of psychotherapy explicitly avow an empirical dedication rooted in observation and experiment, some find their pith in ontologic and even theologic-like precepts. Difference is registered in the degree of allegiance to biological as contrasted with psychological and sociological principles. On the one hand, there are behavioristic schools that orient themselves around a stimulus-response psychology or social learning model, focused on objective observation, accepting psychic phenomena merely as intervening variables. There are hormic schools, which include the dynamic systems, that

deny that behavior is explicable in purely mechanistic or physiochemical terms but rather requires the consideration of contents of mind as objects of awareness.

The various approaches to emotional illness involve many affiliated fields (see Table 2-2). In the main, the following avenues are pursued:

1. Organic-physiological regimens that, rooted in the soil of biology, are strictly speaking not psychotherapeutic.

2. Behavioral-conditioning techniques, psychologically oriented, that deal with the effects of conflict and depend on relearning and the retraining of responses without concerning themselves too much with conflictual sources.

3. Supportive relationship tactics, sociologically based, that draw upon factors that are operative in any "helping process."

4. Dynamic-reconstructive methodologies, psychologically and sociologically inspired, that focus on insight, delineating the origins of conflict, its effect on intrapsychic functioning, its manifestations in character structure, and its impact on problem solving and other vital behavioral activities.

5. Philosophic-persuasive ideologies aimed at alteration of values and meaning systems, toward the development of more adaptive ways of approaching life's burdens.

In actual practice there is often a fusion of approaches, although the followers of specific schools may be loathe to admit this.

3
Extratherapeutic (non-specific) Healing Aids: I. The "Spontaneous" Cure

Psychotherapy attempts to alleviate emotional suffering and to enhance personality adjustment through planned psychological interventions. It is by no means the only medium through which such benefits may be achieved. Indeed, operative constantly on the individual are a variety of forces that serve to ameliorate neurotic symptoms and, even, under fortunate circumstances, to sponsor personality growth. These forces work so subtly that they are usually overlooked. They are an inherent and inevitable part of the living experience. Because they exert their effect during psychotherapy, as well as outside of it, it is difficult to know the proportion of benefit the individual has derived from these congenial non-specific agents and how much that person has gained from the specific psychotherapeutic maneuvers themselves. More importantly, if we are able to define the forces that nurture emotional health apart from psychotherapy, we may be able to incorporate these into our therapeutic program, or at least prevent ourselves from inhibiting them. Among the coincidental factors associated with psychological change are (1) "spontaneous" remissions or cures, and (2) influences that automatically issue out of any "helping" situation. The first of these will be considered in this chapter, the second in Chapter 4.

Spontaneous cures probably occur more frequently than we are wont to admit, for both physical and emotional difficulties are associated with periods of exacerbation and periods of remission and, often, without apparent cause, vanish of their own accord (Stevenson, 1961). Even the most pernicious forms of psychoses show a tendency toward spontaneous remission, and any institutional psychiatrist, even before the era of psychotropic drugs, is acquainted with the patient who, having spent years in the hinterlands of a chronic mental ward, suddenly returns to the world of reality and expresses eagerness to take up his place as a member of society (Wolberg, 1944).

The circumstances surrounding such a "spontaneous cure" are so nebulous that it is customary to look on the phenomenon, when it occurs, as a sort of fortuitous development. Were we, however, able to peer into the complex mechanisms of the psyche, we might be able to discern definite laws of cause and effect relating to the spontaneous recovery.

It is unfortunate that so much emphasis has been placed on the evil consequences of illness that we are prone to concern ourselves chiefly with destructive pathologic effects and forget that constructive regenerative influences may be coincidentally present. It is as if in an infection, we were to concentrate on morbid elements of the disease without considering such protective manifestations as the antibody defenses and the activities of the reticuloendothelial system. Any somatic disease whips into action reparative mechanisms in the direction of health. Cases of unquestionable cancer that spontaneously resolved themselves without benefit of any treatment have been authenticated (Medical Tribune, 1963). This indicates that the individual has internal healing forces that are capable of altering an even presumably fatal illness. A mental or emotional disorder, too, will set into action defensive devices to restore the individual to homeostatic equilibrium; indeed, a study of the symptoms of emotional illness, whether the difficulty be a mild behavior problem or a pernicious form of schizophrenia, will always demonstrate a fusion of dynamisms representative both of the conflict and of the defenses the organism elaborates in an attempt at cure.

The exact mechanisms involved in spontaneous remissions or cures are not exactly known, but a number of operative factors, singly or in combination, suggest themselves.

First, life circumstances may change and open up opportunities for gratification of important but vitiated needs, normal and neurotic. Thus a man with a passive personality organization may, in fighting against passive impulses, elevate himself to a high political post that enables him to exercise secret cravings for power. The expression of these may neutralize inner fears of weakness and lead to feelings of well-being. A masochistic individual may appease a strong sense of guilt through the incidence of a physical illness,

an accident, or a catastrophic life happening. A man with strong dependency strivings may flounder around helplessly until he chances onto a stronger individual, an alliance with whom infuses him with strength and vitality. A woman with schizoid tendencies may be afforded, through advantageous circumstances, an acceptable opportunity to detach herself in her interpersonal relationships. A shift in the current situation may, therefore, work in the interest of promoting psychic stability.

Second, provocative stress sources may disappear as a result of the removal of the initiating environmental irritant, or because individuals extricate themselves from it. A child, selected by a classroom bully as a focus for sadistic attacks will, in all probability, lose tensions and fear with the forceful removal from the class of the disturbed assailant. A young dependent adult overprotected by a neurotic parent may decide to move away from home and be rewarded with an expanding sense of independence. A man, promoted into a highly competitive position that sponsors fears of failure, may, by returning to his previous, more mediocre job, overcome his anxiety and depression. A leave of absence or a vacation may, in a similar manner, remove a person from a disturbing life situation, helping in self stabilization.

Third, crumbling or shattered defenses, whose failure promotes adaptive collapse, may be restored to their original strength, or be reinforced by new, more adequate, and less disabling defenses. The return of a sense of mastery in the course of buttressing failing defenses, will help to restore the individual to functional equilibrium. One way this is accomplished is by consolidating the mechanism of repression, sealing off disturbing conflicts that have managed to get out of control. For instance, a detached individual who has remained celibate all his life due to deep fears of sexuality, falls in love with a young woman. Her demands for reciprocal affection excite sexual fantasies and impulses that frighten him. Anxiety and psychosomatic symptoms precipitately develop. The man then discovers that he is completely impotent and that his interest in the young woman abates and dies. Restored repression of his sexual desires, with a return to isolation from women, brings about a recovery from symptoms. Sometimes, however, the defenses of the individual undergo modification in the direction of greater adaptability to inner demands

and external pressures. More constructive ways of dealing with current difficulties may be evolved. The means by which this is accomplished will vary with the circumstances and with the opportunities at one's disposal. Not only may the old neurotic balances of power be restored, but surprisingly, without design, enduring personality changes may develop.

No matter how victimized by past unfortunate conditionings, each individual is always capable of some determinate learning under propitious circumstances. The expectation of failure, the misinterpretations of the reality situation, the transferential projections, the repetitive compulsive reenactments of self-defeating behavior will tend, of course, to sabotage successes. Inferential discoveries, nevertheless, are going on around the matrix of the neurotic responses, reconditioning at least some neurotically structured reactions.

Instances of reconditioning in even severe neurotic and psychotic disorders have been recorded in persons who have by chance come under the guidance of a well-disposed and intelligent authority or group or who have found a congenial environment that is different from their habitual milieu. These changes are not fortuitous; they follow certain laws of learning. Where the individual finds an environment that does not actively repeat the punitive, frustrating conditions of the past; where it provides a modicum of security and some means of gratifying vital psychological needs; where it gives a feeling of knowing what is expected of each person and some ability of living up to these expectations; where it nurtures in the individual a sense of belonging and of being wanted; where it provides opportunities to expand capacities and skills—there will be optimal conditions for learning. Obviously, those individuals whose emotional problems have undergone minimal structuralization in the form of neurotic and character disorders will have the best chances to learn in a favorable environment. Where extensive organization has occurred, conflictual strivings will tend to be perpetuated even in a good setting. There still may be spontaneous periods of improvement, particularly where the environment absorbs and deals in a tolerant and constructive way with the individual's neurotic impulses and behavior without excessive punishment or withdrawal of love.

Alleviation of symptoms may follow change in one's philosophies and altered ways of looking at things. For example, some people adapting to difficult life situations from which there is no escape may insulate themselves by making a virtue out of suffering or by maintaining a stoical attitude accepting their plight as inevitable, and their endurance a test of competence. Some may even make capital out of personal disasters and secure equanimity through martyrdom. Many of the present-day mystical philosophies stress the unimportance of adversity and external hardship, focusing the individual's attention on establishing contact with the inner self, the essence of being. In this way the individual detaches from suffering and seeks joy in meditation and self-contemplation. An individual may resort to other devices in the belief that one has control of one's destiny, for instance, through reliance on astrology. By classifying oneself in a special category, subject to designated occult influences of the stars, security is gained through regulation of one's life according to a dictated design.

The patient may also evolve the tactic of pushing out of mind sensations of pain, substituting for them thoughts of health and pleasure, hereby eliminating customary preoccupations with suffering. Through proper thinking habits, like "looking at the cheery side of life," "counting one's blessings," and engaging in thoughts of happiness and health, attempts are made to sidestep calamities and illness. Troubles may be rationalized by assuming that one is not alone in strife, that there are others more disabled, more unfortunate. Striving for success and perfection are false objectives that can bring only exhaustion and disappointment. It is better to scale down ambitions and content oneself with modest goals that are within the range of immediate fulfillment. Some people make an inventory of their good qualities and recognize that there is much for them to be thankful. They may rule themselves to live in the spirit of forbearance, tolerance, sympathy, and altruism, reviving, in the course, religious convictions.

By turning to religion, some are able to help themselves tolerate the destructive effects of their neuroses. In the hands of a Power stronger than a human being who can lead one to paths of safety and glory, one can be reassured. In union with God, one does not have to struggle alone; one may be helped to endure travail, to conquer evil thoughts

and impulses, and to find confidence and strength in living.

In addition to philosophic and religious aids, the individual may indulge other modes of gaining relief. Remediable, stressful environmental distortions that sustain and exaggerate tension must be rectified. Moving to a residential area, for instance, that is not so riddled with quarreling and disturbed neighbors may eliminate one source of irritation. Or, some difficulties may spontaneously cease to exist, as the case where a destructive supervisor or foreman is replaced with a genial one, or a hostile member of one's family may regain control over explosive emotions or takes up residence in another city. The patient may also find relief from symptomatic preoccupation by externalizing interests in arts, crafts, hobbies, music, games, dancing, physical exercise, sports, and recreation. Diverting energies into useful channels of activity may thus have a salubrious effect. Engagement in social activities, joining clubs and other groups, in which there is a sharing of experiences can be most constructive.

The patient may also gain relief from some personal problems by running away from trouble sources. A woman may rightfully decide that her difficulty is stirred by a destructive home environment, or an impossible work situation, or a relationship problem with which she cannot cope. She may consequently remove herself bodily from her predicament by going on a long vacation or permanently rupturing her contacts. Thus, she may seek a divorce, quit her job, or abandon her boyfriend; and these disengagements may, if auxiliary problems do not intervene, temporarily at least, relieve her distress. She may act more destructively to escape her suffering by indulging in excessive drinking that deadens her sensations, take tranquilizers that ameliorate them, or take sleeping potions that submerge them.

Some people seek peace of mind by providing what they consider rational answers to explain what they are experiencing. They may do this through self-probing, examining their reactions, questioning their motives, or cogitating on their fantasies. Under situations of stress individuals are particularly disposed to such self-analysis. Adolescents particularly attempt to resolve warring elements within themselves through self-

searching. Such efforts are not always successful since sources of difficulties may be hidden from their rationalizing probes. The capacity for insight varies.

The desire to reach an understanding of one's turmoil will invoke different degrees of logical compromise. Education helps especially through proper readings and personal therapy. Those individuals who have evolved reasonable understanding are most capable of illuminating dark recesses within themselves. Spontaneously, a recovery of forgotten important memories, a relating of present-day patterns to past experiences, a recognition of inexorable and self-defeating demands they make on themselves may occur. Ultimately, new solutions for old problems may emerge.

Sometimes such self-understanding is mobilized by single interviews with a psychotherapist with no further professional help. Malan et al. (1975) at the Tavistock Clinic made a study of untreated neurotic patients who had exposed themselves to one initial interview and had been seen by a therapist no more than twice in their lives. On follow-up, 51 percent were found to have improved symptomatically, and 24 percent were judged to have improved dynamically, some even to the point of recovery. This is a significant number. Considering the fact that the work was done at the clinic by established psychoanalysts who utilized rigid standards of measurement, we, therefore, have evidence that even single encounters may prove of great benefit to some patients. Whatever activity was mobilized during the interview, the patients continued spontaneously on their own to work through residues of their problems.

It will be seen from the above that the so-called spontaneous remission or cure does not take place in a vacuum. It results from the operation of many forces that exert a healing influence. Even though these processes are not deliberately designed, but obtrude themselves through what appears to be chance, each individual takes advantage of some healthful elements in the environment and within the self to reduce suffering and pain.

As a general rule, spontaneous remissions or cures are of a palliative nature, with no great change coming about in the existing mental mechanisms and intrapsychic apparatus. In a few instances, however, rather surprising spontaneous structural alterations develop

in the personality organization itself. Most recalcitrant to spontaneous resolve are deep-seated neuroses linked to repression of infantile anxieties, which are so split off from access to awareness that they do not lend themselves to dissolution. Nevertheless, even here they may be more readily held at bay by a spontaneous strengthening of repressive forces, or improved by avoiding situations that tend to activate them. Focal conflicts may in this way be isolated sufficiently to enable the individual to function satisfactorily without being aware of their content or even existence.

It will be recognized that some of the undercurrent processes in spontaneous cure are similar to those in psychotherapy. Whereas in spontaneous cure the individual inadvertently arrives at conditions in which it is possible to work out problems, in psychotherapy, circumstances conducive to relief or recovery are actively manipulated.

Many opportunities exist in the environment that would lend themselves to a corrective influence on the patient. Unfortunately, the average person does not often take advantage of them because there is no awareness of their potential or because their meaning is distorted, or because they pose a threat to neurotic defenses. During psychotherapy, the resistances of the individual are handled so that the most can be made of the opportunities encountered. In contrast to the fortuitous nature of the spontaneous development, psychotherapy is a planned effort to promote symptom alleviation and constructive learning both within and outside of the psychotherapeutic setting.

4
Extratherapeutic (non-specific) Healing Aids: II. The "Helping" Situation

Turning to another human being for help is an inevitable consequence of a shattered sense of mastery. It represents acknowledgment of the inability to cope with difficulties through one's own resources. Contact with a trusted individual can inspire rapid relief from tension and even restore adaptive functioning. Physicians, ministers, lawyers, teachers, psychiatrists, psychologists, social workers, and even considerate friends may serve as elegant resources for a helping relationship. The effect, while therapeutic, is epiphenomenal. It reinforces the impact of formal psychotherapy. It is a vital, indeed inescapable, constituent of the therapeutic gestalt. Most prominent among the liberated forces are the placebo effect, relationship dimension, emotional catharsis, suggestion, and group dynamics.

THE PLACEBO EFFECT

If a patient and therapist are both firmly convinced that eating oatmeal will cure the patient's symptoms, it is likely that relief will be forthcoming as long as the proper rituals have been organized around the taking of the cereal, and the patient maintains faith in its efficacy. If as a consequence of the conviction of being helped the patient dispels tension and anxiety sufficiently to restore to oneself a sense of control, he or she will possibly return to habitual routines and sooner or later reach an optimal level of functioning. Moreover, if the problems are not too serious and one is fortunate enough to live in a constructive environment, particularly in a productive relationship with some other human being, he may even undergo deeper personality changes. The placebo phenomenon responsible for these permutations is usually minimized by therapists who have been seduced by a belief in the scientific validity of their systems. This is not to minimize the impact of a rational psychotherapy, but it is essential to give credit for part of the benefit to adventitious elements other than technical interventions.

The placebo has been called a "nuisance variable," and yet it historically has served as an important, albeit often unacknowledged, aid in medicine (Shapiro, 1964). Indeed, the prescription of inert substances was a standard part of medical practice for many years, being embodied in the tradition of giving pink sugar pills and injecting sterile water for their suggestive effects. These effects may be quite powerful, even to the point where direct or suggestive statements regarding a presumed drug action induce a psychological reaction diametrically opposed to the true pharmacological effects of the drug (Wolf S, 1950). Research explorations on medicaments in the form of double-blind studies pay respect to the placebo factor, recognizing that a mental influence may contaminate the impartial appraisal of a substance.

There is ample experimental and clinical evidence to substantiate this view. Laboratory reports indicate that pain thresholds are heightened and pain tolerance increased by placebos. Beecher (1970) has stated that placebos relieve pain one-half to two-thirds as effectively as optimal doses of morphine. Apart from the considerable relief of pain, various physical ailments may be helped (Lasagna et al, 1954; Wolf & Pinsky, 1954). The placebo effect probably accounts for the fact that most patients who visit a general medical physician improve with almost any symptomatic treatment. Hypodermic injections of distilled water accompanied by statements that a new remedy for bleeding ulcers was being administered helped 70 percent of patients over a long-term period (Volgyesi, 1954). A study of vaccines for the common cold revealed that while 55 percent of persons injected with the vaccine showed a reduction in the number of yearly colds, fully 61 percent was recorded in a control group who had received nothing more than harmless injections of saline solution (Diehl et al, 1940). Patients with chronic headaches experienced relief with placebos in 60 percent of cases (Jellinek, 1946), and the same percentage of patients noted a reduction of the frequency of herpes simplex with placebo therapy alone (Conant, 1974). Beecher (1955), evaluating 15 studies, including 7 of his own, involving a total of 1082 patients, found that placebos had significant effectiveness of 35.2 percent ± 2.2 percent. He also found that the effect was most powerful when stress, discomfort, and pain were greatest. His remark that "many a drug has been extolled on the basis of clinical impression when the only power it had was that of a placebo" has been

repeatedly confirmed.

The impact on the individual of a placebo is all the more astonishing when we consider that through its suggestive influence it can produce objective physiological changes (Abbot et al, 1952). Thus placebos given to patients with duodenal ulcers produced the healing of ulcers in 65 percent of the cases (Hollander & Harlan, 1973). A significant number of side effects may even be credited to an inert material (Feather & Rhoads, 1972; Rickels et al, 1965). Toxic phenomena have been induced by substances to which the individual could not possibly have been sensitive, solely on the basis of the individual's conviction that he could not help responding in an untoward way. Sugar pills, for example, have produced weakness, palpitation, nausea, maculopapular dermatitis, epigastric pain, watery diarrhea, urticaria, and angioneurotic edema (Wolf & Pinsky, 1954). According to S. Wolf (1950), physiological effects are brought about by a placebo through "objective changes at the end organ which may exceed those attributable to potent pharmacologic action." In patients with anxiety placebos have produced physiological responses similar to those of corticotropin (ACTH) in normal patients.

How placebos work is not known. Faith in a minister, guru, charismatic leader, shaman, physician, spiritualist, shrine, acupuncture, or scientific method— irrespective of on whom or what the individual pins one's hope—this can promote high levels of well-being and healing that on the surface sound miraculous. But modern research points out that the miracle is chemical and not spiritual. Concentrated in the hypothalamic-pituitary region, opiatelike pentapeptides, the enkephalins and endorphins, are apparently liberated through a placebo effect producing analgesia that modulates pain and activates drive and reward systems in the brain. These endogenous substances also interact with other neurotransmitter systems influencing neuroendocrine functions that sponsor important psychoadaptive effects. The healing value of faith is very well documented in popular and scientific literature. Its operation may make the difference between death and survival in serious accidents, illnesses and surgical operations.

When individuals with tension, anxiety, and other neurotic symptoms take recourse

to medicaments in order to subdue their suffering, the effectiveness of the drug is greatly enhanced if there is a conviction that it will work. In double-blind studies with tranquilizers, a sizable number of subjects report marked relief of their symptoms with placebos that are packaged similar to the tranquilizers under test because the deceit excites confidence in the inactive substance. However, even when the patients are told that the material given them is inert, they will still respond positively (Park & Covi, 1965), probably on the basis of faith, hope, and expectancy.

In many parts of the world charms and amulets are still worn for their placebo effect. These objects work their wonders among the less educated by dispelling evil spirits, invoking benevolent deities, and generally protecting the individual against misfortune and disease. Counterparts of the ancient mandrake root and unicorn horn are still sold to quell ague, to staunch blood, to cure headaches, to facilitate childbirth, and generally to promote health and well-being. In some areas the sale of herbs and curious nostrums flourishes, such as in Chinese herb shops in Hong Kong where dried sea horses are prescribed for chest congestion, ground pearl powder for pimply complexions, rhinoceros horn for heart ailments and impotence, tiger bones for rheumatism, and fungus from a coffin growing near the corpse's mouth for tuberculosis. Among the better educated, more refined and highly personalized tokens are coveted to bring good luck and to allay misfortune. Confidence in the charm or token is, as in drug placebos, the essential ingredient. The conviction that a powerful protective agent is at work to support one's claims on life, and to protect against dangers, is sufficient to calm anxiety, to lessen tension, to restore physiological homeostasis, and to promote self-confidence and assertiveness. A more accurate perception of possibilities of action leads to mobilization of effective resources and to more constructive problem solving. Shattered repressions may be restored, and the individual brought back to a functional personality equilibrium.

What holds true for drugs probably holds true for systems of psychotherapy (Rosenthal & Frank, 1956; Frank, 1961; Friedman, 1963; Campbell & Rosenbaum, 1967). Individuals project into these systems their expectations of cure, and they may react quite remarkably to techniques and agencies that they enshrine with powers that the objects

may not really possess. This is suggested by studies of psychiatric outpatients where the sole therapy was oral placebos and in whom a significant (55 percent) improvement rate was actually recorded (Gliedman et al, 1958). Relief of discomfort and symptomatic amelioration have lasted for years solely on the basis of an expectancy of help (Frank et al, 1959). There is a definite correlation between conviction and cure. Thus sitting in the waiting room of an outpatient clinic has resulted in signal improvement in patients (Frank et al, 1963).

Some time ago I was consulted by a man whose sole complaint was that he smoked too much. He wanted me to help him to control his craving so that he could forever eliminate tobacco from his life. He had, he confessed, at one time been a schizophrenic but was now completely cured, having been treated by a therapist who employed a unique method. Twice weekly the patient would appear for his sessions. He would strip to nudity and lie on a couch near an open window. Verbalizations were forbidden. Instead he was ordered to bear, Spartan-like, the discomfort of cold and drafts in complete silence. The therapist, during this ordeal, sat near the patient, huddled in a blanket, recording the patient's muscle movements and general bodily reactions. Interpretations were not offered. The object of his tribulation was to raise the patient's frustration tolerance by exposing him to external suffering so severe as to induce a psychological callus formation that would ultimately encapsulate his weak and sensitive ego. The treatment, while uncomfortable, was, according to the judgment of the patient, eminently successful. In fact, the therapist was the only one of a series of four psychiatrists who had given him any help whatsoever. The previous therapists, applying the conventional psychotherapeutic procedures, had failed completely. While many elements probably entered into the helping process, the fact that a friend of the patient had praised the therapist to the skies had undoubtedly mobilized the patient's expectations of hope and had convinced him that he would be cured.

Therapies that in the mind of the patient possess esoteric or mystical qualities are most likely to induce a placebo effect. Thus, hypnosis and psychoanalysis, charged as they are with supposed meta-psychological powers, are apt to instill in the patient a feeling of

magical influence. This instrumentality, although an artifact, may promote confidence in the treatment method. By the same token, a negative placebo effect may be obtained, if, by virtue of what is imagined will take place, the patient has lack of faith in, or fears being hurt by, a special kind of therapy. The chances are then that this attitude will inhibit the effectiveness of treatment.

Medicaments, amulets, and techniques are potent placebo sources, but not nearly so powerful as a human authority with an inspirational flair. It is here that the quack has an advantage over the ethical practitioner, who, fettered by factual propriety, is unable to flaunt his or her wizardry, and becomes for the patient a vehicle of hope. In their helpless desperation, many victims of illness reach for a magical helper. Medicine man, shaman, priest, physician, or psychotherapist, the patient importunes the agency for relief earnestly engaging in avid prayer at the promise of divine reward, and while eagerly incorporating any worthy theological, philosophic, or psychological formulations as a pledge of trust. The placebo effect of prayer, and of conversion to a system of religion, philosophy, or psychology, are explicable in terms of the bounties the supplicant expects to receive as a result of his dedication. In psychotherapy we are mindful of the phenomenon of patients who regurgitate the prophetic revelations of their therapists concerning the cause, meaning, and future of their illness. How much this "insight" is an invocation for support and how much it constitutes a true discernment of the underlying difficulty must carefully be evaluated. Unfortunately, the therapist is not the most objective and unbiased referee for this task.

Interestingly, a theoretical system may act as a placebo for the therapist. If there is faith in its verity, the therapist will approach the patient with dogged confidence, and will undoubtedly unearth in the patient the exact constituents that compose his or her theoretical scheme. In this way a placebo feedback becomes operative between therapist and patient. The conviction on the part of the patient that the therapist knows what is wrong with him or her and has ways that will bring health encourages restoration of mastery. This is irrespective of how valid the therapist's system may be. Certainly with the abundant theories rampant about health and disease, and the varied psychotherapeutic

techniques that are being practiced, we may rightfully be persuaded that some systems are at least fanciful if not actually wrong. But right or wrong, a patient will be benefited by all systems if there is enough confidence in the therapist. This is probably because the enthusiasm and firm belief of the therapist has aroused the patient's expectations of cure. On the other hand, if the therapist has doubts about the validity of the therapeutic system, it is possible to communicate pessimism, insecurity, and helplessness, nonverbally if not verbally, and thus the element of faith that can kindle hope will be extinguished. In this way the therapist will rob the patient of an important element in the healing process.

Many observers have commented on the powerful factor of confidence in the treatment method as an ingredient in cure. Among native groups who are imbedded in magic and witchcraft, the most adroit application of dynamic psychotherapy produces meager results probably because it does not accord with their belief systems. Where the victim of an emotional problem is convinced that the suffering is the consequence of a curse or other evil magic from an offended spirit, the adroit exorcism of the force presumably responsible for the bewitchery will, in a surprising number of instances, bring about the improvement or cure of even long-standing neurotic and psychotic illnesses.

Assignment of the illness to its presumable responsible determinants tends to alleviate fear of the unknown. It matters little whether the identified source is factual or not. As long as the patient believes it, the catastrophic sense of helplessness is palliated. The healer may diagnose the condition as due to infestation with evil spirits, or regression to an anachronistic psychosexual level of development, or operations of unconscious conflict, or a disrupted biochemical balance within the body. If the patient accepts the proffered "insight," the very focusing on a presumed source of mischief opens up new possibilities of action. The helping agency, having delivered an explanation, proceeds to deal with the matrix of trouble. Rituals to exorcise offended spirits or to destroy them, free associations to liberate unconscious foci of conflict, medicaments to reinstate the biochemical balances, conditioning to restore the individual to healthy habit patterns— whatever the theory of etiology—pertinent measures are executed to resolve the problem source. If the patient has faith in the healer, the virtue of the methods will be endorsed,

whether these be anomalous or scientific. Thus an individual, impressed by a practitioner dedicated to meditation, will do better with relaxing exercises than with insight therapy prosecuted by a dynamically schooled therapist in whom there is little confidence. The feeling that one is being helped, that a curative agency is at work, subdues anxiety and diverts the individual from self-defeating defenses, toward more effective dealings with existing problem situations. The disruptive physiological effects of anxiety are brought under control, and restoration of self-confidence and assertiveness ensues. Repressions are restored, and psychological homeostasis is reestablished.

Placebo effects are usually, but not always, temporary. In many instances the improvement acts, as in the "spontaneous cure," as a vehicle for the reorientation of the individual in the total adjustment. Generally, the resulting security feeling leads to a heightened capacity to handle challenging relationships with people. The placebo may thus act as a basis for reorganization of attitudes, which may then become reinforced and entrenched in a favorable milieu.

The operation of the placebo element helps to explain why patients may be helped by psychotherapies that seem scientifically unsound, provided that there is faith and trust in their validity and power.

THE RELATIONSHIP DIMENSION

Every helping situation is characterized by a special kind of relationship that develops between the authority and subject. In this relationship the individual invests the authority with benevolent protective powers and relates to the latter with expectant trust. Implicit, if not explicit, is the understanding that the authority has the knowledge, the skill, and the desire to help the person overcome the problem for which professional services have been sought. The more bewildered and helpless the person, the greater the reliance that individual places on experts. This is certainly the case in the sick patient afflicted with a physical ailment who seeks relief from pain and distress from a physician. It is a most important factor in the psychotherapeutic situation, particularly at the beginning of treatment.

One way that the relationship operates is that while the patient may want to cling to his or her neurotic patterns, the patient may be willing to experiment with different behaviors solely to please the therapist. Once the patient receives rewards in the form of approving gestures and words for changes in attitudes and behavior, such changes may become solidified. Of importance here is an alteration of the self-image, which contributes to the permanence of change. Modeling oneself after an idealized therapist is another change mechanism and may gear the patient toward new constructive experiences. A relationship with the therapist helps the patient to tolerate, explore, and accept personal aspects that have been repudiated and repressed. The incorporation of a new image of authority as embodied in the more tolerant, non-judgmental therapist helps alter a punitive, intolerant superego. As a consequence of a trusting relationship, the patient may be willing to accept a proffered rationale or myth to explain the existing problem, and this may lessen tension if it accords with the patient's belief system.

Through the instrumentality of the relationship other important processes are liberated that may exert a healing effect on the patient. *First,* the patient, terrified by the disruptive emotions that are out of control, has a chance to put his or her destiny in the hands of a helpful, understanding, protective, and non-punitive authority. There is a tendency to regard the latter as an idealized parental image who is more or less infallible. The sicker and more anxious the patient, the more godlike the projected image and the less realistic evidence the patient will need to reinforce the illusion. As a consequence of this union, morale may be restored to the patient, a contingency believed by some authorities to be the primary function of all the rituals lumped under the term of psychotherapy (Frank, 1974). *Second,* superimposed on this dependency is a need to obtain from the authority a factual explanation for the emotional turmoil in terms that are understandable and acceptable to the patient. The validity of the proposed facts, as has been explained previously, is not as important as the patient's willingness to accept them. *Third,* the patient demands a formula from the authority that will rectify the actual or imagined sources of the difficulty. *Fourth,* the patient utilizes the relationship for encouragement or help in putting into effect the actions that will resolve troubles. *Fifth,* the patient finds in the relationship a medium in which to review attitudes and values.

Since these are in a direct or indirect way associated with concepts of authority, a constructive relationship serves to alter ideas about hostile or rejecting authority. The content of the interviews, and the activities inherent in carrying out the treatment plan, may not be as important as the nonverbal emotional crosscurrents that can potentially provide for the patient a truly corrective experience. Impressive changes under these circumstances can eventuate. The patient will tend to interpret the past and present in a new and less threatening light.

These processes operate in all helping relationship situations whether or not they are dignified with the name of psychotherapy, conditioning approaches, pharmacotherapy, etc. The importance of this relationship factor is too often minimized, and complete credit for ensuing benefits is falsely extended to the special techniques and maneuvers executed by the therapist. It is important to realize that, irrespective of the brand, the depth and the real worth of the healing measures that are being employed, improvement may be sustained in some instances for an indefinite period as a pure product of the relationship. These "transference cures" are not always temporary as has generally been believed. Sometimes they have lasted for years, but if stress sources have been corrected, transference distortions worked through with alteration of perceptions of authority and the patient's self, and if personal values and meaning systems have deviated in the direction of a healthy integration, the change may be a permanent one.

On the other hand, where associations with previous authority figures have been disturbingly stormy, the patient from the start may deploy defenses against a trusting involvement. Or after a brief positive period defiant attitudes may erupt to confound both patient and therapist, the sources of which are rooted, not in reality but in residues of early unresolved childhood ambivalencies toward parental and other important adult figures. Such "transference" outbreaks will interrupt or explode therapeutic progress. The restoration of basic trust is *the* foremost task in all forms of psychotherapy (Strupp, 1972a). This is most effectively accomplished by a therapist who does not have residual interactional difficulties (countertransference) that he or she projects into the therapeutic situation.

While the relationship dimension is operative in every human encounter, it is most effectively utilized by a trained psychotherapist who knows how to deal with the resistance pitfalls of transference and the obstructive ravages of countertransference. These are the usual impediments in nonprofessional relationships or in associations between patients and untrained surrogates.

THE FACTOR OF EMOTIONAL CATHARSIS

The sheer act of talking can provide an individual with considerable emotional palliation (54). It furnishes a motor outlet for the release of tension. It softens inhibitions and liberates conflicts that have been held in check. It exposes suppressed attitudes and ideas that the person has been concealing, and it encourages the individual to subject these to the light of critical reasoning. It brings to the surface repudiated and fearsome impulses, with their attendant feeling of shame. In this way, it takes the strain off autonomic channels that have been used to unload accumulated neurotic energy.

In the unburdening process, there is often a relief of guilt feelings in relation to past experiences, particularly sexual acting-out, hostile or aggressive outbursts, and competitive strivings. Guilt is appeased as one examines presumably shameful fantasies as well as antisocial and unethical impulses. Discussing these with an empathic person gives reassurance that one is not a helpless victim of uncontrollable strivings, that one has not been irreparably damaged by one's past. Reviewing incidents in which one has been hurt, humiliated, or exploited also tends to put these into proper perspective. Sharing one's fears of catastrophe and illness lightens their formidable quality. Relinquished are conscious restraints that rob the person of spontaneity. In short, the putting into words of diffuse and terrorizing feelings, and the acceptance by the listener of the pronouncements without expected condemnation and rejection, enables the person to gain greater control over emotions, to reconstitute new defenses, and to enforce a constructive action plan. The incorporated image of harsh authority softens.

These developments may occur in the presence of any listener, whether this be a sympathetic friend or a respected authority, such as a physician, teacher, lawyer, minister,

or psychotherapist. During psychotherapy emotional catharsis is especially prominent as imaginative conceptions and unconscious thoughts and feelings break through. Training in interviewing and knowledge of how to encourage verbalizations, to direct them into productive channels, to give measured reassurance, or to challenge productions in a deliberately provocative way are important in facilitating the effect. As the patient realizes that there is a consistent absence of vindictiveness from the listener, concepts of punitive authority tend to soften and some alteration of a harsh superego may possibly develop.

THE FACTOR OF SUGGESTION

Human beings are constantly being influenced by various authoritative formulations and directives. Education is dependent on this process, students incorporating the ideas of their teachers whose wisdom and experience qualify them to instruct and indoctrinate. In any helping relationship many forces are operative, including the need to identify oneself with the helping personage who serves as a model. There is then an unqualified tendency to assimilate the precepts and injunctions of the helper purely on the basis of suggestion.

The influence of suggestion in one's daily life cannot be minimized. Propaganda and advertising are dependent on it. It is a factor that promotes thoughts, feelings, and behavior that operate for and against the individual. It is the motor behind the placebo effect, fashion, vogue, and cultism. It shapes many human activities. It is an aspect of every helping situation. Not only may it serve to bring about a relief of tension, but, if the helping agency happens to possess the proper values, it may, through the instrumentality of identification, register a reconstructive personality alteration.

Suggestion operates in all forms of psychotherapy even psychoanalysis (Bibring, 1954), and it has even been postulated that the suitability of an individual for treatment is dependent on the potential openness to the suggestive influence (Strupp, 1972b). The exact nature of suggestion as a psychological phenomenon is not understood, and its eventual identification may supply the sought-for synthesis between the various schools of psychology (Winkelman & Saul, 1972).

During psychotherapy the therapist deliberately or obliquely throws out ideas and directives that the patient often will pick up and utilize. Sometimes these suggestions are helpful and constructive, at other times less so. The therapist may not be aware that cues are constantly being released to the patient, not only from verbal statements, but also from nonverbal signals such as facial expressions of approval or disapproval, hesitancies, silences, the accenting of some of the patient's comments, nodding, shaking the head, grunting, and various physical movements. In this way, suggestive elements may come through, even where the therapist believes that little or nothing is being said.

A simple nod in relation to something the patient has said or done will give the patient the idea that what is being said or done is good and that one should continue in this approved vein. But if the therapist says nothing or shakes the head, this may constitute an aversive suggestion for the patient and deliberately or unconsciously discourage certain types of activity. The technique of paying no attention to a psychotic person's delusional ramblings or hallucinations, but expressing interest in the patient when acting reality-oriented will tend to reinforce constructive preoccupations. All patients pick up from verbal and nonverbal cues of the therapist certain things they should do and believe in. This includes insights that initially act as a placebo. Even if an insight is wrong, if the person believes in it and imagines that it can help, he or she may start feeling better as a placebo consequence.

In dynamically oriented psychotherapy, direct suggestions are kept at a minimum, the patients being encouraged to think through their own solutions. Nevertheless, the factor of prejudicial, inexpedient, or unwise suggestions unwittingly being made must always be kept in mind. On the other hand, if the suggestions are productive ones, the patient may benefit from pursuing them. Nor is it essential in therapy always to abstain from direct suggestions or ego-building persuasive formulations. Homework given to the patient is an example of the constructive use of suggestion. The therapist will have to gauge the patient's readiness to experiment with any anxiety-provoking action before making a direct or indirect suggestion that the patient undertake it. A premature exposure resulting in failure may merely intensify a phobia.

A number of variables may be distinguished that appear to regulate the forcefulness of suggestion (Wolberg, 1962). The first variable is concerned with the significance to the individual of the suggesting agency. The anachronistic residue of need for a protective parent that is present in all persons makes the individual more suggestible in the presence of an authority symbol who approaches an ideal. The higher the dependency level the more apt is the individual to design out of every relationship a child-parent tableau. Behind the helplessness of such gestures is a drive to absorb the strength of the authoritative token through submissive identification. By yielding to the authority's power the hope is to become powerful. Where the dependency need is sufficiently intense, the individual may respond to instrumentalities that possess any kind of protective promise— including drugs, placebos, faith healing, yoga, hypnosis, psychotherapy, etc. Another factor that heightens dependency, and hence intensifies suggestibility, is anxiety. Individuals whose mastery is shattered will cling with desperation to any potential helping resource, responding dramatically to preferred injunctions and commands. The intrusion on the individual of some catastrophic event that damages defensive integrity and diminishes security and self-confidence will thus tend to lower the suggestive threshold. Soldiers after battle, and persons exposed to accidents and natural disasters, often verbalize the need for a loving, protective agency. Under such circumstances the person may respond intensely to suggestions that are more easily resisted later. A momentary regression to the actual or fantasied securities of childhood is the prompting that inspires the anxiety driven soul to aggrandize the expediency that is offered.

Qualities in the helping agency positively correlated with suggestibility are those that inspire confidence in the subject and raise expectations of spectacular performance from the agency. Negatively correlated are characteristics that promote lack of confidence or that arouse resentment. Appearance, diction, status, reputation, and fame usually enhance the authoritative image. Group acceptance and acknowledgment of power of the authority as well as strong charisma of the authority augment the suggestive mystique.

The second variable is the significance to the subject of the specific content of the preferred suggestions. The precise *meaning* of the communications to the individual is

what is of determining importance, rather than their true content. Many vectors are operative, not the least of which is motivation. If the recipient of a communication, verbal or nonverbal, is attuned to respond positively, material will be plucked out of context that seems to justify a positive response. Utterances by prophets wedded to contemporary philosophical and religious movements may sound nonsensical to a casual and uninvolved observer, yet to a believer they are spell-binding and heavenly inspired. Every individual is to some extent the victim of a mirage inspired by the projection of inner needs. Thus the world is fashioned to personal improvisations. If the helping authority is able to divine the incentives of the client, more suitably meaningful arguments and memoranda will be supplied.

The third variable that modulates suggestibility is the degree of anxiety that is mobilized in the subject by the acceptance of a specific suggestion or by the relationship itself. Individuals who fear submitting themselves to others, who retreat from domination, who are reluctant to yield to their dependency drives, who are compulsively independent, who preserve a defensive detachment, or who are fiercely competitive may resist suggestions, even those that can be helpful to them, no matter how convincingly these are phrased. Transferential contaminants often enter into relationships, distorting their dimensions. To some extent, transference may be controlled if the helping person is aware of its presence and restrains untoward countertransferential impulses that neurotically interlock with those of the subject. Nevertheless, even though the helping person attempts to keep the relationship reality-oriented, it may disintegrate through assignment to the agency of the most noxious characteristics of significant personages in the subject's past. As a hated parent, the sentiments of the agency will be bitterly resisted.

In the absence of obstructive transference, suggestions may still be resisted if they challenge or run counter to vital defenses. In the latter case, anxiety will tend to neutralize or modify the suggestion. This was dramatically illustrated by a patient I was asked to see to help differentiate psychic from organic pain. The surgeon who had advised a disc operation for severe back pain suspected a hysterical reaction; to rule this out, he requested a consultation. To see if the patient's pain could be removed by suggestion

(which would help establish a functional basis for the pain), I induced hypnosis, during which I suggested that upon awakening the pain would disappear from his back, but would instead be transferred to his right arm. The patient responded positively with considerable surprise. Upon rehypnotizing him, I demonstrated to him that I could transfer the pain from his arm to his right leg. Thereafter I attempted its displacement to his left arm. To my consternation this suggestion was resisted, but instead the pain was again felt in the habitual back zone. I reinduced hypnosis and repeated the transfer of pain to various areas, which proved successful except for the left upper extremity. Questioned under hypnosis regarding this puzzling phenomenon, the patient replied that his father had died from a heart attack. Prior to his death he had experienced angina pectoris, with referred pain to his left shoulder and arm. The patient feared succumbing to the same illness. Apparently the meaning to him of accepting my suggestion to feel pain in the left arm was to acknowledge succumbing to angina pectoris. His anxiety blocked my suggestion.

Where suggestions upset the adaptive equilibrium, they will tend to be resisted. Thus, where repression is threatened by a suggestion, or where positive gains and pleasure associations are in danger of renunciation, or where unconscious masochistic needs power the existing neurotic operations, the individual may be oblivious to the most sensible maxims or magisterial commands. If prevailing values and philosophies are contradicted, suggestions may also be repelled. Suggestions are best formulated, therefore, in terms that are congruent with the person's ideologies.

The fourth variable concerns the subject's critical judgment. In spite of the fact that suggestion resides in the penumbra of illogic, critical reasoning and common sense are still posted as sentinels. Periodically they will interfere with suggestion's automatic pursuits. One may observe this in somnambulistic subjects during hypnosis, who, compulsively responding to irrational posthypnotic suggestions, force themselves to challenge, to inhibit, and, finally, to oppose acts that are foolish or without purpose. Eventually, an interference with helping exhortations will probably occur should they not harmonize with the individual's intellectual understanding. First accepted on faith, they

finally fall under the critique of logicality.

CONSTRUCTIVE GROUP EXPERIENCES (GROUP DYNAMICS)

Groups exert a powerful influence on the individual. They may be responsible for significant changes among the constituent members. The effect of Alcoholics Anonymous on victims of drink, of Synanon on drug addicts, and of Recovery on former hospitalized patients are examples of how even serious personality and emotional problems may be benefited through constructive group adventures.

In order for change to occur, however, a new and unique group experience is required, one that contributes to the individual's security and desires for belonging, at the same time that it challenges the customary patterns of thinking, feeling, and acting. This generally occurs when the person is forced to participate in a problem-solving situation with an assemblage that is respected, the members of whom join their forces for some united purpose. For example, a body of parents may meet at regular intervals for deliberation and action on problems affecting their children at school. A special committee of a fraternal order convenes for a cooperative pooling of ideas and skills. A council is elected in a neighborhood to devise tactics to fight racial discrimination. A select crew of supervisors in an industrial plant organize to bolster the morale of the workers. A small recreational or hobby club is developed that offers an exciting program. Even though individuals have functioned in various groups during their life span with usual controls and defenses, the new group, if it is to be effective, will not sanction, indeed may challenge, their customary behavior if it runs contrary to the group's standards. This creates conflict and may force them to interact in a different way. Deviants—that is, persons whose standards are in conflict with the group norms—are particularly affected since their conduct upsets the members, who may turn on the deviants and try to force them to conform. If the person has an investment in remaining with the group, the price may be a change in manner or ways of thinking.

As people collaborate in activities and relationships, they learn which of their traits and actions encourage rewards and which bring punishments. Thus a person who seeks to

control the group will sooner or later realize that domineering tendencies are resented, but that acceptance depends on acting cooperatively. The timid, submissive, and detached soul may be goaded into harmonious team work and assertiveness as security in the group becomes more firmly entrenched. Identification with the group assuages the individual's helplessness and isolation.

Approval and disapproval cut deeply into personality defenses. As the individual reacts repetitively with customary patterns to manipulate, monopolize, bully, undermine, lampoon, withdraw, reassure, comply, or collapse, oppositional responses of the group create a crisis. Attacked, the person may then be tempted to leave the group or may be invited to leave. It is at this point that change becomes possible, prompted by a need to remain with the group. The individual may then learn that it is not necessary to shout to be heard or to flaunt one's virtues to be acknowledged. There may be the realization that criticism can be constructive without offending and, conversely, that one can be criticized without being a victim of an evil design; that one may relate without becoming enslaved, accept help without loss of status, stand up for one's rights without being attacked, perform without being rejected, give without feeling exploited; and that one can be liked for what one is and not for what one does. These experiences have a forceful effect, particularly where defenses are not too rigidly set. A remodeling of values, attitudes, and behavior follows upon a more accurate perception of one's role in the group.

Actually, while these happy effects are psychotherapeutic, they cannot be considered in the same light as those accomplished through a structured psychotherapeutic program, for instance, group psychotherapy. Social or problem-solving groups are organized with an objective other than the treatment of its members; beneficial results in personality are a mere by-product of the existing group dynamics. While the individual may retain new patterns, generalizing them toward situations other than the group in which they were evolved, the tendency is to slip back into old habits when pressures to conform are no longer present. If, however, an understanding of disturbed ways of relating has been integrated, a permanent effect on character structure may be registered.

DYADIC GROUP DYNAMICS

In individual psychotherapy a dyadic group situation exists that inspires some of the identification phenomena observed in larger groups. Various cues (e.g., the magazines and books in the waiting room, the pictures on the walls, the office furnishings and decor, the style of therapist's clothing and grooming, and the therapist's comments and behavior) will lead the patient to speculate on the value systems of the therapist and to attempt self-modeling along similar lines, or at least to challenge some personal standards and patterns.

In short-term therapy interpersonal dynamics involving the therapist must be considered also as a factor in reeducation. Karl Menninger (1952a) has emphasized that the value of the psychiatrist is greatest as a person rather than as a technician or scientist. What one *is* has more effect upon the patient than anything one *does.* Because of the intimate relationship between patient and psychiatrist, the value systems, standards, interests and ideas of the doctor become important."

A therapist cannot help but communicate personal values to patients. This will occur no matter how passive, non-interfering and nonjudgmental the therapist tries to be. An attempt may be made to suppress verbal valuations, but nonverbal prejudices will nevertheless come through. Nods, grunts, groans, smiles, immobility, fidgetiness, pauses, choice of topics for questioning, emphasis, repetitions, and interpretations will soon convey to the patient the therapist's worldviews and tendencies toward deviance and conformity. Subtle indications such as the kind of waiting room furniture, pictures and magazines, the therapist's hair style and clothing preferences, and the manner in which office routines, billing, and appointments are conducted are as eloquent in revealing standards as any direct verbal avowal of values. It is useless to try to conceal the fact from the patient that the therapist has a definite point of view and possesses distinctive tastes and prejudices. Indeed, the patient may even divine unconscious values and during transference confront the therapist with a bill of particulars, the validity of which may be staggering.

If a therapist's values are apparent to the patient, the question may be asked whether to express them verbally as articles of personal conviction, at least those of which the therapist is aware? It is obvious to most therapists who believe this that they must nevertheless restrain themselves from political and other declarations, and especially not force their values on patients, even when the therapist is convinced of their moral and pragmatic worth. The patient's right to accept or reject the therapist's standards is usually respected. Moreover, the therapist, assuming an ability to be objective, may subject personal value systems to soul-searching to discern which of these are warped.

A frank encounter with oneself, buttressed if necessary by personal therapy, may be a boon to both therapist and patient, since many patients will incorporate the therapist's theories and moral precepts more or less uncritically on the basis of a need to please, in order to learn from and amalgamate with the idealized authority figure who is rendering help. This is probably allied to mechanisms that take place in any educational process.

EFFECTS OF EXTRATHERAPEUTIC AIDS ON PSYCHOTHERAPY

How can we assay the effect of adventitious, non-specific changes that have nothing to do with a formal psychotherapeutic situation? It is doubtful if we can fully differentiate intercurrent from therapeutic factors. Forces prevailing upon the individual outside of the psychotherapeutic process are often so elusive that they defy detection, let alone analysis. For example, results of psychotherapy are undoubtedly influenced by the implicit assumption of the patient that one is *expected to* and *will change* for the better. Under these circumstances, irrespective of the specific theories of the therapist and the tactics that the therapist employs, the patient may tend to show improvement.

Suffice it to say that the therapist accepts with gratitude the fact that there are supplementary "spontaneous" and "helping" healing aids to assist in therapeutic efforts. The therapist tries not to interfere with these elements except insofar as they detract from treatment objectives. For example, where the individual utilizes escape and control mechanisms to withdraw from relationships, or where existing philosophies negate a productive adjustment, the therapist will treat these devices as resistances to productive

change. But, by and large, the adventitious ameliorative agencies are accepted as unavoidable. Some psychotherapeutic systems attempt to encourage them, exhorting the individual to seek out spontaneous activities that help in growth; creating an atmosphere in therapy to inspire trust, faith, and confidence in order to enhance the placebo element; stimulating emotionally cathartic expressions of feeling; promoting a positive relationship situation by assuming the role of a benevolent, giving authority; suggesting participation in social or problem-solving groups; and fostering the development of philosophical formulas that take pressure off the individual and enhance a new way of looking at one's responsibilities. Indeed some treatment schemes, adopting the tactic that if we cannot eradicate the coincidental therapeutic forces, we should join them, incorporate the extratherapeutic aids into the body of their systems. From a practical point of view, the therapist may assume that whether he likes them or not, these elements are going to play some part in the patient's getting better. The therapist would do well then to acknowledge their part in any results claimed. Logic convinces that the effect of any psychotherapy actually is a summation of that psychotherapy plus intercurrent non-specific healing adjuncts. Once we stop struggling against the impossible task of separating these two protagonists, we can apply ourselves to the task of utilizing both psychotherapeutic techniques and coincidental constituents that make for therapeutic gains.

Can we delineate the kind of psychotherapeutic climate that will expedite the non-specific healing forces? A considerable number of observers have attempted to do this in the past, among whom are Alexander (1948), Rogers (1951), Fromm-Reichmann (1952b), Raush and Bordin (1957), Strunk (1958), Halpern and Lesser (1960), Strupp (1960), Jourard (1959a), and Truax and Carkhuff (1964). We may speculate that the climate of successful therapy depends on a number of factors that are operative in all good helping situations. These include the following:

1. *Hope.* Patients approach the ministrations of the therapist with assured expectancy. A sanguine anticipation of success is present. Therapists have confidence in their methods and theories. This activates the placebo effect.

2. *Trust.* Patients see their therapists as sincere, honest, reliable, guileless,

trustworthy, undeceitful, unaffected, straightforward, and authentic beings. Therapists display respect for their patient in spite of the latter's pathological behavior. Therapists also reveal their own genuineness.

3. *Freedom to respond.* Patients permit themselves to think, feel, and act without restraint. This permits them to verbalize freely and to unburden themselves. Therapists encourage freedom in reactivity. This sponsors emotional catharsis.

4. *Faith.* Patients have a conviction that therapists possess the percipience, sensitivity, wisdom, experience, skill, and ingenuity to understand basic presenting problems and difficulties and to know what to do about them. Therapists convey assuredness, positiveness, and empathic understanding. This facilitates the suggestive factor.

5. *Liking.* Patients conceive of their therapists as empathic individuals who relate to them personally and warmly; in turn, therapists feel a nonpossessive warmth toward the patients. This releases dynamic ingredients present in all human encounters (dyadic and larger groups) that constructively influence attitude change.

5
Significant Variables that Influence Psychotherapy

Apart from extratherapeutic aids that can positively influence results in psychotherapy, multiple variables enter into the treatment gestalt that bear upon results for the good or bad. At the outset it is necessary to recognize that no psychotherapeutic method exists today that is applicable to all patients or germane to the styles of all therapists.

As disparate as the various approaches to psychotherapy may seem, their impact on the patient is often registered in similar ways. First, they offer a unique kind of interpersonal relationship in which one feels accepted for what one is and where judgements concerning attitudes and behavior do not agree with habitual expectations. Second, there is an explicit and implicit reinforcement of selected responses with the object of overcoming important behavioral deficits and of extinguishing maladaptive habit patterns. Third, there are direct or indirect attempts made at cognitive restructuring, through various instrumentalities, such as (1) persuasive arguments and proffering of philosophical precepts, (2) the exploration of conscious and unconscious conflicts aimed at the inculcation of insight, and (3) the provision of a corrective behavioral and emotional experience within the matrix of the patient-therapist interaction. Irrespective of behavioral parameters that purportedly are selected for inquiry and rectification, the patient will respond to the therapeutic interventions being utilized in accordance with personal needs and readiness for change.

These facts have fathered a common idea among professionals that therapists of different theoretical orientations do essentially the same things. The patient presents a problem; an attempt is made to establish a meaningful relationship; some formulation is presented to the patient as a working hypothesis; and special procedures are implemented to enhance the patient's mastery and eliminate disruptive elements in adjustment. If this be true, then techniques are merely forms of communication secondary

to a host of transactional processes that draw from many biological, intrapsychic, and interpersonal vectors.

A reasonable question that may be asked is whether current research can shed some light on how these vectors can be organized and manipulated to make our operations more effective. Specifically, do we have reliable data that will permit us to match patients, therapists, and techniques? Offhand we must admit that empirical studies to date have not settled this question. In an extensive review of research on the assessment of psychosocial treatment of mental disorders by an NIMH working group functioning as an advisory committee on mental health to the Institute of Medicine of the National Academy of Sciences, it is concluded that we do not yet have the answers to the basic question of "what kinds of changes are effected by what kinds of techniques applied to what kinds of patients by what kinds of therapists under what kinds of conditions" (Parloff et al, 1978a). We have insufficient data to date regarding the relative effectiveness of the different therapeutic modalities as well as the patient-therapist preferences to make a scientific matching feasible. When we consider the choice of the best kind of therapy, the report sums up the following way: "In summary, the data does not show that any of the tested forms of therapy are unconditionally superior to any other form." The report goes on with the statement that the existing single studies have proved inadequate to answer questions that we need to resolve. What is required is a coordinated planning of wide-scale sophisticated research utilizing an agreed upon minimal set of standardized measures for describing and assessing the kinds of problems, the variety of treatment interventions, and the nature and degree of behavior change.

Since help from present-day research is so problematic, we must depend on clinical hunches in sorting out the significance of the many variables in psychotherapy. For convenience we may group these into:

1. Patient variables

2. Therapist variables

3. Social and environmental variables

4. Transferential and countertransferential variables

5. Resistance variables

<h2 style="text-align:center">PATIENT VARIABLES</h2>

The Syndrome or Symptomatic Complaint

Are there special techniques that coordinate best with selected symptom complexes, methods that are more rewarding with some types of complaints as compared to other types? How really important are techniques in psychotherapy? Can different therapists get the same results by utilizing various kinds of interventions with which they are individually expert?

By and large techniques do operate as a conduit through which a variety of healing and learning processes are liberated. How the techniques are applied, the faith of therapists in their methods, and the confidence of the patient in the procedures being utilized will definitely determine the degree of effectiveness of a special technique. But techniques are nevertheless important in themselves and experience over the years with the work of many therapists strongly indicates that certain methods score better results with special problems than other methods.

Thus symptoms associated with biochemical imbalances, as in *schizophrenia* or *affective disorders,* may be relieved with proper psychotropic medication, for example, neuroleptics in the case of schizophrenic thinking disorders, antidepressant drugs in depressive states, and lithium for manic excitement and bipolar depressions. While thinking disorders in schizophrenia are helped by neuroleptics, problems in social adjustment are better mediated by behavior therapy, family therapy, and counseling. Indeed, milieu therapy in the form of a therapeutic environment staffed by accepting, supportive persons or proper accepting, nonstressful surroundings in which to live and work (Warner, 1985) often permit an adequate adjustment without the use of drugs. Such a congenial atmosphere must be continued indefinitely, in some cases over a lifelong period. The presence of a hostile or nonaccepting family correlates with an increased

rehospitalization rate. Research studies, i.e., controlled outcome studies for individual or group therapy in schizophrenia, provide no strong evidence for or against the value of psychotherapy. Generally with continued aftercare following hospitalization in the form of a behaviorally oriented program and an adequate residential regime (halfway houses, partial hospitals, rehabilitation units and other community support systems), over 90 percent of patients can be discharged in the community with a 2-year rehospitalization rate of less than 5 percent (Paul & Lentz, 1977).

Our experience at the Postgraduate Center for Mental Health confirms the value of a rehabilitation program in lowering rehospitalization rates and, in rehospitalized patients, reducing the time of confinement. Behavioral token economies are often valuable in hospitalized patients toward regulating ward behaviors in areas such as self-care, grooming, and social adjustment, and to control target behaviors such as job performance. Behavioral extinction procedures have been utilized to manage gross pathological behavior, like violence and destructive tantrums in psychotic autistic children, especially when coupled with differential reinforcement of constructive behavior. Such behavioral gains are consolidated when management techniques are taught to parents or other adults with whom the patient lives. No cure of the basic condition is brought about by these methods, but definite improvement of behavioral repertoires may be achieved.

While drugs influence *depressive symptoms,* they have little effect on patterns of behaving and thinking, which are best mediated through dynamic interpersonal therapy, cognitive therapy, and behavior therapy aimed at reinforcing involvement with pleasant activities and changing target symptoms and behavior toward improvement of interpersonal relations and social functioning. Combined drug and psychosocial therapy is thus best in most depressions. In suicidal depression electroconvulsive therapy has proven to be a lifesaving measure.

In *hyperkinetic children* it is generally found that we may be able to reduce the overactivity with psychostimulant medications, like Ritalin® and Dexedrine®, plus behavioral forms of reinforcement of positive behavior or such mild aversive techniques

as removing the child with disturbing behavior to a "time-out" room for a few minutes. To influence neurophysiological dimensions, as reflected in severe *tension states,* simple relaxation procedures like meditation, relaxing hypnosis, or autogenous training, or emotive release therapy have been instituted.

Certain *psychosomatic conditions,* such as muscle spasms, migraine, hypertension and arrhythmia, may sometimes be helped by biofeedback. Unfortunately, biofeedback has been oversold, its utility being limited to selected patients (Miller, 1978). Behavioral advocates claim that best results with obesity are obtained with measures directed at self- and stimulus control. Behavioral operant reinforcement techniques and systematic desensitization are being used in *anorexia nervosa,* although the evidence of their effectiveness is still unclear. More recently progress has been reported with anorexia and bulimia utilizing antidepressants. *Smoking* control, it is claimed, is best handled by multicomponent treatment packages that program a reinforcement of nonsmoking behaviors and utilize smoking suppressive tactics (Bernstein & McAlister, 1976) supplemented by nicotine gum chewing. Stimulus satiation, i.e., rapid smoking to satiation, is temporarily effective but the physical side effects must be considered. Hypnosis is also useful in combination with follow-up behavioral methods. In *enuresis* behavioral approaches (such as a urine alarm bell) are claimed to be superior to dynamic psychotherapy and imipramine.

Sexual disorders (voyeurism, fetishism, sadomasochism, exhibitionism, transvestism), though difficult to treat, are approached by some therapists with aversive therapy, such as electrical stimulation for transvestism (Marks, 1976) and with certain idiosyncratic methods like having an exhibitionist appear before a female audience to expose himself while talking about his condition, the extraordinary procedure being credited with some success on follow-up (Wickramasekera, 1976). *Sexual dysfunctions* (impotence, frigidity, dyspareunia, vaginismus, anorgasmia, premature ejaculation) do well with various behavior therapies, hypnosis, and dynamic psychotherapy. Of all of these programs, the Masters and Johnson techniques have proven most popular and have in the opinion of some authorities been made more effective when blended with

psychodynamic and interpersonal techniques (Sollod & Kaplan, 1976).

Phobias that have their origin in conditioning experiences (i.e., exposure to parental fears, like a mother who is in terror of mice or a father who shies away from heights), or to a catastrophic personal happening (i.e., an accident in an airplane in which a person was traveling, resulting in a fear of flying), or to an anxiety or physiologically distressing experience linking itself to a coincidental stimulus (i.e., nausea or gastric upset occurring at the same time that one is eating a certain food, resulting in a subsequent refusal to eat that food), seem to respond more rapidly to systematic desensitization, flooding or graded exposure to a phobic object than to any other kind of technique. On the other hand, phobias that are the product of deep personality conflicts, the projected symbols of unconscious needs and fears, are in a different class from conditioned phobias and do not respond as well to behavioral methods. In fact, they may stubbornly resist those techniques and are better suited for dynamic approaches. Of all phobias, agoraphobia seems to be the most resistant to verbal therapies but may respond to antidepressant drugs.

About two-thirds of patients with *anxiety reactions* are helped by both dynamic psychotherapy and behavioral techniques, such as systematic desensitization, progressive relaxation, "participant modeling" (i.e., the therapist modeling how to master anxiety), and temporary drug therapy. Behavioral therapy has moved toward recognizing the importance of cognitive factors (such as irrational self-statements and false attributes) and the need not only to modify environmental parameters, but also to consider the patient's interpretation of events and thoughts that mold reactions to the environment. In line with this, applications of behavior therapy have expanded toward a wide spectrum of neuroses and personality disorders.

Some obsessive-compulsive disorders respond to such antidepressants as clomipramine (Anafranil®), others come under control with aversive behavioral techniques when they resist every other type of manipulation. Prolonged exposure to thoughts or situations that provoke compulsive rituals combined with blocking of the

patient from engaging in such rituals has yielded some successes. In vivo exposure is superior to exposure to fantasies. We may minimize persuasion as a technique, but it can have a potent effect on some *obsessive states, adjustment reactions,* and related conditions (Truax & Carkhuff, 1967). Stubborn as they are, *personality problems* and most *neurotic disorders* that are bracketed to personality problems are conditions most subject to the utilization of a dynamic orientation that probes for provocative conflicts and defenses. *Relationship difficulties* are particularly suited for group therapy, marital therapy, and, especially where children are involved, family therapy.

Some *addictions* seem to respond best to certain inspirational groups (e.g. drugs with Synanon, alcohol with Alcoholics Anonymous, food gorging with Weight Watchers, gambling with Gamblers Anonymous). These groups are preferably led by a person who has gone through and has conquered a particular addiction and is willing to serve as a model for identification. Accordingly, where a therapist works with such groups, an ex-addict co-therapist may be a great asset.

Where repressions are extreme, classical psychoanalysis, intense confrontation, hypnoanalysis, narcoanalysis, and encounter groups have been employed in the attempt to blast the way through to the offensive pathogenic areas. Understandably, patients with weak ego structures are not candidates for such active techniques, and therapists implementing these techniques must be stable and experienced. *Antisocial personalities* subjected to a directive, authoritarian approach with a firm but kindly therapist sometimes manage to restrain their acting-out, but require prolonged supervised overseeing.

Apart from the few selected approaches pointed out above that are preferred methods under certain circumstances, we are led to the conclusion that no one technique is suitable for all problems. Given conditions of adequate patient motivation and proper therapist skills, many different modalities have yielded satisfactory results. It is my feeling, however, that whatever techniques are employed, they must be adapted to the patient's needs and are most advantageously utilized within a dynamic framework.

Transference reactions may come through with any of the techniques, even with biofeedback and the physical therapies. Alerting oneself for transference, one must work with it when it operates as resistance to the working relationship. Unless this is done our best alignment of method and syndrome will prove useless.

The fact that certain techniques have yielded good results with special syndromes and symptoms does not mean they will do so for all therapists or for every patient. Interfering variables, such as will henceforth be described, will uniquely block results or will make the patient susceptible to other less popular methods.

Selective Response of the Patient to the Therapist

At its core the patient's reaction to the therapist often represents how the patient feels about authority in general, such emotions and attitudes being projected onto the therapist even before the patient has had his first sessions. The patient may rehearse in advance what to say and how to behave, setting up imaginary situations in the encounter to come. Such a mental set will fashion feelings that can influence the direction of therapy. Thus, if the patient believes that authority is bad or controlling, oppositional defenses may be apparent during the interview. These global notions about authority and the reactions they sponsor are usually reinforced or neutralized by the response to the therapist as a symbol of an actual person important to the patient in the past (transference). Some characteristic in the therapist may represent a quality in a father or mother or sibling and spark off a reaction akin to that which actually had occurred in past dealings with the person in question. Or the reaction may be counteracted by a defense of gracious compliance or guarded formality.

Confidence in one's therapist is enormously important—even when the therapist's ideas of the etiology or dynamics of the patient's difficulty are wrong. The patient's acceptance of explanations proffered with conviction can have a determining influence on the patient. They are incorporated into the patient's belief system and sponsor tension reduction and restoration of habitual defenses. Through what means this alchemy takes place is not clearly known, but suggestion, the placebo effect, and the impact of the

protecting relationship offered by the therapist undoubtedly play a part. Sometimes unpredictable elements operate in the direction of cure.

This is illustrated by the case of a beautiful, poised female writer of 32 who was referred to me for hypnosis by a friend of mine after many attempts to stop smoking by herself, and after several unsuccessful tries at psychotherapy. While there were no serious emotional problems that I could detect, and her present work adjustment, relationships with people, and sexual life seemed fairly satisfactory, one piece of data that she gave me put doubts in my mind as to how successful I would be in getting her off tobacco. She confessed to me, somewhat shamefacedly, that she still used a baby pacifier that she stuck into her mouth alone at home (she was single) at times when a cigarette wasn't between her lips. Often she went to sleep with it in her mouth. I asked her if she knew what this meant. "After all, doctor," she replied, "I'm no fool. I'm just a plain oral character." Under the circumstances, I confessed to her that the chances of success with a symptom-oriented approach like suggestive hypnosis were poor, and that she had better get herself into analysis without wasting any more time or money. "God forbid," she retorted. Since I had promised to hypnotize her, I induced a trance with less than ardent enthusiasm, and went through my usual paces, hoping to demonstrate that my predictions of failure would surely come to pass. Two days later she telephoned me to tell me she had quit smoking, and she asked if I would make a hypnotic tape for her. We had three visits in all, and while she retained her discrete pacifier habit, she fooled me by staying off tobacco completely. A year went by and she still had not resumed smoking, nor were there any substitute symptoms. This abstinence was confirmed by several reliable friends who knew her well.

Now I have no idea of the dynamics of the symptomatic cure but it is possible that my pessimistic attitude was just the right tactic to use with her. She may have decided to accept the challenge and to show me that I was wrong concerning my estimate of her. Or perhaps the idea she would have to get into long-term analysis was more distasteful to her than giving up smoking. Frankly, I was delighted that I was such a poor prognosticator, even though I still am convinced that a good analysis would have been a worthwhile investment.

The point I am trying to stress is that as thorough as we believe our initial interviewing may be as a way of estimating outcome, we still do not have all the variables at our fingertips. We still can be right in our estimate, but sometimes, as in this case, we can be wrong, and to the patient's benefit.

Where the therapist becomes for the patient an idealized figure, the initial therapeutic impact may be enhanced. Or if the transference is to an irrational authority,

resistance is more likely in evidence. The degree of charisma possessed by the therapist also influences the patient's responses. Reputation, clothing, manner, and appearance all function to nurture the illusion of miracles to come. The various patterns that evolve have a powerful and often determining effect on any techniques the therapist may utilize.

Selective Response of the Patient to the Therapist's Techniques

Patients occasionally have preconceptions and prejudices about certain techniques. Hypnosis, for example, may be regarded as a magical device that can dissolve all encumbrances, or it may connote exposing oneself to Svengali-like dangers of control or seduction. Misconceptions about psychoanalysis are rampant in relation to both its powers and its ineffectualities. Frightening may be the idea that out of one's unconscious there will emerge monstrous devils who will take command—for example, the discovery that one is a potential rapist, pervert, or murderer. Should the therapist have an inkling as to what is on the patient's mind, clarification will then be in order. The manner of the therapist's style is also apt to influence reactions of rage at the therapist's passivity, balkiness at what is considered too intense activity, anger at aggressive confrontation. Some patients are frustrated by having to talk about themselves and not being given the answers.

Moreover, responses to different methods will vary. There is a story of a Gideon Bible (which may be apocryphal) that illustrates this. As is known, practically all hotel rooms contain, as part of the general equipment, a Bible placed there by the Gideon Society, which in the front pages are suggested reading for the weary traveler. For instance, if one is in need of salvation, the reference is to John 3:3; or desires peace to neutralize anxiety, Psalm 46; or relief in the time of suffering, Psalm 41; or consolation in conditions of loneliness, Psalm 23. In a certain hotel Bible opposite Psalm 23, there was written in the margin this inscription: "If after reading this Psalm you are still lonesome, upset, and feel life is not worthwhile, telephone 824-3921 and ask for Phyllis." This is eclecticism! To help in the selection there are minimal techniques an eclectic therapist should know. In my opinion, the following are most useful: dynamically oriented interview

procedures, group therapy, marital therapy, family therapy, behavior modification, pharmacotherapy, cognitive therapy, relaxation methods, and hypnosis.

But irrespective of the techniques we select, we must be sure that they accord with the patient's belief systems. As has been mentioned previously a patient who is convinced that spirit infestation is a cause of illness will do much better with a shaman or witch doctor than with a psychiatrist. The patient's lack of faith in what the psychiatrist does will render worthless the most sophisticated treatment efforts. Knowledge of the cultural concepts that mold a patient's ideas about what emotional suffering is all about may make necessary some preliminary education to prevent embarking on a futile therapeutic journey.

Some attempts have been made to assign patients to certain styles of therapeutic operation according to their unique characterological patterns (Horowitz, 1977). For example, hysterical personalities are presumed to require a mode of therapist management that differs from that effective in obsessional personalities. This distinction considers that certain optimal learning patterns correlate with identifiable personality typologies. The relationship between character structure, diagnostic category, and learning abilities, however, never has been fully clarified. Thus, among patients suffering from the same syndrome, let us say obsessive personality, there are great differences in the way they will respond to certain techniques and therapist styles. While some general principles may be applicable to all or most obsessives, the existing differences prevent our using a blanket approach. People possess different modes, even within the same syndrome, of absorbing, processing, and responding cognitively, emotionally, and behaviorally to therapeutic interventions.

Since psychotherapy is in a way a form of reeducation, the learning characteristics of a patient should best correspond with the techniques that are to be used. Problem-solving activities are often related to the kind of processes found successful in the past. Some patients learn best by working through a challenge by themselves, depending to a large extent on experiment. Some will solve their dilemmas by reasoning them out through

thinking of the best solution in advance. Others learn more easily by following suggestions or incorporating precepts offered by a helpful authority figure. Some are helped best by modeling themselves after an admired person, through identification with that person. Some patients work well with free association, others do not. Some are able to utilize dreams productively, or behavior modification, or sensitivity training, or other methods. It would seem important to make the method fit the patient and not wedge the patient into the method.

The fact that learning patterns are so unique and modes of learning so varied lends justification to an eclectic approach. It would be advantageous, of course, in the initial phases of therapy to find out how a patient might learn best, but no expedient is available today that can give us this information. We usually settle for the fact that when a patient is first seen, learning capacities and styles are unknown and the therapist must proceed somewhat blindly. We more or less shoot in the dark in order to coordinate a patient's specific problem and personality with our techniques. We may get some help during interviewing in discovering how the patient has learned best in the past. More pointedly, we get the most reliable data by actually exposing the patient to the interventions we have to offer and observing the response to what is being done.

A few other attempts have been made to identify variables that can make the selection of a therapeutic method more feasible. Among these are the patient's response to hypnotic induction (Spiegel & Spiegel, 1978) and the isolation of core conflicts through the making of a developmental diagnosis (Burke et al, 1979). Some interesting speculations may emerge in watching how patients react to the induction of hypnosis, but are these sufficiently reliable to pinpoint either the existing diagnosis or choices in therapeutic method? More experimental substantiation is required.

Some therapists have attempted to utilize the area of developmental arrest as a way of selecting the ideal technique. Where the patient's prime difficulty is centered around resolution of separation-individuation, this is believed best accomplished through a technique such as described by Mann (1973) in which the struggle over short-term

termination of treatment threatens the patient's dependency, lights up the separation problem, and offers the opportunity to resolve the conflict in a favorable setting. Where the oedipal conflict is primary, the confrontation styles of Sifneos (1972) and Malan (1964, 1976a) are believed to be most effective. For problems originating in the latency period that precipitate out in the mid-life transition around issues of productivity and creativity, the "corrective action" approach of Alexander and French (1946) is recommended. However, it is difficult to substantiate these views because of the interference of so many other variables that can vaporize our best choice-of-method intentions.

While empirical studies tell us little about factors that make for a good patient-therapist match, we may speculate that the personalities, values, and physical characteristics of both patient and therapist must be such that severe transference and unfavorable countertransference problems do not erupt to interfere with the working relationship. A giving, accepting, warm, and active but not too interfering or obnoxiously confronting manner in the therapist is most conducive to good results.

Readiness for Change

Another important factor is the individual's readiness for change. This is a vast unexplored subject. A person with a readiness for change will respond to almost any technique and take out of that technique what he or she is prepared to use. What components enter into a satisfactory readiness for change have not been exactly defined, but they probably include a strong motivation for therapy, an expectation of success, an availability of flexible defenses, a willingness to tolerate a certain amount of anxiety and deprivation, the capacity to yield secondary gains accruing from indulgence of neurotic drives, and the ability either to adapt to or constructively change one's environment.

Patients come to therapy with different degrees of readiness to move ahead. Some have worked out their problems within themselves to the extent that they need only a little clarification to make progress, perhaps only one or two sessions of therapy. Others are scarcely prepared to proceed and they may require many sessions to prepare

themselves for some change. We may compare this to climbing a ladder onto a platform. Some people are at the bottom of the ladder and before getting to the top will need to climb many steps. Others will be just one rung from the top, requiring only a little push to send them over to their destination.

In therapy we see people in different stages of readiness for change, and we often at the start are unable to determine exactly how far they have progressed. One may arrive at an understanding of what is behind a patient's problem rapidly. From this we may get an idea that benefits will occur with little delay. Yet in relation to readiness for change, the patient may still be at the bottom of the ladder. Others are at a point where almost any technique one happens to be using will score a miracle. We may then overvalue the technique that seems to have worked so well and apply it to many different patients with such conviction that the placebo effect produces results.

We sometimes see patients who have been in therapy for a long time under the guidance of another therapist and who, on the surface, have made no progress at all. Surprisingly, after a few sessions the patient will begin to progress remarkably, creating the impression in both participants that the therapist is a genius in being able to do in three sessions what the previous therapist was not able to accomplish in three years. What actually may have happened is that the previous therapeutic effort succeeded in pushing the patient up the ladder toward the top, requiring only a bit more therapy to be able to take the last step that was accomplished by the second therapist taking advantage of the work achieved by the first.

> I remember one patient who came to see me who advertised the fact that I had cured her in one session. She had been under the care of physicians for years, suffering from a host of physical complaints, and her last few doctors, who were burdened by her incessant shifting symptoms, had given up on her as an obstinate hypochondriac. No medicines seemed to help, and whenever psychiatric referral was mentioned she responded with an angry refusal and a host of new symptoms. Finally, one day she announced in frustration to her doctor that she was ready to see a psychiatrist and the doctor then referred her to me.
>
> At the appointed time a buxom, handsome, middle-aged lady walked into my office and from the moment the door opened started and continued talking without giving me a chance even to introduce myself. My initial interview sheet in hand, I waited for a pause so that I could at least get some statistical data. After what

seemed like an interminable span, she stopped for breath and I threw in an introductory: "By the way, how old are you?" Without pause she avoided the question and continued on her odyssey of voyages to doctors' offices around New York. After several futile attempts to interrupt. I gave up, put my sheet down, settled back in my chair and listened, interpolating an occasional "yes" and "hmm humm." I broke in at the end of the hour with: "Unfortunately our time is up." "Doctor," she said. "I feel so much better—thank you very much," and she got up and walked out without making another appointment.

I was curious about what had happened, so that a week later, I telephoned her doctor. His startling reply was: "I don't know what you did for her, but it was like a miracle. For the first time since I've known her, she's lost her symptoms and is interested in getting out of the house and doing things. And," he added humorously, "she says you are a brilliant conversationalist." Three months later the doctor called me and confirmed her continued improvement.

I do not know what happened but apparently my respecting her need to talk without interrupting was probably the best approach I could have used. She was under such great tension that had I not permitted her to let off steam verbally I may have succeeded merely in frustrating and antagonizing her. Grilling her with questions might have given me more information, but I am not sure what it would have done for her. She apparently had climbed the readiness ladder by herself up to the top rung and what she needed to push her over the top was to have someone sit back and listen. She undoubtedly wanted to talk freely to somebody who was not a member of her family, who was not going to judge her, who was passively objective, and who was, hopefully, nonjudgmental. Whatever qualities she projected onto me, she utilized the relationship in line with her needs.

Obviously, while this passive stance worked well with this woman, it would not have served other patients who might have required more active confrontation over a more protracted period. A person's readiness for change may, more than any other factor, be responsible for how rapidly movement proceeds in psychotherapy.

Degree and Persistence of Childish Distortions

The distorted images of childhood, the ungratified needs, the unwholesome defenses, may persist into adult life and influence the speed, direction, and goals of therapy. These contaminations may obtrude themselves into the therapeutic situation irrespective of what kinds of technique are practiced. Insidiously, they operate as

resistance and they can thwart movement toward a mature integration, no matter how persistent and dedicated the therapist may be.

For example, one patient, a successful businessman of 50, came to therapy in a crisis over abandonment by his mistress 25 years his junior who had run off with another man. A deep depression and anxiety were the chief symptoms for which he sought help. He blamed the young lady's defection partly on his inability to compete with his rival and partly on the ubiquitous duplicity of all females. When he described his life, it became apparent that he had from the earliest days of adolescence looked for and pursued a certain physical type: blonde, fair skinned, long-legged, big-bosomed tarts whose teasing sexual provocativeness and irresponsibility added a fillip to his affairs. He invariably would select young women who were unable to establish a meaningful relationship and who eventually, despite his wealth and generosity, would reject him and finally leave him. This would make the relationship all the more precious in his mind and the rupture of the romance more disastrous.

During therapy he beat at himself, unmercifully proclaiming himself a worthless and destroyed person, a victim of the treachery of womankind. No amount of reassurance, challenge, and interpretation could penetrate his overwhelming despair, and antidepressants proved of little benefit. The fact that the great jewel in his life during the heyday of their relationship had led him a merry chase, deceiving and exploiting him mercilessly, made little difference. Her destructive exploits constituted the main content of his discussions with me, but his depreciating her had little effect on his yearning.

After 12 sessions of gripes in therapy, the lady returned without warning, complaining that her most recent paramour was unworthy of her, unreliable and, most importantly, penniless. She apologized for having hastily run off after knowing the man only several weeks and she begged the patient to take her back. The effect on the patient was electric. What common sense, medications, and psychiatry failed to do she accomplished in one evening. Depression, anxiety, and physical debility vanished. To justify the reunion, the patient offered to bring the lady to me for an interview to prove that she was now reformed.

At the interview there was no question that she had been trading solely on her physical assets, which were indeed ample, but emotionally and intellectually there was much to be desired. In fact, the most generous diagnosis one could bestow on her was that of a borderline case— and this was stretching a point. It was certainly apparent insofar as my patient was concerned that the only motivation he had for therapy was a desire to dull the pain of deprivation, not to inquire into or eliminate its source.

My best efforts to halt the affair were of little avail since the lady could accomplish more with a casual pout than I could with all the armamentaria that Freud, Pavlov, and the other great pioneers had to offer. And even though she soon again started her nonsense, he hung on desperately to the relationship at the same time that he bellowed like a wounded buffalo.

In going into the history, the background for his enslavement became apparent. The death of his mother when he was an infant and his placement with a series of relatives who provided him with a succession of nurses had failed to fulfill his need for real mothering. He was told, he said, that he was a colicky baby with respiratory trouble that was diagnosed as asthma. He failed to see any connection between his childhood and what was happening to him in the present. Interpretations of his orally frustrated dreams fell on deaf ears.

One day on inspiration I asked if he had ever seen a picture of his mother. This he denied. However, a later search by a relative through an old album yielded a startling picture that he excitedly handed me—a picture of a blonde beauty who presented an almost exact image of his present girlfriend. It took no great work to convince him that he had practically all his life been searching for a physical duplicate of his mother. This dramatic discovery had not the slightest effect on his futile mission to look for a symbolic breast, because after another abandonment, he started searching for a substitute blond, long-legged, big-breasted, unreliable paramour, whom unfortunately he found, starting a further round of exploitation, punishment, and anxiety.

Where severe traumas and deprivations are sustained in early infancy, especially prior to the acquisition of language, the damage may be so deep that all efforts to acquire that which never developed and to restore what never existed will fail. Transference with the therapist may assume a disturbingly regressive form and, while the genetic discoveries may be dramatic, the patient, despite intellectual understanding, will not integrate any learning and will fail to abandon patterns that end only in disappointment and frustration. Very little can be accomplished under such circumstances in short-term therapy, and even long-term depth therapy may lead to nothing except a transference neurosis that is difficult to manage or resolve. Lest we be too pessimistic about what may be accomplished through psychotherapy, there are some patients who, though seriously traumatized, may when properly motivated be induced to yield the yearnings of childhood and to control if not reverse the impulses issuing from improper discipline and unsatisfied need gratification. But this desirable achievement will require time, patience and, above all, perseverance.

APTITUDE FOR DYNAMICALLY ORIENTED PSYCHOTHERAPY

Practically all people who apply for help in managing emotional problems can be approached successfully with supportive and educational therapies. Eligibility for

dynamically oriented treatment, however, requires some special characteristics. Some of the available research indicates that patients who respond best to psychodynamically oriented therapy need treatment the least. What this would imply is that persons with good ego strength can somehow muddle along without requiring depth therapy. That this is not always so becomes obvious when we examine the quality of adaptation of these near-to-healthy specimens. In view of the shortage of trained manpower, we may want to look for characteristics in prospective candidates for therapy that have good prognostic value.

The following positive factors have been emphasized:

1. strong motivation for therapy (actually coming to therapy represents some commitment);

2. existence of some past successes and positive achievements;

3. presence of at least one good relationship in the past;

4. a personality structure that has permitted adequate coping in the past;

5. symptomatic discomfort related more to anxiety and mild depression than to somatic complaints;

6. an ability to feel and express emotion;

7. a capacity for reflection;

8. desire for self-understanding;

9. adequate preparation for therapy prior to referral; and

10. belief systems that accord with the therapist's theories.

The patient's expectations, age, and socioeconomic status are not too significant, provided the therapist and patient are able to communicate adequately with each other.

CHOICE OF GOAL AND FOCUS

If a patient through therapy expects to be a Nobel Prize winner, the patient will be rudely disappointed and soon lose faith in the therapist. There are certain realistic limits to how much we can accomplish through treatment, the boundaries largely being determined by the patient's dedication to the assigned task. Added to these are the curbs imposed by the many therapist variables soon to be considered. A great deal of tact will be required in dealing with inordinate expectations so as not to undermine further the already existent devalued self-image.

The selection by the patient of the area on which to concentrate during therapy is a legitimate and understandable theater around which initial interventions can be organized. It may not be the most culpable area stirring up trouble for the patient. But to push aside the patient's concerns with a symptom or a disturbing life situation and insist on attacking aspects of problems the patient does not understand or is not motivated to accept will lead to unnecessary complications and resistances. It is far better to work on zones of the patient's interest at the same time that we make connections for the patient and educate the need to deal with additional dimensions. Thus a man in the manic phase of a bipolar disorder may complain of a marital problem and press for its urgent resolution. Should we attempt to bypass his complaint factor and merely press lithium on him, we may be rewarded with an abrupt termination of treatment. His manic symptoms may subside, but his marital troubles may continue to plague him.

In attempting to choose the most productive arena for intervention we must keep in mind the fact that behavior is a complex integrate of biochemical, neuro-physiological, developmental, conditioning, intrapsychic, interpersonal, social, and spiritual elements intimately tied together like links in a chain. Problems in one link cybernetically influence other links. Elsewhere I have delineated the affiliation between the different links, contingent fields of inquiry, associated therapeutic modalities, and related syndromes. Without denigrating the importance of the patient's chosen area of focus, we may most propitiously deal with a link in the behavioral chain that, in our opinion, needs the most urgent attention, that the patient is willing to work on, and that is realistically modifiable with the patient's current or potential resources. Once we strengthen a pathogenic link

through therapy, the effects will usually reverberate through the entire behavioral chain.

THERAPIST VARIABLES

Personality Factors

Observations of the determining influence of personality traits in the therapist on outcome have been repeatedly made and reported by Whitehorn and Betz (1960), Betz (1962), Rogers et al, (1967), Truax and Carkhuff (1967), and Truax and Mitchell (1972). One finding is that a relatively untrained person with a concerned manner and empathic personality will get better immediate results, especially with sicker patients, than a highly trained therapist who manifests a "deadpan" detached professional attitude. One should not assume from this that a therapist with a pleasing personality without adequate training will invariably get good results. Some of the available research alerts us to the fact that the level of therapist expectations and the triad of empathy, warmth, and genuineness do not invariably represent the "necessary and sufficient" conditions of effective therapy (Parloff et al, 1978b). A well-trained therapist, however, who also possesses the proper "therapeutic" personality is by far best qualified to do successful therapy.

A good deal of the flesh and blood of what happens in treatment, short-term or long-term, is provided by the relationship the therapist establishes with the patient, the quality of which is largely influenced by the therapist's personality in operation. Personality expressions, good and bad, come through not only in the content of verbal communications but in nonverbal manifestations. The latter are not merely the epiphenomena of interaction but are directly related to the outcome. Nor does the factor of experience always operate to subdue damaging traits. In some cases earnest, dedicated beginners may relate better to patients than do more experienced, scientifically oriented, passive practitioners. Of course, we must consider some other variables also since we may be dealing here with different classes of patients, i.e., patients seeking a warm, giving authority as contrasted to those who want less personal involvement and greater ability to probe for and resolve defenses in quest of more extensive self-understanding.

After many years of training students and observing their work, I would estimate that the most meritorious personality traits sponsoring a good relationship are objectivity, flexibility, empathy, and the absence of serious emotional pathology. Successful therapists possess a bountiful blend of these attributes, unsuccessful therapists a dearth. Where a student therapist in training possesses a healthy combination of such positive personality characteristics, we may anticipate a good career, although this is not guaranteed. Where a candidate is less bountifully blessed, but cherishes rudiments of essential traits, these may be maximized by careful instruction and personal psychotherapy. A few enter training with such rigid defenses that they scarcely budge even after years of intensive analysis.

How to find candidates who personality-wise have a good chance of becoming competent therapists is a challenge confronting all training institutions. In the early days of existence of the Postgraduate Center for Mental Health, I once asked Paul Hoch, who was then Commissioner of Mental Health of New York State, what he believed the value to be of recommendations for admission to training from a candidate's personal analyst. "From my own experience," replied Hoch waggishly, "when you first start treating or supervising students, your immediate impression is that they are practically psychotic. But shortly thereafter you develop a relationship with them and you believe that they are only neurotic. And a while later you start endorsing them as either completely normal, or even better than normal." Could it be, I inquired, "that therapy changed their personalities for the better?" "More likely," answered Hoch, "as a therapist works with a student, this changes the therapist's judgment for the worse." What he was referring to, of course, was the ubiquitous problem of countertransference that can mask or distort one's appraisal of a partner in a relationship dyad. Other criteria for selection are undoubtedly more reliable than endorsements from one's personal analyst. But the real test of how effective a candidate will be as a therapist is the actual performance with patients with varying syndromes and degrees of pathology, under the surveillance and tutelage of a competent supervisor. Observation of a student's performance behind a one-way mirror and the use of videotape recordings are also of substantial help.

Specifically, especially where the patient requires rapid stabilization, the therapist's

manner must convey empathy, confidence, and understanding of the patient's turmoil and what is behind it. The patient, no matter how upset, will usually discern these qualities in the therapist and react to them. It is important also that therapists be able to control their own difficulties sufficiently so as to avoid the pitfalls of their own countertransferential problems interlocking with the problems of their patients. Particularly important is sensitivity to and the ability to manage irrational projections of patients, hallmarks of transference neuroses.

Considering that desirable character traits, if absent, are difficult to acquire even with personal therapy, it would seem important in the selection of candidates for training that some criteria be available to spot in advance students who possess or will be able to develop appropriate personality characteristics. This is more easily said than done. When we first founded the Postgraduate Center we experimented with many devices, including projective psychological testing and structured and nonstructured interviews. We failed to come up with any foolproof selection procedure. This is probably because the role that a candidate plays with an interviewer or psychologist tester is different from that assumed with patients.

My own experience convinces me that two personality qualities are especially undesirable in a therapist doing therapy: First and most insidious is detachment. A detached therapist will be unable, within the time span of treatment, to relate to the patient or to become involved in the essential transactions of therapeutic process. A detached person finds it difficult to display empathy. To put it simply, one cannot hatch an egg in a refrigerator. A cold emotional relationship will not incubate much change in treatment. The second quality that I believe is inimical to doing good therapy is excessive hostility. Where therapists are angry people, they may utilize select patients as targets for their own irritations. A patient has enough trouble with personal hostility and may not be able to handle that of the therapist. A therapist, exposed to a restrictive childhood, having been reared by hostile parents, or forbidden to express indignation or rage, is apt to have difficulties with a patient who has similar problems. Thus the patient may be prevented from working through crippling rage by the subtle tactic of the therapist changing the

subject when the patient talks about feeling angry, or by excessive reassurance, or by a verbal attack on the patient, or by making the patient feel guilty. However, a therapist who is aware of personal hostile propensities, who can be objective about these and willing to back down under a patient's challenge, may be able to do fairly good therapy, provided the patient is permitted to fight back, and is not too frightened to challenge and stand up to the therapist. But where the therapist refuses to allow the patient this freedom, and gets upset and vindictive, rejecting or punishing the patient, therapy has a good chance of coming to a halt.

By the same token, a therapist who has serious problems with sexuality may not be able to handle a patient who also has certain sexual impediments. For example, a therapist struggling with a homosexual impulse, may, when a patient with homosexual tendencies brings up the subject, become defensive, overmoralistic, punitive, or so intensely interested in the topic that the patient will be diverted from constructively dealing with other important concerns.

All in all, we hope that in doing therapy the therapist will be slightly less neurotic than the patient. The least we may expect is that the therapist will have a reasonable capacity for maintaining objectivity. Some neurosis or character disturbance is probably residual in all of us, but this need not interfere with doing good therapy provided that we have an awareness of our failings and do not permit them to contaminate the therapeutic atmosphere. One of my teachers, an analysand of Freud, once remarked: "If there ever were such a monster as a completely 'normal' human being, he would very soon get psychotic trying to adjust to the rest of us neurotics." "Normal" probably embraces a host of minor neurotic vexations, but where a therapist finds that good results are not forthcoming, some personal psychotherapy or analysis would seem indicated.

Choice of Techniques

Technical preferences by therapists are territories ruled by personal taste rather than by objective identifiable criteria. As has been previously indicated, it matters lit-tie how scientifically based a system of psychotherapy may be or how skillfully it is

implemented—if a patient does not accept it, or if it does not deal directly or indirectly with the problems requiring correction, it will fail. Because of the complex nature of human behavior, aspects that are pathologically implicated may require special interventions before any effect is registered. Prescribing a psychotropic drug like lithium for an excited reaction in a psychopathic personality will not have the healing effect that it would have in violent outbursts of a manic-depressive disorder. Unfortunately, some therapists still cling to a monolithic system into which they attempt to wedge all patients, crediting any failure of response to the patient's resistance.

A young analyst, for example, one year after having completed her training in a classical psychoanalytic school, wanted to get some further training in hypnosis. It turned out that her entire patient load was exactly the same one she originally had when she started her personal analysis some years previously. All nine patients were being seen four or five times weekly, associating freely in the couch position, analyzing their dreams, but showing little or no improvement, some even regressing. The therapist, maintaining the traditional passive stance, tried to listen to what they were saying, but found herself getting more and more bored and increasingly discouraged at what was happening. She wanted to learn hypnosis, she said, to be able to get at the early memories of her patients, since few significant infantile revelations had been forthcoming. Her patients simply were not coming to grips with their unconscious. Hopefully, hypnosis might be able to break through their resistance and bring to the surface the noxious memories and conflicts that were responsible for their complaints.

In reviewing her caseload, one could see three obsessive patients—one with a germ phobia who avoided contact with people; the second, a compulsive handwasher who spent most of the day in the bathroom; the third, a salesman with an obsession of death and killing, who, when he came across the number 23, had to engage in elaborate counting and other rituals to neutralize torturesome preoccupations. In all of these cases analysis had succeeded merely in providing some answers regarding the sources and meaning of these symptoms. The other six patients ranged from severe borderline cases who went over the border periodically, to various species of schizophrenia, with one man, an engineer,

actively hallucinating. There was not a single case, in my opinion, that could be considered a suitable candidate for classical psychoanalysis. And yet here was an earnest, dedicated professional digging away at their unconscious in the hopes of uncovering some mnemonic treasures that would ransom them from the prison of their past. My unverbalized hunch was that all hypnosis would do for her stockpile of patients would be to add more fascinating imaginative data to the huge store of information that the therapist had already accumulated, without budging their afflictions a single whit.

To expose all of these cases to one technique would be like a surgeon who, because he specializes in appendectomies, removes the appendix in every patient who comes to him with stomachaches, abdominal pains, and diarrhea. No one technique can serve to ameliorate all maladies that burden humankind. This is the best argument for a balanced and conservative eclecticism toward which modern psychotherapy has gainfully been moving in the past decades. But there are still a few diehards who, loyal to the traditions of their chosen theoretical school, try to force a circumscribed method on all patients. Such a tactic, following an analogy once proffered by Freud, usually proves no more effective than trying to appease victims of a famine by passing out menus of a French cuisine. For reasons difficult to justify, some earnest students are unable to break away from the strictures of cherished theoretical systems and virtually become trapped along with their patients in its ineffectualities. The only way some can escape from their stagnant caseloads is by moving out of town!

To return to my student, another dilemma confounded her. When she started working with her patients, most of whom were therapeutic failures referred by other therapists only too happy to get them out of their offices, she had, as a beginner, accepted them at a low fee. Considering that they came four and five times weekly, and could scarcely afford paying the accumulated sum each month, the therapist could not, despite the economic havoc inflation imposed on her, bring herself to raise their fees to even the standard minimal level charged by colleagues of her rank. This added to her dilemma and undoubtedly created resentments that I felt enhanced depression.

My first task, prior to teaching her hypnosis, was to teach tactics of psychotherapy with sick patients. We chose as our first prospect the obsessional patient with a germ phobia and a detached borderline case with masochistic fantasies. She was to get them off the couch and allow them to sit up facing her. She was to reduce their sessions to twice weekly and charge them the same fee monthly as before. Most importantly, she was to stop acting like a "phantom therapist" by dropping her anonymity, with little digging and more relating. Because she seemed bewildered at my unorthodoxy, I had to give her the exact words to say to her patients, which were to the effect that a point had been reached where it was no longer necessary to freely associate, where only two sessions weekly were needed, where only reality problems in the here-and-now were to be the focus. She was enjoined to interest herself in what her patients were doing, smiling naturally, interchanging ideas and, if necessary, giving advice and support. Curiously, the student showed no resistance to accepting my advice.

In two weeks a remarkable change developed in both the experimental patients and the therapist. The patients, for the first time, spoke about how much better they felt. And for good reason—they were relating to the therapist as a real person who was interested in them as people rather than as puppets of their unconscious. The therapist found herself liking the patients, and her resentment resolved as the per session fee approximated that of her colleagues. What occurred then was that she got all of her patients off the couch. Sensing that she was losing her confidence in the analytic method, I had to work on her mistaken belief that the techniques I taught her were standard for all patients. While they happened to be suited for the sick caseload she was currently carrying, they might not be right for other cases. Indeed, classical psychoanalysis could be a boon for some patients carefully selected for the procedure. Her supervision with me lasted one year, during which time she acquired new cases, one of which was a patient for classical analysis.

Skill and Experience in the Implementation of Techniques

The history of science is replete with epic struggles between proponents of special conceptual systems. Contemporary psychotherapists are no exception. In a field as elusive

as mental health it is little wonder that we encounter a host of therapies, some old, some new, each of which proposes to provide all the answers to the manifold problems plaguing mankind. A scrupulous choice of techniques requires that they be adapted to the needs and learning capacities of patients and be executed with skill and confidence. Understandably, therapists do have predelections for certain approaches and they do vary in their facility for utilizing them. Faith in and conviction about the value of their methods are vital to the greatest success. Moreover, techniques must be implemented in an atmosphere of objectivity.

To function with greatest effectiveness, the therapist should ideally possess a good distribution of the following:

1. *Extensive training.* Training, in many parts of the country, has become parochial, therapists becoming wedded to special orientations that limit their use of techniques. Accordingly, patients become wedged into restricted interventions and when they do not respond to these the therapeutic stalemate is credited to resistance. Over and over, experience convinces that sophistication in a wide spectrum of techniques can be rewarding, especially if these are executed in a dynamic framework. Whether a personal psychoanalysis is essential or not will depend on what anxieties and personal difficulties the therapist displays in working with patients. The fact that the therapist does not resort to the discipline of formal analytic training does not imply being doomed to doing an inferior kind of therapy. Indeed, in some programs, where the analytic design is promoted as the only acceptable therapy, training may be counterproductive. Nevertheless, if a therapist does take advantage of a structured training program, which includes exposure to dynamic thinking and enough personal therapy to work out characterologic handicaps, this will open up rewarding dimensions, if solely to help resolve intrapsychic and interpersonal conflicts that could interfere with an effective therapeutic relationship.

Irrespective of training, there is no substitute for management under supervision of the wide variety of problems that potentially present themselves. It is important that therapists try to recognize their strong and weak points in working with the various syndromes. No matter how well adjusted therapists may be, there are some critical conditions that cannot be handled as well as others. They may, when

recognizing which problems give the greatest difficulties, experiment with ways of buttressing shortcomings.

2. *Flexibility in approach.* A lack of personal investment in any one technique is advantageous. This requires an understanding of the values and limitations of various procedures (differential therapeutics), experience in utilizing a selected technique as a preferred method, and the blending of a variety of approaches for their special combined effect. Application of techniques to the specific needs of patients at certain times, and to particular situations that arise, will require inventiveness and willingness to utilize the important contributions to therapeutic process of the various behavioral sciences, accepting the dictum that no one school has the monopoly on therapeutic wisdom.

SOCIAL AND ENVIRONMENTAL VARIABLES

Anyone who believes that the innate lenity of humankind can transcend some of the abuses and indignities that society heaps on one is a victim of Utopian self-deception. Social and environmental variables are probably the most neglected of factors in psychotherapy and sometimes among the most important. If in doing therapy we do not consider the environment in which the patient will have to live and function, we will run the risk of annulling therapeutic gains. An environment that does not support and encourage the patient's newly developed patterns or that punishes the patient for their constructive behavior will tend to reverse the gains brought about by the therapeutic process. On the other hand, an environment that rewards for constructive behavior will reinforce therapeutic gains.

Treatment may be considered incomplete if it does not prepare the patient for contingencies that will have to be faced when treatment is over. Adolescents who belong to gangs, for example, who learn to control delinquent behavior, may find themselves rejected by their peers for abiding by the law. A young adult living at home under the yoke of domineering parents may not be permitted to assume an independent role after the therapeutic resolution of a pathological dependency drive. An alcoholic helped to give up drink may not be able to remain dry so long as membership in a wine-tasting club continues.

During therapy a thorough review of what the patient will be up against after termination will be urgently needed. Either the patient will have to modify a destructive environment, if this is possible, or will have to separate from it. Thus the adolescent and the alcoholic will need to find new friends. The young adult will have to get a job and take up residence in a more permissive atmosphere, that is, unless parents are willing to enter into family therapy and respond sufficiently to permit greater freedom. Too frequently it is assumed that the patient will somehow get along once the treatment sessions have ended. Because the environment will rarely take care of itself, its future impact on the patient must be studied as part of the treatment program.

TRANSFERENTIAL AND COUNTERTRANSFERENTIAL VARIABLES

In therapy the initial positive relationship often serves during the first few sessions to quiet the patient's tensions and temporarily to restore a sense of mastery. A good deal of the responsibility for this happening resides in the patient's need for an omnipotent idealized authority, which urgency is projected onto the therapist. Some therapists advocate ending treatment abruptly when the patient has achieved a windfall of symptom relief, encouraging the patient to resume the customary threads of life and providing some awareness of the circumstances that contributed to this present disorder. Where therapy is terminated after a few sessions the patient may continue to retain the initial image of the therapist as a powerful, benevolent and perhaps magical figure, having utilized this image, however unrealistic it may be, as a vehicle for restoring customary stability.

Where the therapist is more ambitious, or the patient requires more sessions to get well, around the eighth session a change often occurs in the image of the therapist that can precipitate a crisis in treatment. The patient begins to realize that the therapist is not a god, does not have all the answers, and even possesses feet of clay. This disillusionment may exhibit itself in a forceful return of symptoms, and a crediting to the therapist of ineffectual or evil qualities. They draw their substance from a deep reservoir of fear and hate into which malevolent attitudes toward authority, some dating to childhood, have been stored. This transferential pollution may go on unconsciously and be manifested

solely in dreams or acting-out away from the therapeutic situation. The only sign the therapist may detect from the patient's manifest behavior is in the form of resistance to treatment. The patient will complain about not getting well while breaking appointments or coming late for sessions and will delay the payment of bills for therapy.

A dynamically oriented therapist searches for transferential signs realizing both the potential for helping the patient resolve some of the deepest problems through the insightful understanding of transference, and the destructive effect that unrecognized capricious transference can have on the therapeutic process. A therapist who has no awareness of transference will be truly handicapped in managing patients whose reactions to treatment become paradoxical or inappropriate.

Understandably, the more serious the early problems with authority have been, the more likely will transference become apparent, and the more tumultuous its manifestations.

Where the therapist shares the initial illusions with the patient to the effect that he or she is a demigod, changing into a devil will be highly disturbing. Such therapists may try to avoid trouble by confining themselves to the briefest forms of short-term therapy, terminating all treatments before the sixth session. But sometimes this does not help, especially in vulnerable borderline or schizophrenic patients who develop transference reactions toward the therapist even before seeing the therapist at the initial interview. It is far better that professionals who wish to do good therapy work through their godlike image, if it is at all resolvable, by themselves or in personal therapy. At any rate, a good degree of stability is required on the part of the therapist in order to handle transference reactions when they occur. An unstable therapist finds it difficult, because of countertransference, to control responding negatively when challenged or unfairly accused by a patient in transference. Impulsively discharging or furiously cowing the patient into submission will obviously rob the patient of an opportunity to work through problems with authority.

Whether personal psychotherapy is mandatory for all therapists in training as a

means of preventing obstructive countertransference is a question about which there is much debate. If one is a good therapist, personal therapy will probably help make one a better therapist but will not accomplish miracles. There are certain problems that are so deep that personal therapy may not be able to budge them. For example, intense childish distortions developed in very early infancy may resist correction. The therapist may get an awareness of these distortions through personal therapy, yet be unable at times to control their surfacing. Nevertheless, therapy may have enabled the management of reactions sufficiently so that they do not interfere too much with functioning with patients. Personal psychotherapy will accomplish its mission if it can control the therapist's use of the patient for personal designs and projections. Destructive countertransference is probably present to some extent in all therapists, but this need not necessarily be hurtful if the therapist is aware of its presence, recognizes how it is manifesting itself, and takes steps to resolve it.

Countertransference is, of course, not always harmful. It may alert therapists to traits and maneuvers of the patient that arouse important feelings in other people. The important thing is how therapists utilize countertransference toward bringing out the unconscious needs and conflicts of the patient while describing the effect they can have personally as well as on others. The patient may learn something important from this. For example, a great deal of tolerance is required on the part of the therapist in adjusting to the habits of some patients. Most therapists are punctual in appointments (as they should be) even though certain patients are lax in appearing promptly at the scheduled hour. These patients are prone to subject the therapist to a bit of delinquency as a vehicle of testing or defiance. The therapist may particularly be irritated by patients who come to clinics, paying little or nothing yet seeming unappreciative of what is being done for them. There is no reason why the therapist should not focus on the patient's offensive behavior, not as a way of reprimanding the patient, but to clarify the meaning of what is going on. There are certain patients we relish working with and others who are less than a joy to treat. There are therapists who are completely unable to handle adolescents while others do their best work with young people. Schizophrenic, violent, obsessional, paranoidal, psychopathic, hypochondriacal, suicidal, and delinquent patients stimulate aversive

responses in many therapists. Yet other therapists not only tolerate these syndromes but enjoy handling them.

Countertransferential elements encourage therapists to project onto patients aspects of their own inner needs of which the therapists are partly or wholly unaware.

> One therapist whom I was supervising in a class reported that his patient was getting progressively more depressed. An audio cassette of a session brought out a repetitious theme voiced by the patient that nobody cared for her, nobody paid attention to her, nobody liked her; that she was the neglected child in the family whose destiny was to spend her life in misery as an isolate. She insisted that she could never command respect or attention from anybody. She went on and on in this depressive vein, and the therapist from his conversation seemed to be responding correctly to what the patient was saying. We decided then that the therapist should interview the patient behind a one-way mirror with the class observing. The therapist was instructed to set up the furniture similar to the arrangement in his office. When the patient entered the room she seemed fairly animated, but as she talked she appeared to get progressively more and more depressed, the content of her verbalizations centering around feeling rejected by her family, by people, and by the world. What was startling was that the therapist, without realizing it, was actually playing into her theme of rejection. He had placed his chair at an angle so that he did not face her, and while he would from time to time fire an interpretation at her, he was constantly busy writing or looking away toward the opposite corner of the room. Periodically the patient would glance at the therapist, who by all appearances was off in space. One got the impression that she was being treated like a scientific specimen, not like a needful human being. Having been reared by a schizoid mother who in later life was admitted to a mental institution, she undoubtedly interpreted the therapist's manner as rejection.

The interesting thing was that a sophisticated professional in his last year of postgraduate training did not realize that he was providing the patient with a stimulus that activated her habitual rejection theme. On questioning, the therapist admitted that he was losing interest in the patient because she was beating at him constantly with her griping and complaining and getting no better. He was unaware that the placement of his chair was a gesture that signaled his disinterest, nor did he realize that the sessions were as traumatic for the patient as they were for him. He was sufficiently advanced in his training and personal analysis to explore his feelings toward the patient and affiliate them with attitudes toward a hypochondriacal mother who drove his own father to distraction. In this way his countertransference interlocked with the transference projections of the patient.

What the patient was doing with her therapist she did with all people with whom she became intimate. She expected rejection so much that in testing their sincerity she did exactly the things that resulted in her being rejected. People then responded by avoiding her. I suggested that the next time the patient came for a session the interview be conducted face to face. The therapist was to put aside his pad and just talk about the patient's interests and experiences without probing her feelings—in other words to work on building a relationship. In a very short time the whole nature of the therapy sessions changed. The patient became livelier, more interested in what she was doing, and more able to joke and smile. And the therapist developed greater enthusiasm about the patient. Eventually the patient's depression lifted and the patient was able to manage the termination phases of therapy without too great difficulty.

Not all of a therapist's reactions are countertransferential. They may be prompted by deliberate, destructive, and outlandish conduct. I recall one patient whose behavior was so provocative as to challenge my capacity for disciplined objectivity. It was all I could do during some sessions when she acted particularly nasty and insulting to stop myself from responding defensively or punitively.

> The patient was a married woman in her late thirties who came to me not of her own free will but because of the pressures imposed on her by her friends and family, who realized that she was seriously depressed and disturbed. She was the only child of a wealthy couple who adulated, pampered, and spoiled her so that she soon ruled the household like a tyrannical princess with an iron fist without the traditional velvet glove. Screaming tantrums forced her parents and private tutors to yield to her slightest whim.

> When she grew up she transferred these tactics to people around her, responding to not getting her way with violence, headaches, and paranoidal-like projections. Her marriage, she revealed, started off sizzling on a King-sized bed. But soon, after she had succeeded in verbally whip-lashing her husband into partial impotence, the couple retreated into twin beds, and, following the birth of her two children, they sought refuge in separate rooms from which they sauntered out to combat. Added to this the inanities of suburban life were more, she claimed, than human flesh could endure.

> Her initial contacts with me were organized around exploratory maneuvers to determine how much she could win me over and manipulate me. Interpretations fell on deaf ears. She was certain that I was siding with the enemy at home who blamed her for the prevailing mess she was in. Hostility was expressed in subtle and not so subtle ways. On one occasion, she asked me to refer her to the *best*

dermatologist in town. She appeared at his office with her dog whom she brought into the consulting room. It turned out that she wanted treatment not for herself but for her dog "who deserved the best." The dermatologist, who was a dear friend of mine, winked to his nurse and they proceeded to put the dog on the examining table and to treat him like a regular patient, right to the rendering of a prescription with the dog's name on it. Fortunately, the doctor, a dermatologic authority, had a great sense of humor and he went along with the "gag." On another occasion, being more careful to explore her complaint of backaches, I referred her to an orthopedic surgeon who on walking through the waiting room found her sitting in a chair with her feet on a new expensive coffee table. In not too gentle tones, he commanded her: "Won't you take your feet off my table?" Haughtily she turned on him with "It took me four months to hate Wolberg. You I hate right away."

With this as a background, I want to describe an incident where my loss of objectivity resulted in a significant therapeutic gain. During an interview, as she sat facing me, I confronted her with her responsibility in promoting a quarrel with her best friend. Furiously the patient removed a diamond ring from her finger and fired it at me. As the ring, a huge eight-carat gift from her father, whizzed by my ear, I tried to conceal my surprise and dismay by acting nonchalant and by not commenting on her behavior. I could see that she was nonplussed and irritated by my lack of concern. "Give me back my ring," she commanded imperiously. " *You* threw it," I replied, " *You* find it." After several such exchanges, she stormed over to my chair and began to search for the ring. It was nowhere in sight! "You better find my ring," she shrieked, but she got no response from me. However, after several minutes had passed in futile search, the ring remained undiscovered, and I leisurely proceeded to help her. But the ring was nowhere to be seen. By this time, I too was concerned. Yet a minute search of the room produced nothing. The patient burst into tears and I then tried to reassure her, utilizing the incident to accent my previous interpretations that her loss of temper hurt her more than it did other people.

After the patient left my office ringless, I went over the room minutely and finally I found the ring, which apparently had fallen on the couch and bounced off to the side, becoming wedged in between the mattress and the wooden side. The patient was relieved at my telephone call and thanked me. My victory, however, was short-lived. The next day when the patient came for her ring she burst angrily into my office and slammed the door shut with her foot, registering a dirty footprint on my newly painted door. I could feel my anger bubbling up. "You wash that footprint off that door," I ordered. "Ha, ha, ha," she retorted defiantly, "You make me." Reflexively, I grabbed her by the back of her neck and marched a frightened patient into the bathroom, stuck a wet soapy washcloth in her hand, and firmly marched her back to the door. She obediently washed the door, then quietly sat down; then we had our first constructive talk. She acted contented and even smiled. What the patient seemed to have done was to force me to set limits on her behavior that her father had failed to do. What she wanted and needed was some discipline. The positive effect on our relationship was amazing and we were able to achieve changes in her life that earned for me the gratitude of the patient and her family.

If through the relationship the patient is able to modify the introjected image of authority, the therapeutic process will have scored a great gain. Such modification comes

about by a replacement of the patient's imprinted authority figure, which is often harsh or overprotective, or negligent, or distorted, with a new, more rational and constructive figure as vested in the therapist. An opportunity for this may come about through transference on the therapist of feelings or attitudes that relate to the authoritative introject. Manifestations of the transference appear in direct or disguised form, in oppositional resistance to the therapist or to the techniques being employed, in unreasonable demands for favors or affection, in fantasies or dreams, or in acting-out away from treatment with persons other than the therapist. The ability of the therapist to recognize transference when it appears, particularly in its disguised forms, and to deal with it through interpretation and proper management of the relationship will have a determining effect on the direction and results of treatment.

RESISTANCE VARIABLES

Shorr (1972) cited Saul Bellow, who in *Herzog* describes the common resistance to normality so often encountered in therapy: *"To tell the truth, I never had it so good ... but I lacked the strength of character to bear such joy.* That was hardly a joke. When a man's breast feels like a cage from which all the dark birds have flown—he is free, he is light. And he longs to have his vultures back again. He wants his customary struggles, his nameless empty works, his anger, his afflictions, and his sins."* Paradoxically, some people are loath to give up the very chains that bind them to neurotic slavery.

Reluctance to accept normality is merely one of the many resistances that precipitate out in the course of therapy. Some resistances, inspired by lack of motivation and refusal to give up a stereotype of a nonrealistic therapist, occur at the start of therapy. Some, such as transference resistances, convert the therapeutic alliance into a battlefield of archaic projections and interfere with the treatment process itself. Others, like regressive dependency, mobilize anger and grief, and obstruct proper termination of therapy.

Resistances can take many forms, often following defensive maneuvers customary for the individual. Thus patients may become evasive or forgetful, breaking, cancelling or

coming late for appointments, or they may engage in prolonged silences during sessions. They may indulge in superficial, rambling talk. They may try to disarm the therapist with praise, or become aggressive, argumentative, and accusatory. Women may become sexually seductive toward their male therapists and men toward their female therapists.

Destructive as they are, certain resistances protect the individual from catastrophic helplessness and anxiety. They are means of preserving important neurotic coping mechanisms. A phobia, for example, may disable the individual, but it still has a protective quality. A hysterical arm paralysis can shield the individual from awareness of murderous impulses, while blandly protesting the inconvenience of being unable to utilize the limb. Frigidity may mask overwhelming fear in a woman of assuming a feminine role. In all of these cases the yielding of important defenses promises exposure to dangers far greater than the torments the patient already suffers. Moreover, certain secondary gains of a positive nature may accrue to the indulgence of a neurosis. In industrial accidents the victim who is on disability payments may in giving up pain and physical illness lose not only financial security, but also sympathy, freedom from responsibility, and the opportunity of occupying center stage with repetitive tales of what was endured at the hands of doctors. Having been referred to a therapist by an insurance company, which insists on the victim getting treatment, or brought in by family who tire of complaints, the victim is exposed to the threat of health, which is a barren bounty compared to the advantages of disability.

Experience with large numbers of patients convinces that three common dynamic problems most often initiate emotional difficulties and also create resistance to psychotherapy. They are:

1. inadequate separation-individuation;

2. a hypertrophied sadistic conscience; and

3. devalued self-esteem.

These are never isolated units. Rather, they coexist and reinforce each other, and

they create needs to fasten onto and to distrust authority, to torment and punish oneself masochistically, and to wallow in a swamp of hopeless feelings of inferiority and ineffectuality. They frequently sabotage a therapist's most skilled treatment interventions, and when they manifest themselves, unless dealt with deliberately and firmly, the treatment process will bog down in a stalemate. The most the therapist may be able to do is to point out evidences of operation of resistance saboteurs, to delineate their origin in early life experience, to indicate their destructive impact on the achievement of reasonable adaptive goals, to warn that they may make a shambles out of the present treatment effort, and to encourage the patient to recognize personal responsibility in perpetuating their machinations. The frightening hold a self-devaluating resistance can have on a patient is illustrated by the following fragment of an interview.

> The patient, a writer, 42 years of age, who made a skimpy living as an editor in a publishing house came to therapy for depression and for help in working on a novel that had defied completion for years. Anger, guilt, shame, and a host of other emotions bubbled over whenever he compared himself with his more successful colleagues. He was in a customarily frustrated, despondent mood when he complained:

> *Pt.* I just can't get my ass moving on anything. I sit down and my mind goes blank. Staring at a blank piece of paper for hours. I finally give up.

> *Th.* This must be terribly frustrating to you.

> *Pt.* (*angrily*) Frustrating is a mild word, doctor. I can kill myself for being such a shit.

> *Th.* You really think you are a shit?

> *Pt.* (*angrily*) Not only do I think I am a shit, I am a shit and nobody can convince me that I'm not.

> *Th.* Frankly, Fred, I'm not even going to try. But you must have had some hope for yourself; otherwise you never would have come here.

> *Pt.* I figured you would get me out of this, but I know it's no use. I've always been a tail ender.

> *Th.* (confronting the patient) You know, I get the impression that you've got an investment in holding on to the impression you are a shit. What do you think you get out of this?

> *Pt.* Nothing, absolutely nothing. Why should I need this?

> *Th.* You tell me. (In his upbringing the patient was exposed to a rejecting father who demanded perfection from his son, who was never satisfied with his even better than average marks at school, who compared him unfavorably with boys in the neighborhood who were

prominent in athletics and received commendations for their schoolwork. It seemed to me that the paternal introject was operating in the patient long after he left home, carrying the same belittling activities that had plagued his existence when he was growing up.)

Pt. (pause) There is no reason, (pause)

> *Th.* You know I get the impression that you are doing the same job on yourself now that your father did on you when you were a boy. It's like you've got him in your head. (In the last session the patient had talked about the unreasonableness of his father and his inability to please his father.)

> *Pt.* I am sure I do, but knowing this doesn't help.

> *Th.* Could it be that if you make yourself helpless somebody will come along and help you out: (I was convinced the patient was trying to foster a dependent relationship with me, one in which I would carry him to success that defied his own efforts.)

> *Pt.* You mean, you?

> *Th.* Isn't that what you said at the beginning, that you came to me to get you out of this thing? You see, if I let you get dependent on me it wouldn't really solve your problem. What I want to do is help you help yourself. This will strengthen you.

> *Pt.* But if I can't help myself, what then?

> *Th.* From what I see there isn't any reason why you can't get out of this thing—this self-sabotage. (The patient responds with a dubious expression on his face and then quickly tries to change the subject.)

In the conduct of treatment one may not have to deal with conflicts such as those above *so long as the patient is moving along and making progress. It is only when therapy is in a stalemate that sources of resistance must be uncovered.* These, as has been indicated are usually rooted in the immature needs and defenses inspired by dependent, masochistic, self-devaluating promptings. At some point an explanation of where such promptings originated and how they are now operating will have to be given the patient. This explanation may at first fall on deaf ears, but as the therapist consistently demonstrates their existence from the patient's reactions and patterns, the patient may eventually grasp their significance. The impulse to make oneself dependent and the destructiveness of this impulse, the connection of suffering and symptoms with a pervasive need for punishment, the masochistic desire to appease a sadistic conscience that derives from a bad parental introject, the operation of a devalued self-image, with the

subversive gains that accrue from victimizing oneself, must be repeated at every opportunity, confronting the patient with questions as to why he or she continues to sponsor such activities. When we consider the many patient, therapist, environmental, transferential and resistance variables that have been described above, and that are parcels of all therapies, irrespective of type, it becomes apparent that empirical research into their effects may do a great deal in promoting more effective practice and in advancing psychotherapy to its rightful place in the family of scientific methodologies.

Educational, Casework, and Counseling Approaches Versus Psychotherapy

Educational, casework, and counseling approaches all aim at an expansion of the potentialities of the individual and a betterment of adjustment. In this way they pursue some of the goals of psychotherapy. They possess, however, certain distinctive features that should be differentiated from psychotherapy to avoid a confusion of role and function among the disciplines identified with these methods.

EDUCATIONAL APPROACHES AND PSYCHOTHERAPY

Education has been defined as a process of inducing "progressive or desirable changes in a person as a result of teaching and study" (English & English, 1958) and "the systematic instruction, schooling or training given to the young [and, by extension, to adults] in preparation for the work of life" (Oxford Univ. Dictionary, 1955). Even though education has focused on the development of the intellectual capacities of the individual and the acquisition of knowledge, a new direction in education has been fostered by the recognition of the vital significance of human relationships in the learning process. The purpose of education has been extended to include the emotional growth of the individual and more constructive relationships with people.

This progressive movement within the field of education, founded by John Dewey, "emphasizes the needs of the individual and the individual's capacity for self-expression and self-direction" (Hinsie & Campbell, 1960). The discipline of education has accordingly broadened its goals to include "the inculcation of social attitudes," "the development of social sensitivity," and the evolution of "better personal-social adjustment" (Smith & Tyler, 1942; Trecker, 1946). Educational objectives have been widened to foster personal security, and to expand assertiveness and self-direction. A principal aim in education "is to provide rich and significant experiences in the major aspects of living so directed as to

promote the fullest possible realization of personal potentialities" (Giles et al, 1942). More and more schools are including in their curricula material "concerned with the total personality—not merely with the intellect but with emotions, habits, attitudes. ... It [general education] consists of preparation for efficient living, no matter what one's vocation" (N. Central Assn., 1942). Among the most interesting experiments along this line were those of the Bullis, Force, Ojemann and Forrest Hill Village projects (Comm. Prev. Psychiatry, 1951).

An additional factor has been recognized to the effect that emotional blocks may prevent the student from accepting or integrating educational offerings. The traditional pedagogic techniques are usually unable to handle such impediments. Interviewing and group work methods that are continually evolving in educational circles (Cantor, 1946; Slavin, 1950) attempt to deal with learning blocks. Both in objectives and techniques, some of these procedures resemble those in psychotherapy.

The question, however, still has not been answered satisfactorily as to whether these techniques are forms of psychotherapy or pure aspects of educational intervention. Behavior modification, for example, dealing as it does with habit, learning, and adjustment and practiced in schools, hospitals, prisons, and clinical and community settings, appears to fall into both areas. The confusion perhaps lies in the fact that therapeutic techniques often turn out to be educational for the patients in that they discover new things about themselves and learn different ways of behaving. On the other hand, education can register a significant psychotherapeutic impact on some individuals, helping them to control their symptoms and fostering a better life adaptation.

The success of education in promoting the development of growing and plastic personality structures of children has aroused hopes in utilizing educational approaches toward reshaping attitudes, altering values, reorganizing feelings, and refashioning behavior. Recent years have witnessed the popularization of mental health concepts in current periodicals, books, movies, radio, and television. Under certain conditions the simple imparting of the proper kind of mental health information has geared the recipient

toward a more wholesome adjustment. Such simple concepts as that an infant requires the loving presence of a mother and adequate stimulation during the first year of life, or that rebelliousness during adolescence is universal and perhaps a necessary component of the child's reaching for independence, may soften parental anxiety and alter ways of handling problem situations in both parent and child.

Attempts are being made also to educate persons in more wholesome attitudes toward themselves, their families, and the community. Materials are available that are intended to ameliorate the effects of emotional illness on adjustment. This "mental health education" or "psychoeducation" in which there are promulgated precepts of normal personality growth, of psychodynamics and psychopathology, data on the health, adjustment, social and economic hazards of emotional illness, and details on the adoption of mental health information to various problems in the community has sponsored a profession of "Mental Health Educator." The impact on the public has in general been a questionable one, even though the substance of what is taught and the communication techniques have been correct.

The widespread preoccupation with psychological concepts has introduced a flood of writings and lectures formulating doctrines on how to regulate one's life most efficiently. The intent is partly to educate people into the proper handling of their relationships, and partly to mediate their personal conflicts. The effect of such writings and lectures is difficult to assess. Where they do not oppose basic defenses, the person may integrate the teachings with a reeducational result. Where they conflict with basic defenses, they may either wield no influence whatsoever or inspire guilt feelings induced by a realization that one is unable to abandon attitudes or patterns of behavior potentially hurtful to oneself or others. Group seminars oriented around discussion and clarification are much more effective than writings, provided that they are headed by a skilled group leader.

Given the proper motivation, adequate educational media, a congenial setting, an intelligent educator who inspires respect and confidence, and a friendly group bent on

learning objectives with which the individual can identify, an individual may acquire a prodigious amount of knowledge. Some change may also be expected in patterns of adjustment as a by-product of the learning experience, principally due to the relationship with the educator and the group.

There are limitations, however, as to how extensively attitudes, values, feelings, and behavior, in which the individual has a deep emotional investment, may be influenced. Although these may seem senseless and are in opposition to a reasonable and happy adjustment, the individual continues to adhere to them with bullheaded persistence. They are impervious to logic, common sense, and scientific argument. The obese young woman, bloated with avoirdupois, may be better versed in the rationale and methods of calorie control than a trained dietician. She knows every reason why she must diet, yet she is unable to stop stuffing herself with food. The man with a recent coronary attack has read the latest antitobacco literature, yet he invites devastation by chain smoking. The irate business executive, constantly disciplined by her superiors for her spleen, and in spite of a brush-up course in public relations, continues to attack her subordinates and to alienate her peers. The promising young salesperson with a flying phobia has learned all about the safety of aircraft, yet prefers the risks of bus travel to the ease and comfort of a jet plane. These are but a few examples of how limited an educational approach may be in dealing with patterns that reflect deep-seated fears and needs.

Educational techniques are valuable when the individual is able to countenance and to absorb the content they communicate. They are a parcel of all good psychotherapies. But they are unable in themselves to overcome resistances to change, nor can they readily handle the anxieties that inspire the resistances. They usually deal with dimensions peripheral to those that have initiated the individual's neurotic disturbance and that continue to activate that person's mechanisms of defense.

In summary, while educational approaches are important and useful, they are no substitute for psychotherapy. They have a growth potential, but one should not overestimate their impact on firmly conditioned and neurotically structuralized

behavioral patterns.

CASEWORK AND PSYCHOTHERAPY

Psychiatric social work traditionally "is social work undertaken in psychiatric agencies and mental health programs." It has as its aim a contribution "to those services and activities within the community which promote mental health and are conducive to the restoration of the health of individuals who are suffering from mental and emotional disturbances." The social work process employed to promote this aim is "social casework," which is applied in the "identification, diagnosis, and treatment of persons with personal and social maladjustments caused or aggravated by mental and emotional problems" (Knee, 1957). By means of a "person to person helping relationship through individual interviews or group process, the social worker can assist the individual to determine and resolve specific problems in the environment and interpersonal relationships which interfere with adequate functioning" (Am. Assn of Psychiatr. Soc. Workers, 1955).

Among the varied services of the social worker are those that deal with family social work, family life education, adoption, child welfare, foster care for children, day care, homemaker activities, legal aid, public assistance, school social services, youth services, community organization and coordination, rehabilitation, protection of rights, and correctional work involving the broadest aspects of law enforcement, detention, probation, parole, and crime control and prevention. Problems in employment, housing, education, living arrangements, finances, recreation, and health come under the social worker's aegis. In the course of work the social worker must make contact with a wide range of humanity, including the physically handicapped, mentally ill, mentally retarded, indigent, chronically ill, alien and foreign born, aged, unmarried mothers, alcoholics, juvenile delinquents, criminals, drug addicts, and generally unhappy and maladjusted individuals. The enabling, problem-solving process the social worker performs to help individuals and their families resolve social difficulties they are unable to manage by themselves is "casework." With the expansion of government responsibility for financial assistance, private family agencies particularly have employed casework in order to

counsel family members with reference to intrafamilial relations, so that marriage counseling, counseling of parents regarding their children, and counseling of adults regarding their aged parents constitute a substantial part of work in a family agency. Conventionally, the trained worker has executed these functions through the rendering of services of which the client is in need. The focus has been on the external problem or social situation and not, as in psychotherapy, on the individual's inner distress or illness. In rendering social services, no deliberate attempt is made to alter the client's basic personality patterns, the object being to handle situational problems on a purely realistic level.

This classic role in casework has, during the past decades, undergone considerable modification. Operationally, caseworkers have found it difficult or impossible to limit their area of work to the client's external life situation. Indeed, a conviction has evolved that, unless certain capacities are mobilized or developed in clients, they will be unable to utilize the social services offered or the community resources made available to them toward a better life adjustment. Consequently, much more extensive goals have developed in the practice of casework than are implicit in the early definition. This broadening of objectives was largely the product of psychiatric influence, particularly that of Freud and Rank, and of better understanding of the use of sociologic theory and techniques.

Thus, Towle (1947) described the caseworker as one who handles persons "experiencing some breakdown in their capacity to cope unaided with their own affairs." This breakdown, she added, may be caused by external factors, "or it may be partially, largely, or entirely due to factors within the individual." Services may be geared toward reality needs or may be "oriented to feelings and to ways of responding."

Bowers (1951), reviewing definitions of casework, adds this one: "Social casework is an art in which knowledge of the science of human relations and skill in relationship are used to mobilize capacities in the individual and resources in the community appropriate for better adjustment between the client and all or any part of his total environment." Other definitions are (1) "casework is a method of helping a troubled person to

understand what is causing his personal or family problems and to find inside himself, in the home, or in health and welfare agencies the resources to rebuild his or her family's life" (U.S. Soc. Sec. Adm. 1949) and (2) casework is "the function of professional [social] workers who, through social services and personal counseling, attempt to help individuals and their families improve their personal and family adjustments" (Hinsie & Campbell, 1960).

When we examine these definitions carefully, we find that some of the goals toward which casework is directed are identical with those in our definition of psychotherapy. Since the casework process involves an interpersonal relationship, similar emotional phenomena develop between the caseworker and client as occur between a psychotherapist and patient. The relationship has often served to release forces within the individual that are essentially psychotherapeutic in effect. But can we say the casework process is psychotherapy? Some authorities insist that it is and that "when a psychiatric social worker says she is doing case work, within the interviewing room, she does psychotherapy" (Grinker, 1961). Davidson cites Rennie's account of the casework process: "People who have been interviewed by caseworkers … say that they like to be talked with in this way; that they gained insight, came to understand some of the reasons for their problems, and got some inklings of the way out of their difficulty… . The caseworker observes moods, hesitancies, and emotions … expressed in subtle ways. He tries to trace problems to their roots. He accepts the person as he finds him, without blame…. Often the client's anxiety is drained off and his hostility and guilt are lessened. He is freed from the blinding effects of these emotions and sees, for the first time, psychological connections of which he had formerly been unaware." Davidson adds, "Now here, in the words of a distinguished psychiatrist, is a definition of casework— and it's as good a definition of psychotherapy as you can find" (Perlman, 1960b).

When we examine the effects of casework, and scrutinize the dynamics of the caseworker-client relationship, we find a number of similarities to those of psychotherapy. There are, however, differences. First, the casework process is not geared toward the resolution of emotional problems as such, but rather toward a bringing of the

client to a recognition of those problems that interfere with the client's social adjustment and utilization of services. "The particular purpose of social casework is to help people who are suffering from some impairment or breakdown in their adequate social functioning and to restore, reinforce, or enhance the performance of their daily lifetasks" (Perlman, 1960b).

Second, resistances to the use of services, and fears and anxieties about changes that are occurring in the life situation and patterns of relatedness, are managed on a realistic level with active guidance and advice giving. Interpretation of unconscious conflicts and a delineation of the origin and minute operations of mechanisms of defense are avoided.

Third, the usual education of the social worker provides counseling procedures, but not the more extensive psychotherapeutic techniques. While there is general recognition of the fact that psychological disturbances are operating to initiate or reinforce problems in the milieu of the individual or family unit, these disturbances are handled on a different level than in psychotherapy. The procedures are focused on enhancing the client's own problem-solving capacities to cope more effectively with social difficulties or to execute actions to modify or resolve them. The establishment of a working relationship with the patient, the making of a social diagnosis, the understanding of the client's personality workings and resistances, the analysis of the client's assets and liabilities, and the maintenance of an effective communicative climate are important elements in the methodology of the caseworker. Guidance, reassurance, emotional support, opportunity for emotional catharsis through verbalization, environmental manipulation, and interpretation of the client's feelings and resistances are freely employed in the counseling process that develops.

While the contributions of Freud and Rank are readily acknowledged, their influence on social casework practice has not been as vigorous as in previous years. There are instead tendencies to employ the principles of ego psychology (Upham, 1973), systems theory (Hollis, 1974) and behavior modification (Fischer & Gochros, 1975), trends that are also preoccupying contemporary psychotherapy.

Unfortunately, modern casework, for many years the dominant method of practice, is undergoing an unfair attack as too expensive, and that it focuses on getting people to conform to oppressive social conditions. The field of social work itself is in a state of ferment as practitioners seek new, more lucrative roles and values to keep up with the temper of the times (Rein, 1970; Payne, 1972; Vigilante, 1972). In the face of this many social workers are striving for changes in professional identification, moving closer to the clinical field. The social worker, usually a psychiatric social worker, who has had specialized postgraduate training in psychotherapy, may, in addition to casework, function with clients on a psychotherapeutic level, dealing with their intrapsychic mechanisms as they influence the total adjustment of the individual. When the trained caseworker does this, casework is no longer being practiced; psychotherapy is the modus operandi.

Toward this expanded function advanced clinical training is being offered to social workers in training centers around the country on a postgraduate level. With such training, the designation of *psychiatric social worker* is being rejected by many social workers as a term connoting subservience to and imitation of the medical profession. The title *clinical social worker* is favored, which better describes their practice while recognizing their independence of functioning.

COUNSELING AND PSYCHOTHERAPY

Counseling is customarily defined as a form of interviewing in which clients are helped to understand themselves more completely in order that they may correct an environmental or adjustment difficulty. Guiding and helping people to make rational decisions, to organize plans for constructive pursuits, to seek out the best available community resources to satisfy immediate and future needs, and to overcome reluctancies toward and fears of action are among the tasks of the counselor. A wide variety of professional and paraprofessional paid and volunteer workers function in this way as counselors. Clients seek help for a host of problems, some real, some projections of inner distress. And it is the duty of the counselor to distinguish between the two.

The relationship between client and counselor, which is considered of prime

importance in counseling, is used in different ways—from the offering of suggestions as to available resources to the interpretation of the client's attitudes and feelings. The directiveness of the counselor varies. In directive counseling (Thorne, 1950) the counselor assumes the role of an authority offering the client an evaluation of the particular problem and defining courses of action. In nondirective counseling (Rogers, 1942) the counselor functions as an agent who encourages the client's expression of feelings, reflecting these and helping the client to assume responsibility for them. In this way the client thinks things out, develops goals, and plans the course of action. Other forms of counseling draw from the field of dynamic psychology, seeking to utilize the counselor-client relationship to demonstrate the operations of the client's personality structure either in creating the situations for which help is being sought or in blocking the client from finding appropriate solutions.

Counseling programs have advanced rapidly, particularly in the educational, industrial, social work, health, and military fields. Counselors in progressively larger numbers have been utilized for guidance activities and personal counseling in secondary schools, colleges, and universities, for "employment counseling" toward selection, placement, and morale building in industry, for "rehabilitation counseling" to enable handicapped persons to make a transition from disability to productiveness, for job relocation services for returning veterans, for "counseling psychology" in Veterans Administration hospitals and various community agencies. Family agencies offer counseling services on matters of family relationship and social adjustment such as the following:

1. Difficulties in interpersonal relationships manifest within the family, between the client and patient, siblings, spouse, children, and others, resulting in anxiety, symptoms, or deviant behavior.

2. Difficulties in personal adjustment in relation to inner functions, such as sexuality, educational achievement and learning, and employment and work abilities.

3. Environmental problems, such as economic hardships and housing deficiencies.

4. Health problems, such as disabilities, physical handicaps, mental retardation, heredity illness (genetic counseling), etc.

The helping methods in the counseling services rendered include (1) advice giving, environmental manipulation, and ego support, such as reassurance and encouragement, (2) guidance in the client's roles in family and society and in what can be done about a specific situation, and (3) clarification regarding the client's feelings and attitudes and their deviations. Services are given not only to individuals and couples (marital counseling), but also to the total family (family counseling) and to groups (group counseling).

Because of the increasing need for counselors, various training courses have been organized on different levels of sophistication. They range from those that require only a few hours at an undergraduate level to those that lead to a doctor's degree. No unified curriculum exists, but a body of information is gradually being organized from fields of psychology, psychiatry, sociology, social work, and anthropology that are helpful in understanding personality development and structure, human relationships, the vicissitudes of adjustment, and the interviewing process. Goals in counseling have been expanded from simple testing and advice giving to managing the individual's general adjustment problems with the realization that a situational difficulty may be a mere surface manifestation of a more widespread disturbance. For example, the attempt to broaden a person's occupational perspective or to outline a curriculum in line with the person's abilities may fail because of opposing personality forces. This has tended to shift the emphasis of the interview in both individual and group discussions. The client's perceptions, goals, and values as well as feelings about the self and the environment are reflected in behavioral choices. Therefore, they need to be a part of the counseling operation (Cottle, 1973). The counselor may thus act as a catalzyer to a growth process within the client.

The term *counseling* has become diffuse, covering information and advice giving, and merging imperceptibly into psychotherapy (Patterson, 1966; Truax & Carkhuff, 1967; Osipow & Walsh, 1970). Training for a modern counseling role, accordingly, requires, in

addition to supplying the counselor with special knowledge and information about resources, a recognition of symptoms of emotional illness, some comprehension of dynamics, discernment of the forces of transference and resistance that are apt to be released during the counseling relationship, knowledge of how cultural factors influence value systems, and, finally, an understanding of one's own emotional shortcomings and prejudices (including destructive countertransference) that are apt to release themselves during counseling. Particularly important is sufficient diagnostic skill to discriminate depression, paranoidal projections, and psychotic manifestations in their early stages. The counselor should know when, how, and where to refer clients for psychotherapeutic help when their conditions require more than counseling and the counselor is not equipped to function in a psychotherapeutic role.

In summary, one may easily discern from the discussion how difficult it is to separate the goals of counseling from those of psychotherapy. Some attempts have been made to distinguish the methodologies. Counseling requires a relationship between a helping agent and a client. In this relationship emotional intercurrents operate that may have a psychotherapeutic effect on the individual, with an influence far beyond the purposes for which help was sought. But while personality change may be the outcome of the counseling relationship, as it is in psychotherapy, there are certain differences between the two processes.

The reason a counselee seeks help is because there is generally some situational difficulty for which specialized knowledge is required or because the individual is unable to cope with a problem through personal resources. The counselor then executes specialized knowledge of the area of concern to aid the counselee. Thus, the area may be educational, vocational, or behavioral, as in marital maladjustments. Objective instruments, such as psychological tests, may be employed. The counselee is then guided toward adequate courses of action. The approach here is supportive, the counselor making suggestions, offering guidance, presenting to the counselee opportunities for ventilation of feelings, and encouraging the counselee toward the proper actions. Sometimes the approach may, in addition, be reeducative, with an attempt at explaining

the meaning of destructive behavior patterns, helping the counselee to clarify feelings, and fostering an awareness of how the counselee behaves in relationships with family and other people. If emotional factors seem to be responsible for the counselee's inhibitions, this may be pointed out to the counselee as well as ways in which the counselee may overcome blocks. The counselor neither handles resistance and mechanisms of defense in terms of the total psychodynamic operations of the individual nor focuses on early conditionings and the unconscious forces that play upon the person. However, where counselors have received appropriate postgraduate specialized training in psychotherapy, they may be qualified to add to the battery of counseling methods the operations of psychotherapy. They will then function as psychotherapists rather than as counselors. Although counseling borders closely on the domains of psychotherapy, unless some demarcation is made in boundaries and responsibilities, interprofessional communication and cooperation are apt to suffer.

7
Basic Ingredients of Psychotherapy

Emotionally upset people are constantly being assisted in achieving homeostatic equilibrium through a variety of approaches. Taking a vacation, changing jobs, confiding in a concerned and wise friend, consulting a minister, swallowing tranquilizing substances, adopting a different philosophical outlook, and talking to a professional consultant all seem to bring relief. Both informal approaches *and* formal psychotherapy are helpful. The soothing embraces of a human relationship, the automatic arousal of a magical placebo element, and the releasing powers of emotional catharsis are parcels that may bring a person to an adaptive equilibrium. The method is non-specific and diverse: it could be amulet, pill, environmental change, homely philosophy, systematized dogma, or scientific method.

But the fact that any contact between two human beings or that any device, appliance, or technique seems to bring relief does not justify our applying the label of psychotherapist to the healer and psychotherapy to the tactic. People are abidingly achieving relief from symptoms in a propitious environment. But only rarely—and this is most fortuitous—do they acquire a significant enrichment of their behavioral or creative potentials. What we are concerned with is the studied manipulation of forces in a professional relationship that can, in addition to restoring homeostatic equilibrium, bring about behavioral and personality change with greater frequency than would occur by chance or through the activities of nonprofessional "helping" agencies or professional counseling. Can we identify properties of psychotherapy that can bring about deeper and more permanent change than other forms of helping?

One of the great bewilderments in appraising the virtues of psychotherapy is the difficulty of assigning to it *specific* processes and effects apart from the non-specific instrumentalities of "helping" and the subsidies of casework and counseling. In practice, the techniques of helping, counseling, and psychotherapy merge imperceptibly; as to

effects, it is generally impossible to apportion the degree of improvement brought about by non-specific and specific moieties. Nevertheless, it is of more than heuristic value to attempt to distinguish aspects of relating to which we may affix the term "psychotherapeutic" as differentiated from counseling and helping.

Psychotherapeutic-like services are often rendered without intent by persons with no training whatsoever. For example, what would one call the ministrations of an individual who is visited regularly—sometimes as often as six times weekly—by a steady "clientele" suffering from a wide range of psychiatric syndromes, a person who serves the purpose of relieving their emotional symptoms by (1) dispensing a tranquilizing substance more effective than the most powerful psychotropic drug and (2) relating with the clientele, variantly reassuring, guiding, advising, and interpreting. The "clients" in turn interact with this administrative individual as well as with the souls around them, participating in the boons associated with placebo influence, suggestion, and group dynamics. Under the influence of the "tranquilizing drug" their resistances are softened, and they are apt to express themselves volubly, often with free associations, experiencing emotional catharsis, exhibiting transference reactions (sometimes an actual transference neurosis), revealing aspects of their unconscious, and occasionally exhibiting acting-out tendencies that are usually dealt with firmly by the individual in charge. No patients are more dedicated to their "sessions" than are these clients. The individual to whom I refer practices the skills daily in every local bar in the country; his steady clients are among the sickest individuals in our society. There are probably more bartenders functioning in the role of psychotherapists in this country than there are psychiatrists, psychologists, and psychiatric social workers combined. Yet they dispense their medicaments without prescription, and they go through their interviewing maneuvers with no psychiatric supervision whatsoever. To call such an individual a psychotherapist is obviously preposterous, and to dignify his activities as a form of psychotherapy would be a disservice to the art. This is only one example (and there are many) of untutored helping agencies to whom an emotionally upset individual may turn who may serve a therapeutic-like function.

Helpful intervention is also the intent of many professionals whose training equips them to deal with special segments of behavior and to enlist in this process community resources. Human beings in trouble are constantly consulting such professionals to aid them in resolving their distress. Generally the agency selected is authorized by social sanctions to manage a particular complaint; the assessment by the client of the problem will determine the choice of professional. Thus, for marital difficulties a lawyer may be the counsel; for economic hardships, a social worker; for educational failings, a teacher or educational psychologist; for moral quandaries, a minister; and for physical troubles, a physician. The goals of such consultations are (1) to assuage the prevailing tension, (2) to correct remediable disturbances responsible for the individual's present predicament, (3) to rectify deviant behavior, and (4) to prevent the outbreak of more serious disorders. The responsibilities of both counselor and client are more or less explicitly defined, the role expectations of the counselor being structured by training and experience. The effect of such counseling may be psychotherapeutic in essence, but the techniques employed and the objectives approached vary from those of psychotherapy. Moreover, these counselors in other professional areas generally do not have the training or experience to deal definitively and correctly with emotional difficulties, although they may be able to mediate their effects.

Perhaps the most significant way psychotherapeutic relationships (other than supportive psychotherapy, which has a kinship with counseling) differ from non-psychotherapeutic ones is that in the latter the helping agency or counselor enters into collusion with the neurotic forces to achieve an immediate objective. In psychotherapy, there is an opposition to, and a direct attack made on, the neurotic forces in the hope of disposing of them and of reconstituting new and more adaptive defenses. Table 7-1 attempts to distinguish helping, counseling, and psychotherapeutic situations in reference to a number of important variables. Perhaps the main reason that psychotherapy has so often been considered affiliated with casework and counseling is that no attempt has been made to classify supportive psychotherapy in a category apart from re-educative and reconstructive psychotherapy. Unless this is done we are unable to separate psychotherapy from other forms of helping.

All helping, counseling, and psychotherapeutic situations embrace automatic healing elements that are released during the relationship between client-patient and helper-counselor-psychotherapist. These include the positive accruals of a projected idealized relationship along with the bounties of placebo influence, emotional catharsis, suggestion, and group dynamics. A vital aspect of the prevailing interaction is identification with the helper-counselor-psychotherapist. More or less, all clients-patients will regard the person to whom they relate as a model to pattern themselves by. They will incorporate, consciously or unconsciously, that individual's ideas, attitudes, and values into their reality-testing and problem-solving activities. The possession by the helper-counselor-psychotherapist of appropriate personality characteristics and attitudes will enhance this therapeutic dimension, while their absence may interfere with it. Present also in all helping, counseling, and therapeutic relationships are elements of transference and countertransference, the understanding and management of which may constitute the difference between a successful and unsuccessful outcome. In helping situations, counseling, and supportive psychotherapy, positive aspects of transference and countertransference are cultivated to enhance the operations being promoted; negative aspects, if recognized, are reasoned away or avoided. In some reeducative and all reconstructive psychotherapies, positive and negative transference and countertransference are examined and analyzed as a means of understanding the patient's behavior and of aiding him or her in altering it.

COMMON ELEMENTS IN ALL PSYCHOTHERAPIES

Let us now, then, attempt to delineate some processes that are inherent in effective psychotherapy, which while perhaps present to some extent in helping and counseling are not deliberately nurtured. All good psychotherapeutic systems—irrespective of their theoretical underpinnings and while they manifest some differences—employ these processes to a greater or lesser degree, whether they involve conventional dyadic insight approaches, manipulations of the patient-therapist relationship, or selected reinforcement of special aspects of behavior.

Interviewing Procedures

Communication is the channel of interchange between patient and therapist. Practitioners of different methods are usually taught principles of interviewing consonant with their theoretical systems. In the main, the practitioner must be able to subject the patient's communications to selective scrutiny, directing comments toward facilitating and constructively utilizing verbalizations. This involves an ability to employ language that is understandable to the patient. It includes an awareness of nonverbal behavior, an index of some of the most important defensive operations. It entails knowledge of techniques of maintaining the flow of significant verbalizations either toward free association or toward selective focusing on pertinent themes. It embraces methods of understanding or inculcating insight by various techniques, including interpretation. It encompasses an understanding of how to terminate the interview. These formalities are often left to chance during training, and it is only through experience that the practitioner gains the interviewing skills that are most helpful to his patients.

Establishment of a Working Therapeutic Relationship

Unless a cooperative empathic contact is established with the patient, the therapeutic process may come to naught. An effective system must maintain this as a prime objective during the first part of therapy. The techniques of achieving a relationship are rarely formalized, but usually they involve gaining the patient's confidence, arousing expectations of help, accenting the conviction that the therapist wishes to work with the patient and is able to do so, motivating the patient to accept the conditions of therapy, and clarifying misconceptions. Without a working relationship, in reconstructive therapy, there can be no movement into the exploratory and working through phases of therapy; the patient will be unable to handle anxieties associated with the recognition and facing of unconscious conflict. In supportive and reeducative therapy, a good relationship expedites progress immeasurably.

Determination of the Sources and Dynamics of the Patient's Problem

Cognitive learning is present in all therapies. The different psychotherapies attempt to search for and to explain the patient's emotional difficulties in varying terms, such as discordant elements in the environment that mobilize stress, distorted interpersonal relationships that prevent the individual from self-fulfillment, conditionings that rigidly dragoon the patient to destructive behavior, and unconscious conflicts that mobilize anxiety and interfere with a realistic adjustment. All psychotherapies attempt such explorations within the framework of special theories about human development and adaptation that include to a greater or lesser degree some of Freud's monumental discoveries and refinements of Pavlovian concepts. It is generally considered essential in the resolution of a problem toward reconstructive change for the individual to become aware of the fact that one is being victimized by repetitive patterns that force one to actions opposed to a productive life. These patterns are rigid and compulsive; they defy logic and common sense; they are both supported and opposed by ambivalent value systems that have been incorporated within the self; they make for an undermining of security and self-esteem, and for helpless expectations of injury that are registered in reactions of anxiety. The physiologic and psychologic manifestations of anxiety, and the marshalling of defenses against anxiety create various symptoms of neurosis. Much of this dynamic turmoil goes on below the level of awareness, and its recognition is opposed by the mechanisms of denial and repression that both safeguard the individual against anxiety and help to retain the neurotic gains residual in their preservation. A variety of resistances operate to maintain this denial-repression. The individual who is being treated under the aegis of this dynamic model is, through a number of techniques, taught to recognize personal offensive patterns and their consequences, the repudiated conflictual aspects of the psyche, and the origins of difficulties in destructive past conditionings. Awareness of stress sources and conflicts hopefully enables the individual better to challenge current maladaptive patterns, to be liberated from old values, to rectify the disturbed life situation with new modes of relating to people, and to develop a more wholesome and realistic conception of the self. Supportive and reeducative therapies deal more with provocative reality factors in the here and now, while attempting to correct faulty past learnings in line with goals of symptom alleviation and problem solving.

Many contemporary psychotherapeutic systems utilize some of the fundamental principles of Freud, though they affix to these their own labels. To a greater or lesser degree, concepts of the unconscious, repression, transference, and resistance are acknowledged. The means by which the patient is brought to an awareness of problems and the extent of exploration of the unconscious, will depend on the type of theoretical orientation to which the therapist has been exposed. The focused interview, free association, dream interpretation, analysis of the transference, exploration of genetic material, and the buildup of a transference neurosis will thus be employed in varying degrees.

Behavioral therapies, rooted in conditioning theories, do not put much credence on insight acquisition; rather they focus more on tactics of relearning. But inherent in the techniques employed is a relationship between therapist and patient and the inevitable derivation of some insight as part of the corrective therapeutic experience.

Utilization of Insight and Understanding in the Direction of Change

Effective psychotherapies acknowledge that understanding is not enough, that conditioned patterns of behavior do not allow themselves to be displaced so easily, and that various techniques must be implemented to produce change. Techniques, therefore, are put into effect to create incentives for change, to deal with forces that block action, to promote problem-solving and reality testing, to help the patient to master anxieties investing normal life goals, to correct remediable environmental distortions, to encourage adjustment to irremedial conditions, and to accept personal limitations and handicaps while fulfilling creative potential to the highest degree. Behavior therapies focus on this relearning dimension almost exclusively.

Resistance and the Readiness for Change

In all forms of therapy resistance will appear in stark or disguised forms and may block or destroy therapeutic progress. Despite the fact that suffering is intense and symptoms disabling, the patient may resist changing a preferred way of life. Toward this

end the efforts of even experienced therapists may be blocked. The bounties derived from pursuing a course that must inevitably result in anxiety and turmoil may not be apparent on the surface. The patient seems frozen into unreasonable bad habits that refuse to dissolve. And credit for failure may be ascribed to the impotence of the therapist and the worthlessness of the latter's methods. Resistance to change can paralyze all forms of therapy, and the capacity to recognize their subtleties and to deal with them constructively spell the difference in any psychotherapeutic endeavor between a therapeutic triumph or a debacle.

What we seem to be dealing with in all of our patients is their *readiness* for change, which apparently involves the degree to which they have spontaneously or with professional help resolved their resistance to change. An individual with reasonable readiness to move forward will seem to benefit from almost any situation or tactic that can be used constructively. For years there may have been silent building either through spontaneous insights and propitiously reinforcing life experiences or in formal therapy, with few apparent signs of improvement. Should more psychotherapy later be sought, improvement or cure may then unjustifiably be entirely credited to the second treatment experience, however brief or coincidental it may be, or to some dramatic event in life that actually served as a convenience that was successfully manipulated.

Multiple obstructions in the form of resistance are apt to present themselves at every phase of treatment. They may oppose the establishing of a working relationship, the acceptance of explanations of the therapist, the full cooperation with the therapist's techniques, the search for provocative conflicts, the probing into genetic material, the facing of reality, the abandoning of the pleasure values and secondary gains of neurotic tendencies, the acceptance of maturity, and the giving up of the treatment situation when termination is necessary. Obstructions appear in various masquerades, as transference, as "acting out," as forced "flight into health," as self-devaluation, and as innumerable other disguises. The skill of the therapist is revealed by dexterity in recognizing and managing the resistive maneuvers of the patient.

Patient Variables

There are an endless number of variables that the patient brings into therapy that will augment or negate the direction of psychotherapy. The expectations of the patient, the kinds of symptoms possessed, the attitudes and reactions to the therapist as an authority as well as to the techniques being employed, and the intensity and persistence of childish distortions are among the most common factors that must be taken into account. Perhaps of greatest importance is whether or not the patient will utilize the relationship with the therapist for objectives inimical to therapeutic goals. Thus if residual dependency needs exist, the patient may overidealize the therapist and project personal aspirations for magic onto the therapist. Basking in the sun of the therapist's celestial power, the patient will establish a satellite position insisting that the therapist cure him or her even in the absence of any personal effort. We are all victims of past conditionings and habit patterns, some of which interpose themselves subtly on our present-day adaptations. If a person as a child has been able to maintain identity only by resisting or fighting parental authority, there is no reason why we should not suspect that the individual will attempt to treat the therapist with similar defensive tokens. These may never interpose themselves in outright defiance; rather they may take the more subtle form of an inability to respond to remedial promptings. An insidious pattern possessed by some patients who seek to enhance their independence and emancipation is a detachment that separates individuals from others and from themselves and accordingly tends to rob them of many of life's pleasures. The presenting complaint may be depression and generalized anhedonia. We may find that a meticulous application of techniques fails to register marks on the patient's indifference. When we realize that our patient has an investment in maintaining detachment, that it has always served the patient as armor against being controlled and manipulated, that it dulls threatened anxiety and a thousand imagined hurts, we can see that efforts toward its maintenance have greater reinforcement value for the patient than the rewards we as therapists can proffer. There may be nothing faulty in our techniques, but psychological obstructions act as impenetrable barriers to our efforts. This is why a high level of motivation is so important in all therapies.

Therapist Attitudes and Operant Conditioning

The proper therapist attitudes are therefore crucial for effective psychotherapy as they are probably important for all kinds of learning. They constitute powerful reinforcers that strongly influence the patient's behavior. Attitudes of empathy, warmth, and understanding tend to promote positive feelings in the patient; they relieve tension and lower the anxiety level. In such an atmosphere learning is enhanced. Interviewing, focused by the therapist on anxiety-laden content, may then prove rewarding. Thus, if dynamically oriented, the therapist will pursue and encourage the patient to explore zones that are usually resisted or repressed. Approbative responses, verbal and nonverbal, from the therapist reward the patient when repudiated material is prosecuted. In addition to the temporary benefits of emotional catharsis, the patient learns that this material can be tolerated, and when placed it in the context of the historical past, a revaluation may occur. Schedules of selected reinforcement foster the extinction of anxiety-provoking past experiences and their present-day associations.

In behavior therapy the patient is also exposed, in the medium of a rewarding emotional climate, to reinforcers that help extinguish certain reactions that have been self-defeating and accentuate others that have an adaptive potential. Symptom relief and the acquisition of constructive behavior patterns occur without the formality of insight.

Apart from specific reinforcing maneuvers that are implemented in dynamic and behavioral approaches, the therapist-patient relationship itself serves as a relearning experience from which the patient may generalize constructive responses toward other relationships. This gratuity may occur in any helping or therapeutic relationship. Dynamic approaches have the advantage of working with transferential contaminants that can effectively block this happening. Where interfering transference is not bypassed, but dealt with firmly in terms of its genetic roots, and the patterns and defenses that it embraces are skillfully analyzed, it will tend to undergo negative reinforcement and extinction. The therapist relationship will then become a powerful corrective experience for the patient. This does not mean that cure is automatically guaranteed, since in some cases psychic damage is so profound, the secondary gain benefits so intense, the masochistic need so

great, that inner rewards for the perpetuation of transference exceed those the therapist can supply by approving-disapproving tactics. Nevertheless, in a considerable number of patients the developing and unravelment of transference can be most facilitating of extensive personality alterations. Behavior therapies, while remarkably effective in promoting symptomatic improvement and behavior change, cannot approach the depth of reconstructive personality change possible in selected patients exposed to dynamic therapy with trained psychotherapists whose personality structures contain the proper ingredients of warmth and understanding, and who know how to deal with transference and countertransference.

A question immediately poses itself. Is not the proposed climate for some types of psychotherapy, for instance classical psychoanalysis, a neutral, detached one, and, if so, would not the patient then respond in an antitherapeutic way to the traditional detached manner of the therapist? The answer to this question lies in the simple fact that effective psychotherapists, including psychoanalysts, are not really neutral and unconcerned. They communicate, in spite of practiced noninterference and passivity, an understanding of and empathy toward their patients. The patient quickly discerns from nonverbal cues the underlying true emotional feeling of the therapist. Noneffective therapists (including psychoanalysts), on the other hand, who personality-wise are detached, cold, uninvolved, or lacking in empathy will stimulate negative therapeutic reactions in their patients. Extensive training and experience will not compensate for the absence of positive personality qualities, without which no technique can truly be productive.

Psychotherapists generally practice preferred methods that over the years have yielded enough triumphs to reinforce faith in their powers. *What* we do in therapy is tempered constantly by *how* we do it. We have an affinity for some techniques and prejudices toward others. Not all procedures make sense, nor will they work for all therapists. A highly discriminating process generally takes place as therapists gain experience and find that certain theories and special techniques seem effective in their hands. A problem that plagues our field, of course, is the tendency to apply one's personal experience to the world at large. The fact that a therapist finds a particular approach of

great value for her or him does not mean that other therapists will do likewise.

Countertransference

An effective psychotherapeutic system recognizes negative damaging consequences of countertransference. The prejudiced responses of the therapist to the patient, positive or negative, may interfere with the latter's getting well. The nature of countertransferential projections onto the patient will depend upon the specific problems of the therapist that are being activated by the patient at the lime. These may be unique to a single case, or they may occur in different forms with various patients. Where a therapist is victimized by feelings over which he or she has little control, such an individual may not be able to apply techniques with a proper measure of disciplined objectivity. For instance, a therapist repulsed by homosexuality is not the preferred resource for an individual pursuing a nonheterosexual life style. A therapist who is fearful of aggression may display anti-therapeutic behavior when verbally attacked by a disgruntled soul. The passive, ingratiating, helpless patient may arouse overprotective attitudes in the therapist who may act as a crippling shield, isolating the patient from the realities of life. Such attitudes will interfere with the working relationship, the womb in which personality change and other benefits are propagated. In contrast, countertransference may be, if utilized correctly, an important indicator of nonverablized attitudes and feelings that are being projected onto the therapist and thus prove helpful in understanding the patient's conflicts and needs.

Environmental Variables

In considering what ingredients enter into psychotherapy, we cannot neglect social forces. Existing cultural trends and the prevailing life style may motivate patients to seek out special types of therapy and actually influence their learning patterns. In our present-day rock-loving, drug-dominated culture, members of the younger generation are especially attracted either to the expressive types of therapy characterized, on the one hand, by acting-out, screaming, and shedding superego restraints and, on the other hand, to an escape from tensions and responsibilities through meditation, psychotropic

substances, and indulgence in Eastern philosophies. It may be futile to try to impose variant therapeutic techniques on such individuals. They may be more attuned to therapists with unconventional styles, particularly therapists labeling themselves as "avant-garde" who practice original and unorthodox methods that border on the irrational.

The environment itself in which the individual functions will influence therapeutic change both during and following treatment. Thus, a milieu that reinforces destructive behavior will neutralize and one that rewards healthy behavior will encourage the success of the therapist's efforts. Recognition of the environment in which the individual functions and will be forced to live in after therapy will permit the therapist to focus on elements that need to be altered or, if irremediable, adapted to without compromising the gains achieved in psychotherapy.

Termination of Therapy

The termination of all types of therapy is best handled in a planned way and not left to chance. An analysis of any obstructive dependency elements in the therapist-patient relationship is part of this process. The patient is generally induced to shoulder the bulk of probings into personal problems and to take total responsibility for his or her plans and activities. Independence and assertiveness are goals toward which the patient is encouraged. The patient is prepared for possible relapses and reminded that should any symptoms return, the tool of self-understanding acquired in therapy should help him or her regain equilibrium.

SUMMARY

Having delineated the important aspects of process, can we reasonably assume that these will bring good results? In the main, yes; but, as has been indicated, there are important qualifications. There are certain limitations to change in all people; there are certain potentialities for change in all people. If the psychotherapist applies himself or herself to the task with disciplined process, he or she will be best equipped to foster in

patients a successful outcome.

8
Is Psychotherapy Effective?

In some circles the idea still prevails that psychotherapy is a swamp of marshy theories imbedded in a quagmire of metapsychological slogans and convoluted methodologies. This perhaps was the sentiment behind the Congressional queries several years ago regarding the effectiveness of psychotherapy while asking for demonstrated proof of its value.

Unfortunately, it has been extremely difficult to establish, without question, a causal relationship between techniques and methods of any psychotherapeutic system known today and the changes that have been brought about through the expediencies of that system. Both the futility of all forms of therapy in altering neurotic processes (Eysenck, 1952, 1954, 1955, 1960a, 1964, 1965, 1966, 1967; Levitt, 1957, 1963) and arguments against these conclusions (DeCharms et al, 1954; Rosenzweig, 1954; Bergin, 1971) have been voiced. Skeptics insist that neither clinical studies nor ordered observation and experiment have established beyond reasonable doubt the virtuosity of psychotherapy. This does not mean that psychotherapy is unproductive; on the contrary, the experience of "effective" psychotherapists is testimony to its potentialities. However, because present-day propositions that exist in the field of psychotherapy are not of a high order of empirically tested probability, it is difficult to demonstrate the consequences of treatment by any concrete methods and operations. Attempts to apply probability theory to the events of psychotherapy are blocked by formidable difficulties that have up to the present time defied resolution. This has encouraged some iconoclastic research psychologists to apply themselves to the evaluation of psychotherapy with the dedication of assassins.

Present-day outcome studies have yielded impressive statistics about the effectiveness of psychotherapy that contradict published negative reports (Smith et al, 1980; Andrews & Harvey, 1981; Epstein & Vlok, 1981; Am. Psychiat. Assn. Com., 1982). However, the skeptics insist that evidence from statistics is, upon close analysis, vastly

misleading since we have few criteria upon which to gauge the quality of improvement or the specific parameters of personality that are being influenced by psychotherapy. Thus it has been estimated that two-thirds of all patients suffering from emotional difficulties, who turn to and relate themselves with helping agencies other than psychotherapists, will, if the agencies are reasonably mature, experience "cure" or "improvement" purely as a product of the relationship. It has been posited also by some observers that a similar proportion of cures or improvements will be registered should the same kinds of patients come under the care of psychotherapists or psychoanalysts. With non-specific therapeutic measures, principally rest, sedation, and reassurance, Denker (1946) discovered a recovery rate of 70 percent, while Landis (1937) reported a recovery rate of 68 percent in patients who were not exposed to any therapy. If these findings are true, psychotherapy would seem to be a fraud. It would scarcely be worthwhile to expose oneself to the rigors and expense of psychotherapeutic treatments if at the end the results were no better than one could obtain with less elaborate procedures. On the other hand, if one could demonstrate that the *quality* of the two-thirds cure or improvement was of a better grade, or if the *total* improvement rate with psychotherapy could be increased by at least 20 percent, the effort and financial outlay might be justified.

No matter how strong our conviction may be about the positive effectiveness of psychotherapy that is reinforced by some of the modern studies on outcome, we cannot, with a wave of hands, disregard the negative convictions of the skeptics nor the tenets of past published data pointing out the absence of irrefutable documentation that psychotherapy is more potent than spontaneous cure or counseling (Appel et al, 1953; Teuber & Powers, 1953; Barron & Leary, 1955; Frank, 1961; Eysenck, 1962). Indeed, there are studies that seem to indicate that patients who apply for therapy and are merely put on waiting lists, receiving no further treatment, reveal after a six month's follow-up, a 40 percent rate of improvement (Endicott & Endicott, 1963), and five to six years after the initial evaluation, a spontaneous improvement rate of 65 percent (Schorer et al, 1966). The latter rate is held to be superior to that following exposure of patients to an extensive and carefully designed treatment program.

In the Cambridge-Somerville Youth Study (Powers, 1949; Powers & Witmer, 1951; Teuber & Powers, 1953) 2 equal groups of 325 boys were matched. The first group received therapy from adherents of both the psychoanalytic and Rogerian schools. The second group served as controls. Follow-up studies over a period of years disproved the expectation that the treatment group would be less delinquent than the other. Indeed there was a slight difference in favor of the control group. Brill and Beebe (1955), working with soldiers who had experienced a breakdown in the army, also found that no difference was scored in remission of neurosis between those who did and those who did not receive psychiatric treatment. Barron and Leary (1955) treated a group of psychoneurotic patients and compared the end results with an untreated control group. They discovered that "for the most part…the changes tended to be in the same direction for treatment and non-treatment groups, and of about equal magnitude." Three groups of patients were subjected to a follow-up study by Barendregt (1961). The first division of 47 patients had been given psychoanalysis, the second of 79 patients received psychotherapy other than analysis, and the third of 74 was exposed to no form of psychotherapy. The results showed little difference among the different groups. Gliedman et al. (1958), on the basis of their work, insist that placebos are as effective as psychotherapy in psychiatric cases exposed to both. Walker and Kelley (1960), working with male schizophrenic patients, reported that short-term psychotherapy brought about no greater improvement than ordinary custodial care; indeed, it seemed to delay the discharge of patients.

The quoted results of psychotherapeutic treatment of over 70,000 cases reviewed by Eysenck (1952, 1965) concluded that these "fail to prove that psychotherapy, Freudian or otherwise, facilitates the recovery of neurotic patients." Approximately two-thirds of patients will improve with or without psychotherapy. Exposed to psychoanalytic treatment, the cure-improvement rates average 44 percent, variously being reported as 39 percent (Fenichel, 1920-1930), 62 percent (Kessell & Hyman, 1933), 47 percent (Jones, 1926—1936), 50 percent (Alexander, 1932-1937), and 67 percent (Knight, 1941). With "eclectic" psychotherapy the cure-improvement rate was cited as higher, averaging 64 percent. This figure was drawn from the following: 46 percent (Huddleson, 1927), 41 percent (Matz, 1929), 55 percent (Luff & Garrod, 1935), 77 percent (Ross, 1936), 58

percent (Yaskin, 1936), 61 percent (Curran, 1937), 54 percent (Masserman & Carmichael, 1938), 73 percent (Landis, 1938), 53 percent (Carmichael & Masserman, 1939), 63 percent (Schilder, 1939), 66 percent (Hamilton & Wall, 1941), 51 percent (Hamilton et al, 1942), 50 percent (Wilder, 1945), 58 percent (Miles et al, 1951). The data of the Central Fact-finding Committee of the American Psychoanalytic Association, according to Brody (1962) and Masserman (1963), appear to reveal that of 210 "completely analyzed" cases, 126 were "cured" or "greatly improved." Of the remaining 385 "incompletely analyzed patients," it is estimated that about half achieved some improvement. Levitt (1957), summarizing many studies on the psychotherapeutic treatment of children, arrived at a figure of 67.05 percent of cases who improve at the end of therapy and 78.22 percent at follow-up. Eysenck (1965), in examining this mass of data, concluded that psychotherapy registers a small effect, if any, on patients, with the exception of therapies based on modern learning theory. His conclusions, while upheld by Astrup (1965), Zubin (1965), Meehl (1965), Davidson (1965), and Wolpe (1965), have been vigorously challenged by Zetzel (1965), Frank (1965), Glover (1965), Barendregt (1965), Matte-Blanco (1965), Strupp (1965), Handlon (1965), and Bergin (1971). To all of these criticisms, Eysenck (1973) has replied that there is not one single study that indisputably demonstrates that psychotherapy succeeds better than no treatment, or behavior therapy, or any other alternative. Indeed, he avows that Rachman (1972) in his book, which exhaustively reviewed the literature, substantiates his own conclusions made in 1952. He states, "I believe that psychotherapy of the usual interpretive kind is simply the premature crystallization of spurious orthodoxy, a verbal exercise without any proof of effectiveness."

Bergin (1971) reviewing the data that Eysenck cites in his 1952 review comes up with a different statistic by taking another point of view. For example, Eysenck quotes a study by Fenichel evaluating the work of the first ten years of operation of the Berlin psychoanalytic clinic and shows that the improvement rate was two-thirds. However, Eysenck obtains this rate by including those patients who dropped out of treatment after brief contact with the clinic. If these patients are not included, then the improvement rate jumps to 91 percent. Scientifically, however, one can validly argue for either including or

excluding the dropouts in computing the percentage rates as improved. Bergin has also demonstrated that the spontaneous improvement rate of two-thirds shown by control groups supposedly receiving no treatment is fallacious. The reason that one cannot have an adequate control group in an outpatient psychotherapy study is because patients who are suffering and are refused help will usually look elsewhere for assistance. They will go to friends, neighbors, or practitioners of various sorts (Gurin et al, 1960). They thus do not constitute a scientific control group. At best we must compare the results of professionally trained therapists with the results of nonprofessional operators in the community. Some of the latter may influence patients toward improvement as or more effectively than professional therapists, largely perhaps because they are adept at impressing on their clients an unshakable optimism and thus stimulating non-specific elements of the helping relationship. Published reports of spontaneous recovery or improvement rates on emotionally ill persons in whom no formal therapy had been validated are below the two-thirds figure and range from zero upward: for instance, *negligible* (Orgel, 1958; Cappon, 1964; O'Conner et al, 1964; Koegler & Brill, 1967); *30 percent* (Shore & Massimo, 1966); *25 percent* (Kringlen, 1965a) and *18 to 22 percent* (Paul, 1967). These studies, which indicate a median rate of 30 percent, deal with varying patient populations with widely different syndromes and hardly satisfy rigorous empirical criteria (May, 1971). Despite later writings disputing Eysenck's ideas (Bergin & Lambert, 1978; Vandenbos & Pino, 1980), these continue to influence opinion and are upheld by some (Erwin, 1980).

To round out the statistical muddle, the different schools of psychotherapy cannot agree among themselves regarding the fruitfulness of their particular brands of therapy, published figures displaying a greater divergence among proponents of a special approach than between those of different schools. There is general agreement, however, among non-analytic groups that results with their methods are superior to those of psychoanalysis. Behavior therapists, for example, score their curative yield as roughly double that of psychoanalysts. Psychoanalysts, on the other hand, label the results of non-analytic therapy as "temporary" and "superficial."

THERAPEUTIC IMPROVEMENT IN RELATION TO GOALS

Comparison of the effectiveness of competitive brands of psychotherapy is meaningless without considering the goals to which they direct themselves. Symptom relief or cure, a legitimate and important target, is easier to achieve than attitude and behavior change, which, in turn, is more readily attainable than reconstructive personality change. The reason for this is that habit patterns constitute for the individual a way of life. They contain vital defenses and security operations, interference with which is bound to provoke anxiety. The painful confrontations to which the ego must inevitably be exposed will promote resistance that may take diverse forms, one of which is flight from therapy. Where a patient interrupts treatment before the goal of reconstruction has been reached, the initial symptoms, kept alive by resistance and transference, may still be present. Therapy may then be graded as a failure. Paradoxically, had treatment been discontinued during the early treatment phases when the salubrious glow of the placebo effect was still felt, and before resistance and transference had restored some symptoms, therapy may have been considered successful by the patient. However, more extensive goals would not have been reached where potentially achievable.

Whereas an effective psychotherapist can obtain 80 to 90 percent of symptom cure or improvement, the positive results will be reduced where behavior change is the goal. In the event the therapist seeks reconstructive changes in patients, a figure of only 40 percent will probably be as high as can be attained, even where the therapist is highly trained.

There are many reasons why so small a percentage of patients can be influenced beyond the benefactions of symptom relief and attitude change. With the best of intentions the therapist may succeed in tearing down, in sicker patients, their defensive structures, expectantly waiting for a new personality edifice to rear itself. Helpless and deprived of customary neurotic resources, which have been "analyzed away," the patient will cling to the therapist with a dependent desperation that will confound both participants. Hopeful expectations go unrewarded, the patient symptomatically being worse off than before treatment.

As in major surgery, the risks are greater in reconstructive therapy than where palliative measures are employed. The results will best justify the risks where cases are carefully selected. This calls for diagnostic skills that enable the therapist to exclude patients who are least disposed toward extensive change (such as fragile psychotics, severe alcoholics, psychopathic personalities, drug addicts, borderline cases) profound characterologic dependencies, severe obsessive-compulsive neuroses, etc. Reconstructive treatment necessitates sophisticated training and wide experience in the handling of stormy, long-term therapeutic relationships. Nevertheless, with the skillful application of techniques, the rewards should more than justify its application in selected patients as the preferred treatment method.

THERAPEUTIC IMPROVEMENT IN RELATION TO TREATMENT PHASES

At the beginning of any treatment effort, irrespective of type, extratherapeutic helping agencies operate to bring about improvement in symptoms. Counteracting these positive non-specific influences during early treatment phases are (1) defective motivation, (2) continuing conflict that, sponsoring anxiety, revitalizes symptoms, and (3) the defensive dividends and secondary gains that make the retention of symptoms advantageous for the patient. These interferences must be dealt with energetically by therapists as part of their technical pursuits.

Assuming that negative forces are not too prominent, or that they have been handled with proper therapeutic craftsmanship, the patient will register symptomatic improvement. This boon is the conjoint product of such forces as the placebo influence, emotional catharsis, the projection of an idealized relationship, suggestion, and group dynamics (see Chapter 4). Abatement of tension and anxiety and restoration of a sense of mastery will then promote a better outlook toward life.

If therapy is stopped at this period, the patient may be able to continue improvement, particularly if the sources of difficulty are dealt with constructively. This can best be accomplished during the brief therapeutic effort after existing troubles have been explored and especially when a continuity has been established between the

immediate complaints, habitual personality operations, and determining childhood experiences and conditionings. If, however, therapy continues beyond this early phase, initial benefits may soon expend themselves in the wake of the patient's realization that the idealized properties with which he or she has invested the therapist are truly nonexistent. Faith, hope, and trust no longer will temper the therapeutic climate. It is, of course, possible where the patient's need is sufficiently great—as in certain characterologically dependent personalities—for the patient to continue to endow the therapist with godlike qualities, particularly where the therapist narcissistically shares the patient's omnipotent delusions. Under these circumstances the patient will bask in the therapist's sun, soaking up the power of celestial exposure, and feel protected and continue symptom free as a result.

On the other hand, neither the patient nor the therapist may be capable of keeping alive such a sainted image. Indeed the therapist may purposefully retreat from playing a protective role and, particularly where striving for reconstructive goals, may even challenge the patient's defenses by pointing out existing behavioral improprieties. An inescapable increment of the protracted therapeutic time period to which patients are exposed for purposes of extensive personality alteration is the furtive or dramatically explosive obtrusion of resistance and transference. Where the patient's inherent personality strengths are sufficient to reconstitute personal defenses in a new climate of strife, and where the therapist is sufficiently skilled and by disposition equipped to handle the patient's insurgency, the patient will best be enabled to proceed toward a remodeling of relationships and toward values beyond the benefactions of symptom relief. At any rate, we may expect that by-products of most therapeutic endeavors that extend themselves in time are an eruption of symptoms and a mobilization of tension and anxiety. Stopping treatment at this middle phase will usually expose a patient who insists that therapy has brought little benefit. And yet, had treatment halted earlier, at the crest of the non-specific improvement wave, the effectiveness of the effort might have been endorsed.

In reconstructive therapy, therefore, we may expect a recrudescence of symptoms. Challenge of resistance, maneuvers toward insight and working through, are aspects of

the therapeutic process, however painful they may be, that force patients to learn new modes of adjusting.

It is to be expected also that prolonged therapy will tend to promote dependency. This silent saboteur may interfere with the patient's efforts toward self-actualization. It may keep the patient reduced to an infantile status, violently promoting a return of original symptoms when the patient perceives a threat of termination of therapy. As the therapist works through this "separation anxiety," the patient may be able to rely more and more on himself or herself and gradually to expand the feelings of assertiveness. Table 8-1 outlines some of the foregoing processes.

THERAPEUTIC IMPROVEMENT IN RELATION TO THE THERAPIST'S PERSONALITY

One of the most important variables in psychotherapy is the helping or therapeutic personage, whose character traits and technical skills are bound to influence results. In Table 8-2 an attempt has been made to grade rates of cure or improvement that we expect in relation to desired areas of change (goals), the kinds of processes to which the individual is exposed (techniques), and the quality of the agency administrating help.

Starting with the baseline of what we might anticipate should the individual spontaneously exploit random avenues of help, we may then compare these rates with what could happen if the individual related himself or herself to some "helping" person, such as a minister, physician, teacher, friend, or authority who, while trained in a particular field, has had no special schooling in counseling or psychotherapy. "Effective helpers" are those who possess personality qualities that inspire in the subject with whom they are working *hope, faith, trust, liking,* and *freedom to respond.* Such helpers generally have characteristics of sincerity, honesty, a capacity to respect people, confidence in what they are doing, positiveness of approach, and what Rogers (1946) has called "genuineness," "empathic understanding," and "non-possessive warmth."

Whitehorn and Betz (1960) and Betz (1962) substantiate the vital role the personality of the therapist plays in securing results with schizophrenics in

psychotherapy. Effective therapists, they discovered, see a patient as a person and not a problem, stress assets of the patient not liabilities, challenge self-depreciatory attitudes, are reasonably permissive, behave naturally with the patient, and focus on securing a trusting relationship. Ineffective therapists are too permissive, focus on the patient's mistakes, evince the qualities of an aloof teacher, and are more passive and permissive. Betz (1967) suggests, however, from research studies that the outcome of therapy depends on the quality of the relationship that develops as a result of the blend of the personalities of therapist and patient.

Truax and Carkhuff (1967) have derived three scales of traits of effective therapists derived from ratings of typescripts: (1) positive regard for the patients, (2) accurate empathy, and (3) congruence. The *accurate empathy* scale would seem to be related to the concept of accuracy of interpretation of what is going on within the patient, although no studies have been done to date to relate these two concepts. *Congruence* refers to therapists being in touch with their own feelings. If therapists assert that a patient is "liked," yet by tone of voice and previous statements show anger toward the patient, they are rated to be in low congruence. Truax and Mitchell (1972) have reviewed the results of 10 years of such studies and have found that the results are very consistent across many studies employing different diagnostic groups, with therapists of different theoretical persuasions and with differing lengths of therapy.

Rogers et al. (1967) reported an extensive controlled study of psychotherapy with schizophrenic patients who were hospitalized at a state hospital. They found that patients whose therapists offered high levels of non-possessive warmth, genuineness or congruence, and accurate empathic understanding achieved significant positive personality and behavioral changes on a wide variety of indexes; while patients whose therapists offered relatively low levels of these interpersonal skills during therapy exhibited deterioration in personality and behavioral functioning.

These studies point to the existence of a "therapeutic personality" that effective therapists possess irrespective of their operational modes (techniques). Ineffective

helpers do not possess therapeutic qualities and traits, and their absence, as may be seen from Table 8-2, will damage their capacity to render proper help. Parenthetically, every helper (or counselor or psychotherapist for that matter) will relate differently to special persons. Warmth and liking may be shown toward some individuals with whose personalities and problems the helper identifies and with whom there is a feeling of security. On the other hand, detachment and hostility may be manifested with other persons toward whom the helper feels alien and who tend to light up countertransference. All helpers will consistently be more effective with certain individuals than with others.

Counselors are those who have been trained in casework and counseling techniques. If they have the personality qualities outlined above, such training will enable them to function more expertly than non-trained helpers. Effective counselors should accordingly score higher in results than effective helpers. However, irrespective of how thoroughly trained, if counselors lack appropriate personality qualities, they may be classified as ineffective counselors, and the results will be no better than those of ineffective helpers.

When we consider trained psychotherapists, we view a somewhat complex picture since their theoretical and methodologic orientations vary so greatly. We may expect that the average trained psychotherapist whose personality contains the positive units described above (i.e., an effective therapist) will be able to achieve symptom relief, as well as behavior change, above that brought about by an effective counselor. Additionally, if the psychotherapist is trained psychoanalytically to do "depth therapy," we may expect that the most extensive and difficult to achieve goal of reconstructive personality change, potentially possible in patients selected for this approach, will at least be double that seen with therapists and counselors who do not employ insight techniques, and who depend on the adventitious operation of constructive relearning alone, which, sometimes, in a favorable atmosphere, may result in some reconstructive change. Again, though a psychotherapist has had exhaustive training, should that therapist lack the proper personality qualities, the results will be no better than those of an ineffective counselor or an ineffective helper. Patients may temporarily improve on the basis of non-specific extratherapeutic agencies, but soon these dividends will expend themselves as the

patients find themselves locked in a frustrating and unrewarding relationship situation. Where a therapist with suitable traits is not too well trained or skilled in executing therapeutic maneuvers, the results will be no better than those of an effective helper who has had no training. They will, however, eclipse those of the trained ineffective therapist who may have spent many years in exhaustive postgraduate studies that, though sharpening the cognitive processes, have made no dent on the individual's antitherapeutic personality.

The reason why the patient is impeded rather than benefited by an ineffective helping agency, counselor or psychotherapist is that the patient is blocked, by being trapped in an unrewarding situation, from spontaneously seeking out other helping resources that may bring homeostasis. Moreover, the relationship with the ineffective helper-counselor-therapist will in all probability promote hostility and release transference distortions that will activate regressive defenses, like hostile dependency, lighting up new and galvanizing old symptoms.

We are inevitably drawn to the awesome and unpleasant conclusion that a person suffering from a psychological problem is better off with no treatment at all than if that person enters an emotionally inadequate helping or therapeutic situation, whether this involves an untrained helper, a trained counselor, or an intellectually sophisticated psychotherapist.

A crucial question is whether the appropriate personality ingredients essential for therapeutic change may be taught those who seek to administer help. There is some evidence that helpers, counselors, and psychotherapists who do not inherently possess such traits, may be trained to communicate warmth, empathy, and genuineness without themselves entering into depth therapy. However, this would probably apply only to those personality structures that were not too rigid, hostile, or detached—in short, to basically healthy individuals. There is some evidence, too, that certain inflexible, hostile, and detached individuals may, with properly conducted personal reconstructive psychotherapy, work through extensive flaws in their personalities and acquire the

qualities important for functioning as effective psychotherapists. This development, however, is not at all guaranteed, and we see evidences repeatedly of professional persons who have undergone extensive training, including personal didactic psychoanalysis, who are as arrested in their growth as when they first exposed themselves to treatment, and whose contributions to the ailing masses the world could very well do without. The consequences of their education and training have become the target of critics who are constantly sniping at the results of psychotherapy. Available statistics do not convey an accurate picture of the potentialities of psychotherapy since they lump together the results of effective with those of ineffective therapists that because of the "deterioration" impact (Bergin, 1963, 1967; Truax & Carkhuff, 1967) cancel each other out and reduce the score to a figure not too much higher than that of the spontaneous cure.

Psychotherapy has vast potentials as a healing force, but it is the product of a complex equation, the elements of which require careful scrutiny, contemplation, and unravelment. It can be executed properly only by selected individuals who inherently possess or have acquired appropriate personality characteristics that will enable them to relate constructively with their patients. It is enhanced by scholarly grounding and sophisticated postgraduate schooling best available through disciplined educational resources specialized to teach an extremely complex skill.

THE MEASUREMENT OF THERAPEUTIC IMPROVEMENT

General procedures for the measurement of outcome have been detailed by a number of authorities, including Waskow and Parloff (1975) and Gottman and Mark-man (1978). Of primary concern is identifying the specific variables that are significant to measure and that give us reliable and valid data. Of concern also are the research designs that can best provide answers to our questions about outcome. The instruments that are used for the gauging of outcome must be selected carefully, recognizing that no one instrument is suitable for different patient populations and for varying forms of psychotherapy. Rather, multiple outcome instruments are indicated. Among the measures in use today are: self-reporting that deals with the patient's daily functioning (Cartwright,

1975; Imber, 1975); broad anamnestic material as in the popular Minnesota Multiphasic Personality Interview (Payne & Wiggins, 1972; data from family and friends (Hargreaves et al, 1975; Waskow & Parloff, 1975); a "Community Adjustment Scale" (Ellsworth, 1974); therapist assessment scales (Green et al, 1975; Endicott et al, 1976; Newman & Rinkus, 1978; Mintz et al, 1979); material from community agencies or members (Cummings & Follett, 1968; Halpern & Biner, 1972; Cummings, 1977); and changes in economic and creative output (Riess, 1967; Yates, 1980). Insofar as research designs are concerned, a number of authorities have offered their ideas, for better or worse, including Glass et al. (1973), Luborsky et al. (1975), Bandura (1978), Cronbach (1978), Kazdin (1979), and Cook and Campbell (1979).

Formidable problems exist in any attempt to measure the results of psychotherapy or to verify its empirical propositions (Pumpian-Mindlin, 1956; Kubie, 1960). Paradigms for psychotherapy evaluation that will identify and possibly quantify clinically relevant parameters that consider the uniqueness of each patient require further development (Glass, 1984). Ideally, we should like to observe exhaustively what takes place in the course of treatment, to study the results by subjective and objective means, to erect comprehensive hypotheses concerning the relationships between events, to deduce the consequences of such relationships, and to elaborate methods of testing inferences under controlled conditions in order to construct scientifically valid concepts. Most efforts in this direction, however, applied to the staggering uncertainties of the clinical situation, have merely accented the fallibility of our present research tools and techniques.

The methodologic problems encountered in studies on the outcome of psychotherapy are compounded by semantic befuddlements. Hazy language and even hazier concepts permeate the field of psychotherapy. When we attempt to put into words what treatment aims have been achieved, we are handicapped in translating the complex formulations of the different psychotherapeutic approaches into abstractions that possess reasonable unity. We discover that each school has its particular way of talking about and emphasizing essentially similar elements in human behavior. The nuances that are being stressed in these ideas are often not as important as the advocates of the particular

schools would make them out to be. Another confusing thing is that the same labels may be employed to designate markedly diverse ideas, for instance the words *relationship* and *ego* mean entirely different things when used by select theoretical schools. Furthermore, therapists may inject into words their own private meanings that may not at all resonate with the concepts under examination.

Another pitfall is that the bewildering number of variables, many of which are not manipulable, tempt one to grapple with only a few that can be handled with relative ease. When these are lifted out of the context of the tremendously complex physiologic-psychologic-sociologic continuum that constitutes human adaptation, they often lose their significance. We are rewarded with a catalogue of beautifully compiled categories that mean little, particularly when we try to generalize conclusions beyond the material with which we are dealing.

Before proceeding, let us review the outstanding problems in applying scientific method to evaluation studies:

1. There is disagreement as to which observable phenomena are worthy of observation.

2. The data available for study are difficult to manipulate and control, interfering with conditions ripe for experiment.

3. It is cumbersome to qualify the quantitative data of psychotherapy due to the complexity of the variables involved.

4. Available units of measurement are ill-defined, interfering with comparisons and with the synthetization of similarities and differences into a homogeneous unity.

5. Theoretic prejudices and personal biases make for a loss of objectivity and an interference with the ability to utilize imagination in hypothetic structuring.

6. The absence of an accepted conceptual framework that can act as a basis for communication obstructs the formulation of inferential judgments regarding order in the observed phenomena— blocking the deduction of

valid analogies justified by the available facts, and hindering the exploration of causal connections between antecedents and consequences.

7. The reliability of our results is distorted by a variety of other difficulties that are related to special problems of the therapist, the resistances of the patient, the amorphous status of diagnosis, the prejudiced selection of the sample, the involvements of outside judges, coders, and raters, the inability to employ adequate controls, the interferences of adventitious non-specific changes, and certain complexes inherent in the psychotherapeutic process itself.

With advances in computer technology, the development of treatment manuals to standardize therapeutic operations, the use of video tape recordings to enable independent assessors to monitor adherence to the prescribed techniques, the greater employment of adequate controls, the development of more sophisticated research designs, and improved follow-up studies on research, findings should become more reliable. The question is how much will such findings enhance our techniques for the better. The answer to this is still uncertain because individual interpretations of research findings can be different, and styles of operation vary so much that one therapist may completely foul up a prescribed method that another has utilized with great effectiveness. This is one problem that a prepared "Manual of Operations" poses. How the manual fits in with the preferred style of a therapist will determine its usefulness. It may put some therapists into a straight jacket and may totally cripple their spontaneity and flexibility. On the other hand, it may structure operations for some and make them more precise. What a therapeutic manual may be able to do is to define more precisely what enters into a specific form of treatment (behavioral, psychoanalytic, eclectic, etc.). When we examine what therapists do under the banner of a specific form of psychotherapy, we sometimes find that their operations deviate from what is commonly accepted as standard (Strupp, 1978).

Problems Related to the Therapist

Not the least of the sources of error are the individuals who supply the data on

which we are dependent, particularly the therapists and the patients (Lambert & Utic, 1978; Parloff et al, 1978b). A psychotherapist's assessment of what is accomplished in treating a patient is apt to tell us more about the therapist's narcissism than it does about what actually happened to the patient. One pointed example of how therapists may contaminate the data is their direct or indirect influencing of the verbal content. This is significantly affected by comments and even indications of approval or disapproval as contained in nonverbal cues (Greenspoon, 1954a,b). The material that is brought out may consequently be a facsimile of the therapist's ideas and values that have been subtly communicated and are now being regurgitated by the patient upon proper stimulation.

We repeatedly are confronted with productions from patients that seem to validate the specific theoretical systems espoused by the therapist. Most psychotherapists have a tremendous investment in their theories and methods. By the time they have completed training they have some firmly set ideas about human behavior. As students in training, affirmation of the approach in which they are being groomed offers rewards of approbation, of completion of training, of admission to the special graduate society with status privileges, and of economic security in the form of patient referrals. Denial of the verity of the system poses the hazards of being accused of hostile resistance, of exclusion from the ranks of the privileged, of dismissal from training, of excommunication and possible financial doom. Against these odds, the preservation of the thinking integrity is put under a strain that few students can resist. Glover (1952) has remarked, "There is a tendency in the training situation to perpetuate error." This error may be carried over to the patient who is the recipient of the therapist's values, no matter how passive and nondirective the therapist imagines himself or herself to be. The very nature of the psychotherapeutic process demands that the therapist have a conviction about what he or she is doing. As. F. C. Rhodes Chalke remarked in his presidential caveat at the Canadian Psychiatric Association (Psychiatric News 9:1, 1974): "It has been demonstrated that much of the therapeutic effectiveness of psychiatrists resides in an inherent faith in one's curative powers. This can be significantly diminished if one were to be confronted in measured terms with one's failures or successes."

Dedication to one's system is an important constituent in the therapist's mental set. If the therapist evinces a scientific attitude of skepticism, it may be interpreted by a patient as unsureness and lack of belief in the method. This may influence adversely the patient's expectations of help and reduce faith in the therapist. The therapist, therefore, may find that dogma tends to stabilize some patients as well as himself or herself. While it may help one area of functioning, it does introduce errors that may be fatal in the experimental evaluation of therapeutic activities and results.

The therapist's bias also extends itself to patient selection, so that our examining the results may be handicapped by a restricted sample. Therapists are inclined to select patients who will, according to their experience, respond best to their methods. A not too inconspicuous screening process may be employed to eliminate a wide spectrum of patients and problems. In intensive long-term therapy, an economic factor also enters into the picture, an important criterion of selection being, not the syndrome or personality, but the ability of the individual to afford the financial drain that will have been made. Thus the patients who avail themselves of long-term treatment may belong to a different subcultural group than those who apply for short-term therapy, with value systems and social pressures that make for distinctive reactions and singular responses to psychotherapy.

Economic and status factors also interfere with the reliability of a therapist's accounting of results. As a recording apparatus, the therapist possesses many defects. Bias may divert from presenting factual data, leading the therapist to some erroneous conclusions. Berg (1952) has humorously commented that when a patient loses his or her job, the therapist will find outside factors responsible; however, when the patient gets a salary increase, the therapist is willing to take credit for singular clinical competence. A therapist is generally unwilling to stand by passively and offer an unprejudiced account of why patients have failed to get well. He or she has, as Greenacre et al. (1948) pointed out, "too great a stake in the patient's recovery." When a researcher seeks to examine records or to listen to session recordings, the therapist most likely will refuse to deliver them. Why become a sacrificial victim? Why should one be a party to one's own discredit as a

therapist?

What constitutes a well-trained professional person who is qualified to do good psychotherapy is another delicate matter around which many heads have been shattered. Avoiding the ever annoying topic of medical-non-medical, we can say that an individual who has been graduated from a reputable postgraduate school run by qualified and trained psychotherapists, which has an adequate screening process for candidates, a well-formulated program of didactic instruction, competent and elaborate supervision of a varied caseload, and provisions for personal psychotherapy or psychoanalysis of its students, can arbitrarily be considered a psychotherapist. A study of cases handled psychotherapeutically by persons whose qualifications are questionable is certainly not a reliable index of the value of psychotherapeutic techniques. After all, not every person who drives a nail can be considered a cabinetmaker. Among the graduates of postgraduate schools for psychotherapy will be those with relatively fair, average, and excellent degrees of competence; there will be differences in the results of the individual practitioners with special kinds of patients and problems; there will be varying personality difficulties and aberrant characteristics among them that will determine, as has been indicated in an earlier part of this chapter, whether they will be effective or ineffective psychotherapists. Of importance also is the ability to utilize methodologies that have proven valuable for special syndromes. Many therapists attempt to squeeze all patients into the kinds of technique with which they are familiar. This is understandable, but the patient may become a sacrificial victim as a consequence.

Problems Related to the Patient

There are many sources of error in the patient's statements about results achieved in therapy. Notoriously, many patients are poor judges of what actually is going on, but unfortunately, they may be the only witnesses at our disposal to testify. They may, however, prove to be reluctant witnesses. Patients are motivated to seek help for their suffering; their objective is not to offer themselves as research vehicles. Asking them to subject themselves to psychological studies, to interviews with observers and research

workers, and to follow-up manipulations may mobilize attitudes and feelings that negate therapeutic aims.

It is always necessary to validate, by objective criteria, subjective reports by patients, good or bad, since their judgments are obviously colored by resistances. These may operate either in the service of a false report of well-being, as may be the case where the patient conceives of further therapy as a threat; or they may evoke a depreciation of legitimate developmental progress, for instance, where such progress does not conform with personal value systems or those of the subcultural group to which he or she belongs. The patient may have firm convictions of what is desired out of therapy that do not parallel the objectives of the therapist or meet the goals of reasonably good mental health. For example, Mary Jones may be interested merely in resolving her tension, neutralizing her anxiety, and reducing her symptoms so that she can function comfortably. She may be willing to restrict specific life functions, adopt protective or precautionary defenses, or forego important measures of self-fulfillment in order to achieve peace and relief from suffering. From her standpoint her therapy will be a success, if she achieves these goals, and if she symptomatically feels better she may consider herself cured. From the standpoint of the therapist, Mary Jones may be only moderately improved, since she has not altered any of her basic life patterns. From the yardstick of ideal mental health objectives, she may have retrogressed, in view of her abandonment of vital human functions.

The Problem of Diagnosis

Another factor that interferes with good evaluative research is that our present-day psychiatric nosologic systems are still in need or reordering. They embrace conglomerate labels that depict anxiety, symptomatic manifestations of anxiety, defenses against anxiety, character traits, and disintegrative phenomena. Often a diagnosis is made of that symptom complex that is most disturbing to the individual even though coordinate pathologic elements exist that are more fundamental and more serious, but happen to be less annoying to the patient than the complaint factor. Or the therapist may favor a special

group of manifestations and focus attention on these. Even well-trained therapists examining the same case may, therefore, arrive at different diagnoses. This is, to say the least, confusing to the researcher who attempts to establish some unity among the diagnostic categories. The sharpening of diagnostic systems would certainly lead to a greater clarity about goals in therapy and help in our evaluative effort. The authors of DSM-III and DSM-III R have made estimable progress toward this end. New attempts are now in process, of working out more suitable classifications. The problem is a most complex one since emotional difficulties influence every facet of functioning—physiologic, intrapsychic, interpersonal, and community relationships. What distinguishes one individual from another is the unique configuration of tendencies and traits in the form of residues of faulty conditionings, fingerings of immature personality promptings, defective modes of dealing with aggression and sexuality, manifestations of anxiety and its neutralized derivatives, and defensive and characterologic distortions. A person is qualitatively different from others because each individual is quantitatively constituted and disposed differently. What we perhaps need to do in establishing a more serviceable classification is to determine which clusters of traits and problems, or combinations of the latter, respond best to special therapeutic approaches.

The ability to define significant clusters that have responded to special treatment attempts presupposes that we have a way of identifying them. Of great handicap is improper, and even downright irresponsible, recording at the time treatment was begun. It is manifestly impossible to gauge what has been accomplished for an individual if we have no starting point from which we can begin our measurements. Too often we find ourselves desperately grasping for clues, attempting to reconstruct from memory or from the feeble jottings in our notebooks the approximate status at the beginning of treatment.

The fact that so many areas are pathologically afflicted in any emotional problem makes inadequate our simple designations of change. Labels of "cured," "much improved," "moderately improved," "unchanged," and "worse" mean little in view of the complex systems with which we are dealing. Rarely is the patient influenced similarly throughout the physio-psycho-sociologic spectrum. The patient may have experienced great

symptomatic improvement and even cure of a disabling condition, yet the patient's interpersonal difficulties may continue in force. The patient may have improved in work capacities and community relations, but marital and sexual adjustment may have deteriorated. When we utilize ratings of change, it would seem important, therefore, to assign these to the areas to which they relate. This would enable us better to appraise the specific zones of disturbance that respond to special approaches and techniques. In group therapy, for example, we may find that the patient derives great help for interpersonal problems, while entrenched intrapsychic defenses have scarcely budged. Among the areas we may consider for our ratings are the following:

1. Changes in manifest symptoms

2. Changes in interpersonal, family, work, educational, and community adjustment

3. Changes in physical health

4. Changes in feeding, eliminative, sexual, rest, sleep, and activity patterns

5. Changes in consumption of alcohol, sedatives, tranquilizers, and other medications

A fruitful area of research is in the development of scales by which we can assess the various outcome criteria. We may then better be able to compare the results of varying kinds of therapy, performed by different therapists, with diverse types of problems and patients, and then contrast these results with what happens when no formal treatment has been administered. Some years ago attempts in this direction were made by defining change in descriptive and operational terms without evaluating the changes (Witmer, 1935; Hunt & Kogan, 1950; Watterson, 1954). How an evaluative scale may then be employed to utilize such descriptions has been described by Malamud (1946).

The Problem of the Sample

In evaluating a psychotherapeutic system one may tend to neglect how the sample was selected. Because many therapists screen their patients, choosing those whose

problems, in their opinion, are best suited to their methods and skills, a prejudiced weighting of the caseload is possible. Our conclusions regarding the worth of a therapy, therefore, may have to be restricted to a special group of patients and problems. For instance, an individual applying for formal psychoanalysis may be rejected if that individual does not possess a balance of characteristics that are lumped under the designation of "ego strength." Other therapies may practice no partisanship in choosing candidates for their methods. Attempts to contrast results between different therapies must obviously take into account the fact that we may be dealing with varying populations. Thus, O'Connor and Stern (1972) studied the effects of psychoanalysis (4 sessions weekly for a minimum of two years) and psychotherapy (semiweekly for no longer than two years) on 96 patients with functional sexual disorders. They reported an improvement rate of 77 percent with psychoanalysis and only 46 percent with psychotherapy. This might sound significant except that the group selected for psychoanalysis "evidenced less illness than those who received psychotherapy." We are dealing then, at least in the area of this sample, with two dissimilar groups.

Some workers, in judging the results of treatment, include all individuals who have been interviewed and accepted for therapy, even though they do not continue beyond a few sessions. Others exclude persons who have discontinued therapy against advice. Obviously this discrimination alters the percentage of individuals improved. It is very easy to manipulate statistics to substantiate almost any bias, such partiality being not always unconscious.

Another error commonly overlooked is failure to mention the cultural and subcultural background of the persons composing the sample. Therapeutic results are influenced to a marked degree by conditions in the social environment to which the patients must adapt themselves after they have completed their treatment. Indeed, certain neurotic defenses may be mandatory if the individual is to survive in a predatory environment. Value systems regarded as constructive from the standpoint of ideal mental health may be a source of victimization where one must adapt to groups perpetuating erratic conventions and folkways. It is essential in doing comparative studies to include a

description of the individuals who are being evaluated, how they were selected, their background, their socioeconomic status, the length of treatment, and other information that might influence the treatment results. What is important also is when in time evaluations are made "whether repeatedly, during the course of, or immediately afterwards, or at variable and increasing intervals after it is over" (Kubie, 1973). These considerations will help reduce the error involved in generalizing beyond the sample to the population at large.

In our effort to select a homogeneous sample, we must keep in mind the fact that no two persons are alike even though their diagnosis is similar. Thus individuals in a sample of agoraphobic patients will vary in their physiologic makeup, developmental conditionings, educational backgrounds, environmental experiences, intrapsychic structures, personality organizations, living milieu, values, and sundry other personal determinants, including age, severity of symptoms, and motivation. These will make every patient a totally unique human being, who in a pool of other human beings, looks and behaves in certain ways distinctively from the rest. In responses to the same kind of psychotherapy, we may expect differences.

In measuring change we need to know what area or areas are to be assessed. The selection of different criteria by which to estimate improvement or cure has led to a great deal of confusion. Thus the measure of successful problem-solving, symptom relief, or behavior change accepted by behavior therapists may not be acceptable to psychoanalysts who gauge improvement by reconstructive personality alterations. Neither may be considered basic by therapists practicing humanistic approaches whose criterion would be inner peace, happiness, and creative self-fulfillment. What has been suggested is the establishment of multiple measures that cut across the different kinds of psychotherapy.

Therapeutic changes involve many facets of an individual's functioning, not all of which are easily measurable. Among these are symptoms, relationships with people, values, self-esteem, work capacity, self-image, economic status, creativity, etc. No patient progresses equally along all dimensions of possible change. To assess these we would

require a variety of instruments. The usual pronouncement of "improvement" or "cure" generally connotes merely a relief of symptoms, and does not indicate what sacrifices are being made to achieve this. For example, a patient with depression initiated by loss of a loved person who served as a maternal object may find his or her depression cured when a new maternal companion is found. Should the patient coordinately be in therapy, the cure falsely may be ascribed by the patient to the effect of treatment.

In estimating change, we are confronted with the dilemma that the multiple change criteria with which we deal are not standard and that situation-specific behaviors (like efficiency at work) are more easily assessed than personality traits. To bring some order to this muddle attempts have been made to establish a battery of measuring devices. Waskow and Parloff (1975) have recommended as a standard test battery: the Minnesota Multiphasic Personality Inventory (Dahlstrom et al, 1972); the Hopkins Symptom Checklist (Derogatis et al, 1973); the Psychiatric Status Schedule (Spitzer et al, 1967, 1970); Target Complaints (Battle et al, 1966); and a choice of either the Personal Adjustment and Role Skills Scales (Ellsworth, 1975), or the Katz Adjustment Scales (Katz & Lyerly, 1963). The value of these or any other proposed batteries will require further evaluation.

For the most part, outcome assessment will rely on the patient's divulgences, on disclosures of the therapist, as well as on the reports of family and friends, all of which may be highly biased. Nevertheless, we may have no other way of assessing change than through these declarations and through the use of instruments such as the battery of tests cited above by Waskow and Parloff (1975). Lambert (1979) has written an excellent review of measurement batteries, and useful measures have been described by Miles et al, 1951; Lorr and McNair, 1965; Strupp et al, 1969; Malan, 1976a; and Meldman et al, 1977. Insofar as personality tests are concerned, they have not been found too useful (Mischel, 1977).

The Use of Outside Judges, Coders, and Raters

Assuming that we are able to define concretely the variables that we wish to

observe, we would heighten the reliability of our observations to employ a number of competent and trained judges to go over the data on which we will base our estimates of therapeutic change. A number of problems arise here related to the confidential nature of the material, the need on the part of the patient to retain anonymity, the belief that observational intrusions alter the behaviors of patients and therapists, and the fear of the therapist that his or her therapeutic competence may come under challenge. During the training process in an outpatient clinical setting, the patient may be prepared to accept outside adjuncts as part of the treatment and the therapist may be motivated to work with raters and coders. In private practice, however, this is practically impossible.

In the event we are able to employ qualified accessories, the reliability of the measuring and rating instruments that we have at our disposal at the present time is probably high enough to permit consistency in our results (Herzog, 1959). It is essential, however, that we have dependable data, that we be explicit in the definitions of what is to be coded and rated, and that the accessory workers be properly qualified and trained in the use of the selected categories.

Whether or not accessories are used, once we have settled on the categories to be rated and are satisfied that our methods of rating are reliable, we must still question the validity of what we are doing. Let us say that we have accurate statistics about changes in symptoms and adaptive patterns; does this necessarily give us accurate information about the emotional status, whether the individual has been cured, is improved or unimproved? An example may make this clear. In going over the record of a patient who has completed therapy, the patient's work performance will come up for appraisal, work being one of the factors in evaluation. We discover that shortly after leaving therapy, the patient was demoted. This does not seem to be a good indication of the patient having made progress in treatment. Yet when we examine the circumstances closely, we see that the basis for the patient's demotion is that he or she has become less obsequious and masochistic; hence the patient is more capable of resisting unfair demands. This independence surely will not endear the patient to a domineering and exploitative foreman or employer. On the other hand, it is conceivable that an increase in salary or job advancement may be the product of

a neurotic acquisition of overambitiousness and self-exploitative character traits that drive a person to be dedicated to the job with a merciless grimness that is so often rewarded by money and position. A safeguard to the faulty assessment of environmental data is that each item is not viewed in itself, but rather is related to the totality of the patient's adaptation. Not only must reports of environmental adjustment be questioned for their validity, but other indices of change must also be considered with caution, and only in relationship to the entire range of indices. The relative weights to be given to each variable in the adjustment picture is a matter that needs to be decided individually after all of the elements have been put together. Obviously, variables of change cannot be scored on an even basis, nor can the emphasis in rating extended to a set of criteria in one individual be transferred to any other individual. The total constellation of forces that operate will determine the unique emphasis, if any, that is given to each variable. Ratings of adjustment following a point scale system are consequently invalid unless the scores are considered of unequal weight, depending on special circumstances.

Because the weighting of so many of our items is based on the opinion of the observer, the element of prejudice cannot be eliminated from our results (Miles et al, 1951). The sole safeguard we have is the background, training experience, and reputation of the researcher, which gives us some indication as to the researcher's reliability. Yet we cannot be at all certain that a researcher for emotional and other reasons, consciously or unconsciously, may not abandon objectivity for the triumph of verifying a preconceived idea. A good researcher is one who not merely can do an analysis of variance or compute a chi square, but more importantly, perhaps on the basis of personal experience, can blend common sense with the nuances of therapy.

The Problem of Controls

The problem of controls in psychotherapy is perplexing. Let us suppose that we have a clinic staffed by trained, competent psychotherapists who employ accepted psychotherapeutic techniques, and that we reject every other patient applying to the clinic for help and utilize the rejects as controls. Assuming that we have developed proper

criteria for evaluating change in the direction of mental health, that we have evolved efficient ways of data gathering, and a methodology that enables us to deal expertly with this information, we still would not be able to say with reasonable certainty that psychotherapy was the only dimension of difference between the experimental and the control groups. Our quandary is that there is no such thing as exactly the same kind of an emotional problem. Subtle and oft indetectable cognitive, emotional and behavioral differences within the same syndrome may actually be the determining factor. By no stretch of the imagination can we say that the environmental pressures, or the healing adventitious situational elements, that impinge themselves on any two people are the same, nor can we keep them anywhere near constant throughout the period of our differential study. Experience with control groups shows that it is difficult to regulate the lives of human beings so that they behave the way a research sample should. The matching of similar cases is, therefore, a haphazard process, based more upon hunches than facts. Indeed any attempt to use controls may introduce new errors. It is conceivable that if we followed thousands of cases that had been treated over a period of years, as well as a roughly similar number of control subjects, our errors would be reduced. However, this could not be guaranteed even though we could afford the formidable costs that such research would entail.

From a practical standpoint we are limited in using the sound experimental method of pairing individuals as a means of equating experimental and control groups with respect to relevant variables. The proposals of utilizing each individual as his or her own control in the tactic of "wait" control (Dymond, 1955), the analysis of variance (Miller, 1954), the use of statistical control through covariance methods (Dressel, 1953), the dealing with control phenomena through "control in data" (Gordon et al, 1954), casual visits but no real treatment ("attention" or "placebo" control) (Kazdin & Wilson, 1978), treatment as needed ("PRN contact") (Weissman, 1979b), and the employing of the principles of "randomization" (McNemar, 1949) are ingenious, but they do not resolve all of the essential problems, no matter how we manipulate the sophisticated statistical devices we have at our disposal. It is difficult to obtain a large number of homogenous patients who randomly can be assigned to special treatments for a set period of time.

The use of dropouts ("terminator controls") of those who fail to keep any appointment or stop visits early in treatment also has many flaws (Gottman & Markman, 1978). As a way out, it has been suggested that, instead of using a control group of untreated individuals, we employ two groups of the same population being treated by different methods. Our results would surely then be dependent upon the skill and experience of the therapists, accepting the contention that good therapists get approximately the same results, irrespective of their theoretical and methodologic differences (Fiedler, 1950a,b, 1951). We would have to make sure that therapists practicing different methods be comparable in ability. Zubin's (1953) idea of establishing a "standard control group" that would act as a basis for comparison with treated groups is interesting, but, as he puts it, still somewhat idealistic. It is impossible to match patients on any more than a few personality variables.

Frequently a "no-therapy" group is set up as a control after an initial interview. No-therapy is an invalid concept. An initial interview *is* a form of therapy and patients can benefit significantly from a single contact with a trained professional person. After the initial interview, the patient who is not accepted for therapy does not exist in a vacuum. That patient will exploit many measures to relieve his or her symptoms or to resolve problems. These range from tranquilizers, to self-help measures, to relationships with sundry individuals through whom the patient may work through some of the difficulties. The idea that the patient is receiving no therapy then is not true, even though the therapy is non-formal.

Other problems relate to informed consent in order to protect the rights of patients, and to the ethical issue of withholding treatment from a needy patient who happens to fall into the control group. To disclose to a patient that he or she is being used as a guinea pig, and an untreated one at that, may not meet with universal acceptance and may thus compromise the research design. To deny a patient treatment we know is needed constitutes a dilemma that the lofty principle of research for the sake of science cannot resolve.

The Problem of Adventitious Change

One of the bewilderments of evaluation is that we have little against which we can compare our results. Statistics, as has been previously indicated, generally uphold the dictum that approximately two-thirds of all patients improve irrespective of the kind of psychotherapy to which they have been exposed. They also attest to the fact that approximately two-thirds of persons with emotional problems also improve by arranging for their own destinies. These figures mean next to nothing because we have no idea as to what is connoted by the words "improvement" or "psychotherapy" or "no treatment whatsoever." We have no data on the practitioners who have presumably rendered therapy, nor on the constituent problems and syndromes, as well as their severity, that have been treated in contrast with those that have not been treated. We have no idea of the specific parameters of personality influenced in the patients who have received psychotherapy, as opposed to those who have achieved stabilization through the circumstance of extratherapeutic forces. Are persons who apply for professional help those who have in greater proportion failed to achieve benefit through extratherapeutic elements? It would seem more than coincidental that individuals who have exploited every device and resource in quest of relief from anxiety begin to improve with the institution of psychotherapy.

Problems in Dealing with the Statistical Data

It is not irrelevant to point out that research studies in mental health can be flawed by an improper analysis and reporting of the quantitative results. Spitzer and Cohen (1968) describe three common errors: inability to distinguish between statistical significance and magnitude of association, measurement of reliability, and neglect of statistical power analysis. Because professional people in the field of therapy are generally untrained in quantitative techniques, it is essential that a researcher skilled in statistical methods be consulted whenever a serious research study is contemplated. Before data is collected, it is important carefully to review the hypotheses to be tested, the kinds of data to be accumulated, and the statistical techniques to be employed. This emphasis does not justify a deification of statistical methods as ends in themselves, but rather as tools that

can order massive data and lead to reasonably valid inferences.

CONCLUSION

Concern with the rising costs of health care has focused the spotlight on the safety and cost-effectiveness of psychotherapy. Governmental authorities and insurers are asking for proof regarding the usefulness of the various kinds of psychotherapy. Can we verify the worthwhileness of an expensive project of psychiatric or psychological treatment? The difficulty of supplying scientific evidence of merit is complicated by the fact that, no matter how good a species of psychotherapy may be, it will not prove cost-effective in the hands of a bad therapist. But even if we accept what the most dubious researchers now concede, that psychotherapy is at least minimally effective and better than no treatment or the use of a placebo, most impartial observers would have to consider it a beneficial enterprise. But can we say it is cost-effective and that the benefits justify the expenditure of time, effort, and money? This depends on how we rate the tangible and intangible costs of emotional disturbance and how much monetary value we put on human suffering and the misfortunes psychological illness foists on the community. When we consider the misery wrought by neurotic symptoms—the awesome damage to families, the wrecked marriages, the derailed lives, and the shattered productivity that follow in the wake of a neurosis—and add to these calamities, crimes, delinquencies, rapes, arsons, murders, suicides, violence in the streets, and the ravages of alcoholism and drug addiction that are neurotically or psychotically inspired, we may ask: "How costly is it to society *not* to try to prevent these tragedies through some kind of corrective procedure?" Is not even a minimally effective solution better than no solution at all?

The motive on the part of governmental authorities for inquiring into the safety and cost-effectiveness of psychotherapy is understandable. The various procedures employed today in treating mental and emotional problems, such as dynamically oriented psychotherapy, behavior therapy, family therapy, group therapy, marital therapy, pharmacotherapy, and others, are substantially safe and effective *when executed by trained, experienced, and skilled professionals*. What makes a procedure unsafe and

ineffective is not the technique itself, but how it is applied. A scalpel in the hands of an unskilled surgeon can be a dangerous and useless instrument. Pardes, while Director of the National Institute of Mental Health, pointed out that the question of solid proof of treatment effectiveness extends across the entire health care field. In a 1978 report from the Congressional Office of Technology Assessment, only 10 to 20 percent of *all* health care technology had been proven effective by formal methods. Many of the commonly employed medical procedures have never been satisfactorily evaluated. Controlled studies in the mental health field definitely show that psychological treatments rate at least no worse than treatments in medicine and surgery. But further research in psychotherapy is necessary.

Research in psychotherapy is still burdened by many handicaps. Yet the literature is replete with studies flaunting impressive statistics that "prove" the superiority of one brand of psychotherapy over others or that downgrade all forms of psychotherapy as worthless or limited at best. We still do not possess a model of psychotherapy research that we can consider uniquely applicable to the special problems and conditions existing in psychotherapy (Frank, 1979; Karasu et al, 1984). Nevertheless, in the opinion of the majority of practitioners, of patients who have received treatment, and of unprejudiced observers, psychotherapy, properly instituted, is the most effective measure available to us today for the treatment of emotional problems and for the liberation of potential adaptive and creative resources in the individual.

The fact that research in psychotherapy to this date has had surprisingly little impact on contemporary clinical practice, should not discourage future attempts to substantiate the effect of psychotherapy by scientific means. There is evidence that with recognition of the complexity of the variables involved and vitality and sophistication that is currently being manifested by researchers in the field, the outlook is an optimistic one. Malan (1973) in a historical review terminates his paper with the prediction that we will eventually find "that there are particular techniques appropriate for particular types of patients, which give outcomes for which words written very long ago by Kessel and Hyman (1933) are appropriate: 'this patient was saved from an inferno, and we are

convinced this could have been achieved by no other method.' "

9
Supportive Therapy

The object in supportive therapy is to bring the patient to an emotional equilibrium as rapidly as possible, with amelioration of symptoms, so that the patient can function at approximately his or her norm. An effort is made to strengthen existing defenses as well as to elaborate better "mechanisms of control." Coordinately, one attempts to remove or to reduce detrimental external factors that act as sources of stress. There is no intent to change personality structure, although constructive characterologic alterations may develop serendipitously when mastery has been restored and successful new adaptations achieved.

There are times when supportive therapy is all that is needed to bring about adequate functioning. This is the case where the basic ego structure is essentially sound, having broken down under the impact of extraordinary severe strains that sap the vitality of the individual. A short period of supportive therapy will usually suffice to restore equilibrium. On the opposite end of the pathological scale are those victims so deeply scarred by childhood experiences that the radical surgery of intensive psychotherapy can only increase the disfigurement. The only practical thing we can do for some of these casualties is the topical cosmetic repair of symptom alleviation so that they can live more comfortably in spite of their handicaps. While we do not yet possess the diagnostic tools to assess accurately which patients will benefit most from supportive expedients, some therapists rely on the pragmatic principal of resorting to supportive therapy where more extensive measures fail to produce an adequate response. On the other hand, where case loads are overwhelming, therapists may be inclined to utilize supportive measures as a routine, reassigning patients for educational or reconstructive approaches where results are not satisfactory.

Since supportive therapy attempts the achievement of symptom relief or symptom removal, the question presents itself regarding the value of symptomatic cure. Among the

most solecistic of legends is the notion that elimination of symptoms is shallow if not worthless. This notion stems from the steam engine model of psychodynamics that conceives of energy in a closed system, bound by symptomatic defenses, which when removed, releases new, more dreadful troubles. This is in spite of the fact that physicians from the time of Hippocrates have applied themselves to symptom removal in both organic and functional ailments with little or no baneful consequence. Yet, legends survive from one generation to the next. The presumed dangers of symptom removal are now as threatening to some younger therapists as they were to their teachers. Little proof is offered of a causal relationship between the fact of symptom relief or removal and any pathological sequelae. The evidence persuades that supposedly precipitated disasters are either coincidental or the product of inept therapeutic interventions (Spiegel, H. 1966). The complaint, then, that symptom removal is an arbitrary, incomplete, irrational, and unsatisfactory approach in psychotherapy is apocryphal. Yet, we cannot entirely dismiss the anecdotal accounts and experimental studies (Szasz, 1949; Browning & Houseworth, 1953; Seitz, 1953; Jones, HG, 1956; Paneth, 1959; Crisp, 1966; Bruch, 1974a) of infelicitous effects, but on the whole the empirical evidence for symptom substitution is not consistent. I have, in my own consultative practice, seen occasional untoward results with supportive approaches. However, I have also seen baneful consequences with reeducative and reconstructive approaches. My impression is that it is not the method that produces bad results; rather it is *how the method is applied,* as well as the fragility of the ego structure on whom it is applied. A callous therapist who batters away with any technique without adapting tactics to the immediate reactions and sensitivities of patients may become a greater instrument of harm than of help. The transference reaction can negate any therapeutic benefits; indeed, it may in itself be responsible for a therapeutic debacle. Experience convinces that supportive measures, carefully and selectively applied, can, as a result of desirable symptom alleviation, promote substantive behavioral benefits.

In summary, symptom relief or removal is an essential goal in any useful psychotherapeutic program. It may occur "spontaneously" or be brought about by a variety of methods, such as by drugs, by conditioning techniques, by faith and prayer, and by insight. While one may not agree with Eysenck (1960a) that elimination of a symptom

cures the neurosis, there is evidence that it contributes to a better adjustment and to the elimination of auxiliary symptoms clustered around the original complaints. Any therapy that leads to enlightenment and greater self-understanding *without* symptom relief may legitimately be regarded as a mediocre success if not a failure. But this does not mean that symptom control should constitute the sole objective of therapy. Undermining of the basis of the individual's symptoms, the resolution of past conditionings and current conflicts that nurture more symptoms expands one's potentials for happiness and creativity. While such an objective may come about as a byproduct of symptomatic change, its studied achievement should be an important target.

In many patients receiving supportive therapy, consequently, an effort should be made to motivate them toward some kind of reeducative or reconstructive change in order to insure greater permanence of results.

Supportive measures thus may be utilized as the principal treatment or as adjuncts to reeducative or reconstructive psychotherapy. They are employed as:

1. A short-term exigency or expedient for basically sound personality structures, momentarily submerged by transient pressures that the individual cannot handle.

2. A primary long-term means of keeping chronically sick patients in homeostasis.

3. A way of "ego building" to encourage a dedication to more reintegrative psychotherapeutic tasks.

4. A temporary expedient during insight therapy when anxiety becomes too strong for existing coping capacities.

An understanding of how and when to do supportive psychotherapy is, therefore, indispensable in the training of the psychotherapist.

Supportive therapy does not work in many cases where the problems with authority are so severe that the patient automatically goes into competition with the helping individual, depreciating, seeking to control, acting aggressive and hostile, detaching

himself or herself, or becoming inordinately helpless. These reactions, appearing during therapy, may act as insurmountable resistances to the acceptance of even supportive help.

Therapies with designations of "palliative psychotherapy," "social therapy," "situational therapy," and "milieu therapy" fall into the supportive category. Many of the tactics utilized are similar to those in casework and counseling. Among procedures employed in supportive therapy are guidance, tension control and release, environmental manipulation, externalization of interests, reassurance, prestige suggestion, pressure and coercion, persuasion, and inspirational group therapy.

GUIDANCE

Guidance is the term given to a number of procedures that provide active help, in the form of fact giving and interpretation, in such matters as education (educational guidance), employment (vocational guidance), health, and social relationships. Many casework, counseling, and educational operations come under the category of guidance.

The extent to which the patient's life is manipulated varies with the patient's condition and with the system of guidance employed. Most of the guidance schemes are patterned after those described years ago by Payot (1909), Vitoz (1913), Walsh (1913a, b), Barrett (1915, 1925), Eymiew (1922), Traxler (1945), and, Erickson (1947). The role that the therapist plays may be that of a directing authority who arranges for a planned daily regimen and allows no time for idleness and destructive rumination. A balanced program may thus be organized, relating to the time of arising, bodily care and grooming, working schedule, diet, rest periods, recreation, sleep, and other activities that will account for every hour of the day. Such complete control of the patient's routines, however, is rarely necessary. Usually, guidance is aimed at a specific disturbing problem that interferes with adjustment. Instruction is given in ways of detecting, examining, and avoiding stressful situations. Courses of action realistically suited to the problem are then outlined. Recommendations may also be made toward specific adaptive goals, like enhancing one's career, furthering one's education, etc. This advice is particularly helpful to individuals whose emotional problems are not too severe.

Guidance is based on an authoritarian relationship established between therapist and patient. One of the problems inherent in such a relationship is that a dependent patient may tend to overestimate the capacities and abilities of the therapist to a point where the patient's reasoning abilities and rights to criticize are suspended.

Under these circumstances any doubt regarding the strength or wisdom of the authority will arouse strong insecurity. Hostility and guilt feelings, if they develop at all, may be rigidly repressed for fear of counterhostility or disapproval. One may recognize in such irrational patterns the same attitudes that the child harbors toward an omnipotent parent. Actually, the emotional helplessness of the neurotic individual resembles, to a strong degree, the helplessness of the immature child. The neurotic person may project the original authority that was invested in parents, and may be seeking from the therapist extravagant evidences of support and love. Characterologically dependent persons particularly demand demonstrations of infallibility. Should the therapist display human frailties or appear to lack invincible qualities, the faith of the person may be shattered, precipitating helplessness and anxiety. Mastery may then be sought by annexing oneself to another agency in whom magical and godlike features lacking in the previous host are anticipated. The life history of such dependent individuals shows a flitting from one therapist to another, from clinic to clinic, from shrine to cult, in a ceaseless search for a parental figure who can guide them to paths of health and accomplishment.

Because they have so often been disappointed in this search, some persons will resent guidance, even though they feel too insecure within themselves to direct their own activities. Others will reject guidance because of previous experiences with an authority who has been hostile or rejecting or who has made such demands on them for compliance as to thwart their impulses for self-growth. Acceptance of advice may, to certain individuals, be tantamount to giving up their independent claims on life.

In spite of its disadvantages, guidance may be the only type of treatment to which some patients will respond. Desperately helpless in the grip of their neurosis, such individuals have neither the motivation nor the strength to work with a technique that

requires self-direction. Resistance to self-assertiveness is so strong that a parental figure must prod them into performing their daily tasks.

A guidance toward religion is sometimes deemed expedient (Holman, 1932; Blanton & Peale, 1940; Poole & Blanton, 1950). An attempt is made here to convince the patient that health and self-fulfillment can be achieved by self-devotion to prayer. In yielding to a stronger power, the patient can crush dread, overcome fear, and even achieve peace of mind. Christian Science (Bates & Dittemore, 1932) and other "faith cures" draw on these principles. Tormented by self-doubt and riddled by anxiety, the individual may reach for a solution through salvation. By confessing his or her wickedness the patient becomes a candidate for forgiveness and a future blessed existence. Attitudes of defeatism change to those of hopeful anticipation. As one of God's chosen instruments, a sense of dignity is acquired. Competitiveness may then be abandoned for compassion and hate for love. Some patients, comforted by religious forms of therapy, benefit also through participation in church activities.

Within its limited orbit, therefore, guidance has utility in therapy. One does not employ it under the illusion that any deep changes will occur in underlying conflicts or the dynamic structure of the personality. Causal factors are usually whitewashed, and the person is encouraged to adjust to problems rather than to recitfy them. The patient may be taught many methods by which emotional blind alleys can be avoided. The patient may learn to correct certain defects or to adapt to circumstances that cannot be changed. However, where guidance is not supplemented by other therapies calculated to render the person more self-sufficient and independent, fundamental difficulties in interpersonal relationships will probably not be altered.

TENSION CONTROL

Tension activates many disturbing physiological and behavioral tendencies. More subdued than anxiety, of which it is undoubtedly a component, it often registers its effects subversively through the autonomic nervous system, influencing the functioning of various organs. It is one of the earliest signs of emotional disturbance, and once mobilized

it may continue to torment the individual even after neurotic defenses have been established. Tolerance of the effects of tension varies. There are some persons whose repressive mechanisms work so well that they are unaware of how tense they are even though their physical health is affected by resultant physiological imbalances. There are others whose sensitivity to tension is so extreme that they are in a constant state of uneasiness and discomfort. Individuals with poor impulse control may release their tension in passionate outbursts even though this leads to violence, sexual acting-out, and sundry behavioral improprieties.

Because tension is so discomfiting, it is little wonder that escape from it constitutes a chief preoccupation of human beings, who will eagerly utilize assorted devices in pursuit of peace of mind. Some of the contingencies exploited have a destructive potential. Alcohol, for example, is often employed as a potent tranquilizer; its use is universal, a part of our social tradition. It narcotizes the brain and easily, while its effects last, subdues awareness of tension. Most people are capable of controlling the intake of drink, but for those who attempt to utilize it as a prime calmative resource, it poses serious hazards. In recent years other tranquilizing substances (such as Valium and Xanax) have entered the scene. Enthusiastically prescribed by physicians (by far, they constitute the most commonly sold drugstore medicaments), they are fervently utilized by patients, some of whom after several months may become addicted. Barbiturates and nonbarbiturate hypnotics continue to enjoy a risky popularity. This is not to deprecate the value of tranquilizers, sedatives, and hypnotics as temporary expedients, but caution must be exercised in their use since they cannot be employed as a way of life.

Among the less noxious modes of regulating tension are exercises in self-relaxation, self-hypnosis, meditation, and biofeedback. There is no reason why these devices cannot be employed as part of a comprehensive program where tension is too unsettling. Their influence is palliative and can be helpful, but their value is greatest where they are utilized with psychotherapy (see Chapter 56).

It is to be expected that many practitioners, with and without proper qualifications,

will offer unique schemes for tension release, including bodily massage, tapping, slapping, touching, intimate games, screaming exercises, spiritual discipline, and self-induced altered states of consciousness. Popular volumes flood the market and have varying virtues for individuals seeking self-help direction for tension control. The professional person may derive some good ideas from a few of these volumes (e.g., Krippner & Kline, 1972) that can be adapted to one's own technique and style of operation.

Muscle relaxation exercises have been used for many years. Many of these are founded on the system of the nurse, Annie Pay son Call (1891), which combined muscle relaxation, rest, and "mind training" for purposes of repose. The best known modern exercises are those of E. Jacobson (1938) and Rippon and Fletcher (1940). D. H. Yates (1946) and Neufeld (1951) have described a series of exercises that enables the individual to gain voluntary control over tension. Massage enhances muscle tone in addition to encouraging relaxation (Jensen-Nelson, 1941; Mennell, 1945). Enforced rest also has a relaxing effect on the individual's muscular system. In part, this was an objective of the old Wier-Mitchell (1885) "rest cure," which combined isolation, diet, massage, and electrical stimulation. These measures were often reinforced by prescribed isolation from relatives. Weir-Mitchell's method gained wide repute, although beneficial effects were probably as much induced by psychologic as by physiologic factors. Schultz's "autogenic training" (Schultz & Luthe, 1959) provides the dividend of muscle relaxation during self-hypnotic exercises. The influence of muscular relaxation on the individual's tension is purely palliative and should be accompanied by some form of psychotherapy.

Unlearning of dysfunctional habits that escalate tension will require daily practice of a chosen method (Benson, H., et al, 1974). This may involve nothing more than E. Jacobson's simple progressive relaxation of muscle groups (1938) from scalp to toes or vice versa. Such self-relaxation techniques can quiet major muscle groups and ultimately lead to substantial tension control. It is estimated that on the average approximately 2 months of daily practice are required for satisfactory results. As the subject experiences a sense of awareness about his or her bodily reactions, the subject may be able deliberately to reproduce at will an adequate state of relaxation without needing to go through all the

prescribed exercises. Autogenic training (Schultz & Luthe, 1959) strives for a reorganization of subconscious thinking patterns through the use of a technique of "passive concentration," an unstructured relaxed form of cogitation and association. No formal muscle relaxation maneuvers are utilized, yet the technique promotes a sense of warmth and lightness over the entire body. Suggestions emphasize peacefulness and quietness and enjoin the subject to allow such feelings to develop without forcing them.

Meditation has a long history, most frequently being associated with the Buddhist religion (particularly the Zen cult) and with Yoga. More recently Transcendental meditation has attracted large groups of people, particularly the young (Forem, 1973). Experimental studies have shown that meditation can produce striking psycho-physiological effects, including alleviation of tension, lowering of oxygen consumption and metabolic rate, and decrease of cardiac output (Wallace, RK, 1970; Glueck & Stroebel, 1975). Many techniques exist for the production of meditation, ranging from practiced suspension of thinking to concentration on monotonous environmental stimuli, to repetition of certain sounds or words (mantras), to special forms of physical exercise. The association of meditation with mysticism is understandable. As in hypnosis, a change of body image and the evocation of weird fantasies may strike some as evidence of preternatural worlds. But meditation may be practiced apart from mystical union with the absolute and without achievement of "enlightenment" and "universal wisdom," should these essences not suit the philosophical bent of the subject. Faithful practice of meditation from 20 to 30 minutes daily is usually required for proper practice toward mastery of tension (Carrington & Ephron, 1975).

Biofeedback training is a recent entry into the arena of self-regulated tension control (Stroebel & Glueck, 1973; Glueck & Strobel, 1975). There is considerable evidence that one may gain conscious command over involuntary bodily functions by receiving sensory information from visceral organs. There gradually develops a type of operant conditioning that enables a person to monitor certain physiological functions. The most common instruments employed are those that record changes in skin potential (psychogalvanic meter), brain-wave activity (EEG machine), muscular function (electromyograph

machine), and skin temperature (thermal machine). By learning to diminish or increase the auditory signals or amplitudes on a visual scale, one may be able to produce greater quantities of alpha waves (a phenomenon associated with lessened anxiety), to reduce activity of the sympathetic nervous system, and to achieve profound muscle relaxation. Lowering of blood pressure in hypertension, healing of stomach ulcers, and relief of migraine are among the conditions that have been successfully managed.

Relatively easily mastered instruments are available for biofeedback training through which most persons are able to develop an ability to regulate subconscious physiological activities. This kind of visceral learning holds out great promise for the future in treating psychosomatic ailments. Therapists may profitably explore this field to see whether it may enhance their therapeutic repertoire, should their practice involve the treatment of many patients with psycho-physiological ailments. In the event the therapist does not possess the instruments, the patient may be referred for adjunctive biofeedback therapy to a behavior therapist skilled in the method. Most patients can be trained in about 10 sessions.

Some practitioners utilizing tension control as the primary treatment method employ a combination of techniques, for example, progressive relaxation, skin galvanometry, hypnosis, and meditation. In my own experience, I have found that most patients do well with self-relaxation alone, utilizing an audiotape, the making of which is described later in the book. Where this does not suffice, I have sometimes employed an inexpensive psychogalvanometer with electrodes that attach to the fingers as a way of measuring skin resistance. Some patients do better if they possess a means of overtly gauging their progress, and a biofeedback apparatus in this way serves them well. Patients with tension headaches often benefit from learning how to relax the frontalis muscle with the electromyographic (EMG) machine, while migraine may respond to learning to direct the blood flow from the head to a hand, employing a thermal biofeedback apparatus.

MILIEU THERAPY (ENVIRONMENTAL ADJUSTMENT, SOCIOTHERAPY)

A vast number of stimuli from the outside impinge on the individual daily. Some of

these are clearly responsible for an existing acute emotional upset. Some are habitual aggravations that keep chronic troubles alive. In milieu therapy we attempt to define and eliminate provocative environmental irritants or to remedy deficits in the living situation that create problems for the person. Long considered an exclusive province of the social worker and rehabilitation counselor, many psychotherapists are recognizing the importance of dealing with defective environmental contingencies as part of the treatment process. Broadening the scope of their concerns beyond their usual intrapsychic and interpersonal focus acknowledges that the patient is subject to influences away from the therapist's office that can sabotage the treatment effort. Perhaps more important are the preventive aspects of a regulated environment that regard such things as nurseries as more than a dumping grounds for the children of working mothers, and hospitals as more than a warehouse for the storage of the mentally disabled. The writings of Aichorn (1948), Bettelheim and Sylvester (1948), Main (1946), M. Jones (1952, 1956, 1957, 1959), Stanton and Schwartz (1954), Cumming and Cumming (1962) have documented the growth of the movement outlining the history, rationale, and value of milieu therapy for preventive and therapeutic purposes. Therapeutic nursery schools, residential treatment centers for children, psychiatric hospitals, halfway houses, daycare centers, rehabilitation centers, nursing homes, and other institutions have attempted to apply principles from education, psychoanalysis, and behavior therapy to the organization and management of therapeutic units (Greenblatt et al, 1955; Cumming & Cumming, 1962; Sherwood, 1975; Kramer & Kramer, 1976; Gunderson et al, 1983; Noshpitz et al, 1984). Dominating the thinking has been the concept that supplying patients with the benefits of a scientifically organized therapeutic community has, in practice, displayed both benefits and limitations (Greenblatt et al, 1955; Knobloch, 1960, 1973; Rapaport, L, 1962; Karasu et al, 1977; Talbott, 1978; Gunderson, 1980; Oldham & Russakoff, 1982; Gunderson et al, 1983).

Great diversity of design are obviously possible varying with the specific facilities and resources available in a community. Their efficacy, no matter how ingenious they may seem, is crucially dependent on (1) the dedication and skill of the involved personnel, (2) how completely the environment accords with the demands of the patient, and (3) the singular reactions of the patient to what is being done for and to him or her.

No matter how benevolent a controlled environment may seem, the attitudes and reactions of administrative and clinical professionals will determine its therapeutic impact. Many programs have been wrecked by negative countertransferential reactions of the persons in charge. The treatment and rehabilitative facilities must also be vigorous and varied to fit in with the requirements of different patients. Unless a program is flexible and possesses many alternative resources, it will not be suitable for all assigned individuals. Finally, some patients respond adversely to certain environments no matter how therapeutic they may seem. For example, detached and schizoid patients may not be able to tolerate the overload of stimuli characteristic of some programs (Van Putten, 1973).

Very often patients are so bound to an existing life situation, because of a sense of loyalty or because of a feeling that they have no right to express demands, that environmental distortions are tolerated as unalterable. They may be unaware that tension and anxiety are generated by specific conditions, blaming their difficulties on things other than those actually responsible. This may act as a deterrent to psychotherapy. The therapist may have to interfere actively with environmental aspects that are grossly inimical to the best interests of the patient. This may necessitate work with the patient's family, for it is rare that the patient's difficulties are self-limited. The various family members may require some kind of help before the patient shows a maximal response to therapy (see Family Therapy, Chapter 52).

Social work more than any other discipline has evolved the most complete and best organized system of *environmental manipulation* (Atkinson et al, 1938; Bruno, 1948; French, LM, 1940; Jewish Board of Guardians, 1944; Lowrey, 1946; Menninger, WC, 1945; Pray, 1945; Ross & Johnson, 1946; Towle, 1946; U.S. Children's Bureau, 1949; Van Ophuijsen, 1939). Among services rendered are mediation of financial, housing, work, recreational, rehabilitative, marital, and family problems. Many of the environmental manipulative techniques elaborated in social work may be employed by the therapist when situational difficulties are so disturbing to the individual that he or she is unable to live with them. Or the therapist may utilize the services of a social worker as an adjuvant

toward this end.

Home treatment is a modality through which inaccessible patients may be reached before a crisis makes hospitalization inevitable (Becker & Goldberg, 1970; Goldberg, HL, 1973). It is especially applicable to disturbed individuals who are unable or unwilling to seek psychiatric help. For such people a team effort is best. That a visiting team sees the patient in the family and customary social setting facilitates diagnosis and treatment planning. In many cases, the visit promotes greater confidence and trust and elicits far less anxiety than would be the case in a strange setting like a hospital clinic. The interdisciplinary team with the different backgrounds of its constituent members can improve the quality of the total evaluation. The interaction of the entire family at the initial home visit permits a better understanding of the dynamics that have led to the upset in the identified patient. Although home treatment may seem an expensive process, the cost to the community is probably less than maintaining the patient in an institution and providing aftercare. When several visits have been made, sufficient confidence may be inspired in the patient to be motivated to continue contacts with one or more members of the team in the central clinic. Family therapy and drug treatment are particularly suitable in home treatment: paranoidal patients have benefited from the use of long-acting injectible phenothiazines at intervals of 2 weeks (Goldberg, et al, 1970).

Sometimes the results of minor environmental adjustments are most gratifying, constituting all that the patient will need (Duncan, 1953; Suess, 1958; Murray & Cohen, 1959; Redl, 1959; Ytrehus, 1959; Lander & Schulman, 1960; Stanton, A, 1961; Wilkins et al 1963). At other times, considerable psychotherapy will be required before the patient is able to take advantage of improved environmental adjustments. We should never lose sight of the fact that environmental difficulties, while accentuating the patient's problems, may merely be the precipitating factors. The basis for the maladjustment exists largely in the personality structure. As a matter of fact, most people have a tendency to objectify their problems by seeking out conditions in their environment that can justify feelings of upset. For example, if a person has a problem associated with the fear of being taken advantage of by others, that individual will relate this fear to almost any situation in which

the person is involved.

Environmental correction may, therefore, have little effect on the basic difficulty that has been structuralized in such widespread character disturbance that problems in interpersonal relationships appear to perpetuate themselves endlessly. Indeed, the individual seems to create adversity toward which one is capable of reacting with customary defenses. More confounding is the desire for martyrdom, a disturbed atmosphere actually being needed. The individual may, for instance, seek to be victimized by others in order to justify feelings of hostility that could otherwise not be rationalized. In cases such as this, the correction of environmental stress may produce depression or psycho-physiologic illness due to an internalization of aggression. One of the most discouraging discoveries to the therapist is that in liberating a patient from a grossly distorted environment, the patient may promptly become involved in another situation equally as bad as the first. The dynamic need for a disorganizing life circumstance will have to be remedied first before the patient responds adequately to environmental manipulation.

However, there may be no alternative in helping some patients (particularly non-motivated, psychotic, psychopathic, or mentally defective persons) than to substitute for their habitual setting a radical change in the conditions of life even while they resist psychotherapy. This may be the only practical means of management. Even where there is an avoidance of intimate involvement, a milieu that taxes coping capacities minimally and supplies some gratifying experiences may bring about homeostasis and lead to greater self-fulfillment.

Hospitalization will occasionally be needed. When considering hospitalization for an acutely disturbed, depressed, or psychotic patient, it is important to recognize the disadvantages and advantages of removing the individual from the situation to which that individual will have to adjust on returning home. Most patients can be adequately cared for with partial hospitalization such as a well run day hospital. Research studies show that this resource is to be preferred in the majority of cases and yields better results than full

hospitalization (Herz et al, 1971; Washburn et al, 1976). However, if the patient is too disturbed or uncooperative, or if suicide is likely, admission to an institution may be advisable for the protection of that person and others. What must be considered then is whether emotional stabilization is the preferred goal. Under these instances, a short-term crisis-oriented period of patient care of 1 to 3 months may suffice. However, where deeper structural personality changes are the objective for persons who have the capacity for such change but who resist altering their behavior, a longer period of hospitalization—1 year or more will be required. In the latter case, the referring therapist should ascertain that the staff of the hospital contains professionals trained in approaches that aim for deeper changes. Instead of hospitals, many rehabilitation units exist that may be ideally suited to some patients. It may be productive for a therapist to visit some of the rehabilitation facilities in the area to see what services they render. Some patients may be better suited for sheltered workshops than for other programs. Still others will need halfway houses that act as a bridge to community living. What is essential is the formulation of a plan both for immediate care and for therapy after the critical situation that necessitates referral has subsided. Guidelines are suggested in the book by Frances et al, 1984.

A *day hospital* may, in many cases, serve as a substitute for hospitalization (Budson, 1973). The cold impersonal institutional setting is replaced by a small intimate familylike atmosphere in which the individual may find a suitable identity. In a controlled study, investigators at the Washington Heights Community Service of the New York State Psychiatric Institute discovered that "on virtually every measure used to evaluate outcome, there was clear evidence of the superiority of day treatment." Small community-based residential facilities in the form of *halfway houses* or neighborhood residences have also been increasing in great numbers for alcoholics, drug addicts, criminal offenders, maladjusted youths, and persons variously handicapped physically and psychiatrically. These facilities may serve as intermediate stations for the mentally ill patient after institutionalization, as a preliminary step to reentry into community life. They may also function as a form of continuous aftercare (Axel, 1959; Bierer, 1951, 1959, 1961; Boag, 1960; Cameron, DE, 1947; Cameron, DE, et al; 1958; Carmichael, DM, 1960, 1961; Cosin,

1955; Craft, 1958, 1959; Fisher, SH, 1958; Goshen, 1959; Harrington & Mayer-Gross, 1959; Harris, A, 1957; Jones, CH, 1961; Kramer, BM, 1960; Kris, EB, 1959; Odenheimer, 1965; Rafferty, 1961; Robertson & Pitt, 1965; Steinman & Hunt, 1961; Winick, 1960; Zwerling & Wilder, 1964). Obviously, emptying out mental hospitals and throwing sick patients onto the mercies of a community without adequate alternative rehabilitative facilities can be a disaster for both the patients and the community. What is essential is that the environment to which patients are assigned be organized as a "therapeutic community," which is more easily said than done.

In hospital, day care, and other institutional settings *occupational therapy* plays a most important role [Fiddler, 1957; Schaefer & Smith, 1958; Subcomm. Occup. Therapy (no date on publication); Wittkower& LaTendresse, 1955; Conte, 1962], In this reference it may be possible to regulate the lives of patients so that a group work project becomes part of the daily routine. The patient's responses and distortions of reaction to the group and work experiences may then be employed for counseling and psychotherapeutic purposes, in this way improving the patient's capacities for self-observation (Greenblatt et al, 1955; Mesnikoff, 1960). Aftercare management of mental patients may also incorporate rehabilitation house programs (Tyhurst, 1957; Brooks, 1960), night care in a night hospital unit (Harris, A, 1957); neighborhood community centers (Kahn & Perlin, 1964), halfway houses (Williams, DB, 1956; Clark & Cooper, 1960; Wechsler, H, 1960b; Wayne, 1964; Landy & Greenblatt, 1965; Wilder & Caulfield, 1966), sheltered workshops (Black, 1959; Meyer & Borgatta, 1959; Hubbs, 1960; Olshansky, 1960), family care (Muth, 1957; Crutcher, 1959; Ullman & Berkman, 1959; Patton, 1961; Mason & Tarpy, 1964), aftercare clinics (Muth, 1957), social clubs (Bierer, 1943; Palmer, MD, 1958; Wechsler, H, 1960b; Fleischl, 1962), and self-help groups, such as Recovery, Inc., Alcoholics Anonymous, Gamblers Anonymous, and Synanon (Bromberg, 1961; Wayne, 1964).

In rehabilitative planning, the focus may be on the individual's physical work problems or social difficulties rather than on total functioning. The skills brought into play here often involve a multidisciplinary approach, including methods and techniques from medicine, surgery, psychology, pedagogy, mechanics, sociology, etc. (Greenblatt & Simon,

1959; Schwartz, CG, 1953; Bauman & Douthit, 1966; Eustace, 1966). Some of the beneficial emotional effects of rehabilitation come from the sense of mastery that is restored to the individual when the handicap is overcome for which help was sought.

Programs organized around restoring the individual's social responsiveness help to eliminate isolation. Recreational activities may constitute the bulk of services rendered in a day care center or in special units such as Fountain House (Fisher, SH, et al, 1960; Goertzel et al, 1960; Fisher & Beard, 1962), The Bridge, and the Social Therapy Club of the Postgraduate Center for Mental Health, in New York City (Fleischl, 1962). Services may also include vocational training and placement, such as those of the Altro Workshop (Meyer & Borgatta, 1959). There is much to be said for the development of comprehensive rehabilitation centers that contain a full range of services, including psychotherapy (Gelb, 1960).

The pioneer experiment of Maxwell Jones (1952, 1953, 1956, 1959) in establishing a *therapeutic community* has illustrated how useful this facility can be. Since then, many comprehensive units have been erected, organized around social, recreational, work, and educational objectives, with and without formal programs of individual and group therapy (Agrin, 1960; Bennett, LR, 1961; Blackman, 1957; Brace-land, 1957; Caplan, 1961b; Clark, DH, 1971; Cohen, M, 1957; Denber, 1960; Edelson, 1964; Greenblatt, 1961; Irvine & Deery, 1961; Kepinski et al, 1960; Knobloch, 1960; Koltes & Jones, 1957; MacDonald & Daniels, 1956; Main, 1946; Meijering, 1960; Papanek, E, 1956, 1958; Rabiner et al, 1964; Rapaport, RN, 1960, 1961, 1963; Raskin, 1971; Rees, 1957; Siegel, 1964; Stainbrook, 1967; Talbot et al, 1961; Veomans, 1961; Visher & O'Sullivan, 1971; White, RB, et al, 1964; Wilmer, 1958).

An important aspect of the therapeutic community is that it removes patients from the irritants of their customary environment, theoretically giving them an opportunity 24 hours daily to build a new and viable personality. The hope is that sufficient personality restructuring will occur to carry over into the patient's life situation after leaving the therapeutic facility. There is some evidence that this can occur without formal psychotherapy. In British Columbia Knobloch (1973) and a research team set up a

therapeutic community at Haney patterned after the Lobetch community of Czechoslovakia in which great behavioral changes were produced with dramatic economy in about 15 percent of the time required for an equivalent stay in a hospital. Fifty-four patients were housed at Haney for 6 weeks and results compared with matched samples of patients treated in a day-care program and as inpatients. Treatment efficacy was greatest at Haney at a fraction of the cost. The results were credited to the use of a relatively closed socioecological system with a small group, assignment of work similar to the life work situation, the use of a variety of procedures including play, games, fantasy, psychodrama, kinesthetic therapy, and dramatic and pantomimic exercises, the homogeneity of the patients who all entered voluntarily into the program, and shared leadership. Knobloch stresses that "this confusion about leadership makes some so-called therapeutic communities in North America lamentable examples of disorganization—social slums with unnatural reinforcement contingencies which demoralize the patients." Follow-up studies have shown that the patients at Haney retained their low symptomatology.

The regressive impact of institutionalization has been consistently reported, but there is no reason why this has to be so. There will always be patients who cannot adapt to any facility other than an institution. The problem is not that institutionalization is antitherapeutic, but that the way institutions are run contributes to the illness and withdrawal tendencies of many patients. "As long as we continue to view the purpose of institutions as lumber rooms for individuals with deviant behavior, we will continue to foster countertherapeutic atmospheres" (Jones, M, 1973). It is not enough to load up patients with drugs and assign them to clean quarters. There is no reason why enlightened administration cannot organize institutions as viable therapeutic communities, with activities to enhance latent growth factors in patients. Describing one hospital organized around psychotherapeutic lines, Gralnick and D'Elia (1969) explain, "We began to believe we had created a society that had a positive effect on patients because it permitted them to discover, explore, and overcome their sick ways and learn healthier ways of relating to others—ways that became part of them for the rest of their lives."

We undoubtedly will find in the future that institutions will become less custodial than therapeutic because they will have flexible programs that consume the interests of patients, enabling them better to relate to one another and to the personnel, permitting them to develop new adaptive skills, and broadening their stress tolerance, which may carry over into the extrainstitutional environment.

EXTERNALIZATION OF INTERESTS

Anxiety, depression, and excessive concern with symptoms may foster a withdrawal of the individual from interests and diversions that are a healthy component of living. Where this has occurred, it may be expeditious to encourage such patients, as part of their psychotherapeutic program, to resume activities once meaningful to them or to help them to develop new diversions for leisure time (Davis, JE, 1938, 1945; Martin, AR, 1944, 1951; Slavson, 1946b). Among the many outlets are sports (such as golf, tennis, swimming, handball, table tennis, boating, and riding), crafts (woodwork, needlecraft, weaving, metal work, and rug making), games (bridge, chess), photography and fine arts (painting, sketching, carving, sculpture, and mosaics), and various other activities (hiking, gardening, collecting—stamps, coins, etc.—music, and dancing). Countless hobbies and recreations may be exploited where appropriate resources are available. Apart from physical exercise and the creative stimulation and temporary distraction from neurotic concerns, leisure time activities serve to bring the individual into contact with other persons, thus invading the individual's social isolation and exposing him or her to the influences of group dynamics. They become a kind of bridge to a more adequate contact with reality. Organized recreational programs may provide a consuming interest for patients that may be symbolically meaningful and perhaps serve as a way of relating themselves to the recreational workers and to their peers (Haun, 1967). With this as a model they may then learn to act more constructively with other people.

Occupational Therapy

Among the best organized activities, universally employed in mental institutions, is

occupational therapy, which has proved itself a vital means of restoring the individual through the relationship with the occupational therapy worker, the symbolic meaning to the therapy worker of the tools used, and the end products of his or her manipulations, toward a more adequate integration (Am. Occup. Therap. Assn., 1972; Dunton, 1915, 1945; Fiddler, 1957; Haas, 1946; Linn, 1975; Linn et al, 1962; Meyer, 1922; Schaefer & Smith, 1958; Sub-comm. Occup. Therapy (no date on publication); Wittkower & La Tendresse, 1955). Occupational therapy is more than merely recreational and diversionary. It may be the sole means of entering into the inner world of the withdrawn and regressed patient. The occupational therapy worker has become an important and respected member of the psychiatric team (Conte, 1962). As such, the therapy worker must be capable of providing adequate support and understanding for patients whose stability is at best tenuous and who are hostile, defeated, and uncooperative. At the same time the occupational therapy worker must be able to set limits and to apply adequate controls when necessary. The ability to detect, understand, and help the patients to work through conflicts as they manifest themselves in the patient's performances and relationships with fellow patients requires a high degree of training, perceptiveness, and stability. Facilitating these aims are an understanding of both rehabilitation and psychodynamic concepts.

Further objectives are improvement in work, socialization, and activities of daily living. Accordingly prevocational guidance, work adjustment, self-care, home-making, child care, and other services are offered to patients of all ages in hospitals through sheltered workshops, public and private schools, group homes, correctional institutions, day-care centers, community mental health centers, and in private facilities with special "concern for the complexities of sensorimotor and cognitive skills, personal motivation, self-determination, and adaptation" (Fine, 1984). Essentially what is attempted is restoration of a sense of mastery that has been eroded by the emotional illness.

Quality assurance is an objective of the American Occupational Therapy Association that has a membership of over 35,000 professionals. The Association as well as the Committee on Allied Health Education and Accreditation set standards for training and

practice. Certification as an occupational therapist requires completion of standard training and full-time field work. Registration and licensure are necessary for practice in many states.

<center>**THE CREATIVE ARTS THERAPIES**</center>

Among the creative arts therapies, art therapy, music therapy, drama therapy, and dance movement therapy have been developing rapidly as adjuncts to the more traditional psychotherapeutic procedures, in addition to serving as supportive and educational methods in their own right. Recognizing the usefulness of these modalities especially with the chronically mentally ill and severely disturbed children and adolescents, legislation was formalized during the late 1970s in the Mental Health Systems Act that resulted in new federal job classifications in the creative arts therapies and thus vitalizing these fields of therapeutic activity. Originally designed for use in hospitals and institutions, these methods are increasingly being utilized with individuals, their families, and other groups in outpatient clinics and even private practice. Standards of training, qualification, certification, registration, and licensure have been developed by emerging national organizations that are related to each area of the creative therapies, and research and writings have been increasing steadily in the last few years as a consequence of this ferment.

Art Therapy

Art therapy has become more formalized over the past decades and has developed from a casual technique used with children in clinics and with withdrawn patients in mental institutions to a sophisticated vehicle, which in the words of the American Art Therapy Association, is capable of "reconciling emotional conflicts and fostering self-awareness and personal growth." In this way it may serve as a bridge to help an individual "find a more compatible relationship between his inner and outer worlds." Understandably, art therapists trained in different theoretical schools will fashion their methods and interpretations around their special orientations whether these be

behavioral, Gestalt, humanistic, psychoanalytic, etc. They will also devise uniquely personal ways of conducting the art session and of relating themselves to a co-therapist or team, if there be one, in an adjunctive collaborative, or supervisory way. Art therapy may be done individually, in groups, or with families. With schizophrenic patients, art therapy helps to bring them out of their regressive state and to establish a relationship with a helping individual. Kwiatkowska (1967) has developed a popular evaluation method for art therapy candidates that designates strengths, weaknesses, and family interactions. The diagnostic value of children's drawings in learning disabilities has been pointed out and detailed by Levick et al. (1979).

Music Therapy

There is an inherent quality in sound that tends to calm or disturb, contingent on its physiologic and psychological effects. Thus, sudden loud noises may arouse fear and apprehension; coordinated musical resonance may evoke pleasure; rhythmic cadence stimulates motor activity and relieves tensions; dissonant and shrill reverberations promote tension and may actually be experienced as painful. Sounds influence both cortical and subcortical areas, affecting the autonomic nervous system. Harmonious and rhythmic tones can arouse emotional feelings, promoting happy, excited, and sad moods. For this reason, increasing interest has been shown in the use of music in medicine (Gaston, 1968; Licht, 1946; Mathews, 1906; Nordoff & Robbins, 1977; Ruud, 1980; Reese, 1954; Schullian & Schoen, 1948; Stein & Euper, 1974; Walters, L, 1954; Zimney & Weidenfeller, 1978). A *Journal of Music Therapy* exists with many interesting articles on the subject.

There is little doubt that music can stimulate, relax and sedate, depending upon past associations and present symbolic significances (Colbert, 1963). Accordingly, it has been employed in various ways in both psychotic and neurotic patients (Altshuler, 1944; Blaine, 1957; Blair et al, 1960; Folsom, 1963; Gutheil, 1954; Ishiy-ama, 1963; Jenkins, 1955; Joseph & Heimlich, 1959; Masserman, 1954; Muscatenc, 1961; Pierce et al, 1964; Reinkes, 1952; Rogers, 1963; Rose et al, 1959; Simon, B, et al, 1951; Soibelman, 1948; Winick &

Holt, 1960b; Wortis, 1960). In some cases comprehensive programs have been organized around music appreciation assemblies, rhythm bands, singing groups, and concert and community singing clubs (Van de Wall, 1936; Soibelman, 1948; Gilliland, 1961, 1962), providing the means for both personal achievement and socialization. In hospitals, day hospitals, and other settings background music may help release tensions, allay fears, provide an escape from boredom, and encourage teamwork (JAMA, 1956).

Music may also serve as a means of opening up channels of communication among patients (Snell, 1965). It becomes a stimulus for the verbalization of emotion and a vehicle for the encouragement of interaction in a group (Heckel et al, 1963; Lucas et al, 1964). From *projection* of feelings the indivdiual is helped to assume *responsibility* for his or her feelings. Initial comments about the musical composition and its sources are followed by verbalization concerning inner emotional stirrings. These are at first dissociated from the self, but later are acknowledged as part of the person. The patient talks increasingly about how different forms of music affect him or her. In a group setting there is an opportunity to listen to others, to compare feelings, and to identify with members of the audience (Weiss & Margolin, 1953; Sterne, 1955; Shatin & Zimet, 1958). Transference toward the music therapist and the group members is almost inevitable and provides opportunities for exploration, clarification, and interpretation. Fultz (1966) contends that music therapy properly employed may serve the following rehabilitative goals: (1) to aid in diagnosis and treatment planning, (2) to establish and cultivate socialization, (3) to promote self-confidence, (4) to control hyperactivity, (5) to foster the development of skills, (6) to assist in the correction of speech impairment, and (7) to facilitate transition from nonverbal to verbal codification systems. In this way, music becomes an adjunctive therapeutic agent, and the music therapist who is properly trained may be employed constructively as part of a team in a treatment program. The education and professionalism of music therapists is constantly being improved and monitored by the National Association of Music Therapy and the American Association of Music Therapy.

Drama Therapy

Drama therapy includes those "approaches that stress the appreciation of creative theatre as a medium for self-expression and playful group interaction and that base their techniques on improvisation and theatre exercises." (Fink, et al, 1984). The field has developed during the past 10 years and has led to the organization in 1979 of the National Association of Drama Therapy, which has developed standards of training and competence as well as qualifications for functioning as registered drama therapists. Theater techniques were introduced into mental health practices by a number of pioneers such as Jacob Moreno, Peter Slade, Winifred Ward, and Jerzy Grotowski, which focused on the inner experiences of the actor rather than the audience, utilizing fantasy and role playing. Since then, creative theater methods have been introduced into hospitals, prisons, outpatient clinics, and schools and have been found helpful in disturbed and handicapped individuals as well as other populations who are not approachable by the usual psychotherapeutic methods (Jennings, 1974). D. Johnson (1982 a,b) has employed a developmental approach on the theory that a block in development sponsors mental illness, which may be resolved by an external organized environment with definite boundaries, expectations, and rules. Such a structured environment is provided in drama therapy through specifying the roles of therapist and group members and designating physical and other material arrangements. The use of movement, sound, and imagery attempt to reconstruct "sensorimotor," "symbolic," and "reflective" stages, such as depicted by Piaget and kindred developmentalists as a means of progressing from preverbal to verbal forms of expression.

Characters chosen for parts in the designed drama represent forces, objects, animals, people, etc., with which or whom the individual is neurotically fused and identified, or who are idealized or conflicted entities. Acting out of feelings and attitudes is encouraged through a set script or by improvisations and role playing. The therapist participates actively, attempting to resolve any impasse and restraint in free expression.

Role playing brings out both stable patterns of behavior and styles of interaction, as well as fleeting undercurrent inhibitions and impulsive outbursts that are both constructive and destructive in their consequences. What is especially interesting is the

relationship of the actor to the role that is being played, as well as the interactions with the other actors in the play (McReynolds & DeVoge, 1977) (see also Psychodrama, Chapter 52).

Dance and Movement Therapy

Dance and movement therapists work in clinics, psychiatric hospitals, day-care centers, correctional centers, and special schools all over the world on an individual and group basis. In this way they serve as adjuncts to primary psychotherapists. Such technical terms as *movement empathy, interactional synchrony,* and *replication* refer to how body movements have symbolic meanings and reveal information about inner emotions and mental process.

An individual's movements—posture, carriage, gait, and muscular coordinations—reveal tensions and character traits (Birdwhistell, 1952, 1959). The way people dance—their body direction, coordination, and use of space—communicates many of their conflicts. Free dance improvisations often bring forth gestures and movements of special parts of the body. Sequences of expression, hesitations, and aggressive motions have meaning for the dancer. Thus, dance may be exploited, not only to secure emotional release, providing an outlet for energy, but also as a way of bringing out attitudes and conflicts. Solo dance performance and improvisations, folk dancing, and ballroom dancing help externalize feelings and act as a bridge to greater social participation (Rosen, E, 1957). As in music therapy, the greatest effect on the patient is the interpersonal involvement. In a dancing relationship the patient has an opportunity to work through some of his or her shyness and embarrassment toward greater assertiveness and self-expression. Movement therapists also employ body-awareness techniques on an individual and group basis. The techniques employed draw from various sources, ranging from Yoga and Tai Chi Chuan to Jacobson's "Progressive Relaxation." The object is not only to induce relaxation but also to promote emotional catharsis, mental and physical alertness, and greater awareness and acceptance of the body (Winston, 1966). Awareness of muscle tension, of posture and body alignment and of freedom or inhibition in

breathing and body movements helps to focus attention on the self, its defenses, and its conflicts. Exercises to improve muscle tone and posture help reduce anxiety, release energy and enhance self-confidence. Focusing on select muscle groups may release an outpouring of memories and encourage the reexperiencing of affect related to past events. As the patient is stimulated to move body parts that are held rigid, the patient often begins to work through the fantasies and fears that have sponsored the original immobilizations. Obviously the relationship with the movement therapist, and the latter's ingenuity and sophistication, will have a determining influence on results (Smallwood, 1974).

Dance and movement therapy was endorsed by the President's Commission on Mental Health for use in federally assisted facilities. A number of educational programs now are available leading to a master's degree, and the American Dance Therapy Association coordinates activities in the field. Also available is a journal, *The American Journal of Dance Therapy.*

Structural Integration

A method that has been utilized in recent years is that of *structural integration,* developed and practiced for many years by Ida Rolf. It has been given the name of Rolfing (Rolf, 1958, 1973; Sperber et al, 1969). The object of this therapy, which is usually confined to no more than 10 sessions, is to regulate posture and motor control defects that are said to influence emotional factors adversely. *"Deep message"* is systematically applied to different anatomical areas. Since there is no formal interviewing, therapists need not be psychologically trained. By producing proper muscle coordination, a psychological integration is said to be obtained, a development attested to by testimonials proffered by many clients who have undergone Rolfing. The method is organized around a dubious and anatomical electromagnetic theory. Carrera (1974) has stressed the need to develop a conceptual framework with clear observable referrents before one is capable of judging the true value of this technique. It is quite probable that potent factors in the helping process here are the placebo effect and the impact of the relationship with the therapist.

Poetry Therapy

A new ancillary technique, poetry therapy had its inception in Greenwich Village, New York, when Eli Greifer, a lawyer and poet, brought together groups of mentally ill persons and recited poems that he later published in many books and pamphlets, including "Philosophic Duels," "Rhymes for the Wretched," "Poems for What Ails You," "Lyrics for the Lovelorn," and "Psychic Ills and Poem-therapy" (Leedy, 1966). Griefer was aided in his campaign by a number of Village poets, including Maxwell Bodenheim and John Rose Gildea. Poems, according to Leedy, may incite patients to constructive action as well as contribute to the evolvement of a life philosophy. Various techniques may be employed to secure group participation and interaction, including the recitation by patients of poems from readings or through memorization, and the writing of original poems (Harrower, 1974). Discussion of the emotional stirrings created by poems and their meaning for the individual serves to bring the individual to greater self-understanding. Various techniques may be employed along with group reading, such as, if the therapist is dynamically oriented, or if acting as a co-therapist to a poetry therapist, the discussion of fanatasies and the encouraging of free associations to the poems (Pietropinto, 1975).

The advocates of poetry therapy contend, with compelling examples, that poetry can be an aid in reconstructive therapy; repressed and unconscious feelings are accelerated by the reading, listening to, and writing of poetry. Thus Arsula Mahlendorf contends that "Harmoneous emotion, allows catharsis, reaches into the unconscious by rhythm, rhyme, and imagery, creates coherence, order, and insight into hidden relationships, promotes integration between the conscious and unconscious, and thereby increases self-understanding, self-esteem, and mastery." (Psychiatric News, Oct. 1, 1982). A National Association for Poetry Therapy has drawn together therapists interested in this modality.

Social Therapy

The protected atmosphere of an institution, clinic, or agency encourages the organization of groups that can participate in a full spectrum of social activities (Bierer, 1943, 1958; Palmer, MB, 1958; Wechsler, H, 1960b). At the Postgraduate Center for

Mental Health, in New York City, a program has been in operation for years that offers the individual who is or has been in psychotherapy expressive opportunities for emotional growth and development (Fleischl, 1962; Fleischl & Waxenberg, 1964; Waxenberg & Fleischl, 1965; Fleischl & Wolf, 1967). An environment is provided that is favorable for the overcoming of detachment, aggression, and social isolation. While patients may have gained insight through psychotherapy into their characterologic distortions, they may be unable to overcome these defects in their usual environment that customarily imposes harsh penalties for even minor deviations. A therapeutic social club fosters real life experiences through interaction with other persons, directly or by means of such creative activities as arts, crafts, games, reading, dramatics, dancing, and music. Parties, visits to museums, and attendance at plays and outings provide further possibilities for rich experiences. The influence of group dynamics here cannot be discounted, many deviant patterns altering themselves in the relatively tolerant setting of the club. Group psychotherapy and vocational rehabilitation are often coordinately employed.

Social therapy is particularly valuable where normal familial relationships, social activities, and work situations produce upsetting and self-defeating reactions in a patient in spite of exposure to psychotherapy. The organization and variety of activities are limited only by the inventiveness of the staff and the creative planning of the director. A screening of members is essential to eliminate hallucinating and delusional psychotics, chronic alcoholics, drug addicts, violent and assaultive persons, and criminal psychopaths. While supportive in its intent, social therapy may become reconstructive in its effect as it enhances self-understanding and furnishes rewards for socially constructive behavior. Changed attitudes and emotions lead to greater self-realization and capacities for less ambivalent relationships.

REASSURANCE

Reassurance is a partner in all psychotherapies, even where there is purposeful avoidance of pacifying consolations. The very presence of the therapist serves to conciliate the patient, apart from the auxiliary agencies of placebo and suggestion. This is especially

the case in severely upset patients who, lacking the capacity to handle their anxiety through their own resources, seek comfort in the shadow of an idealized parental figure. Coming to therapy, therefore, in itself constitutes for the patient an inspiration that he or she is not hopeless.

Verbalized reassurances are often given the patient in supportive therapy, particularly when doubts are voiced concerning the ability to get well. The patient is also solaced whenever in the grip of fears conditioned by irrational thinking. The therapist discusses such fears openly with the patient, offering explanations of how baseless they are, in the hope of diverting the patient from destructive thinking patterns.

The most common misconceptions nurtured by patients are those that are related to a fear of going insane, of being blemished by a hereditary mental taint, of harboring an undetected malignant disease or abnormality, of having sustained irreparable damage through early masturbatory excesses, or of being overwhelmed by murderous impulses or perverse sexual fantasies. Such fears lead to brooding and self-recrimination.

Where the patient is convinced of the sincerity of the therapist and accepts the therapist's authority at face value, that patient may be helped, by verbal placating, to master some misconceptions. Reassurance is least successful when it is directed at basic, egosyntonic personality difficulties, particularly devaluated self-esteem and its derivatives.

PRESTIGE SUGGESTION

Among the oldest of techniques is prestige suggestion, which is still employed extensively throughout the world by witch doctors, religious healers, and even professional psychotherapists. Reported results vary from unbounded enthusiasm to a discrediting of the method as an irrational form of influencing. Because it deals with effects rather than with causes, the method has many limitations; nevertheless, it may in certain cases be the only tactic to which the patient will respond.

Suggestion plays a part in every psychotherapeutic relationship even though the therapist seeks to avoid it. It need not be direct.

> A patient came to see me with the complaint that intercourse was getting to be burdensome. Her husband demanded it twice weekly, which in her opinion was too often. She found it difficult to be aroused, and she had to strain mentally to achieve orgasm. When she finally climaxed, she was exhausted from the effort, and it took hours to recover. When I asked her how often she had orgasms, she replied: "Always." "Why *must* you have orgasms each time?" I asked. A long pause was followed by, "Maybe I shouldn't." The effects of her restraint were immediately apparent. She began to stop challenging herself, to relax, and after several weeks to enjoy sexual contacts with and without orgasm.

Generally, patients will tend to select from the content of what the therapist says or implies certain things they want to hear, to which they feel it important to respond. However, suggestion may be used deliberately by some therapists in the form of directives delivered with authoritative emphasis to influence the patient in calculated ways. A positive and optimistic bearing on the part of the therapist helps reduce anxiety that the situation is hopeless and encourages motivation to address the tasks of therapy.

Where the therapist occupies an omnipotent position in the mind of the patient, certain symptoms may be dissipated on command. Symptoms that are removed by prestige suggestion probably disappear because the patient has an unconscious need to obey. The motivation to comply is usually conditioned by a wish to gratify important security needs through archaic mechanisms of submission to and identification with an omnipotent authority. So long as this motivation is greater than the gain the patient derives from the indulgence of symptoms, complaints may lessen or be abandoned by ordinance, and relative comfort will prevail, provided that faith in the power and omniscience of the therapist is continued. Results are best where the symptom has minimal defensive purposes and where the need for symptom-free functioning constitutes a powerful incentive. Certain physical symptoms and habit disorders, such as nail biting, insomnia, excessive eating, inordinate smoking, and drinking, are sometimes partially susceptible to prestige suggestion, especially when they are incapacitating to the person. Results are most pronounced where the patient has no other motivation for therapy than to abandon his or her symptoms or to bring them under control.

Contrary to prevailing opinion, the banishing of symptoms by suggestion need not be temporary. Where the environment supports or rewards symptom-free functioning, benefits may persist indefinitely. Only where the symptom is strongly anxiety binding or where it brings strong secondary gains will it return or will substitutive symptomatic replacements appear.

Relief or removal of symptoms is often accompanied by a general reorientation in the patient's attitudes (Kraines, 1943). The removal of a symptom may, then, as a byproduct, have an important effect on the total functioning. Individuals handicapped by a disturbing symptom often lose self-respect, withdraw from people, and get more and more preoccupied with themselves. The symptom becomes a chief concern, around which individuals organize their insecurity and inferiority feelings. Here, the removal of a symptom may alter the person's whole pattern of adjustment. Minimizing the individual's symptom, if this is at all possible, may start a process of personality growth. An individual with an hysterical tic may isolate himself or herself because of the embarrassment caused by the symptom. Abolishing the tic can influence the individual's general adjustment materially. A patient with a paralytic limb of psychological origin may be restored to economic usefulness, and that patient may benefit emotionally to a point of satisfactory social rehabilitation.

Autosuggestion is regarded by many as a form of prestige suggestion directed at the self. Here the individuals employ their internalized authoritative image as a dissociated surrogate who delivers commands to themselves. It has been claimed by some that autosuggestion is one of the most powerful forces at the disposal of the person (Coub, 1936). Thus, organs may sometimes be restored by self-suggestion to proper functioning and normal emotional attitudes may be vitalized. These claims are, of course, open to challenge.

Among the techniques employed to reinforce prestige suggestion, *hypnosis* is paramount (Wolberg, LR, 1948). The peculiar powers vested in the hypnotist make the subject absorb suggestions with greater readiness than in waking life. But even with

hypnosis as a reinforcing agent, the permanence of suggestions may be limited where symptoms serve important coping purposes or where strong conditionings have been organized, as in certain phobias. No symptom will be readily abandoned that neutralizes intense anxiety or possesses powerful pleasure values.

Another limitation of prestige suggestion is that a sizable group of patients fail to respond to symptom removal because they are unable to conceive of any authority as infallible (Wolberg, LR, 1962). Where there is doubt as to the capacities and powers of the therapist, the patient will have limited motivation to comply, and may successfully resist the therapist's commands.

There are, nevertheless, occasional patients whose need for an invincible and protective authority is so strong that they will faithfully follow suggestions, even to the yielding of an important symptom that serves the psychic economy. To compensate for this loss, in cases where there is a psychological need for the symptoms, other symptoms may develop that have the same significance to the patient as the original symptom, but are perhaps less incapacitating.

The relapse rate among disabled patients who have had their symptoms removed purely by suggestion is understandably substantial. Needless to say, the chances of helping a patient permanently are much greater where one does a reintegrative kind of therapy that treats the problem source. The concomitant rebuilding of ego strength and inner security gives the person the best chance of remaining symptom-free, even in the face of a disturbing precipitant. In suggestive treatment, where no change has developed in the intrapsychic structure, there is always the possibility of a relapse. This, however, is not inevitable; the patient's life situation may get less complicated, or the patient may, as a result of therapy, develop more adaptive ways of dealing with conflict and of getting along with people. Here the loss of symptoms may be permanent.

Another objection that has been voiced to suggestive therapy, which is not entirely valid, is that it is apt to eliminate an important motivation for deeper treatment. It is said that the inconvenience and discomfort of symptoms incites the individual to want to

inquire into their source. If made too comfortable by removing symptoms, incentive may be lost. Where the goal in therapy is to achieve reconstruction in the dynamic structure of the personality, suggestion or any other strongly supportive therapeutic method may thus act as a deterrent. This contingency is balanced by the paralyzing effect of strong symptoms on faith, hope, and trust. Modulating symptoms may actually be essential in keeping many patients in therapy since they will be prone to regard treatment as an unrewarding venture if they have no immediate proof regarding its efficacy toward reducing their suffering.

In spite of its limitations and disadvantages, there are instances when prestige suggestion has to be resorted to as an expedient. A symptom may be so disabling and may cause such great distress that all psychotherapeutic efforts will be blocked until the person obtains some relief. Furthermore, deficient motivation and minimal ego strength will destine to failure psychotherapeutic methods that are aimed at increasing self-knowledge. The most that can be hoped for here is that the patient will respond to palliative or supportive devices, such as prestige suggestion. As therapy succeeds, however, incentives for a more extensive treatment approach may evolve.

PRESSURE AND COERCION

Pressure and coercion are authoritative measures that are calculated to bring to bear on the patient rewards or punishments that will stimulate the patient toward fruitful actions. F. C. Thorne (1950) has indicated that coercive measures are useful in some dependent personalities who refuse to face life under any other circumstances than to be forced to comply. Injunctions may be of value for immature individuals who tend to act out their problems, for persons who habitually shy away from reality, and for those who refuse to take resolute actions by themselves and manifest discouraging, indecisive wavering. In emergencies where the individual is endangering himself, or herself or others, and in uncontrolled emotionality where other methods fail, coercive devices may be mandatory.

Therapeutic pressure may be exerted in the form of assigned pursuits. Thus

Herzberg (1945) advised that the patient be given tasks that are directed against (1) impulses that maintain the neurosis, attempting to remove them or lower their intensity below the critical threshold, (2) obstacles toward satisfaction of impulses, (3) neurotic gains, and (4) "delaying factors," which operate to prevent essential fulfillments.

Threats, prohibitions, exhortations, reproaches, and authoritative firmness lend weight to repressive defenses. Because such measures may reduplicate the disciplinary strictures of the parent-child relationship, the patient is apt to react to them with hostility, obstinacy, masochistic self punishment, and other responses characteristic of the ways the patient had adjusted to parental commands. It is rare that a permanently good therapeutic effect issues out of the use of such authoritative procedures since the patient will resent being treated like a child, and will ultimately tend to defy the therapist, even to the point of leaving therapy. Accordingly, pressure and coercion, if they are ever used, should be employed only as temporary instrumentalities in critical situations.

PERSUASION

Playing an authoritarian role, the therapist may serve as a mentor to persuade the patient to revise values and life philosophies. The object is to change the significance of habitual attitudes against which the patient is rebelling and to provide new goals and modes of adapting to reality.

The persuasive technique is based upon the belief that the patients have within themselves the power to modify their pathologic emotional processes by force of sheer will or by the utilization of common sense. Appeals are made to the patients' reason and intelligence in order to convince them to abandon neurotic aims and symptoms and to help them gain self-respect. They are enlightened as to the false nature of their own concepts regarding their illness, as well as the maladaptive habits they have formed. By presenting them with all the facts in their case, an attempt is made to show them that there is no reason for them to be ill. They are urged to ignore their symptoms by assuming a stoical attitude, by cultivating a new outlook aimed at facing their weaknesses, and by adopting an attitude of self-tolerance. In this way they are brought into harmony with

their environment, and induced to think of the welfare of others.

A number of psychotherapists, in utilizing persuasion, strive to indoctrinate their patients with their own ideologies. The therapist establishes a directive relationship with the patient, who, in turn, seeks approval by acknowledging that the therapeutic authority must know what is best for the patient. The approach is a somewhat more mature one than that of guidance, since it presupposes active participation of the patient in the cure and aims for an expansion of personal powers and resources. The majority of popular books on mental therapy are modified forms of persuasion.

The use of persuasion was first advocated by Paul DuBois (1909, 1911) of Switzerland, who held conversations with his patients and taught them a philosophy of life whereby they substituted in their minds thoughts of health for their customary preoccupations with disease and suffering. Much of the success that DuBois achieved by his persuasive methods was due to his own vigorous personality, which exuded confidence and cheer.

DuBois recognized the importance of the interpersonal relationship, and he insisted that the physician treat the patient not merely as an interesting case, but as a friend. He declared that the doctor must be inspired by a real sense of sympathy and affection for the patient and should manifest these sentiments so openly that the patient "would really be very ungrateful not to get well." The physician must be sincere in this conviction that the patient would get well because if he had any doubts, he could not help imparting them to the patient.

The aim of mental persuasion, according to DuBois, was to build up in the patient a feeling of self-confidence, to make the patient his or her own master. This was done by imbuing the patient with a belief in himself or herself by "education of the will, or, more exactly the reason." The physician was enjoined to hammer the truth into the patient's mind with the ardor of a barrister convinced of the justice of his or her plea.

In order to approach the patient's problem rationally, it was first necessary to

understand clearly the nature and sources of the disorder. The therapist had to distinguish those symptoms of a physical nature from those of psychic origin. The analysis with the patient of the symptoms, and the understanding by the patient of how these symptoms were debilitating and inconvenient were important, particularly because they made the person feel that the therapist was interested in him or her and was sympathetic to his or her suffering. The patient had to be shown how one utilized the symptoms to escape responsibilities in life. The patient had to be convinced that nervousness had crushed morale, that, even though that patient believed the trouble to be physical, it was really mental. Urged to "chase his troubles from his mind." The individual was promised that discomforts would vanish. No medicine was needed, DuBois insisted, "for there is none to turn a pessimist into an optimist."

DuBois recommended prolonged discussions, during which it was necessary to convince the patient of his or her errors in reasoning. The patient had to be shown that the symptoms were the product of emotional stress. Though annoying, they were not serious in themselves. The less one concentrated on symptoms, the less disturbing these would become. If the heart palpitated, let it pound; if the intestines were active, let them grumble. If one had insomnia, that person had best say, "If I sleep, all the better; if I don't sleep, no matter, "Undue attention aggravated the difficulty. The best way to overcome symptoms was to stop thinking about them. Fatigue, tension, and fear were all exaggerated by attention. It was necessary to stop thinking of pain and suffering and to dismiss petty ailments with a smile. "The proper philosophy," he said, "easily learned, can restore the mental balance."

DuBois contended that healthy people disregarded their bodily sensations. The emotionally upset person, on the other hand, concentrated on them until they became the chief preoccupation. For this reason one was upset by improper thinking habits. Notions of happiness and health must then replace ideas of disease and suffering. Happiness depended less on external circumstances than upon one's inner state of mind. One might be ill, or have some financial misfortunes, or have lost dear friends, but the intensity of suffering depended upon the spirit with which one accepted these calamities.

The education of the *self* was the first step in securing real happiness, cultivating the belief that one would without question get well. So long as the patient was convinced that pain, fatigue, or other symptoms were inevitable, they would be felt vividly. If baneful thoughts were brought under control, problems would eventually be solved.

Every sign of progress was to be held up to the patient and even exaggerated. Improvement was to be stressed as proof of the patient's tenacity to get well. As soon as ideas of health entered the mind, ideas of disease would vanish. The patient was to be shown that he or she was not the only one with this trouble, that everyone had difficulties that varied only in their manifestations. Concern with symptoms was understandable but the problem was deeper, involving basic convictions, alteration of which held forth the greatest chances for cure. Above all, hopelessness about the outcome must be banished even though it required a long time to experience improvement. And after cure had come about, one might anticipate a relapse if improper thinking habits returned; however, these would be easier to combat since formulas of bearing discomforts cheerfully and of leading a bold and active life had already been learned. Soon confidence in one's own powers of resistance would be developed.

A questioning of the patient about standards was important. False views were to be criticized, while logical viewpoints were to be encouraged. An effort was to be made to discover qualities of superiority that would elevate the patient's stature. Toward this end an optimistic inventory of one's good qualities was essential. If difficulties had been brought about by tragic events, reassurance and sympathy were in order. If irritability and emotional instability were pressing, the patient had to be taught the spirit of forbearance. Therapeutic efforts were not confined to the patient, but also could be extended to those with whom one lived.

Among proper philosophic ideas to be imbibed were moral notions that could guide one's life and make for good relationships with others. The best way to forget oneself was to devote more thought to other people. The best road to happiness was altruism, a dedication toward making others happy. Tolerance, sympathy, and kindness were the

keynotes of a serene life. Religious sentiments were to be awakened and turned to good account.

Dejerine (1913), using the methods of DuBois, also emphasized the "reeducation of the reason." but he stressed emotion rather than the weakened will as the basis for neurosis. He speculated that the emotions under certain conditions might overwhelm the intellect and cause illness. Dejerine believed that therapy must, therefore, aim for a liberation of the personality from the effects of harmful emotions. The emphasis in therapy was to get the patient to talk about traumatic incidents in his or her life, especially fears and sorrows in the present. Unlike DuBois, Dejerine did not try to impose his philosophy; rather he worked toward developing an emotional relationship with the patient until a state of confidence developed. When this was obtained, Dejerine practiced persuasion to encourage the patient to correct the "bad habits." He contended that to cure nervous illness one had to fight the deceptive systems of "monism, fatalism, skepticism, and determinism." Reason could overcome obsession once emotions were given a proper outlet. It was necessary to keep salubrious ideas before the mind; to think thoughts of the noble, the just, and the beautiful; to learn to gain satisfactions by the fulfillment of duty, yet the brain had "always to be guided by the heart."

Modern persuasive methods, even though coached in "scientific terms" and borrowing from psychoanalytic lore, draw largely for their inspiration on the works of DuBois and Dejerine. Stress is laid on cultivation of the proper mental attitudes, on the facing of adversity, on the accepting of environmental hardships, and the tolerance of self-limitations. Accenting existing assets, the patient is encouraged to expand positive personality qualities, to control overemotionality, to live with anxiety, to accept and endure deprivation, frustration, and tension while acquiring proper controls for them. *Cognitive therapy* and *cognitive behavioral therapy* employ some of the formulations and methods of old-time persuasive methods.

Psychocybernetics a term coined by Maxwell Maltz (1960), purports to change the self-image through a "teleological approach" designed after the "goal-oriented behavior of

mechanical systems." The approach is essentially persuasion coupled with relaxation exercises. Change is best achieved by resourceful "experiencing." Results through diligent practice are said to be obtained in about 3 weeks. Basic to the philosophy of psychocybernetics is that there is a creative guidance system in all people that can be used as a "Success Mechanism" rather than a "Failure Mechanism." New habits of thinking, imagining, and remembering are essential and obtainable through the built-in "servomechanism" of the brain and nervous system. The reader is enjoined toward thinking about an attainable goal. Mistakes and errors are to be expected as in all mechanical systems and should encourage a change of one's course. Force through too much conscious effort is unnecessary—" 'Let it' work, rather than 'make it' work." One must employ one's *imagination* for 30 minutes daily, alone and undisturbed, relaxing, closing the eyes and picturing scenes of "acting and reacting appropriately, successfully, ideally." This practice usually later translates itself into "acting differently without trying" in real test situations. Utilizing *relaxation exercises* also while visualizing a relaxed scene for at least 30 minutes daily, one may "dehypnotize himself' from the delusion that one is inferior or superior. There is no reason why one cannot utilize one's God-given power of reasoning to change negative beliefs and behavior, even those unconsciously determined. Errors that one makes in the present, and past mistakes, should be deliberately pushed out of the mind; successes are to be remembered and thought about. Causes of remorse *should* be examined and their absurdity emphasized. Foolish thoughts or feelings must be banished and rejected. Wrestling with false beliefs and substituting reason is vital to adjustment. Even during one's daily activities one will find time, though it be a few minutes lounging in a chair, to relax and remember briefly in detail the sensations of relaxation that one experienced during the 30-minute practice period. One may repeat to oneself, "I feel more and more relaxed." One may acquire the habit of happiness by thinking pleasant thoughts. Each morning, perhaps while tying one's shoes, one may give on-self suggestions to start the day with optimism, to act more cheerful and friendly, to anticipate success. It is essential to accept oneself as is, tolerate one's imperfections and shortcomings while striving for a goal of self-betterment. Maltz presents formulas of how to overcome failure, manage loneliness, overcome personality blemishes, and achieve

peace of mind.

Criticizing persuasion, we may say that most forms of persuasive therapy are, at best, very superficial and are often based on the acceptance by patients of banalities uttered by the therapist, who utilizes aphorisms and examples from the lives of the great to reinforce ideas that are scientifically unsound. The dynamic basis for many persuasive cures lies in the repression of symptoms by appealing to the patients' sentiments of patriotism, family pride, altruism, and self-respect. The therapist builds up in patients a desire to get well in order to indulge pleasures inherent in being healthy and sociable. Patients are constantly reminded that if they regard themselves as better persons, others too will have a better opinion of them. Their duties and responsibilities to get well are continuously emphasized.

Persuasive therapy, nevertheless, serves a purpose in that it provides certain people with a mental crutch where a psychologic analysis of their problem is impossible. The substitution of persuasive philosophic precepts for destructive habit patterns is probably the lesser of two evils. Some obsessive-compulsive personalities do remarkably well with persuasive methods. Indeed, they respond better to persuasion than to psychoanalysis.

The greatest fallacy in persuasive therapy lies in the exaggerated value attached to the reasoning powers as potentially capable of diverting inner emotional processes. There is, furthermore, an assumption that the patient is conscious of basic defects and is therefore capable of mastering them through concentrative effort. Since unconscious conflicts and emotions are most important determinants of neurotic behavior, this explains why reason, knowledge, and will power often fail to bring about the mastery of symptoms. The same effort should, therefore, be made in persuasion as in guidance where these are ineffective to bring about a change in the relationship with the therapist and to motivate the patient to work toward resolution of inner conflicts.

CONFESSION AND VENTILATION

Confession, "talking things out," and "getting things off one's chest," in relation to a

friend or a professional person, such as a physician, minister, or teacher, are common methods of relieving emotional tension. Beneficial effects are due to the release of pent-up feelings and emotions and the subjection of inner painful elements to objective reappraisal. The mere verbalization of aspects of the self of which the individual is ashamed or fearful helps to develop a more constructive attitude toward them.

Ventilation by the person of fears, hopes, ambitions, and demands often gives relief, particularly when the verbalizations are subjected to the uncritical and sympathetic appraisal of the listener. Hitherto, the patient has covered up memories, conflicts, and impulses that could not be countenanced or admitted to others. A growing confidence in the therapist secures an ally to help the patient tolerate and reveal inner secrets. The ability to share troubles with a sympathetic and understanding person robs them of their frightening quality. In addition, the patient may find that one's judgment as to the viciousness of one's experiences is distorted. The very act of translating inner feelings into words helps to restore mastery. The fact that revelation of shortcomings has not resulted in rejection by the therapist, encourages increasing self examination.

Many of the patient's disturbing concerns have their origin in fantasies or misinterpretations of early childhood. Verbalization of faulty ideas gives the therapist an opportunity to correct misconceptions hitherto accepted without question. The patient may need clarification on phases of life relating to the physical functions or interpersonal relationships. Often one's preoccupations are interpreted as unique to oneself. When assurance is gained that this is not so, that many impulses and needs are more or less universal, and that it is one's attitudes toward them that are faulty, a great deal of tension may lift.

Discussion of the patient's problem is continued until there is no longer an emotional reaction to it. Repeated verbalization of unpleasant and disagreeable attitudes and experiences permits the patient to face past fears and conflicts with diminished inner turmoil.

Many of the benefits that come about from confession and ventilation are contingent

on the fact that the patient becomes desensitized to those situations and conflicts that are disturbing but which reality demands endurance. The tolerance of pain, disappointment, and frustration is inordinately low in neurotic persons, and it is necessary to build up the ability to deal with difficulties and painful experiences without collapse.

Because the individual conceives of certain memories, feelings, attitudes, and impulses as damaging to himself or herself and others, the individual tends to repudiate them. Particularly traumatic are past sexual incidents, perverse fantasies, hostile strivings, and attitudes that brand the person as inferior, evil, or contemptible. Some of these elements are fully known to the person. Others are so frightening that they have been at least partially shunted out of awareness by the mechanism of repression.

The pathologic consequences of suppression and repression are legion. The individual overreacts to incidents that threaten to bring the hidden material to awareness. Symptoms may be elaborated, such as phobias, compulsions, and hysterical manifestations, that give vicarious expression to the repressed while shielding its direct manifestations. Only by facing the disturbing experiences and forbidden impulses, by dissociating them from past misinterpretations, and by reevaluating them in the light of present-day reality is it possible for the person to gain true relief.

Methods of desensitization during therapy will vary with the extent of repression. Conscious conflicts may be handled, as has been indicated, by open and unrestrained discussion. Less conscious material, however, will require techniques discussed under reeducative and reconstruction therapy. Hypnosis may be helpful as an adjunct in encouraging ventilation of feelings (Wolberg, LR, 1948). Hypnotic drugs by intravenous injection have also been employed as a means of facilitating catharsis and desensitization. This method, termed narcoanalysis by Horsley (1943) and narcosynthesis by Grinker and Spiegel (1945), produces a hypnotic-like state that resembles, but is not similar to, hypnosis. Barbiturates, especially sodium amytal and sodium pentothal, are the most commonly used substances. With hypnotic drugs the patient may find relief in a relatively short time divulging material that would have required prolonged interviewing.

Repressed conflicts and traumatic memories are released, generally producing temporary palliation. For this reason, narcosynthesis is particularly applicable to the acute neuroses of war, especially in dealing with functional amnesic states and conversion symptoms. The released material is worked through in a waking state in the hope of insuring more permanent results. Where this happens, the techniques employed are no longer supportive; rather, they embrace reeducative or reconstructive stratagems. Narcosynthesis is not so effective for conflicts that date back in time, even though considerable emotional catharsis may be achieved. What is required is a rather long-term working through of the accretions of defense that serve in the interests of repression.

One may classify under emotional catharsis the procedure that has been named "dianetic processing." Beneficial effects, if any, of dianetic processing are probably the product of a cathartic effect with the recounting, remembering, and reliving of past traumatic experiences or fantasies. Originally introduced by L. Ron Hubbard (1950), an American engineer, dianetics has been elaborated into a "church of Scientology" and has attracted a large group of "auditors" who practice "auditing." According to the theory of dianetics, painful, traumatic memories and experiences are recorded in the subconscious mind as "engrams," which invade the conscious mind and produce a variety of emotional ailments. During dianetic processing restoration of the memory of subconscious experiences is said to eliminate the effect of engrams. Search for engrams is often aided by a psychogalvanometer.

The subject, reclining on a couch, voluntarily associates freely, probing past incidents that have a painful import, this is called "taking the patient back along the time track." In the accepting atmosphere provided by the auditor, the patient often finds himself or herself dealing with material in the early past or speculating about past in an elaborate system of fantasies. Although these fantasies are claimed to be actual memories, there is little question that a recounting of experiences prior to the age of two, and particularly in the prenatal stage, draws upon the vivid imagination of the person. The subject is encouraged to "relive" painful past events and to reexperience sensations in the same form that the subject had them originally. The determining effect of prenatal

impressions is an important aspect of dianetic theory. Repetition of past traumatic events or fantasies is said to "take the charge out of an engram." With its exaggerated claims, pseudoscientific theory, and theatrical methods many authorities contend, dianetics and Scientology do not belong among the accredited scientific therapies.

The method of confession has certain serious limitations. Inasmuch as the most important sources of conflict are often unconscious, it is impossible to verbalize the basic sources of some anxieties. Nevertheless, there are many conscious conflicts that plague a person, ventilation of which may have a beneficial effect. The ability to express fearful memories helps to rebuild self-respect and neutralizes the damaging effects of guilt. Furthermore, the very process of exploring incidents in one's past may lead to a more intelligent approach to the problems plaguing the person in the present. Delving into controversial courses of action opens up possibilities that do not seem apparent at the moment. Thus, Schwitzgebel (1961), experimenting with a "street-corner group" of delinquent youths, took advantage of their need for money by offering the boys a chance to talk to him directly and into tape recorders for a fee. The boys, accepting the invitation as an easy way to gain some extra cash, verbalized their ideas and recounted their experiences with greater or lesser vehemence. This process had a surprising effect on the participants. Without their realizing it the youngsters gained a clearer picture of themselves and a greater sense of control that cut into and reduced their delinquent patterns. In another study with nurses in training it was determined that engaging merely in a discussion group during the stress period of entering nursing training lowered the dropout rate from 24 percent to 6 percent (Rosenberg & Fuller, 1955).

Actually, confession and ventilation are ingredients of all psychotherapies and therefore need not be regarded as a special system.

SOMATIC THERAPIES

While they cannot be considered forms of psychotherapy, the somatic therapies are useful adjuncts. The studies of Sakel (1938) on insulin coma, of Meduna (1950) on convulsive therapy with cardiazol, of Cerletti and Bini (1938) on electroshock, and of

Delay and Hart (1952), and Delay and Deniker (1960, 1961) on chlorpromazine introduced a new era into uses of the somatic treatments (Kalinowsky & Hoch, 1961; Paterson, 1963; Sargant & Slater, 1963; Ruesch et al, 1964). Through somatic measures mental ailments have yielded to a point where an adequate social adjustment for many patients previously considered hopeless has become possible. Patients inaccessible to psychotherapy have also, because they have become more stable emotionally, been brought into reeducative and reconstructive treatment relationships that have proven to be productive. Each year new chemical substances and special devices are introduced that hold forth revolutionary promises, but which need conservative testing over a period of time before they can be accepted as reliable and safe modalities in the armamentarium of the therapist. Somatic therapies are no substitutes for psychotherapy; their effects are adjunctive and complementary to the influence, where it is indicated, of psychotherapy. Their benefits must be balanced off against the side effects they produce.

PSYCHOACTIVE DRUGS

Psychopharmacology essentially involves study of the action of drugs on neurotransmitters that regulate synaptic transmission in the brain. Neurones that secrete norepinephrine, serotonin and dopamine, though relatively small quantitatively, greatly influence emotional behavior and reactions to stressful stimuli. In recent years, there has been work on opioid peptides especially the enkephalins that are also involved in the control of stress reactions and pain. Neurotransmitters are liberated into the synaptic clefts to foster nerve transmission. They are then inactivated by reuptake back into the nerve terminals and broken down by enzymes such as monoamine oxidase.

According to the current hypothesis, some forms of depression, namely, the endogenous depressions, are produced by a relative diminution of the neurotransmitters norepinephrine, and serotonin in the synapses. The antidepressant drugs are believed to enhance the synaptic actions of the neurotransmitters, the tricyclic drugs by inhibiting the reuptake process, the monoamine inhibitors by blocking the action of the enzyme monoamine oxidase thus increasing the concentration of the neurotransmitters. Some

authorities believe that electroconvulsive therapy (ECT) similarly acts by enhancing the synaptic actions of norepinephrine. It is believed that some of the symptoms of schizophrenia are due to overactivity of dopamine transmission, and there is evidence that neuroleptics such as the phenothiazines and butyrophenones exert their antipsychotic effects by blocking dopamine receptors. The benzodiazepine antianxiety drugs are believed to act by facilitating the synaptic inhibitory actions of the neurotransmitter GABA.

Pharmacotherapy has advanced in the past decade to a point where it may be considered the primary treatment in some disorders and an important adjunctive supplement in others. This does not preclude the concurrent use of psychosocial approaches that deal with behavioral, interpersonal, intrapsychic, and social dimensions that are implicated in the illness. In the main, drugs are utilized to influence and rectify biochemical disturbances in the brain and nervous system, in order to suppress a variety of pathological symptoms, such as hyperactivity, agitation, excitement, violent rage, listlessness, social withdrawal, thinking disturbances (including hallucinations and delusions), depression, tension, and anxiety. Drug therapy has revolutionized the treatment of psychotic patients, dramatically reducing hospitalization, and making many disturbed individuals more amenable to treatment. It has changed the outlook for persons suffering from depression, reducing the suicide rate and halting the prolonged suffering characteristic of this condition. It has enabled many patients to make a more adequate social adjustment that would otherwise be impossible. It has also proved its usefulness in the less serious emotional ailments by modulating anxiety and reducing symptoms that interfere with psychotherapy, thus helping in psychological exploration and working through.

The fear expressed by some professionals, especially those practicing reconstructive therapy, that an anomalous guidance-supportive element is introduced into the relationship by administering medications has not proven itself to be a valid contraindication. On the contrary, there is growing evidence that the prescription of essential medicaments tends to enhance the working relationship, making the patient

more cooperative in therapy. As with any other intervention, some patients may exhibit toward drugs psychological reactions in the form of neurotic defenses and disturbed personality responses. Such reactions may reveal important aspects of the personality that productively may be examined and analyzed as part of the psychotherapeutic operation. In reconstructive therapy this can provide grist for the analytic mill.

By their action on the brain, psychoactive drugs influence such provinces as perception, discrimination, conditioning, reasoning, learning, conflict, and motor behavior. Drug effects depend on their depressant or stimulant impact on neutral masses. Thus, the barbiturates depress the neocortex, reticular formation, limbic system, and hypothalamus while stimulating the thalamus. The substituted alkenediols (meprobamate) depress the thalamus and limbic system. The Rauwolfia derivatives (reserpine) stimulate the reticular formation and limbic system, depress the sympathetic mechanisms of the hypothalamus (at the same time that they activate parasympathetic mechanisms), and deplete cerebral amines (serotonin, norepinephrine). The phenothiazines depress the reticular formation and sympathetic mechanisms of the hypothalamus, stimulate the thalamus and limbic system and have antiadrenergic properties. Table 9-1 illustrates some of the presumed effects of different drugs.

The use of psychoactive drugs to influence "target symptoms" is still in an expanding stage, although sufficient data have accumulated to indicate that drugs constitute an important, perhaps vital, adjunct in the management of emotionally ill persons. More or less, drugs are employed on an empirical basis, the mechanisms by which they exert their beneficial effects being only partially clear. They are generally divided into neuroleptic, anxiolytic, antidepressant, psychostimulant, and psychodysleptic groupings.

The neuroleptics have a calming effect in tension and anxiety as well as a controlling (antipsychotic) influence in schizophrenic and orgnic psychosis, producing what has been referred to as a "chemical lobotomy." The neuroleptics (phenothiazines, Rauwolfia derivatives, thioxanthenes, tricyclic antipsychotics, butyrophenones; dihydroindolones) suppress conditioned avoidance behavior and reduce aggressive activities in animals.

Anxiolytics (meprobamate, diazepam, chlordiazepoxide, etc.) have an effect on mild to moderate anxiety. Antidepressants (tricyclics, MAO inhibitors) reduce psychomotor retardation, whereas psychostimulants (amphetamines, methylphenidate, oxazolidine, theionized caffeine) increase alertness and enhance physical and mental activity. Psychotomimetics (mescaline, psilocybin, [lysergic acid diethylamine] LSD) act as toxins to nerve tissue, inducing "model psychoses." Table 9-2 outlines the therapeutic uses of the more popular drugs.

Paradoxically, drugs do not affect all persons the same way. Individuals vary in the constitutional sensitivity (elaborateness of neural circuits?) of their nervous systems and in their chemical structure (enzyme systems?). It is to be expected that there will be varying responses to the array of substances that are available in the drug market. This is borne out clinically by the highly selective reactions that all individuals display toward drugs. Thus, some persons respond better to Ativan than to Valium and vice versa. Some cannot tolerate Thorazine, yet do well with Mellaril. Eysenck (1957) has posed the interesting idea that persons with excitatory and inhibitory personality dispositions behave differently with drugs not only in terms of speed of reaction, but also in strength of response. The current status of one's metabolism ("law of initial values," Wilder, 1958) also influences how one reacts; thus a drug may have a pronounced effect at one time and a minimal effect at another. One of the most important of intervening variables is the placebo factor, faith in and anticipated reactions to the drug determining the quality of response, even to a suggested action being diametrically opposite to the true chemical reaction. Fluctuations in the environment of various kinds also register significantly on drug reactivity. Perhaps even more important is the relationship with the individual administering the drug.

Psychostimulants that are clinically useful include the sympathomimetic amines. Amphetamine and its derivatives (Benzedrine, Dexedrine, and Desoxyn) are employed to combat fatiguability and lack of interest and drive (Myerson, 1936). In doses of from 5 to 10 milligrams twice daily, amphetamine is used to relieve mild depression to produce a sense of well-being and vitality in patients who complain of lack of energy and a sense of

exhaustion. It is used also temporarily in certain cases of alcoholism and drug addiction. In children its effect is extraordinary in that hyperactivity and excitability are reduced in aggressive and disturbed youngsters (Bradley, 1950) and those suffering from attention deficit disorders. This reaction is also observed in excited schizophrenics, helping to reduce the need for sedatives and hypnotics (Bis-choff, 1951). Great caution must be exercised in prescribing amphetamine drugs since more than temporary use may result in addiction and where large doses are employed, a paranoid psychosis may be produced (Connell, 1958; Leake, 1958). These drugs have been placed on the list of compounds whose prescription is controlled by the federal government.

Among the antidepressants, imipramine (Tofranil) and its derivative, desipramine (Norpramin, Petrofrane), amitriptyline (Elavil), doxepin (Sinequan), protripyline (Vivactil) and its derivative, nortriptyline (Aventyl), doxepin (Sinequan), amoxepin (Asendin), and trazodone (Desyrel) are most commonly employed, and to a lesser extent the monoamine oxidase inhibitors (tranylcypromine [Parnate], phenelzine [Nardil], and isocarboxazid [Marplan]).

Drugs that reduce reactivity are sedatives and hypnotics, minor tranquilizers *(anxiolytics)* and major tranquilizers or *neuroleptics.* Among the popular *sedatives* and *hypnotics* are the barbiturates (pheno-barbital, amytal, pentobarbital, secobarbital), which are employed in mild dosage to reduce agitation and anxiety and in larger dosage to induce sleep. Most useful of these drugs are phenobarbital (taken in doses of 1 to 2 grains daily as a long-acting sedative) and sodium amytal (taken in doses of 1 to 2 grains as a short-acting sedative during the day and in doses of 3 to 6 grains at night as a hypnotic). Because of the dangers of barbiturate addiction, the use of barbiturates must be carefully regulated (Fraser et al, 1958). They have largely been replaced by the benzodiazepines (Dalmane, Halcion, Restoril, Xanax). Paraldehyde is, for many reasons, an ideal hypnotic, although the disadvantages inherent in its taste and residual odor have not given it the popularity it deserves. Chloral hydrate (Noctec) is another hypnotic and sedative prescribed at times for various conditions. Barbiturates are sometimes employed intravenously as an emergency measure in quelling intense excitement, sodium amytal

most often being prescribed for this purpose in doses of from 3 \ to *1*\ grains. Barbiturates should be employed for short periods only because of the possibility of habituation. They should be avoided in borderline cases since they tend to lessen the patient's hold on reality. The piperidine-diones (methyprylon-Noludar, glutethimide-Doriden) are sometimes employed as hypnotics in substitution for barbiturates, although habituation with them is possible if they are used over a long period. The tertiary carbinol ethchlorvynol (Placidyl) is also used as a short-term (1 week) hypnotic, although its effect is diminished in the presence of anxiety. Caution must be exercised in prescribing nonbarbiturate sedatives as well as the minor tranquilizers since physical dependence and addiction may result similar to the barbiturates.

Anxiolytics are employed to reduce muscle tonus, to combat anxiety, and to relieve stress. Most important are: (1) the *benzodiazepines* (Librium, Valium, Xanax, Ativan), which, possessing both tranquilizing and antidepressant effects are employed alone in anxiety, tension, phobic, and agitated states, or in depression in combination with trycyclic and MAO inhibitor antidepressants; (2) the *diphenylmethane derivatives* (hydroxyzine [Vistaril] and benactyzine [Deprol]), which are sometimes prescribed for mild anxiety states (Jacobson, E, et al, 1955; Simms, 1958) possibly for their placebo value, and *diphenhydramine* (Benadryl), which is used in the behavior disorders of children (Fish, 1965); (3) the *substituted propanediols* (meprobamate-Equanil, Miltown), which, while decreasing conductivity along spinal interneuronal pathways, do not affect conditioned reflexes or the autonomic nervous system, and are occasionally used primarily for relief of tension, particularly in anxiety states of recent origin. Minor tranquilizers, particularly meprobamate and the diazepines, should not be employed steadily for more than 3 months at a time. Buspirone is a recent entry into the anxiolytic arena and has a relatively low profile of disagreeable side effects.

Antipsychotic drugs (neuroleptics) are noted for their influence on psychotic states. Most prominent of these are the phenothiazines, which have not only effected a revolution in the management of the disturbed mentally ill in institutions but have permitted a return of previously hopeless patients to the community. Because of serious side effects and

sequelae, supervision is necessary. Among the neuroleptics, thiothixene (Navane), haloperidol (Haldol), and molindone (Moban) have been enjoying increasing popularity. Chlorpromazine (Thorazine) still continues to be used, with thioridazine (Mellaril) an adequate substitute. Greater antipsychotic potency is possessed by phenothiazines with a piperazine side chain at position 2 in the phenothiazine ring system, for example, trifluoperazine (Stelazine), perphenazine (Trilafon), fluphenazine (Permitil, Prolixin). However, side effects, such as Parkinsonian symptoms, akathisia, and paroxysmal dystonia, are also greater. Such reactions are not serious since they can be controlled by an anti-Parkinsonian drug, such as benztropine (Cogentin) or trihexyphenidyl (Artane). The problem of the choice of neuroleptics often arises. Where patients are disturbed and agitated, an antipsychotic with sedative value, such as Thorazine or Mellaril, may be used. Where patients are withdrawn and retarded, a drug with less sedative effect, such as Stelazine or Trilafon, may be employed. Apart from these distinctions and the factor of individual idiosyncratic responses, there is little difference in the effect of antipsychotic drugs on psychotic processes. If patients do not respond to one class of drugs, another class may be tried. A trial period of 6 to 8 weeks with proper dosage of a drug is generally adequate. If the response is satisfactory to one drug, there is little point in changing to others. Insofar as combinations of drugs are concerned, there is no convincing evidence that they are any better than a single drug in the treatment of schizophrenia (Hollister, 1972). The presence of extra-pyramidal syndromes may be expected with adequate dosage and is no cause for alarm. Clonidine is another medication that has had an excellent effect on some cases of schizophrenia who have not responded to the usual antipsychotic drugs.

Because over 50 percent of chronic schizophrenic patients who require maintenance drug treatment fail to take psychotropic drugs, there has been a greater accent on the use of prolonged-action phenothiazines, such as fluphenazine enanthate and fluphenazine decanoate, which are given by injection. The effects last from 2 to 4 weeks and patients are relieved of the responsibility of monitoring their own intake. There are those who believe that the future treatment of psychosis lies in the prolonged-action drugs, particularly the depot preparations (Ayd, 1973). In fractional doses side effects are

reduced for long-term maintenance.

At one time it was believed that treatment could continue for years and perhaps indefinitely. However, because of the danger of tardive dyskinesia, attempts are now made both to avoid high dose rapid neuroleptization and to get patients on a reduced or drug-free regimen utilizing milieu and rehabilitative therapies to foster a better adaptation.

Experimental studies with *psychodysleptics* (psychotomimetic, hallucinogenic, or psychedelic drugs) particularly mescaline, LSD, and psilocybin are indicative of the contemporary efforts that are being made to correlate neurophysiologic, biochemical, and psychological processes that have both heuristic and practical value. Psychodysleptic drugs effect the individual in a number of ways. First, they encourage a psychotic-like experience with panic, grandiosity, paranoid delusions, impairment of reasoning and depression being most common. Second, they introduce a unique, often lucid, mode of seeing problems from a unique perspective. Third, there is a change and intensification in sensory perception. Fourth, an upsurge of unconscious or preconscious ideation occurs with reliving of past incidents or symbolic portrayal of conflicts. Fifth, distortion of ego boundaries is accompanied by peak cosmic transcendental or mystical experiences. According to Pahnke et al., (1970) who worked with the drug at the Maryland Psychiatric Research Center, the effects of LSD "can be an enhancer of skilled psychotherapy when integrated with an intensive psychotherapeutic program of sufficient duration (30 to 50 hours)." This conclusion was generally endorsed by a sizable number of investigators who believed that the administration of the psychotomimetic drugs, usually LSD, was justified as an adjunct in psychotherapy since ego defenses become weakened and the patient is better able to reveal himself or herself (Savage et al, 1969; Kurland et al, 1971; McCabe et al, 1972; Savage & McCabe, 1973; Grinspoon & Bakalar, 1985). The effects, however, cannot be predicted being dependent on the method of administration, the state of patient immediately prior to treatment, the surroundings, and the attitude and activity of the therapist. There is little agreement regarding the conditions that may be benefitted. Some observers believe anxious, upset, obsessional, and hysterical patients are most responsive (Sandison et al, 1954; Cutner, 1959). Other therapists exclude such patients (Cohen, S,

1960). Some are of the opinion that psychopathic personalities and alcoholics are helped most. Others restrict the use of LSD to detached, inhibited, and uncooperative patients. There is little question that channels are opened to forgotten or repressed memories and that the abreactive effect may be great. How therapeutic this will be is another matter. In patients who find it difficult to make contact with their inner feelings, and who have gained little from prolonged psychotherapy, hallucinogens may prove to be a means toward greater reexamination of the self. Its specific effect cannot be dissociated from the placebo influence, emotional catharsis, suggestion, and other auxiliary healing forces. The coordinate use of psychotherapy is mandatory and the manner of its employment will have a determining effect on the results (Crocket et al, 1963).

Against the possibility of some therapeutic gain is the real danger, in vulnerable patients whose hold on reality is tenuous, that hallucinogens may undermine defenses and throw the patient into a state of psychological decompensation. The upset may be temporary ("the bad trip") lasting 8 to 12 hours, or may last longer with periodic flashbacks of frightening images or thoughts or more prolonged reactions requiring appropriate therapy. The empathy, understanding, and skill of the therapist are probably the key factors as to whether an experience with hallucinogens will prove destructive or rewarding. Psilocybin, the active agent of the intoxicating mushroom used by Indians in Mexico during religious ceremonies, produces effects similar to but less intensive than those of LSD. Other hallucinogens in use are 2,5-dimethoxy-4-methylamphetamine (DOM) or (STP), hashish, myristicene (Nutmeg), dimethyltryptamine (DMT), and a number of other natural and synthetic substances. Psychedelic drugs are now rarely employed in therapy except by therapists skilled in their use for nonresponsive alcoholics, sociopaths, and obsessive compulsives unresponsive to other forms of treatment. On the whole the use of these drugs is questionable.

Miscellaneous Drugs

Tonics and vitamins are indicated in instances of dietary deficiency. Where there is evidence of specific glandular impairment, appropriate hormones may be employed

(Hoagland, 1957; Paredes et al, 1961). The most commonly utilized products are thyroid and estrogenic and androgenic hormones. During physiologic upsets in the involutional period, natural estrins (Premarin), and stilbestrol and other synthetic estrogenic hormones, have been found useful. Androgens, such as testosterone (Oreton), are prescribed in males who show a deficiency in this hormonal substance, manifested in waning libido, muscular weakness, and atony.

Since J. F. J. Cade's report in 1949 *lithium carbonate* (Eskalith, Lithobid, Lithonate) have been employed in bipolar affective disorder both during the active manic psychosis and as a form of maintenance therapy in cases subject to recurrent attacks. A constant check on the blood-level of lithium is essential to insure the therapeutic effect. In addition to being an impressive remedy for manic and associated depressed states, lithium does not dull feelings or reduce clarity of thinking as is so common with the large dosage of phenothiazines needed to calm excited patients. Lithium has also been tried with other syndromes, such as borderline conditions, aggressive episodes, intermittent explosive disorders, pyromania, and schizoaffective disorders, but its value here is not as yet as fully established as with the bipolar disorders.

Continuous sleep treatment with drugs (Klaesi, 1922; Palmer & Braceland, 1937; Walsh, J, 1947; Williams & Webb, 1966) is sometimes used where other forms of therapy have failed. The patient is narcotized for at least 7 to 10 days with intervals for feeding, urination, and defecation. Drugs are gradually withdrawn, and sleep terminated slowly. Since patients must be monitored over a 24-hour day period, hospitalization is essential. The technique is utilized mostly in Europe and Russia, rarely in the United States. Chlorpromazine is the chief drug employed along with a short-acting hypnotic, amobarbital sodium (sodium amytal). Coordinately, depending on the symptoms, antidepressant drugs and ECT (2 or 3 times weekly) may be used. On this regime more than 70 percent of patients suffering from obdurate chronic tension states, depression and phobic anxiety states, 43 percent from obsessional neuroses, and 41 percent from long-standing schizophrenia or schizoaffective states are said to have become symptom-free or much improved.

Antabuse, originally used in Denmark (Hald et al, 1948), is still widely employed is a means of controlling alcoholism (Bowman et al, 1951). Although the drug is generally nontoxic, symptoms of a frightening nature occur when a patient under antabuse medication imbibes alcohol. The reaction is so disagreeable that the individual willingly abstains from drink. The individual's self-confidence soon is restored and self-esteem increases as a result of his or her ability to remain sober. Psychotherapy should always be administered jointly with antabuse (Child et al, 1951), to help prevent a relapse, and the patient should be encouraged to join Alcoholics Anonymous. In drug addiction, methadone (Dole & Nyswander, 1965) and cyclazocine (Martin, WR, et al, 1965; Jaffe & Brill, 1966) are being given to control the ravages of this disorder.

Carbon dioxide, introduced by Meduna (1950), was used as a method of treating neurotic and addiction problems alone and in combination with psychotherapy. Its use continues to be controversial. Hargrove, Bennett, and Steele (1953), for example, challenge the findings of Meduna and present evidence that most patients subjected to carbon dioxide show no improvement in their emotional condition. It is difficult to judge how much of the beneficial effect is due to the placebo influence or to psychotherapy that is conjunctively employed (Tibbetts & Hawkings, 1956).

Orthomolecular psychiatry. Utilizing large doses of B & C vitamins and various minerals and hormones, attempts have been made to reestablish chemical imbalances of the brain presumed to be responsible for schizophrenia. While megavitamin therapy has not been proven effective nor the theory on which it is based substantiated, there is growing evidence that nutritional factors do play some part in neurotransmitter synthesis and brain metabolism, the specifics of which will undoubtedly be empirically explored in the forthcoming years.

Miscellaneous somatic therapies. As might be expected a host of somatic therapies have been introduced that have not proven themselves to be of lasting value. Among these are implantation of brain pacemakers, detoxification procedures as with hemodialysis, desensitization with histamine, administration of acroagonine suspensions and

acetylcholine, cerebral oxidation procedures, cerebral pneumotherapy, use of a hyperbaric chamber, and acupuncture. Where a pateint has faith in any of the above or other procedures, and the therapist applies them with conviction and enthusiasm at least temporary improvement may be expected purely through the placebo and relationship dimension.

CONVULSIVE THERAPY

In severe depressions, and in some cases of mania and acute catatonia, particularly where there is danger of suicide, *ECT* is the treatment of choice (Kalinowsky & Hoch, 1961; Paterson, 1963; Kalinowsky, 1965; APA Task Force, 1978; NIMH, 1978; Fink, M, 1979; Abrams & Esman, 1982; Kalinowsky et al, 1982). Approximately 80 to 90 percent of all patients suffering from involutional melancholia or major depression psychosis recover with 6 to 10 ECTs. In schizoaffective disorders a somewhat lower recovery rate (about 60 percent) is scored, and more treatments are needed. Neurotic depressions are generally treated by psychotherapy alone or in conjunction with antidepressants, except where the depression is leading to exhaustion or poses the risk of suicide. Under these circumstances four to six treatments may suffice to restore patients to their predepression state. In excited reactions that cannot be controlled and in anxieties that become so overwhelming that a psychosis is threatened, as in obsessive-compulsive and borderline patients whose defenses are crumbling, ECT may serve to restore the psychological equilibrium. Periodic *maintenance ECT* may be helpful in recurrent depressions and some chronic schizophrenic and very unstable borderline patients, who totter on the verge of disintegrative reactions.

An anesthetic agent (Pentothal, Surital, Brevital), atropine, and a muscle relaxant (succinylcholine chloride—Anectine) administered prior to the electrical stimulus, reduce discomfort and eliminate skeletal complications. To minimize the memory loss, unilateral ECT rather than bilateral ECT may be employed, though in the opinion of some, a somewhat attenuated antidepressive effect results (Abrams, 1972; Abrams & Taylor, 1976). This is disputed by other unilateral ECT advocates who claim equal antidepressant

effects provided the induced seizure is adequate. *Indokolon* (hexafluorodiethyl ether) administered by inhalation is an alternative method of inducing convulsions (Krantz et al, 1957; Esquibel et al, 1958; Karliner, 1966). It is employed by some therapists when regular ECT treatments are unacceptable or have failed. Since it is not manufactured in the United States it may be difficult to obtain.

A task force in Massachusetts (Psychiatric News, 7, [22] 1972) investigating the use of electroconvulsive therapy made comments that are still pertinent today on the ever widening gulf between doctors who seek a biological approach to psychiatric illness and those concerned primarily with human emotions. The task force, however, did discover abuses and that there were some psychiatrists who were "so enthusiastic about shock treatment that they recommend it for almost all patients, believing, with only their personal clinical experience to support their opinions, in the relative omnipotence of ECT." The study, as we would expect, indicated that there was no evidence that shock was able to modify character or personality structure in any way. According to the task force the study revealed that in severely depressed patients with suicidal tendencies the procedure could be life saving.

ELECTRONARCOSIS AND ELECTROSLEEP

Subconvulsive electrical stimulation (electronarcosis) has occasionally been employed for its sedative effect in prolonged anxiety or panic, and in excited states that do not yield to psychotherapy or drugs. Subconvulsive electric current of high intensity has also been recommended to produce abreactions to supplement the abreactive methods of hypnosis and narcosynthesis. A. S. Paterson (1963) reported that good results may be anticipated in traumatic neurosis, antisocial personality disorder, and other patients with a poor prognosis. The general experience has been that electronarcosis is less effective than full ECT. The electrical induction of sleep has also been attempted, which may be followed by abreaction and dissociative reliving of traumatic experiences.

Utilization of weak electrical currents have been employed to produce behavioral and subjective relaxation without concurrent changes in heart rate, blood pressure, and

respiratory rate (Rosenthal, SH, 1971). Improvement in anxiety, depression, and sleep disturbance has been claimed (Rosenthal, SH, 1972). The best results have been obtained with chronic anxiety and tension states. However, Frankel, BL, et al. (1973) reported an ineffectiveness of electrosleep in chronic insomnia. Treatments are usually given from 3 to 5 times weekly, each session lasting i hour, treatment current ranging from 0.5 to 1.5 milliamps. In this age of electronics we may expect that the mysterious equipment trappings have great placebo value for some patients. The relaxation induced, which may proceed to a hypnotic state, increases the suggestive dimension. A rapid positive relationship with the therapist is also established. Whether there are specific therapeutic effects beyond these intercurrent influences is difficult to say.

INSULIN COMA

Because of the expense of administration, the relative danger, the long time contraindications, and the effectiveness of the neuroleptics, the use of insulin coma has gradually diminished. However, it may still have some utility in early schizophrenia, deep, long, and frequent comas being of value in interrupting a process that, neglected, may proceed to chronicity (Sakel, 1938; Hoch & Kalinowsky, 1961; Paterson, 1963; Sargant & Slater, 1963; Kalinowsky et al, 1982). Between 50 and 150 1-hour-long comas may be given to selected patients on a 6-day-a-week basis. Subcoma insulin treatment is of little service in schizophrenia, although it may sometimes be helpful in acute anxiety and toxic confusional states. In such conditions the patient may quiet down sufficiently so that psychotherapy may be used. All in all, we may consider insulin coma of little practical utility today. Among the coma treatments that are now only rarely employed are atropine coma, nitrogen and nitrous oxide inhalation, and ether and trichloroethyline inhalation.

PSYCHOSURGERY

Psychosurgery is only rarely done today being restricted to long-term, disabling, severe psychiatric illness after all medicinal, somatic, and psychosocial procedures have failed after being tried for at least one year (Freeman & Watts, 1942). The most frequent

condition for such a radical intervention is endogenous depression that has not responded to antidepressant drug treatments as well as ECT. Sometimes psychosurgery is done to eliminate long-term unmanageable pain not helped by any other method. A much less frequent indication has been intractable obsessive-compulsive neurosis and, even more rarely, schizophrenia with affective symptomatology.

Through cuttings made in the frontal lobes of the brain and the cingulate bundle (cingulotomy), an attempt is made to interrupt impulses traversing the limbic system. This operation is modest compared to earlier surgery that had resulted in untoward personality and physical sequelae.

Psychosurgery, while having a minimal influence on the thinking process, does relieve or eliminate strong emotional undercurrents that may be creating severe problems for the patient. It is important, prior to making arrangements for surgery, that the patient and responsible relatives, are informed of the risks and possible benefits of the operation and that the informed consent or refusal is noted carefully in the case record. Since a number of states set up rules to be followed for or have statutes prohibiting the operation, the legality of the procedure in a certain locality should be checked.

INSPIRATIONAL GROUP THERAPY

Inspirational group therapy continues to be of value for a large number of people who may not be willing to accept more formal therapy, or are unable to afford it, or are unmotivated for any other type of intervention. It is a time-honored method that has brought relief to many distraught people and whose influence is unfairly underrated. An example of important inspirational groups are those run by Alcoholics Anonymous, Recovery, Inc., and Synanon. There are other helpful groups in operation, some of the most successful being those organized for addiction problems, e.g., drug abuse, chronic gambling, cigarette smoking, and obesity. There are groups oriented around objectives of education and of social rehabilitation dealing with various adjustment problems. They are composed of members seeking support, companionship, and opportunities for discussion as in parents anonymous, widows clubs, etc. (Greenblatt, 1985b). Indeed, such groups,

often led by leaders who have experienced and successfully conquered the same problems for which help is being sought by the group members are more successful with certain problems in some situations than formal psychotherapy. In order to deal with underlying personality difficulties, some participants may become motivated as a result of the group experience to seek formal psychotherapy.

Some inspirational groups are oriented around a charismatic leader who is established as an omniscient personage whom the patient is expected to obey. To a great extent, these groups exist as an appendage of the leader, and beneficial results are maintained as long as the followers are capable of supporting an image of the leader as powerful and protective. Symptom relief is largely brought about as. a result of repression of conflict and a desire on the part of the individual to identify with and gain status in the eyes of the leader. Such inspirational groups are particularly tempting to dependent souls whose inner will to develop is diminutive, and who flourish in a setting in which they are able to establish a submissive relationship to a stronger individual. They then become interminably attached to the leader, the group, or authoritative individuals within the group. The group, nevertheless, continues to exert an important independent effect on the individual, being composed of members suffering from problems as severe as, or more severe than one's own. In a group of normal persons, the individual often feels handicapped and inferior and may succumb to defenses of self-justification or building up self-esteem or of striking out aggressively in order to avoid fancied hurt. In a supportive therapeutic group, the individual is not subjected to the same pressures and cannot help but feel a sense of unity in the course of identifying with many of the problems of fellow members.

Inspirational group therapy is also employed as part of a psychotherapy program by some therapists who claim beneficial effects for it, including the mastery of symptoms, the institution of self-discipline, the tolerance of anxiety and tension, and the repression of antisocial impulses and drives (Pratt, 1934; Rhoades, 1935; Harris, HI, 1939; Wender, 1940; Blackman, 1942). The patient feels an acceptance in the group that could not be experienced elsewhere. The patient finds that he or she can be self-expressive and that

admitting to certain strivings does not make one "bad" or worthless in the eyes of others. The patient may eventually discover that status can be gained within the group. Emphasis is upon day-to-day victories, self-control, finding new social outlets, and strengthening will power.

Herschelman and Freundlich (1972) have described an inspirational group experience in working with a large group of patients utilizing multiple therapists. Group therapy meetings were held at the Philadelphia Naval Hospital inpatient psychiatric service attended by the entire patient population of 35 to 45 patients and staff (5 psychiatrists, 2 or 3 psychiatric residents, 2 hospital corpsmen, and 1 psychiatric nurse). Meetings were of one hour's duration on a weekly basis. Most of the patients were poorly motivated for formal psychotherapy, and the staff at first was resistant, passive, and non-participant. As the latter gradually resolved their anxiety, they became more enthusiastic and participant. Staff-patient conference techniques were utilized such as those proposed by Berne (1968) in the spontaneous meetings held immediately after large group sessions. The results exceeded expectations and point to the advantage of utilizing multiple therapists rather than single therapists with large groups.

Many persons benefit chiefly through the social contacts that they make in a group setting, particularly when they find other persons with whom they can share experiences. The relationships established in the group help to ease social tensions and to promote self-confidence. After the formal group experience the participants may continue on their own in self-help groups.

The self-help movement has been gaining momentum over the years, many taking the form of "therapeutic clubs" of members suffering from various habit, behavior, and psychiatric disorders. Curiously, some of the most stubborn problems that resist the ministrations of professional personnel appear to be benefitted by group experiences without the presence of a therapist, in which the patients relate to each other and share their past experiences, present difficulties, and progress with peers suffering from similar ordeals and backgrounds. Perhaps the oldest group of a self-help type is Recovery, Inc.,

consisting of former mental patients. Founded in 1937 by Abraham Low, Recovery, Inc., has rendered service to many thousands of patients. At present there are hundreds of such groups in the United States. They are generally headed by nonprofessionals drawn from the membership. At their meetings a panel discussion format is employed with the leader selected from the group and trained along lines of Low's book *Mental Health Through Will-Training* (1952). Hanus J. Grosz (Psychiatric News, 7, [14], 1972, 1973; and 8, [12], 1973) has studied and reported positively on the results of Recovery, Inc., as a resource that is available to many patients who otherwise would have no other form of help available to them.

Many other self-help groups have flourished because they provide a helping resource that for considerable numbers of individuals eclipses that provided by trained professionals. Why this is so is still shadowy, but such factors undoubtedly operate as fear of and subtle antagonism against authority as vested in traditional psychiatry and psychology, the presence in the group of individuals with whom the person can identify, the opportunity for modeling by group leaders who have overcome destructive habits the person seeks to relinquish, opportunities for constructive group interaction and postgroup companionship, the force of peer pressure to maintain improvement, and other bounties of group dynamics. Economic factors also play a part especially for those on meager incomes since attendance is usually free or at a low cost.

To a large extent the success of these movements is related to the leaders who run them. Intelligent, empathic yet firm direction is essential in running a group of this kind due to the inherent personality problems of members who seek help, particularly those who have difficulty with authority and with interpersonal relationships in general, borderline cases, severe obsessive-compulsives, paranoidal individuals, and psychotics. Many have tried outpatient resources and private therapists without success. They require special reassurance and the installation of hope. Members are usually most responsive to a warm, non-authoritarian yet structured environment, led by leaders who have experienced and conquered the devastation the members themselves have gone through. The leader must consequently be relatively free from emotional illness and

capable of dealing with transference and personal countertransference. This will usually require training and some personal therapy that some leaders refuse to accept. Self-help groups that run into problems generally are victims of poor or destructive leadership. In leaderless self-help groups, the most aggressive individuals with needs for control usually take charge, which may cause difficulties unless the other members are strong enough to prevent the leader from becoming too dictatorial.

Alcoholics Anonymous (see Chapter 60) particularly has inspired many self-help groups. These include Narcotics Anonymous (NA) for persons seeking to overcome narcotic addition, as well as Nar-Anon for their families; Pills Anonymous (PA) for those habituated to various sedatives, tranquilizers, hypnotics, and stimulants, and Pil-Anon for their families; and Overeaters Anonymous. All of these organizations allege themselves to be nonprofit societies with no initiation fees or dues and are self-supporting through their own contributions, with no affiliations with any sect, denomination, politics, organization, or institution. In all of these habit controlling groups 12 steps toward recovery are presented. The individual is enjoined (1) to admit and accept one's inability to manage one's life single-handedly, (2) to recognize that only a Power, an ultimate authority greater than oneself, can restore one to health (this Power can be God, a force in the Universe, the group in itself, or nature), (3) to decide unequivocally to turn one's life and will over to this Power; (4) to make a searching and fearless moral inventory of oneself; (5) to admit the exact nature of one's wrong to oneself, to God (or the Power) in order to remedy one's defects of character, (7) to ask this Power to remove one's short-comings, (8) to list the people one has harmed and be willing to make amends to them all, (9) to see that such amends are made if possible except where some injury may result, (10) to continue to take a personal inventory and when wrong to admit it, (11) to improve, through meditation and prayer, one's contact with this Power as one understands it, praying for knowledge of God's (or the Power's) will and the ability to carry out what is necessary, and (12) after having a spiritual awakening, to carry this message to others in need and to practice these principles in all of one's affairs.

We may see in the 12 steps the devotional help and protection one expects of

religion or other guidance resources, as well as the need to alter one's values and meaning systems such as occurs in cognitive therapy. Not insignificant also in these groups are the benefits of emotional catharsis and group dynamics. The principles and practices of groups organized for addictions and habit disorders have also been extended to general emotional problems in a self-help group calling itself Emotions Anonymous (P.O. Box 4245, St. Paul, Minnesota 55104). Other self-help groups following to some extent the format of Alcoholics Anonymous are Gambler's Anonymous and Weight Watchers. Excellent pamphlets, articles, booklets, audio tapes, films, and video cassettes dealing with self-help groups are sold by Hazelden Educational Materials (Box 176, Center City, Minnesota 55012). Branches of self-help groups, where they exist, are listed in local telephone directories.

The accomplishments of self-help groups point to the need for a new psychiatric task force that can combine with adjunctive disciplines to help shift the emphasis from institutional based therapy to domiciliary and community involvement (Dean, 1970-1971). This is all the more advisable in view of the fact that results in some self-help groups have been found wanting, particularly where encounter and confrontation techniques are utilized, as with ex-drug addicts who are unable to relinquish their defenses or where they are suffering from borderline conditions (Shick & Freedman, 1975). Acting-out, paranoidal, and psychopathic patients do not do well in self-help groups. The involvement of trained professional people for screening purposes and to manage emergencies serve as an important safeguard.

10
Reeducative Therapy

The relationship between patient and therapist in reeducative therapy has as its object the achievement of more extensive goals than in supportive therapy, namely, an actual remodeling of the patient's attitudes and behavior in line with more adaptive life integration. The therapist here attempts either (1) to influence the processes directly between the patient and his or her neurotic behavior, rewarding healthy responses, or (2) to release in the patient self-actualizing tendencies by utilizing the relationship as a corrective emotional experience. There is less emphasis on searching for causes than on promoting new and better forms of behavior. It is posited that individuals with help from a therapist have within themselves the ability to reorganize their values and behavioral patterns. Such approaches are more or less reeducative in nature and, therefore, may be designated as "reeducative therapy."

The objective in reeducative therapy, thus, is the modification of behavior directly through positive and negative reinforcers, and/or interpersonal relationships, with deliberate efforts at environmental readjustment, goal modification, liberation of existing creative potentialities, and, it is hoped, promotion of greater self-growth. No deliberate attempt is made to probe for unconscious conflict. Under these circumstances individuals may achieve sufficient command of their problems to enable them (1) to check acting-out tendencies, to rectify remediable environmental distortions, or to adjust to irremediable ones; (2) to organize life goals more rationally and to execute them in a facile manner; and (3) to consolidate some adaptive defenses and to alter others that are less adaptive. These are eminently worthwhile objectives, and, for reasons that will be considered later, are often as far as many patients can progress, even with the most intensive reconstructive approaches. Indeed, in many instances, reeducative therapy is the treatment of choice.

A fundamental assumption in reeducative therapy is that if one succeeds in altering a significant pattern in one's life, the restored sense of mastery will generalize over a

broad spectrum of behavior. If substantial improvement is scored in one dimension of functioning, this may importantly influence other parameters of personality operation.

Reeducative therapy is conducted through (1) the implementation of a variety of techniques aimed at reconditioning behavior or (2) an examination by the patient and the therapist of ways that the patient relates to people and to himself or herself. In the latter, manifestations of tension and anxiety are explored, and the patient is helped to recognize certain aspects of his or her behavior that are destructive to adjustment. The patient is then encouraged to experiment with new interpersonal attitudes and additionally stimulated to utilize his or her assets to best advantage so as to expand positive qualities within. While interview procedures are employed, little or no use is made of dream material, transference manifestations, and free association. Sometimes reconstructive changes occur as a consequence of reeducative therapy, although these are not specifically the objectives toward which treatment is directed.

The application of reeducative therapy requires specialized training that sensitizes the therapist both to aspects of behavior that require and will be amenable to alteration and to the recognition of gross interferences to the therapeutic process of transference and resistance. While personal psychoanalysis or personal reconstructive therapy for the therapist is helpful, it is not absolutely essential in executing this approach, provided the therapist does not have severe neurotic difficulties and can control countertransference if this begins to project itself harmfully into relationships with patients. Among reeducative therapeutic measures are "behavior therapy," therapeutic counseling, directive psychotherapy, casework therapy, "relationship therapy," "attitude therapy," distributive analysis and synthesis, interview psychotherapy, semantic therapy, reeducative group therapy, and certain philosophical approaches.

BEHAVIOR THERAPY

Behavior therapy continues to spread its influence over the entire field of human afflictions and disabilities. This is no fortuitous event since its methods have proven valuable in the hands of skilled practitioners. Books and articles on the subject and

membership in behavior therapy organizations have increased in the past decade. To the traditional zone of behavioral distortions have been added internal mental processes and psycho-physiological ailments and habits. Maintaining the original dedication to the principles and findings of experimental psychology, behavior therapy has elaborated a plethora of techniques and a diversity of views that go far beyond learning theory and that are dedicated to the alleviation of all aspects of human suffering and the general enhancement of functioning. More specifically, behavior therapy is said to address "clinical problems using (a) a testable conceptual framework, (b) treatment methods that can be objectively measured and replicated, (c) outcome criteria that can be validated, and (d) evaluative procedures for determining the effectiveness of specific methods applied to particular problems" (Lazarus & Fay, 1984).

Lazarus (1984) has stated that "there is scarcely a clinical entity for which a behavioral intervention strategy cannot be proposed and implemented." The literature includes discussion of behavior therapy in the treatment of these and other problems: affective disorders (De Rubeis & Hollon, 1981), alcoholism (Chaney et al, 1978), asthma (Creer & Kotses, 1983; Dekker et al, 1957; King, 1980, Philander, 1979; Richter & Dahme, 1982), back pain (Cairns et al, 1980; Gottlieb et al, 1977; Newman, et al 1978), cardiac arrhythmia (Benson et al, 1975), cardiac problems (Matarazzo et al, 1982), dental problems (Ingersoll et al, 1977), depression (Lewinsohn & Hoberman, 1982; McLean & Hakstian, 1979), geriatrics (Patterson & Jackson, 1980; Patterson, 1982), headache (Blanchard et al, 1979), insomnia (Ascher & Efran, 1978; Ascher & Turner, 1980; Bootzen, 1972, 1977; Borkovec & Boundewyns, 1976; Jason, 1975; NaHauri, 1979; Turner & Ascher, 1982), obesity (Stunkard, 1982), obsessions (Emmelkamp & Kwee, 1977; Foa et al, 1980; Marks et al, 1975, 1980; Marks, 1981; Rachman & Hodgson, 1980; Steketee et al, 1982), overeating (Stuart, 1967); pain (Fordyce et al, 1973; Fordyce, 1976; Roberts & Rheinhardt, 1980; Sanders, 1979; Stegar & Fordyce, 1982; Swanson et al, 1979), phobias (Ost et al, 1981, 1982), problems of children (Benson 1979; Brownell et al, 1977; Drabman et al, 1978), schizophrenia (Curran et al, 1982), smoking (Litchenstein & Brown, 1982), and urological disorders (Doleys & Meredith, 1982).

The many varieties of behavior therapy are commonly related to a behavioral learning model of psychopathology that focuses on "observable behavior" instead of on "hypothesized personality structures or presumptive subjective experiences" (Phillips & Kanfer, 1969). Speculation, appraisal, and interpretation are in terms of environmental stimuli and behavioral acts rather than inner conflicts and other "conjectural constructs." Modification of behavior is presumably bracketed to research findings and studies in experimental psychology laboratories. Being data-oriented, behavior therapy attempts to avoid speculative inferences about the meaning of events. This is not to deny the importance of such inferences or the usefulness of the reports of subjects about what is happening to them. But these concepts are not employed to explain behavior. The historical genesis of behaviors selected for modification is not considered material for diagnosis and treatment, even though there is recognition that abnormal behaviors have historical origins. Rather, the circumstances that control and sustain these behaviors in the here-and-now are the central targets of treatment.

It is a common observable fact that encouraging a patient o behave in emotionally constructive ways and helping him or her to derive pleasure or to secure rewards for such behavior may reinforce the behavior to a point where it becomes an established pattern. Such relearning often results in the evolvement of new attitudes and values and sometimes even in cognitive restructuring. Though the auxiliary healing agencies (placebo, emotional catharsis, idealized relationship, suggestion, and group dynamics) play a role in the interaction between therapist and patient and transferential experiences and the working through of resistance undoubtedly take place, the principal therapeutic instrumentalities are directive stratagems and maneuvers designed to provide the individual with a corrective relearning experience. While not always successful (as with any therapy) such "behavior" or "conditioning" therapy has become a valuable instrument with which to approach certain emotional problems, and it has proved successful in many cases that have not yielded in the least to insight therapies. Particularly dramatic have been results in retarded, schizophrenic, psychopathic, addictive, and other patients who do not respond to the traditional interviewing and insight approaches.

Unlike conventional proponents of psychopathology who regard symptoms as surface manifestations of unconscious disease processes, behavior therapists base their operations on a social-learning model (Bandura, 1965b; O'Leary & Wilson, 1965; Franks, 1969; Rimm & Masters, 1974). This conceives of most maladaptive behavior as primarily learned response patterns that may be altered directly by manipulating stimulus variables of which the behavior distortions are said to be a function. Since it is believed that the distortions can be dealt with directly and adequately, it is unnecessary, in the opinion of behavior therapists, to introduce the concept of underlying pathology into their model on either practical or theoretical levels. Behavior therapy is thus organized around the conception of neuroses as learned maladaptive patterns of thinking, feeling, and behaving, conditioned by aversive experiences and sustained by reinforcements that prevent their extinction. It is also recognized that these learned patterns of behavior are superimposed upon biological determinants. Learned habits become fixed and refractory to elimination. Neither postulated unobservable events nor purposive and teleological principles, the bedrock of psychoanalytic theories, are employed as the basis for therapeutic maneuvers. Behavioral deficits or excesses are considered to issue out of the patient's immediate historical environment. Consequently, a search is organized for pathogenic environmental variables in order to manipulate and modify them. Implicit in behavior therapy is the precept that whatever has been learned can be unlearned by reversing the learning process (Eysenck, 1960a&b; Staats & Staats, 1963; Reyna, 1964). But, by the same token, behavior therapists recognize that learned behavior can also be modified by nonbehavioral techniques (e.g., drugs) and, similarly, that changes brought about other than by learning (e.g., physical trauma) can be modified by some form of learning process.

A number of modes of learning reversal have been suggested. Originally, behavior therapists focused exclusively upon modification of overt behavior and the presenting complaints or "symptoms" of the patients. Gradually, behavior therapy is said to have evolved into its present sophisticated multimodal framework, which— while by no means ignoring presenting complaints—focuses upon all maladaptive systems within the patient, as determined by an intensive behavioral assessment conducted as a cooperative project by the patient and therapist in concert. Cognitions, affects, drives, and certain

physiological processes are all considered modifiable in accordance with the principles of classical and operant conditioning, modeling, and related concepts. Classic is the historic case reported by M. Jones (1924a&b) of a child who had developed a great fear of animals in general after being bitten by a rabbit. Jones formulated the hypothesis that if he could get the child to associate rabbits with a pleasant emotion, fear of rabbits—and perhaps of all animals—might disappear. Upon complaints of hunger, he fed the child appetizing foods in sight of the rabbit held at a secure distance. Gradually he diminished the distance until the child was able to tolerate the close presence of the rabbit. This eventually extinguished the fear. D. Yates (1939), treating a girl who was upset emotionally by the presence of men, had her repeat the word "calm" while associating with it at the same time ideas of security, well-being, and peace. She gradually learned that constant repetition of the word in the presence of men sufficed to maintain her emotional composure. The use of aversive stimuli to correct untoward behavior was reported by Max (1935) and Mowrer and Mowrer (1938). Max treated a homosexual patient who was obsessed with homosexual thoughts whenever he came into contact with a certain inanimate object. Presenting this object to the patient and giving him an electric shock at the same time sufficed to terminate the power of the object to excite homosexual thoughts. Mowrer and Mowrer treated enuresis by constructing an apparatus that was placed in the bed of the enuretic child. The bed, when wet, caused a circuit in the apparatus to close and to ring the bell, thus awakening the child. They discovered that after three or four such experiences the impulse to urinate in itself sufficed to arouse the child.

Modern forms of behavior therapy follow these early reconditioning tactics, but they base their rationale on current ideas about learning theory, particularly classical (Pavlovian) and operant (Skinnerian) conditioning (Hilgard, 1956; Kimble, 1961; Wolpe & Lazarus 1966). Self-knowledge and efforts toward reconstruction of personality, as the psychodynamic therapist views these concepts, are felt to be too time-consuming, productive of untoward side effects, unscientifically founded, and, above all, ineffectual. Accordingly, the reliving of the original formative experiences and knowledge of historical precursors of present problems are deemphasized both diagnostically and therapeutically.

Instead, the individual is exposed to stimuli and to autonomic responses that neutralize fear and anxiety (classical or respondent conditioning). Where the repertoire of learned behavior must be expanded, principles of operant conditioning are employed, new behavioral tendencies being shaped by reinforcements toward specific goals.

In the past decade, formulations derived solely from learning theory have been considered too restrictive and concepts from experimental and social psychology have been employed to evolve useful interventions. The resulting techniques are relatively directive and aimed at manipulating the forces of behavior, which are believed to be recognizable, contemporary stimuli. Identifying the direction of the treatment, however, is a collaborative process arrived at by the patient, therapist, and involved "others." Treatment is an ongoing process that is subject to change and periodic review. The aim is always to maximize the individual patient's control of and responsibility for determining the nature and course of what is to be changed. Behavior therapy that imposes directives for change upon a patient is bad behavior therapy. Objectives are explicitly defined by mutual agreement with the patient, and conditions are deliberately controlled in order to change disturbing emotional reactions to provocative situations. Among the procedures used are the following:

1. *Desensitization* by exposing the patient to a rapid repetition of the stimulus and/or the response, with or without reinforcement.

2. *Extinction* of old responses by omitting either reinforcement or the original unconditioned stimulus that followed the eliciting stimulus or the instrumental responses.

3. *Punishment* by subjecting the patient to an aversive stimulus whenever the patient makes an undesirable response.

4. *Counterconditioning* by affiliating a different and opposing response with the conditional stimulus, followed by direct reinforcement of the opposing response.

5. *Cognitive restructuring* by dealing with attitudes and faulty ideas that influence behavior.

Positive Counterconditioning

In counterconditioning, the quality of the anxiety-inhibitory response utilized is related to the ultimately desired reaction. Thus, "assertive responses" are encouraged by the therapist, even to the point of "acting-out," in patients who have neurotic anxieties about asserting themselves with people. This idea is the basis of Salter's *Conditioned Reflex Therapy* (1961), in which, through authoritarian direction, the patient is enjoined to abandon destructive patterns of behavior and to practice new habits that will be of value to him or her. Postulated is the theory that healthy biological organisms are in a state of free emotional expressiveness (excitatory state). On the other hand, unhealthy organisms with emotional illness are said to be in a state of pathological inhibition, which has become a conditioned response and which blocks normal excitation. Therapy must be directed toward unlearning conditioned inhibitory reflexes and replacing them with conditioned excitatory reflexes. This is accomplished by deliberately practicing excitatory emotional reactions until they become established as conditioned reflexes. Thus, patients are encourged to express their feelings openly, accompanying these by appropriate or exaggerated motor reactions. Whenever they are in a situation where they disagree with others, they must deliberately and forcefully express themselves instead of inhibiting their feelings. Spontaneous reactions to new situations are preferred to assumed or conventionalized behavior. Expressing self-praise and promulgating one's own opinions and values are urged as a means of increasing self-confidence. By making them repeat such "positive" and "excitatory" acts, patients are said to be liberated from the harmful effects of inhibition. Thorne (1950) describes a method somewhat along these lines whereby fear reactions may be dissipated through a conditioning process of verbally admitting the presence of fear, of appreciating that it is a common reaction, of anticipating its arousal, and of training oneself to avoid inappropriate responses. Tasks are assigned that enhance emotional control and self-control, and the patient is reminded that many months will be required before success is complete.

"Relaxation responses" through "systematic desensitization" are recommended for fears associated with almost every aspect of behavior. By presenting anxiety-provoking

cues in a climate of pleasure or relaxation, aversive stimuli are, one hopes, mastered in progressively stronger forms. Amenable to this tactic are said to be a variety of emotional conditions, including tension states, anxiety reactions, behavioral inhibitions, phobias, and some psycho-physiological disorders. Among positive stimuli jointly presented with and calculated to neutralize the aversive stimuli are muscular relaxation (Wolpe, 1958; Eysenck, 1960a), pleasurable associations to interpersonal situations (English, 1924; Bentler, 1962), imagery of an emotive nature (Lazarus & Abramovitz, 1962), pharmacological agents that reduce sympathetic reactivity (Walton & Mather, 1963b), and food and sexual fantasies.

A form of this method known as "reciprocal inhibition" was developed by Wolpe (1958, 1961, 1969), who exposed animals with an experimental neurosis, while feeding them, to stimuli at first remotely related to and then more closely approximating the conditioned aversive stimulus. Increasing increments of anxiety were thus mastered until the original conditioned stimulus brought forth no reaction and the experimental neurosis was relieved. Around this finding Wolpe developed his theory of "reciprocal inhibition" to the effect that "if a response inhibitory of anxiety can be made to occur in the presence of anxiety-evoking stimuli it will weaken the bond between these two stimuli and the anxiety." In his technique Wolpe enjoins the patient to identify and to list in rank order a number (say, 20) of categories of upsetting stimuli. The patient is taught how to relax (hypnosis and self-hypnosis may be employed) for several sessions, and then in a state of relaxation is asked to bring to mind, for a few seconds, the the weakest of the anxiety-evoking situations in the anxiety hierarchy. When the anxiety response is zero, the next stimulus in the hierarchy is envisioned. Since relaxation inhibits anxiety, the offensive stimuli are progressively mastered until the most provocative and disturbing stimulus can be countenanced without upset.

A simple illustration of classic conditioning technique may be found in the account of Rubenstein (1964), who describes the conditioned reflex treatment of tubercular patients addicted to morphine. The first was a man of 38 who consumed 8.5 grains of morphine daily. The method employed consisted of the ringing of a bell at the start of each

hypodermic injection. This was abandoned after a few days, massage of the dorsal surface of the forearm being substituted for one minute after each injection. Gradually the dosage of morphine was lowered by substituting sterile injections until, after 4 weeks, the amount was 2.5 grains. At the end of 6 weeks, injections were discontinued. There were no withdrawal symptoms. In the second case, a woman of 38 who was getting 2 grains of morphine daily, the conditioning stimulus was a tuning fork held close to the ear, and the patient counted until the vibration ceased. Replacement of the morphine by sterile water was accomplished without withdrawal symptoms in 10 days, the vibrations of the tuning fork apparently substituting for the morphine. Should Rubenstein's findings be duplicated by other therapists, this would constitute a most revolutionary approach to the treatment of drug addiction. The report lacks detail regarding any conversation between the patients and therapist so that it is difficult to judge what other factors besides conditioning entered into the picture.

Experimental corroboration for counterconditioning is reported in studies by Lazarus (1961) and Lang and Lazovik (1963). Claimed for the desensitization techniques, in contrast to interpretive techniques, are quicker, more effective and more lasting elimination of phobic symptoms. In the study by Lazarus patients with acrophobia, claustrophobia, and impotence were matched in pairs according to age, sex, form, and severity of phobic symptoms. They were then randomly assigned to desensitization and interpretive treatments. Patients delegated to group desensitization were exposed to items of a common stimulus hierarchy in a deep state of relaxation and were asked to signal by raising their hands when an item was disturbing. Treatment was terminated when no stimulus item in the hierarchy upset any of the group members. Traditional group psychotherapy was employed in the control group. One month following therapy, the acrophobic patients were required to climb a fire escape 50 feet high and to take an elevator to the roof garden of an eight-story building from which they had to count the number of automobiles passing by for 2 minutes. The claustrophobic patients were subjected to an equally rigorous task, being required to remain undisturbed for 5 minutes in a tiny enclosed space. Of the 18 patients treated by group desensitization, 13 were completely recovered, as compared to only 2 out of 17 patients in the interpretive group.

Of the unsuccessful cases in the latter body, 10 were then treated successfully by group desensitization within 10 sessions. On follow-up, 80 percent of the successfully treated patients had experienced no return of fear.

Employing an apparatus to measure psychogalvanic responses as an index of autonomic reactivity, MacKay and Laverty (1963) demonstrated a progressive reduction of anxiety responses with desensitization procedures. Paul (1964) subjected four groups of college students with stage fright (1) to insight-oriented psychotherapy, (2) to an attention-placebo situation, (3) to counterconditioning associated with fantasies of public speaking, and (4) to mere assessment procedures (the control group). After 6 weeks, exposure to a stressful speech test and measurement of physiological variables, behavior dysfunctioning, and self-re-ported distress showed that all members of the first three groups showed improvement as compared to the control group, with the counterconditioning group rating far above the others.

Aversive Counterconditioning

Pairing certain behavioral deviations with aversive stimuli sometimes has succeeded in controlling or abating them. Among the earliest treatments of this type was the conditioned relfex therapy for alcoholism using a pharmacological nauseant (Lemere et al, 1942; Lemere & Voegtlin, 1950; Ruck, 1958; Miller et al, 1960). Treatment along similar lines for homosexuality, transvestism, and fetishism has been reported by K. Freund (1960), Glynn and Harper (1961), and A. Cooper (1963). Because of the difficulty in controlling the effects of drugs, several experiments in aversive conditioning have employed faradic stimulation as an aversive stimulus. This presentation of an unpleasant stimulus in close temporal relationship to an undesirable behavior, with the object of extinguishing it, is not as popular or successful as other forms of therapy. The dedication to the behavior, conscious or unconscious, may be too great to abandon it. Or a masochistic need for punishment may enable the patient to endure the painful consequences in order to appease a demanding sense of guilt. Moreover, for some patients aversive methods serve to reproduce the parental precedent of punishment for

infractions; the patient will then rebel against the therapist or passively resist getting well. In certain cases, however, when nothing else seems to work and an obnoxious habit or behavior must be controlled, aversive therapy may, surprisingly, be the only method to which a patient will respond.

Currently, several types of aversive schemes are occasionally used, principally those that follow the Pavlovian model and those that are patterned after the operant model. In the former group of therapies are the conditioning of alcoholics with such nauseating drugs as Emetine and Antabuse and, more rarely, with electric shock. Painful shock has also been used in the treatment of cases of self-injurious behavior as headbanging, self-biting, and face-slapping in retarded children and of self-induced vomiting. Aversive or punishing sequelae are employed less often than withdrawing positive rewards or reinforcements, such as shutting off a TV set during an argument between children over the choice of a program. A more severe disciplinary action is to penalize the individual for reprehensible behavior by levying a fine. Some therapists still use aversive stimulation for delivering an unpleasant stimulus like an electric shock from a small battery-operated unit or snapping a rubber band placed around their wrist whenever they indulge in certain behaviors they wish to control. In cases of hair plucking and skin mutilation that have not responded to other methods, a painful stimulus may replace the masochistic need to torment oneself.

Rapid inhalation of cigarette smoke to a point where the mucous membrane hurts or burns for the purpose of overcoming the smoking habit is another example of aversive control. The use of an alerting system to eliminate bed wetting and of delayed auditory feedback in stuttering has elements of both Pavlovian and operant methods. Compulsive overeating, gambling, and sexual deviations (fetishism, exhibitionism, voyeurism) and obsessive-compulsive symptoms have also been treated with aversive control methods, with undocumented claims of success. A substantial literature has accumulated detailing aversive techniques for the reversal of homosexuality in cases eager to change to heterosexuality (Freund K, 1960; Glynn & Harper, 1961; Cooper A, 1963). Virtually all behavior therapists now question the ethics involved in using aversive measures to treat

severe sexual deviations, even at the request of the patient. The emphasis today is on positive treatment strategies, cognitive involvement, and sophisticated evaluation of complex situations, leading to multimodel interventions. While not strictly an aversive technique, use of a diary in which the patient simply charts the frequency of undesirable behaviors for which control is sought appears to lessen the incidence of such behaviors.

Extinction Procedures

Exposure of the individual to graduated anxiety-provoking cues, and the mastery of such stimuli, are said to support an increased ability to tolerate and overcome certain avoidance reactions. Thus a patient fearful of entering elevators may be encouraged to walk into small rooms with the door open, then closed, following which the size of the room used is decreased, until the patient is able to tolerate remaining in a closet for a relatively long period. Thereafter, entering an elevator and stepping out before the door closes, then going up one flight, increasing the trip floor by floor, may enable the individual to extinguish the elevator fear. Unfortunately, this practice by itself has not proved to be altogether successful. Patients refuse to follow suggestions for a variety of reasons, including the secondary gain dividends they derive from their illness. Nevertheless, stratagems can be devised, tailor-made for each patient, which may on occasion prove successful (Herzberg, 1941; Saul et al, 1946; Kimble & Kendall, 1953; Walton & Mather, 1963a&b). Psychotherapeutic interviewing also embodies gradual mastery of anxiety. At first patients respond with anxiety to certain content, but repetition with increase of the depth of probing, along with permissive responses from the therapist, gradually extinguishes aversive responses as measured by the galvanic skin reflex (Dittes, 1957a, b), generalizing to related forms of behavior (Dollard & Miller, 1950).

In general, extinction procedures require frequent, even massive exposure to extinction trials with not enough interval between trials to build up resistance (Edmonson & Amsel, 1954; Calvin et al, 1956).

Because behavior deficits and neurotic symptoms often become reinforced when they break out against the will of the patient, certain procedures have been introduced

that purposefully and deliberately encourage the patient to engage in the disturbed behavior or to produce a symptom in the absence of the usual reinforcement contingencies (Dunlap, 1932; Lehner, 1954). Thus, if an individual's hand shakes while lifting a glass or holding a fork resulting in avoidance of eating with people, he or she is requested to eat or drink in the presence of the therapist and ordered to produce shaking in as exaggerated a form as possible. If he or she has a tic, he or she is encouraged to practice reproducing it voluntarily, then to engage in prolonged rest. This is claimed as the best method of extinguishing tics (Yates, 1958). Stuttering, too, is often benefited by the stutterer admitting to the speech defect to others and calculatedly trying to bring it on, or at least not struggling to hold it back (Fishman, 1937; Rutherford, 1940; Meisner, 1946; Sheehan, 1951; Sheehan & Voas, 1957).

Very often deviant behavior is reinforced by the reaction of individuals in the environment. Schedules in which the person is not reinforced for this behavior sometimes lead to its extinction. Thus, in children, screaming spells, tantrums, refusal to eat, and other forms of misbehavior calculated to attract attention, positive or negative, may be handled by ignoring such performances (Williams C, 1959). These principles have also been adopted in psychotics with some positive results (Ayllon & Michael, 1959; Ayllon & Houghton, 1962).

Operant Conditioning

Operant behavioral approaches offer a prolific group of behavior change methodologies, as well as guidelines for their evaluation. A contingency relationship exists between operants and the environmental events that follow them. Thus, behavioral responses may be set up, accelerated, and strengthened (reinforced) or diminished and eliminated (extinguished) by their succeeding environmental consequences. In applying operant methods, schedules of positive or aversive reinforcement are developed at fixed or variable intervals or ratios, which will gradually shape the desired behavior. This design has been used with variable success for overcoming behavioral deficits, eliminating maladaptive activities, and continuing therapeutic gains. Success is not always possible for

the same reasons as in any other therapy: lack of skill in the therapist, secondary gains that reward illness, inner conflictual resistances that obstruct progress, a masochistic need that supports suffering, anxiety that accompanies the achievement of health, and transference reactions that sidetrack therapeutic aims. Operant conditioning probably plays a part in all therapies, in that the therapist reinforces certain verbal and behavioral responses that are in accord with his or her theoretical convictions and the goals toward which treatment is directed. A vast bibliography on operant conditioning is available. A brief review is contained in the article by Karoly (1980).

Behavior deficits or behavioral impoverishment, in which traits that make for a productive adjustment are in default, may sometimes be overcome by developing adaptive responses through operant conditioning. Dramatic examples of what can be done with autistic children who are dissociated from reality and are unable to engage in gratifying interpersonal relationships have been reported by Goldfarb (1943), Freud and Burlingham (1944), Ayllon and Michael (1959), Lindsley (1960), Ferster (1961), Ferster and De Myer (1961), and Gerwitz (1961). As Bandura (1965b) has pointed out, the existence of inadequate social-reinforcer systems inhibit the use of positive attention and approval in these sicker patients. Indeed, other human beings have weak or negative reinforcing value for such patients (Bandura & Walters, 1959; Cairns, 1961; Ferster, 1961). To develop adequate behavior repertoires, ingenious schemes of operant conditioning have been elaborated. Selection of adequate primary reinforcers that are contingent on the execution of desired behavioral sequences and proper programming of rewards without setting criteria for initial reinforcement too high often result in a gradual shaping of behavior toward an adaptive objective. For instance, in the study of King et al. (1960) on withdrawn schizophrenics, the performance of simple motor tasks was rewarded with verbal approval, pictures, candy, and cigarettes. Gradually these bounties were made contingent on more complicated behavior, such as communication and cooperation with the therapist and other patients in solving simple problems. The result was an emergence from their private worlds toward relationships with others.

Working with nursery school children, Baer et al. (1963) concluded that attention

paid to withdrawn children (the conventional approach) merely tended to reinforce detached behavior. The investigators consequently avoided attending to this behavior when it occurred, but immediately rewarded the appearance of any evidence of social interaction. Social responsiveness immediately increased. To test this further, they again consoled and paid attention to the same children when they relapsed into solitary play, with the result that withdrawal tendencies rapidly returned. Reversing this process for the second time and rewarding social interaction, they readily brought the children back to cooperative relationships. As soon as patterns were consolidated, the reinforcers were slowly withdrawn, reinforcement being made contingent on the usual rewards of everyday life. Follow-up studies confirmed the stability of the acquired patterns. Other observers have validated the efficacy of these procedures in both behavior disorders and behavior deficits (Allen E, et al, 1964; Wolf M, et al, 1964).

The use of operant conditioning in unmotivated patients, such as delinquents, has resulted in the elimination of some antisocial patterns. When "hard-core" delinquents were compensated with money, candy, and cigarettes for their service as subjects in talking about themselves and their ideas, constructive activities soon were observed and their delinquent behavior diminished (Slack, 1960; Schwitzgebel & Kolb, 1964).

Response-correlated aversive stimulation is an example of how operant conditioning may be employed. Here unacceptable forms of behavior result in removal of positive reinforcers (such as music) or the delivery to the individual of a disagreeable stimulus (faradic electrical stimulation) (Liversedge & Sylvester, 1955; Goldiamond, 1965). Results depend on the intensity, frequency, and temporal sequence of the stimulus in relation to the response to be eliminated (Church, 1963). By manipulating the social consequences of certain forms of behavior, modifications in behavior may be secured. Thus Wolf et al. (1964) successfully treated a refractory 3-year-old child whose violent temper tantrums could not be controlled with drugs and physical restraint simply by removing him to another room until his tantrums ceased. In some compulsive-obsessive patients, unapproachable by conventional methods, who are torturing themselves with destructive thoughts and impulses, success had been obtained by use of a small toy (a battery-

operated shocking apparatus, activated by closing a switch when the container of a card box is opened) that provides the aversive stimulation. The patients, engaging in practice sessions at home, deliberately bring on their fantasies, then turn on the current until the fantasies disappear. Eventually some are able to divert their thinking from obsessional concerns. Bandura (1962b) aptly cautions that aversive stimuli may through classical conditioning serve to motivate and reinforce undesirable patterns.

Social Learning through Identification (Modeling)

Modification of social responses through patterning of the self after observed models has been described as a usual means of acquiring new behavior repertoires and of changing existing maladaptive ones (Bandura, 1962a, 1965a, 1977; Bandura & Mcdonald, 1963; Bandura & Walters, 1963; Rachman & wilson, 1980) By perceiving the behavior of the models, including associated rewards or punishments for this behavior, marked changes in the observer may be scored in terms of (1) moral judgments (Bandura & McDonald, 1963), (2) control of aggression (Bandura et al, 1961, 1963a, b; Feshbach, 1961; Walters & Llewellyn, 1963; Berkowitz, 1964; Bandura, 1965b), (3) tendencies toward violation of prohibition (Blake, 1958; Walters et al, 1963), and (4) various other responses (Bandura & Huston, 1961; Bandura et al, 1963c).

Conditioned emotional reactions may be acquired by observing pain and fear in models (Berger S, 1962; Bandura & Rosenthal, 1965). Thus, Chittenden (1942) exposed hyperaggressive children to a series of plays in which dolls exhibited alternating aggressive and then cooperative acitivity. The consequences of aggressive behavior (two dolls fighting over a wagon) were shown to be destructive (the breaking of the wagon with unhappiness in the children). On the other hand, constructive interaction resulted in the boys enjoying themselves (taking turns playing in the wagon). An impressive decrease in aggression resulted in the audience in comparison with a matched control group. Other examples of modeling procedures have been described by Levy (1939), Slavson (1950), and Kelly (1955), who essentially assign to the therapist the task of executing in real life or symbolically the desired behavior.

The efficacy of the therapist in serving as a model for the patient will depend upon the role the therapist plays and how this is conceptualized by the patient. If in a position to mete out rewards or occupy a prestige role, the therapist will have the greatest chance of being accepted for the desired modeling (Lippitt et al, 1952; Bandura & Huston, 1961; Bandura et al, 1963c). Once social response patterns have been obtained, they may be secured by reinforcers.

Cognitive Behavior Therapy

Emphasis on cognitive processes represents a shift from stimulus-response and drive models to the dynamics of systems and subsystems of thought. Psychotherapy, following this paradigm, is organized around the direct influencing of thought systems and the interpretation of events. Behaviorally oriented methods that have taken on a cognitive dimension have been classified under the label of "cognitive behavior therapy." The distinctive quality of these techniques is that they do not attempt to force ideas on the patient but rather seek cooperation by providing the patient with graded tasks and assignments calculated to instill new ways of thinking. Thus, through instruction and modeling patients are taught to replace negative thoughts with thoughts that are more relevant to a proper adjustment (Meichenbaum & Cameron, 1974). Messages may be written out and given the patient for study and reflection. The aim is to soften the projected consequences of worrisome or destructive ideas. Eventually, it is hoped, negative self-statements and irrelevant cognitives that provoke untoward behavior may be eliminated.

Disturbed thoughts and ideas are believed capable of setting off chain reactions ranging from emotional outbursts to behavioral aberrations to physiological upheavals. Such thoughts and ideas, which we may call cognitions, are often the product of faulty belief systems acquired through improper upbringing and false cultural values. The end result is interference with a satisfactory personal and social adjustment. Therapeutic efforts are therefore directed toward the forthright and immediate correction of erroneous ideas.

In contrast to dynamic therapy, which tends to alter cognitions through insight into how past conditionings mold attitudes and behavior, cognitive therapy deals directly with present-day thoughts, irrational assumptions, destructive self-statements, and self-defeating ideas. Their influence on feelings and behavior is explored with the object of regulating a more harmonious adjustment and helping the patient reduce or eliminate anxiety, depression, anger, and accompanying physiological residues.

The original work in this field was done by Ellis (1962). Several elaborations of Ellis's ideas have occurred, for example, the work of Meichenbaum and Cameron (1974), who have concentrated on the determining effect of the patient's negative self-statements and other irrelevant cognitives on behavior. A. Beck (1976) and Rush (1978) have also contributed substantially to the field through their stress on faulty thinking patterns, particularly in depressive states. When rudiments of adaptive skills are present and anxiety is not too paralyzing, the individual with proper therapy along cognitive lines may be able in a relatively brief period to reorganize his or her thinking skills and to find alternative, constructive solutions for difficulties in living. Intervention programs of this type have been designed for application in a variety of clinical and educational settings (Spivack et al, 1976).

Behavioral Medicine

Behavioral medicine is a term used to describe health and illness as they relate to the biological and social sciences, as well as the techniques that lead to diagnosis, prevention, treatment, and rehabilitation. A large number of publications have attempted to define this important but rather amorphous behavioral field (Berk, 1973; Collins, 1981; Davidson & Davidson, 1980; Doleys et al, 1982; Epstein & Cluss, 1982; Melamed & Siegel, 1980; Miller N, 1983; Pomerleau & Brady, 1979; Swartz & Weiss, 1978; West & Stein, 1982; Williams & Gentry, 1977). A number of subspecialties have appeared that attempt to divide the field into pediatric, adolescent, gerontologic, ophthalmologic, urologic, dental, and other areas of behavioral medicine, some authorities consider psychological methods that are used adjunctive to medical techniques, as in the treatment of asthma, insomnia,

obesity, pain, cardiovascular disease, and habit disorders (smoking, overeating), within the parameters of the field. Hypertension, Raynaud's disease, arrhythmias, and coronary artery disease have been shown to respond to methods related to behavioral medicine (Agras & Jacob, 1979; Benson et al, 1975; Brady et al, 1974; Berk, 1973). An excellent bibliography of behavioral approaches to pain, asthma, insomnia, headache, alcoholism, and other problems may be found in the article by Lazarus (1984).

Conditioning techniques have been used to modify behavior and to control physical symptoms in every age category. In children, problems ranging from nail biting to colic have been addressed. Parents have sometimes been trained in behavior management interventions as primary therapists or adjunctive helpers (Patterson & Gullion, 1968). In adults, there is scarcely a syndrome or symptom complex that has not been approached with behavioral methods. In those elderly patients in whom the deficits of aging have been amplified by environmental impoverishment and relative lack of reinforcements (Patterson, 1982), behavior therapy can help restore a good deal of constructive functioning (Berger & Rose, 1977). It may be valuable in terminal care problems.

Behavioral Prostheses

Several mechanical or electronic devices have been developed that can be carried by patients to help them acquire more adaptive behavioral patterns. Severe stuttering, for example, has been helped by an auditory metronome with a volume and rate control that the patient wears behind the ear like a hearing aid and that delivers rhythmic beats, permitting a pacing of speech and leading to greater fluency (Burns & Brady, 1980). A coordinated behavioral program, which may be used unaided by the prosthesis, is employed to decondition anxiety related to speaking (Brady, 1985).

Social Skills Training

Behavioral approaches are indispensable in the rehabilitation of persons who have failed to acquire or have lost social and self-care skills because of faulty upbringing or the development of psychiatric illness. Deficits and ineptitudes in human relationships and

communicative skills are reflected in awkwardness, poor impulse control, and offensive habits and behavior, resulting in rejection and social isolation. Programs designed to overcome social and self-care deficits have been developed around behavior therapy principles and are used primarily in day hospitals and rehabilitation centers, as well as private practice. Individual and group therapy, using role playing and the modeling of appropriate behavior in simulated social situations, have proven singularly effective. Homework assignments are an important part of the program to encourage the generalization of learnings to the specific environment in which the individual will function (Hersen & Bellack, 1976; Trower et al, 1978; Wallace et al, 1980).

The Practice of Behavior Therapy

No two behavior therapists function alike, but all have a common respect for the methodology of the behavioral sciences and an emphasis on some form of stimulus response or social learning theory as a potential but not exclusive conceptual idea. It is this focus that characterizes modern behavior therapy, together with its emphasis on accountability and openness to scrutiny from within and without. The debatable clinical advantages and short-term therapeutic "successes" in the long run are probably of less significance.

As in traditional psychotherapy, considerable flexibility is exercised in the stratagems that are employed, which generally incorporate both interviewing and conditioning tactics. Therapy is usually started with a "behavioral analysis" to describe the maladaptive behavior pattern in objective and explicit terms, to review environmental and other variables that initiate and sustain the behavior, and to outline the tentative treatment plan. Each step of the treatment as it proceeds is explained to the patient, including what will be expected of him or her. "the patient's behavior toward the therapist is examined *only* when it points up important "maladaptive responses" (Storrow, 1965). In the opening phases of treatment, the main tasks are diagnosis, structuring of the therapeutic situation, designation of goals, and permitting the patient to "adapt" to the experimental situation by avoiding sensitive areas. The circumstances that led to

treatment are reviewed, with discussion of the patient's general reactions to these. The present is considered rather than the past. Patterns to be changed and the methods to be used in changing them are delineated. To become an adequate agency of reinforcement, it must be established that the therapist is a source of rewards. This is done by developing a relationship with the patient and giving him or her some immediate relief through medication or practical assistance with a pressing problem.

Once the therapist understands the causal relationship between the patient's behavior and other variables, the true therapeutic effort begins when the therapist uses available stimuli to extinguish the maladaptive behavior (Meehl, 1962) and to strengthen adaptive responses. New patterns are most effectively shaped through the principle of "successive approximations" (Skinner, 1953), during which the therapist expects only small steps of improvement, never pushing the patient beyond his or her capacities. "The basic principle is to start with some response pattern remotely similar to the missing adaptive behavior and to shape the new behavior by differentially reinforcing new responses as they approach the goal." For instance, if a woman is fearful of aggressive behavior, she is encouraged to grouse at her husband or coworkers when she feels like it, and she is complimented when she reports success. She gradually is encouraged to stand her ground when criticized and to assert herself with authority, always being sure that her behavior is not destructively designed. Should the patient be unable to express herself openly, fantasy and role-playing techniques are employed, such as those suggested by Cameron (1951). For instance, she can first imagine herself in a certain role; then she may act it out with the therapist, who plays the part of the threatening figure. Should the reinforcements gained from her environment for her behavior prove unsubstantial, tangible rewards may be given, like those described by I. Stevenson (1962), such as special attention being shown her outside of the interview or reduction or cancellation of the fee for one or more sessions. Leads toward social reinforcement in difficult problems have been suggested by R. Lundin (1961), Storrow (1962), Staats and Staats (1963).

The quickest way of overcoming a response is "to condition an incompatible response in its place" in the form of counterconditioning (Kimble, 1961; Lundin, 1961).

Thus, an adaptive response may be chosen to replace an avoidance response. Verbal self-stimulation may be helpful, words and thoughts serving as conditioned stimuli and acting as reinforcers. First "the erroneous assumptions underlying the patient's anxiety and avoidance behavior" are pointed out, "arguing with him about this, if necessary." A cognitive behavioral approach may be indispensable. The patient is then instructed "to bombard himself with opposing thoughts when he next confronts the threatening situation." This approach is similar to that of Albert Ellis (1962).

Mild punishment may be used as a means of suppressing maladaptive behavior. This may be in the form of verbal disapproval or may consist of such methods as those suggested by Stevenson (1962), for example, "increasing the fee for one or more interviews or postponing an appointment when a patient fails to complete an assigned task."

In the closing phases of treatment, liberal approval during the interview is sometimes yielded in favor of rewards available in the environment. Advantages that will accrue to the patient as a result of the new behavior are pointed out. Little difficulty is usually experienced in terminating therapy.

HOW EFFECTIVE IS BEHAVIOR THERAPY? COMPARISON WITH PSYCHOANALYSIS

Some attempts have been made to compare the results of behavior therapy with those of conventional therapy. Reporting on three series of unselected patients (psychotics and psychopaths were, however, excluded from treatment), Wolpe (1958) states that of 210 neurotic patients, 90 percent were cured or much improved after an average of 30 therapeutic interviews. This figure is topped by a claim by Hussain (1965) of 95.2 percent in his treatment of 105 patients. Lazarus (1961) argues that while insight therapy brought satisfactory results in 1 out of 15 cases suffering from phobic reactions, behavior therapy cured 13 out of 18 cases. In a later study of 321 cases, he found that 78 percent had achieved a strikingly good outcome. Follow-up observations show that the results by conditioning methods are durable.

On the basis of these findings, in the formative years, behavior therapists have launched a frontal attack on both the precepts and results of psychoanalysis, branding it as an inferior treatment method that may contain elements that not only do not foster but actually retard improvement or cure. Among the charges are the following:

1. Psychoanalytic treatment is founded on the unsubstantiated premise that emotional problems are the product of repression of unconscious conflicts. The objective in cure, therefore, is to resolve resistances, thus restoring repudiated impulses to consciousness.

2. Statistical reports prove that results with psychoanalytic approaches are inferior to those of other forms of therapy, and particularly to behavior therapy.

3. On any comparison study, behavior therapy scores higher than other types of treatment; indeed, conditioning frequently overcome neuroses that have been treated for years unsuccessfully through psychoanalysis.

4. The evidence justifies substituting behavior therapy for psychoanalysis in the training of therapists.

5. It confirms a community interest in behavior therapy, since it permits the therapist to see large numbers of cases over a short period of time, producing "a higher proportion of lasting recoveries from the distress and disability of neurosis than does psychoanalysis," at a fraction of the cost.

Insight Versus Reinforcement

Behavior therapy conceives of neuroses as residues of faulty learning and conditioning that are amenable to tactics of relearning and reconditioning. In such retraining, "insight," as we conventionally conceive of it, plays a minor role or none at all. There is little evidence, contend behavior therapists, that "insights" gained during interview psychotherapy or psychoanalysis have any influence in modifying social behavior. For the behavior therapist the term "insight," if it is used at all, pertains to the appreciation gained by the patient of the relevant contingencies in his or her life and their consequences as well as the consequences of responding to available options. Generally,

"insights" are the regurgitated sentiments of the therapist, rather than true discoveries of the patient. Studies of verbal conditioning show that almost any response can be elicited from a subject under interview by positive reinforcement from the interviewer and that it may be reduced by withholding reinforcement (Salzinger, 1959; Krasner, 1958, 1962). The content of a patient's stream of thought is thus definitively influenced by suggestive probings on the part of the therapist (Bandura et al, 1960; Murray, 1956). It is perhaps for this reason that patients are constantly feeding back to the therapist the latter's psychodynamic schemes (Marmor, 1962). Rather than being a precursor to change, insight is often a consequence of change, during which, due to a strengthening of the personality, certain ideas are allowed access to consciousness (Alexander & French, 1946). Awareness of the responses made, and of the reinforcements, expedites learning. Awareness alone, however, does not guarantee behavioral change. Rather than waste time exploring hypothetical unconscious conflicts that turn out merely to reflect the therapist's theoretical predilections, is it not more practical as well as scientific to apply oneself to modifying responses through methods that have proved themselves efficacious? Indeed, where patients improve with insight therapies, it is probable that they do so not because of cognitive factors but because they have been subjected by the therapist to differential reinforcements, to counterconditioning, to extinction and to modeling—in other words to principles of learning rather than to the divulgence of unconscious content. Is it not then reasonable that insight therapists give up their esoteric rituals and forays into the unconscious and deliberately apply themselves to effective social learning procedures (Bandura, 1965b)?

Criticism of Behavior Therapy

Modern clinical and experimental research has contributed to the sophistication of behavioral interventions and has extended their usefulness for dealing with many syndromes, ranging from adjustment and habit disorders, to neurotic symptomatology (e.g., phobias, obsessions, compulsions, and depressions), to problems of retardates and psychotics. Questions continue to be asked about the utilities and dangers of behavior therapy, many based on misconceptions, for example, the ideas that the method is too

authoritarian, coercive, controlling, and punitive; that behavior therapists avoid history-taking and focus extensive attention on data-gathering; that the removal of symptoms often results in symptom substitution or in only temporary benefits; and that the therapist-patient relationship is not considered very important.

Accusations are still levied at behavior therapists to the effect that they disregard such nonmeasurable aspects of inner experience as feelings and fantasies, and even that some therapists are so tied to a simple stimulus-response ideology that they consider the human brain "an irrelevant and unnecessary intervening variable." These ideas are largely erroneous and contribute to the existing climate of misunderstanding. Although analysts and behavior therapists act as if they were more tolerant of each other's ideas, there is still a good deal of distance and distrust between them that, one hopes, time and constructive dialogue will resolve. Franks (1984) believes that it is important to recognize the pervasive differences between behavior therapy and the Freudian system. Fundamental philosophical, conceptual, methodological, and practical distinctions make meaningful comparisons (other than for certain circumscribed situations) virtually impossible. For example, the two models have incompatible notions about the nature of acceptable data and the goals of therapy, and both the criteria and process of outcome evaluation are different. In the early days of behavior therapy, rivalries resulted in potentially destructive thinking in terms of "better" or "worse." The prevailing climate for many individuals in either "camp" seems now to be that the two systems are fundamentally incompatible and that in the long run advancement will best be served by encouraging each to work within its own framework. A perhaps smaller but vociferous and responsible group believes that some form of integration is both possible and beginning to occur (see Goldfried, 1982).

A great deal of concern has recently been expressed about the ethics of behavior modification and the infringement of rights of individuals on whom behavior change is practiced. This is particularly directed at work with populations in institutions and prisons where motivation for change may be lacking. It is also pointed out that follow-up studies are not particularly impressive regarding the permanency of change once the individual leaves the milieu in which appropriate reinforcements exist. These criticisms

are, however, not unique for behavior modification and can equally be applied to all mental health programs. It is assumed that professionals are sufficiently ethical to weigh advantages against risks, to gain informal consent if possible for programs, and to impose proper safeguards so that individual rights are not abrogated. Monitoring routines by a review committee, supplemented by reports to guardians or advocates of the person whose behavior is to be modified, have been proposed. Preoccupation with the issue of control has been overemphasized. As W. Brown et al. (1975) have stated, "On the whole, the goal of behavior modification, as generally practiced, is not to force people to conform or to behave in some mindless, automaton-like way. Rather, the goals generally include providing new skills and individual options and developing creativity and spontaneity." Contemporary behavior therapists are highly sensitive to ethical considerations and the potential for infringement upon human dignity, rights, and privacy. Historians and behavioral architects stress that the saga of behavior therapy is an evolution from simplistic beginnings to the present form of the discipline (Kazdin, 1978). One major strength of behavior therapy is its willingness to accept modification in the light of new data and thinking and its sensitivity to personal and social needs. Effective behavior therapists recognize both their limitations and the need to grapple with scientific, ethical, and philosophical issues (Erwin, 1978).

One of the drawbacks of any symptom-oriented short-term method of therapy, including behavior therapy, contend dynamically oriented therapists, is that there is little or no time spent on evaluating the individual's personality needs, and particularly the meaning to the patient of his or her symptoms. To impose behavior modification on a patient without thorough cooperation and the resolution of resistances to change will impose, in the least, barriers to ready progress and in some cases will inflict serious dangers. This is not to say that alterations may not be forthcoming, as one may witness in the token economies practiced in a state institutions with unmotivated patients. But when a symptom serves as a defense, initial improvements with forced behavioral techniques, unless they resolve the need for the defense, are apt to be short-lived and may even precipitate anxiety, with further disabling compensations. Admittedly, this is not a usual phenomenon, but it does occur as Bruch (1974b) reported in her follow-up studies of the

effect of behavior therapy on a group of patients with anorexia nervosa. The clinician will obviously be at an advantage if he or she recognizes that an individual's needs for autonomy and self-determination are sacrosanct and that imposing a regimen on any unwilling patient poses hazards that have to be evaluated carefully before undertaking treatment. It is here that dynamically oriented therapists have an advantage over their colleagues who dissociate themselves from approaches that acknowledge the determining power of existing personality drive and conflicts.

There is little question that the techniques of behavior therapy constitute important additions to the armamentarium of the psychotherapist. Employed with skill, they offer effective forms of treatment for the relief of certain inhibitory coping mechanisms and symptoms, such as phobias. They are applicable to a broad spectrum of the population, including less verbal and less educated patients. An improved total adjustment often comes about as a by-product of the control or resolution of symptoms. Proficiency in the use of behavioral therapy techniques may be acquired without extensive or expensive training, an advantage in the face of the current shortage of psychotherapists. Fears and other symptoms resolved through behavior therapy may be permanently extinguished and, instead of symptom substitution, may be followed by constructive influence on many other elements of the personality. Behavior therapists strongly stress, however, that proficiency in newly acquired behavioral techniques does not make one a behavior therapist; nor does it mean one is practicing behavior therapy. Behavior therapy is a conceptual and methodological approach that is both complex and time consuming to master. Techniques may be readily acquired and easily applied by anyone, but this is not behavior therapy.

On the debit side of the ledger we find that, in their zeal, unsophisticated behavior therapists have tended (in the past but less so now) to downgrade other forms of treatment, claiming, first, that theirs is a more scientifically based therapy, grounded in substantial learning theory rather than esoteric personality theory, and, second, that results are statistically better than those reported by therapists of other schools. Such signal successes are credited to the singular corrective powers of conditioning.

Actually, as modern behavior therapy takes pains to stress (Franks & Wilson, 1975), there is little basis for any autocratic assumptions about learning theory. It possesses no special magic, nor does it occupy a preferred place in the vestibule of science. Indeed, there is as much confusion about how complex learning takes place, and as much controversy about which of the prevailing learning theories is sovereign, as there is in the field of personality theory. It is better to ascribe the effects of behavior therapy to the disciplined use of learning principles and the methodology of the behavioral scientist than to the dubious application of learning theory.

The beneficial effects scored by *any* of the psychotherapies are probably the consequence of the unlearning of old and the acquisition of new patterns. Even psychoanalysis owes many of its gains to constructive relearning. How learning principles enter into the methodologies, circuitously or by design, has been described elsewhere (Wolberg LR, 1966). Learning principles are not the monopoly of any of the psychotherapeutic schools. Nevertheless, it cannot be denied that behavior therapy is one of the few systems of therapy that *explicitly* endeavors to unravel and then *systematically* and consistently apply these principles of learning in the therapeutic situation. Ideally, speculation and subjective intuition—while having their place as an occasional starting-off point—yield to evidence, data, controlled study, and the rigorous application as an *ongoing process* of the methodology of the behavioral scientist. It is this that really gives behavior therapy its unique position and its advantage, if it be an advantage, rather than any grandiose claims to extraordinary successes.

A well-deserved criticism is that early behavior therapists tended to regard conditioning as the cardinal if not exclusive agency in the therapeutic process. Little attention was paid to the factor of spontaneous remission and to the non-specific benefits of the helping process, such as the placebo effect, the relationship dimension, emotional catharsis, suggestion, and group dynamics, which in themselves may account for a certain percentage of recoveries. Nor was the enthusiasm with which therapists apply themselves, and the faith inspired in their patients, considered to be too significant. Neglected also were the factors of transference and resistance that operate in all

relationships in which one human being is influenced by another. This, of course, is of primarily historical relevance at this stage. Behavior therapy has matured since these stormy and dogmatic days of infancy and early adolescence.

At this stage it is essential to differentiate between the techniques of behavior therapy that any therapist may acquire and apply as the occasion demand, but which do *not* make the therapist into a behavior therapist, and the consistent application of a conceptual model or framework with which all problems are approached regardless of technique employed or maladaptive function to be altered. Technical eclecticism (the use of any technique that has been empirically demonstrated to work) is justifiable and perhaps the hallmark of the good therapist. Theoretical eclecticism— the switching from one conceptual framework or theoretical set of constructs to another, from one patient to another—leads the therapist to a conceptual disarray that is akin to philosophical schizophrenia. Lazarus (1971) has elaborated on this important point.

A case described by J. White (1964), as an illustration of the application of learning theory to the treatment of anorexia in a child, brings up some of the problems in accounting for therapeutic results. A child who had become conditioned to eating while on her father's lap stopped eating regularly at the age of 5 when her father died. Various devices were utilized to incite her appetite; however, her eating steadily deteriorated. Therapy consisted of a reconditioning process, the therapist, then other members of the family playing the father's role. Play therapy, four times weekly, was also employed. It was soon apparent that the child, in her contrariness, was using food rejection as a way of frustrating her mother. On one occasion when the child refused to stay in the playroom with both her mother and the psychologist, she was sent home without the cup of coffee promised her. Thereafter, she was rewarded only when she did useful little jobs around the clinic. In 5 months the patient began showing an interest in food. Whether learning theory, relationship therapy, or pure suggestion operated here is quite pertinent to our concern as to what is important in the healing process. The author has successfully treated a number of anorexic children with hypnosis, employing pure suggestive techniques. In one instance cure took place after one session (Wolberg LR, 1965, p. 290).

The most biting criticisms of behavior therapy are voiced by adherents of psychodynamic models of psychotherapy, who consider behavior deviations the symptomatic manifestations of underlying pathological processes. Such criticisms contend that the behavior therapist operates falsely on the assumption that it is possible, from the patient's behavior or expressed complaints, to discern all the variables that require correction. Actually, the aspects of personality that require greatest alteration may be repressed or shielded by manifest defenses or by symptoms that mask more fundamental problems. Applying oneself faithfully to the extinguishing of such symptoms may prove futile, unless one discloses and makes available to the patient the conflicts behind his or her symptoms. This is not to say that many symptoms have not outlived their usefulness as defenses against anxiety, persisting as conditioned responses. In such cases they will yield to tactics of symptom removal, such as are practiced in some forms of behavior therapy. When they serve some anxiety-binding or pleasure-producing purpose in the psychic economy, however, their origins and function will have to be explored and exposed, and resistances to giving them up "worked through." Only then will conditioning procedures be effective. To this, of course, the sophisticated behavior therapist would reply that there are no hard data demonstrating the need to introduce superfluous intermediary concepts, such as the unconscious or psyche. They would also point out that behavior therapists go to great lengths to explore with the patient the whole range of presenting complaints and pertinent issues, some of which the patient may not be aware of. For example, treating a lawyer by systematic desensitization for the presenting complaint of difficulty in speaking in public may be useless if the real or only partly recognized problem is fear of losing a case in court and of losing face. It is this, among other things, that must be modified rather than the face-saving presenting complaint.

Another challenged assumption in early behavior therapy was that the therapist always can function as an adequate source of reinforcement—approval and rewards meted out by acting as positive reinforcer and disapproval as an aversive stimulus. This is not always true. When the patient has a problem in accepting the therapist as an authority, he or she will not be influenced too much by the therapist's approval or disapproval. In patients who have a need to frustrate, compete with, defy, and fight authority, resistance

to commands and blandishments may obstruct reinforcement. Moreover, an unconscious masochistic need in the patient may dictate suffering as a way of life. Relinquishing a disturbing symptom may then constitute too much of a threat. Where there is resistance to accepting social rewards for any reason, reinforcements from the environment will have little effect on the patient. It is necessary in such cases to deal with transferential projections, differentiating the therapist as a real person from the image of authority residual in the patient's past experiences. To do this, reconstructive techniques may have to be employed. Contemporary behavior therapy, then, is both interperson- and intraperson-oriented. Emphasis is on those contingencies within the environment that modify the patient's life style. For example, it is of little use to help an alcoholic reduce drinking or to change a basic life pattern in the clinic if there is return home to the same unfortunate set of contingencies that contributed to the distress (or foibles) in the first instance. Behavior therapists have, therefore, developed techniques such as contingency contracting and cognitive restructuring for modification of the various systems within which the patient has to operate. Such a *systems approach* necessitates concern with virtually every aspect of the patient's social, economic, biological, and physical environments. Flexibility and ingenuity, coupled with scientific rigor and attention to detail, are essential, if hard to maintain, ingredients of this approach (Franks, 1974; Franks & Wilson, 1975; Lazarus, 1976). At the same time, contemporary behavior therapy no longer neglects the "inner being." Cognition and self-control rather than direction from without are increasingly important in the behavioral approach (Mahoney, 1974). Self-instruction and self-monitoring, utilizing advances in behavioral biofeedback, are considered to be focal goals. Lazarus (1976), with his acronym BASIC ID, provides an outstanding example of the direction in which forward-looking behavior therapy is going, a direction shown by the current interest in differential therapeutics (Frances et al, 1984).

Two major problem areas remain for this new breed of behavior therapist to contend with. By definition, the strength of behavior therapy and its identity lies primarily in its unswerving adherence to the methodology and rigor of the behavioral scientist within a learning theory framework and its unique combination of this with the flexibility and acumen of the patient-oriented clinician. The problem is that the more broad

spectrum or multimodal the behavior therapists become, the more they are in danger of losing the behaviorally oriented foundations upon which their system of therapy is founded. From the patient's stance, this, of course, is irrelevant. From the point of view of behavior therapy, which may, of course, be of little consequence in the long run, this is very important.

The other problem area—with which behavior therapists are contending more successfully (Franks, 1974; Franks & Wilson, 1975)—pertain to such vital and timely issues as ethics, accountability, licensing, and its public and its private images. Now that behavior therapy is demonstrably viable and highly visible to both mental health professionals and the public at large (witness the not-altogether unmerited furor about aversive control and token economies in the prison system in the popular press), it is essential that such matters be given top priority along with matters of further research.

Behavior therapists insist that schedules of reinforcement rather than internal psychodynamic factors account for the genesis and continuance of disturbed behavioral patterns. By removing positive reinforcers, deviant patterns are said to be reversible. The origin of these reinforcement schedules may well lie in early parental conditioning and be determined in part by constitutional, biochemical, and even genetic variables. This, all but the most radical of behavior therapists recognize, sets an inevitable limitation upon what reinforcement *alone* can accomplish. Within these limiting factors, the emphasis is on the contingencies that maintain the behavior now. Behavior therapy has developed techniques for working with these contingencies, whether they be operating primarily in the external environment or largely (or even exclusively) in the imagination of the patient. The reinforcing agencies are sometimes not in the environment but in the residues of parental conditionings imprinted on the psyche that carry on the re-ward-punishing activities irrespective of reality. The individual's superego may be a more powerful reinforcing agency than any external personage including the therapist. Because the force and even existence of this intrapsychic body is usually unknown to the individual, the patient cannot deal with it until, through releasing measures, he or she becomes aware of its nature and manifestations. Liberation of such forces from the unconscious is an

important objective in the insight therapies, such as psychoanalysis.

The fact that not all patients are cured by psychoanalysis and that behavior therapy yields symptomatic relief more readily does not invalidate psychoanalysis as a method. Freud himself considered psychoanalysis as a technique applicable to a limited number of patients in whom the objective was extensive reconstruction of personality. By rendering repressed impulses conscious through the resolution of resistances, by working through the infantile neurosis in the more readily resolvable transference neurosis, he attempted to release the arrested personality growth. Rapid symptom relief was sacrificed in favor of future, more widespread change. The goals in psychoanalysis are thus more extensive than those in behavior therapy, even though its application is limited to a selected group of patients who are properly motivated and who possess sufficient ego strength to endure the rigors of depth therapy. It is recognized that release of repressed material may for a considerable period aggravate a patient's symptoms instead of relieving them. It is acknowledged, too, that greater self-awareness does not guarantee that change will take place; it merely motivates the individual to approach life from a different perspective, a contingency that may or may not bear fruit. Behavior therapists are themselves now among the forefront of clinicians prepared to accept and make constructive use of their failures. In this respect the emergence of a searching volume entitled *Failure in Behavior Therapy* (Foa & Emmelkemp, 1983) is a signal event.

To attack a theory simply because therapeutic results are not always positive constitutes an error in logic. For example we have some established theories of kidney functioning and pathology, and we try to design therapies in line with these theories. The reality that we are unable to cure some types of kidney disease, or even to halt its steady retrogression, means that our methods are still too unrefined, not that our theories are necessarily wrong. In many fields we know much more about what creates derangements than what to do about them. This is the case in the relatively new field of psychoanalysis. Early behavior therapists, with the insecurity and messianic fervor that tends to accompany most new movements of significance, focused upon the "evils" of psychoanalysis rather than the "good" of behavior therapy. Those forward-looking

behavior therapists acknowledge the futility and dangers of such a position. They recognize that true science is open-minded and that techniques and modes of thinking that are acceptable strategies for either practice or valid research in one paradigm may not be viable in the other. To the extent that this is recognized both psychodynamics and behavioral approaches are continuing and acquiring adult perspectives. By the same token, psychoanalysts increasingly recognize that all known methods of extinction may not budge some habits and that this does not disprove conditioning as a basic process in learning. It merely points up that we still do not possess sufficiently refined procedures of extinction and new response replacement.

The minimization of insight as an important force in behavior change constitutes a vital shortcoming of most behavior theories. By insight we mean an awareness of forces within the self and of motives and values that sponsor maladjustment. This is not to be confused with hypothetical, often mythological formulations that upheld a therapist's biased doctrines and credendas. Unfortunately, a good deal of folklore is extant in the psychological field, particularly as it applies to personality theory and psychotherapeutic process. Such "insight," fashioned by mimicry, has little other than a placebo effect and, as such, serves a limited purpose. But the human person as a thinking animal operates on the basis of capacity for insight and understanding. A recognition of the irrationality of impulses, a realization of their purpose and origins, and apprehension of one's reality situation structure a person's field and foster the extinguishing of old destructive patterns and the reinforcement of new adaptive ones. It is hardly conceivable that any type of complex problem solving can take place in our entangled social environment without the mediation of insight.

Another point of controversy concerns the statistical reporting through which behavior therapists attempt to verify their claim as the most effective professionals in the psychotherapeutic field. Statistical results reported by any school of psychotherapy must be looked upon with skepticism. The evaluation of results of psychotherapy pose insuperable problems, including, among other things, definitions of change. For example, in the reports of some groups utilizing insight approaches, symptom relief, for some

reason, is not considered to be an acceptable sign of improvement. What is believed to be important is "character change," whatever this may mean in terms of orientation of the particular school. As a short-term method geared toward symptom relief, behavior therapy probably can effectuate palliation in larger groups of patients than can psychoanalysis. Whether it can surpass other forms of short-term therapy in speed, effectiveness, and permanence of improvement is a moot point. A pioneer pilot project of Group Health Insurance, Inc., in which a large group of patients treated by 1200 participating psychiatrists, most of whom were analytically and long-term oriented, limited to 15 sessions per patient, revealed that cure or improvement of 76 percent was reported by the psychiatrists (Avnet, 1965). A follow-up study after an average of 2 ½ years following termination revealed that 81 percent of patients reported sustained recovery or improvement. With a caseload this size, and with psychiatrists employing a host of varied procedures, the rate of improvement is impressive. The fact that a few skilled behavior therapists report a high percentage of improved patients may be ascribed to their skill and experience as well as to dedication to their method, rather than to the specific virtues of the method itself, effective as it appears to be. nondirective and client-centered therapists, transactional analysts, psychodramatists. "Gestalt therapists," directive counselors, casework practitioners, and therapists of a great many other schools report improvement rates of approximately 80 percent and, in some cases, as high as 95 percent. When we consider the diversity of methods employed, the similarity of results is puzzling. Apparently there is release in all psychotherapies of processes of a healing nature that are not described or that are subordinated to the specific procedures heralded as *the* effective therapeutic agencies. A properly controlled comparison series would, of course, help solve this question, but whether it is possible to arrange for such controls in psychotherapy, where the variables are so great that no two cases are even remotely alike, is doubtful.

Not all behavior therapists are convinced of the infallibility of their conditioning, counterconditioning, and extinction instruments. While there is general agreement that phobic patients are helped significantly, there is some question as to whether other kinds of problems respond better to behavior therapy than to other treatment methods. Franks

(1965), in summing up many reports, stated what a good number of experienced clinicians are now emphasizing, namely, that we do not yet know for whom or when behavior therapy had best be applied or whether or not it is shorter and the remission rate in its employment lower than that of conventional therapy. He commented on the *potential* advantages of behavior therapy in its being more goal-directed toward specific symptoms and more adaptable at all levels of intellectual and linguistic sophistication than psychoanalytic therapy. Selection of patients, therefore, need not be so discriminating. A study by E. J. Ends and C. W. Page (1957), who employed group therapy based on learning theory on alcoholics, concludes that this approach was not only not helpful but deleterious, in contrast with approaches that employed client-centered and psychoanalytically oriented approaches. What is lacking in all the statistical and research reports is a description of the quality of the agencies administering treatment, their education, experience, sophistication, bias, and, above all, their personality structures— their capacity to relate, to empathize, to understand, and to control and utilize countertransference to good advantage. These ingredients are probably much more important to results in psychotherapy than are the theories or some of the methods that are being practiced.

Actually, there is little to be gained from the polemic that is taking place between the groups deifying insight and those worshiping behavior therapy. Psychoanalytically oriented therapists, while deriding behavioral approaches as superficial, are constantly though unwittingly utilizing learning principles, including extinction and counterconditioning. Deliberate avoidance of behavioral techniques in patients who cannot benefit from insight approaches alone constitutes an unfortunate defection. On the other hand, not all of the forces operating in any interpersonal relationship, including psychotherapy, are immediately identifiable and manipulatable. The refusal to acknowledge that a patient may unrealistically project negative attitudes that have nothing to do with the immediate situation but owe their force to generalizations toward authority, the original stimulus of which dates back in the patient's life history, will handicap the behavior therapist greatly. Similarly, refusal to believe that reinforcements that sustain symptoms are internally inspired by such disguised rewards as sexualization

and masochism will confound the therapist, since he or she will have done everything obvious to foster an extinction that simply does not come to pass. Cognizance of such forces may not always improve the results obtained with behavior therapy, but they enable us better to explain the phenomena taking place within the conditioning situation. The willingness of behavior therapists to abandon their defensiveness, to share the throne of empiricism with other therapists whom they consider unscientifically steeped in the mystique of their arts, and to amalgamate their findings with those of schools different than their own could lead to an enrichment of psychotherapy as a whole. Out of this unity may come the wedding of the insight and behavior therapies, dynamic explorations helping the individual to structure and refine his or her learning field, and conditioning techniques expediting the unlearning of neurotic and the incorporation of healthy patterns.

A dynamic orientation to behavioral and other problem-solving approaches is taken not for the purpose of expanding the goals of treatment beyond symptom cure or problem solving but for dealing with some of the most powerful resistances that impede progress. These have to do with unconscious needs to perpetuate a childish dependent adaptation, to assuage guilt through masochistic self-punishment, and to project onto the therapist needs and attitudes originating in early relationships with important parental and sibling figures (transference). These drives can distract the patient from aims congenial with the objectives of treatment and make a shambles out of the most dedicated and skilled efforts of the therapist.

In part, behavioral therapists have come to recognize the importance of cognitive factors that operate as resistance and in some cases have adopted recent approaches used in cognitive behavior therapy. What is still lacking is recognition of the importance of unconscious conflict as one of the significant determinants of behavior. Of course, a dynamic orientation is not always necessary, since considerable numbers of patients do not resist behavioral and other symptom-oriented approaches. For those who do not respond, however, the understanding of unconscious motivational deterrents, as well as application of this understanding toward their resolution, can mean the difference

between success and failure.

COGNITIVE LEARNING

Cognitive learning approaches are designed to deal as rapidly as possible with symptoms and adjustment problems without probing for causes or attempting diagnosis. This is done by assigning to the patient (who is called a "student" since the medical model is assiduously avoided) a series of problem-solving activities calculated to alter customary attitudinal and behavior patterns. The student and therapist (who is called the "teacher" or "instructor") jointly agree on goals that have a reasonable chance for alteration, and the format (individual, couples, or group) is specifically organized to deal with the problem areas in a set number of sessions. Students are encouraged to utilize all existing constructive forces in their environment and in themselves and to accept greater responsibility for their past actions and present learning enterprise. As in behavior therapy, the student's difficulties are conceived of as problems in learning. The value of other behavioral approaches is acknowledged and their methods even utilized, such as operant learning and the proper timing of reinforcements, imitative learning, and the observation of models (e.g., programmed instruction, tape recordings, videotapes, television presentations, movies, books, and actual live plays and demonstrations), and emotional learning (e.g., systematic desensitization). Concentration, however, is on information giving, verbal instructions, role playing, and the proper timing of cues.

An example of how cognitive learning operates is provided by an Adult Development Program of the Department of Psychiatry and Behavioral School of Medicine, University of Washington, which was established in 1970 by Cornelis B. Bakker and Hubert E. Armstrong, Jr. Students in the program are accepted who have a desire to make changes in themselves and their situation, are willing and able to assume responsibility for their behavior, and are ready to approach new ways of dealing with their problems. As many courses as are desired may be chosen from a few hours a day to an entire day. 5 days a week. Some courses are arranged in "pathway" groups of six units of four sessions (3-hour evening sessions, once weekly for 4 weeks). Couples sign up for one unit at a time, which

while taken in sequence can be completed in 6 months. The Marital Enhancement Pathway, for instance, enables couples to set goals and master skills to achieve these goals in a graded series. The classes are as follows:

1. *Human territoriality* (learning to bargain to resolve conflicts).

2. *Assertiveness training* (learning to substitute more constructive modes of communication for nonproductive interchanges).

3. *Precision behavior change* (learning to bring mutually agreed upon changes in oneself and one's partner).

4. *Marital myths* (recognizing and learning to overcome false ideas about oneself and the marital relationship that block change).

5. *Fixed role* (practicing through role playing, alteration of behavioral patterns to overcome defects in the marital relationship).

6. *Sensuality and sexuality* (enhancing pleasure in sexual relations in marriage).

Small groups are available for specific goals.

Thus an Assertiveness Laboratory of two 2-hour sessions each week for 3 weeks teaches people to role play to learn to accept responsibility for permitting others to take advantage of them, to learn to say "no," and to recognize and "do what one wishes" rather than "what one should do." A Couples Communication course of 2 hours once weekly for 8 weeks teaches how to negotiate disagreements "without making each other feel miserable." Here each couple is encouraged to practice fighting about an unresolved issue while other couples referee. Each member has a "second," a classmate who helps define gripes, feelings, and demands. An Effective Communication course of two 75-minute classes each week for 4 weeks focuses on learning through structured exercises, such as how to say things in different ways to avoid hurting others, how to exchange compliments, and how to ask for and receive positive comments. A Fixed Role course of two 2-hour sessions each week teaches how in changing one's behavior other people's behavior changes and how to overcome resistance to change. This is done through following a detailed script written jointly with the instructor that permits practice through role

playing of a new way of dressing, talking, and behaving. A Human Relations Laboratory of three sessions a month for 2 hours each presents two models: one following the scheme of transactional analysis., i.e., parental injunctions and childish demands operating simultaneously within oneself, mediated by one's inner adult self in relation to specific situations; the other, patterned after Ellis's *A Guide to Rational Living,* explores how interpretations of events rather than the events themselves are the keynote to one's irrationalities. A Human Sexuality Seminar of one 2-hour session for one month teaches how to break down myths about sexuality and to replace them with information to enhance sexual functioning. No attempt is made to deal directly with actual sexual dysfunctions. The Human Territoriality Seminar teaches bargaining skills to avoid being exploited, to gain and defend legitimate demands by standing up for one's own rights, to resolve conflicts, and to increase self-confidence and enjoyment in dealing with people.

Another example has been provided by B. L. Greene (1975), who, working with a more or less homogeneous group of "hard science" professionals at the Midland Community Mental Health Center, who were resistive to traditional psychoanalytic and conditioning cognitive approaches, related to the proposition that behavior is determined by thinking patterns that may be analyzed and modified. Explored within the therapy session and assigned as homework were goals, attitudes, expectancies, and beliefs with the object of both modifying handicapping perspectives and thought processes and the adoption of constructive alternatives. A wide variety of therapeutic techniques were then exploited to facilitate the achievement of this object. The method is not designed to change basic characterologic defects, which usually will require long-term dynamically oriented interventions. It is a short-term course geared toward enabling a better reality adaptation.

Criticisms of Cognitive Learning

Cognitive learning bases its techniques on the premise that people are capable of changing their behavior by altering the immediate environmental circumstances in which they function. It is claimed that many forms of psychiatric intervention rather than fostering change tend to stabilize undesirable personality patterns. By labeling a person

with a diagnosis, we tend to increase the probability that that individual will respond in a way consistent with the diagnosis. Psychological testing, while its validity and reliability are notoriously low (Little & Shneidman 1959; Chapman & Chapman, 1967), stamps the individual with a pathological blemish. By concentrating the attack on the inner psychic structure to the neglect of situational alteration, psychotherapists are said to become counterproductive. The results of attacking the environment instead of the intrapsychic structure, of avoiding diagnosis and psychological testing, and of focusing on methods that directly influence behavior, it is furthermore avowed, tend to shatter the myth of unchangeability of human nature.

In view of the savings of time and costs, cognitive learning offers the motivated patient who is able and willing to learn an opportunity for substantive benefits. In a community mental health program its short-term nature will greatly reduce the patient load. In private practice it may well serve as a way of initiating therapy in many patients in combination if necessary with behavioral and other educational approaches. In some cases, as a result of tension relief, restoration of mastery, and a more wholesome adjustment, patients may show in addition to symptom relief and enhanced adaptation considerable personality growth. Like any other therapy, however, it is not universally applicable. Blocks to learning fostered by inner conflicts, self-destructive masochistic impulses, lack of motivation, a need for failure, irremediable environmental stress circumstances, intellectual inhibitions, and attention failures may obstruct progress. Here other long-term psychotherapeutic approaches are better applied, although their success obviously is not guaranteed. It goes without saying that a well-designed program geared toward specifically oriented learning and executed by a well-trained, dedicated, and empathic professional is mandatory for progress.

The experience with many cognitive learning programs has been most encouraging, pointing to the inherent flexibility within people that enables them to learn from short-term educational techniques.

There is obviously nothing new about the cognitive educational model. It was

popularly utilized in the mid-nineteenth century. It fell into discard with the rise of the psychoanalytic model in the first half of the twentieth century. Its revival is predicated on better information that we now have that we can communicate to clients, much of which comes from dynamic psychology, and on work in experimental psychology laboratories. Persons suffering from severe mental problems or from extraordinary stress situations may not be able to take advantage of the learning techniques offered and may require additional specialized psychotherapeutic and psychiatric help. Success is also dependent on the acceptance of the role that the teacher plays in providing information and guiding the learning process. A psychotherapist who wishes to exploit the value of educational techniques may well benefit from taking a course in executing techniques, such as helping the student to define attainable goals, establishing successful criteria for change, designing courses of study, acquiring essential information for acquisition of skills and changed attitudes, selecting the proper format of studies, and ensuring that motivation in the student continues. An advantage is that staff can be recruited from a wide variety of disciplines, thus reducing time and cost.

THERAPEUTIC COUNSELING (PSYCHOLOGICAL THERAPY)

In Chapter 6 the rationale and the principles of counseling were described and reference was made to the fact that some forms of counseling were reeducative in nature. In recent years formal training in reeducative counseling techniques has been extended to individuals such as ministers, rehabilitation workers, police officers, and paraprofessionals who in their work come into contact with persons with problems. The focus for which help is sought often involves specialized information. The focus also labels the kind of counseling rendered. Among the more common forms are vocational counseling, premarital counseling, marriage counseling, genetic counseling, spiritual counseling, and educational counseling. In actual practice, irrespective of the specific focus, common principles obtain in relation to such important areas as setting up a client-counselor relationship and managing it toward productive objectives. Some of the older readings in the field are still valuable, including those of Williamson and Darley (1937); Williamson (1939); Rogers (1943); S. E. Goldstein (1945); Garrett (1945); New York State

Counselors Association (1945); and Snyder (1947a&b). More recent literature is contained in the section on counseling in Chapter 6 and in the Selected Texts section (page 1397). Audiovisual aids are also described in the designated sections.

Some forms of psychological therapy downgrade technical and intellectual methods, contending that they are non-meaningful in the treatment process. What is considered important is to bring up and express feelings. It is believed that only through emotional arousal can one's potentials be actualized. The traditional therapeutic authority-patient alliance is rejected as a proper basis for personality change. Instead of manipulativeness on the one hand and anonymity or detached noninterference on the other, the climate of the therapeutic relationship is one of empathic warmth, friendliness, and expressed regard for the patient. Neither knowledge of the developmental past nor promulgation of present insights is considered important. The emotional encounter between client and therapist is the basis for significant movement. Defenses against proper relating are dealt with by confrontation and the assignment of tasks. Experiencing the encounter as a different mode of relating eventually is said to lead to self-actualization. Among the different types of treatment that operate on this philosophy are client-centered therapy, psychodrama, Gestalt therapy, experimental groups, EST, and existential therapy.

Client-centered Therapy

The client-centered methods of Carl Rogers (1942, 1944, 1946, 1951, 1959, 1961a&b, 1980, 1983) have long been a favorite with psychologists, although in recent years the impact of psychoanalytic concepts and behavior therapy have made inroads into their popularity. Nevertheless, they are still employed, and aspects of them are utilized in group work, play therapy, community development, and educational, religious, marital and industrial counseling (Snyder WU, 1943, 1947b; Hart & Tomlinson, 1970; Meador, 1975; Rogers CR, 1973).

Essentially, the philosophy around which client-centered approaches are oriented is a humanistic one, embracing the idea that a human being is possessed of innate goodness, actualizing tendencies, and capacities for evaluative judgments leading to "balanced,

realistic, self-enhancing, other-enhancing behavior." A human being becomes ineffective, hateful and self-centered, and then incapable of making proper judgments and responses as the result of faulty learning. This leads to incongruence between what is being experienced and the concept of self. Through the medium of special kinds of relationships, it is possible for the individual to rectify improper learning and to acquire new and productive patterns. Release of the self-actualizing potential will lead a client to emotional growth. It is essential, however, for the therapist or facilitator to be genuine or real (congruent) in the relationship and to possess a caring or an acceptant attitude in order to experience empathically a sensitive understanding of the client. The client, in turn, must perceive these qualities in the therapist (Rogers CR, 1975).

Over the years the theories and methods of client-centered therapy have undergone some revision as a result of experience and research (Rogers & Sanford, 1985), but on the whole the original formulations are still the basic underpinnings of the method. Rogers, drawing to an extent from Rankian methods, based his personality theories on research findings and on his own observations in psychotherapy. These contend that subjectively observable responses of individuals are potentially available to their awareness and constitute the body of their "experience." There are, first, non-symbolic correlates of experience of an organismic nature that exist in the form of sensory, visceral, and emotional or "feeling" responses, through which the raw data of the environment can potentially become available to the individual's awareness. Second, there are symbolic correlates, composed of attending responses accompanied by "free and undistorted awareness" of external and internal events, clearly perceived and faithfully symbolized. The innate human capacity to symbolize permits the individual to register events accurately unless faulty learning has produced distortions. The driving force of life is innately governed by an "actualizing tendency" around which all other motivations revolve (such as tension reduction, the drive for autonomy, etc.). All behavior is holistically organized around this innate tendency and is patterned by the capacity to differentiate between effective (pleasure-producing) and ineffective (pain-producing) responses, a capacity that Rogers terms the "organismic valuing process." If responses are positively evaluated as effective and actualizing, they continue or recur; if they are

negatively evaluated as ineffective or nonactualizing, they are avoided or terminated.

Some of Rogers's early concepts draw from the theories of Rank, Goldstein, Sullivan, Maslow, Angyal, and Lecky. They embrace ideas from existentialism, Gestalt therapy, Eastern philosophies, information theory processing, and group dynamics. They reflect a phenomenological viewpoint, contending that each individual has a "phenomenal field" that determines behavior, and that shifts from time to time according to needs. Aspects of the phenomenal field that one recognizes as part of oneself, such as perceptions about one's physical self and one's relationships with the world, make up one's "self-concept." Significant experiences may exist that the individual does not admit to awareness and that are therefore not a part of his or her self-concept. Thus, certain needs, such as organic experiences and drives, may not be symbolized, rather being "disowned," since they are not consistent with the self-concept. As such, they can create tensions. Values that may become incorporated in the self-concept are those derived from personal experiences and those absorbed from other individuals ("learned evaluative thoughts"). A clash may result between these two sets of values ("incongruence between self and experience"). The fundamental urge in all persons is to preserve their phenomenal selves; impulses and experiences that do not coordinate with the self-concept are perceived as a threat. The individual responds to the "basic estrangement" that results with contradictory behavior and rigidity in the self-structure. If the self-structure cannot meet the demands of the reality situation, if there is a great disparity between ambitions and accomplishments, if responses elicit both positive and negative self-evaluative thoughts, the individual will experience tension and anxiety. He or she will then react with two types of defensive mechanisms to avoid awareness of the contradictory responses: first, by ignoring important responses ("denial to awareness") and, second, by distorting thinking about the responses ("distortion in awareness"). Where defenses that sponsor neurotic symptoms fail the individual, he or she may "break down" and manifest grossly disordered behavior such as psychosis.

The object in treating neurotic victims of faulty learning is to provide them with an atmosphere that does not threaten their self-structure but that enables them to examine,

recognize, and reorganize it, thus permitting an integration of their organism and their self and acceptance of experiences previously excluded as alien. The phenomenal fields of both therapist and client are usually sufficiently related to allow intelligible communication and meaningful interchange of feeling. During therapy the client, obsessed with self-criticism and self-devaluing because of failure to live up to the idealized image, soon becomes aware of contradictory attitudes. In the accepting and approving atmosphere of a therapy that is totally devoid of threat and imbued with empathy, the client becomes more tolerant of oneself and one's failings. Tension abates and a reintegration develops as discordance resolves between the ideal image and the actual self-perception.

Constructive personality change is thus contingent on a number of stipulations. *First,* it is essential that the client be motivated to seek help. This is generally in the form of some anxiety produced by an awareness of a state of "incongruence," in that a disparity exists between the client's self-picture and actual experiences. *Second,* a special kind of human contact is required. In a client-therapist relationship, it demands (1) that the therapist be both empathic of the client's awareness of his or her own experiences and able to communicate what is going on in the client's inner world on the basis of this empathy, (2) that the therapist has ample self-awareness, is honest about personal feelings, and is capable of "being oneself" in the relationship in order to function congruently, and (3) that the therapist possesses a positive regard for the client, accepting fully every aspect of the client's experience and right to be and feel as he or she is. This does not mean that the therapist must be completely free of deviant response patterns as long as they do not force him or her to be authoritative and evaluating. *Third,* it is important that the client perceive, by the therapist's behavior and verbalizations, that he or she is fully accepted, understood, respected, and "cared about," irrespective of experiences, problems, and feelings.

Entering into a relationship situation with a client-centered therapist provides the client with a unique encounter in which he or she is neither challenged nor condemned, every aspect of the client is respected and accepted, and the client can yield defenses

without hurt. Out of this adventure, a new conceptualization of the self evolves, with greater capacities to symbolize more accurately sensory and visceral experiences and with reconstitution of one's system to values in concert with the perceived self.

The guiding principle of client-centered therapy is oriented around the fact that the client or patient is the one responsible for his or her own destiny: the client possesses the right of choice of solution for his or her problems, irrespective of the choice of the therapist. Residual in each individual, it is contended, are resources for growth that need merely be released to enable the person to achieve maturity. The therapist strives to unleash growth forces by refraining from imposing patterns and values on the client and by promoting in the relationship the free expression of feeling.

Among the activities of the client-centered therapist are (1) attentive listening to the client's communications for content and feeling, (2) responding by a friendly non-punitive, empathic attitude and by occasional verbal comments that neither approve nor disapprove, (3) pointing out the client's feelings, (4) structuring the extensions and limitations of the therapeutic relationship, (5) encouraging the client in his or her efforts to manage problems, (6) engaging in answering questions and giving information only when it is essential to do so to help a client work through problems, yet avoiding this directive role at the slightest threat of emerging dependency, and (7) refraining from insight offerings, advice giving, environmental manipulation, censure, commendation, or the posing of questions and suggestions regarding areas of exploration. The client is given complete responsibility for the choice of topic, the extent of concern with it, and the interpretation of the meanings of reactions. The therapist's responses are chiefly in relation to the evaluative ideas that the client verbalizes about himself and other people, and the feelings associated with such ideas. The role of the therapist is solely to direct the client's attention to his or her ideas and not to interpret or clarify.

The feelings of the individual are always accepted in a tolerant, nonjudgmental way and are reflected back to the person in order to bring to the client's consciousness the full pattern of his or her emotional attitudes. At times the rephrasing of the client's utterances

helps the client to clarify facts. The catharsis involved in the process, as well as the therapist's activity in reflecting feeling, are believed to lead to genuine self-understanding and insight in the individual's own terms. The release of normal growth potentials helps the client to gain control over discordant forces in the self. The role of the therapist, thus, is to act as a catalyst of growth, a ("change agent") not to impose growth on the client.

Treatment, as can be seen, is oriented around the idea that the individual has the capacity to deal effectively with those aspects of his or her personality of which he or she becomes conscious during the relationship with the therapist. It is assumed that the client can achieve insight in the relationship and can accept and make constructive use of responsibility. Because efforts to interpret, evaluate, or guide the individual are felt to hamper the emerging sense of self-direction and self-growth, a passive role on the part of the therapist is mandatory. Rogers insists that a nondirective approach is not to be confused with a laissez-faire policy, which the patient is apt to regard as evidence of rejection or indifference. A truly nondirective attitude avoids clarification of the individual's attitudes, since this is a form of subtle directiveness. The function of the therapist is to perceive empathically the *feelings* of the client and to communicate this understanding. It is essential for the therapist to discard a preoccupation with diagnosis, to stop making professional evaluations, to eliminate estimates of accurate prognosis, to abandon all attempts to guide the individual, and to concentrate solely on accepting and understanding the attitudes of which the client permits himself or herself to become conscious.

During therapy there is a gradual shift in the content of the material discussed— from symptoms to explorations involving the self. Changes develop in the perception of and attitude toward the self, with more positive appraisals and a more realistic consideration of oneself and one's environment. Judgments are recognized as originating in values residing within, rather than outside, the self. Perceptions shift from wide generalizations to more limited ones rooted in primary experiences. Symbolizations become increasingly adequate and differentiated. Movement is registered in awareness of denied or repressed experiences and feelings. Changes occur in personality structure and

organization toward expanded unification and integration. Anxiety abates; neurotic tendencies decrease with greater acceptance of the self. There is heightened objectivity in the handling of reality, a more constructive mediation of stress, a harmonious expression of attitudes and feelings, and better intellectual functioning. Developing changes in behavior are in line with improved adjustment and maturity. Decreased tension, lessening of defensive tendencies, and greater tolerance of frustration are concomitant.

As has been indicated, diagnosis in client-centered therapy is not felt to be essential to the treatment process. Indeed it is conceived of as a hindrance. Making a diagnosis is also felt to involve the dangers of subordinating the individual to an evaluation by authority, putting the therapist in a godlike role. This opposes an atmosphere of equality. Psychometric tests similarly are not encouraged, for the therapist's attitudes toward the client may be colored by the test findings and the client is ill equipped to handle most of the information revealed by testing. The medical model, with its focus on pathology, diagnosis, and specificity of cure as a basis of understanding or working with emotional problems, is considered inaccurate. Not only is it likely to enhance dependency but it avoids the basis of the prevailing difficulty.

Rogers revised upward his original idea of client-centered therapy as being most useful in essentially normal people who have sufficient personality integrity to solve their problems with a minimum of help from the therapist. His contention is that his method is universally applicable from childhood to old age, from mild adjustment difficulties to severe psychoses, from "normal" to deeply neurotic situations, from immature dependent people to those with strong ego development, from lower-class to upper-class citizens, from lowly to highly intelligent persons, from physically healthy souls to those with psychosomatic ailments.

It is claimed that transference does not develop too intensely in client-centered therapy since the individual is not evaluated nor held subject to specific rules. Self-esteem consequently is prevented from crumbling, thereby avoiding a dependent relationship. Where transference erupts, it is more or less disregarded; it is simply accepted, not

explored or interpreted. In a climate of empathic understanding transference attitudes are said to disappear or to express themselves so minimally that they do not interfere with progress.

Past experiences and future projections are subordinated to the reality of the present, even though it is acknowledged that they might not be symbolized and thus operate to provoke tension. Conscious material is felt to be sufficient, and probings into unconscious motivation are not considered of too great importance.

In practice it has been found by many present-day client-centered counselors that a purely *nondirective* method does not suffice. Reflecting back to the client his or her words often failed to release the spontaneous growth forces postulated in the original client-centered approach. To be successful, therapeutic interventions needed to be conducted in a participant climate, provided by the operator, of accurate empathy, unconditional positive regard, and congruence. This constituted a base for "experiential therapy." Empathy requires that the therapist perceive expressed and unexpressed feelings of the patient, experiencing them as if they were his or her own. Unconditional positive regard necessitates respecting and valuing the patient's self-components. Congruence means manifesting authenticity and sincerity of feelings for the patient, whatever these may be, avoiding phony facades and revealing true responses rather than playing games.

The popularity of the client-centered approach is contingent on the fact that its theories are uncomplicated and relatively easy to understand; its techniques are simple to master, requiring little clinical experience for satisfactory results and involving few dangers to the patient, who actually works out his or her own problems.

Criticisms of Client-centered Therapy

Client-centered psychotherapy is tailor-made for persons who need and respond to a kind, caring, nonjudgmental atmosphere and who are ready for and possess a strong motivation for change. It is helpful to individuals with a relatively sound personality structure who require aid in clarifying their ideas about a current life difficulty or

situational impasse and who may be responsive to a "helping process." It is less helpful in the treatment of emotional problems that contain strong anxiety elements. Anxiety is the greatest motivator of all human behavior; it impedes and even blocks the emergence of positive growth potentials no matter how tolerant and permissive the therapist may be. Anxiety nurtures resistance that can effectively prevent thinking about, or spontaneously focusing on, significant conflictual patterns. Left to one's own devices, the individual will usually avoid coming to grips with deep anxieties. He or she will even choose to retain neurotic defenses, warding off inherent impulses for growth. It is doubtful that anxieties rooted in unconscious conflict can be dealt with effectively by approaches that deal exclusively with conscious ideation. It is essential, then, that a therapist enter actively, at times, into a neurotic cycle. Resistances may have to be dealt with in a blunt and even forceful way. Similarly, even though the person may acquire self-understanding, anxiety may prevent his or her utilizing insight in the direction of change. Here, directive measures of challenge and confrontation may be required before inertia yields. Thus choice or rejection of a traditional client-centered therapy will depend on whether or not the individual is deeply disturbed emotionally, has existing ego strength, and the nature of the problem for which he or she seeks help.

For some patients, a completely accepting atmosphere will do little to interrupt repetitive, destructive defensive operations. Without arguing the advantages of a humanistic over a medical model, traits of genuineness and empathy, such as described by Rogers, are of distinct advantage in any kind of therapy and are indispensable aspects of a therapeutic personality. Such traits and the conduct of therapy along caring, nonjudgmental lines may reduce the severity of introjected authority imprints and help soften a harsh image of the self. They will not suffice, however, in dealing with pathology residual in unconscious variables that are provoking problems in adaptation. Dealing with such variables will require interventions other than or supplemental to the recommended client-centered techniques.

The field of client-centered therapy has, nevertheless, made an important contribution to psychotherapy by pointing out basic elements in the "helping process," by

emphasizing some essential principles in interviewing, by encouraging research into process and outcome (Seeman & Raskin, 1953, Cartwright, 1957; Shlien & Zimring, 1970), by stimulating a vast amount of professional literature, and by elucidating the management of certain phases of treatment, especially termination.

Directive Approaches

Directive approaches put the therapist in an active role in determining which of the basic problems of the patient to attack, the immediate and remote objectives, and the promotion of a plan of action. Persuasive and commanding tactics are often employed, the therapist exerting strong pressures on the patient, even purposefully mobilizing tension or reducing it with supportive techniques if tension becomes unbearable. Goals are thus more or less vested in the therapist, who makes an effort to dissect, tear down, rebuild, and resynthesize the personality.

A number of techniques aimed at these goals were originally delineated by F. C. Thorne, (1944, 1945, 1946, 1950) under the title *directive psychotherapy.* For instance a patient might be given information with the object of reorienting his *Weltanschauung.* This was done by confronting the patient with factual information about himself in an effort to get the patient to reevaluate his or her attitudes. The case history was used by Thorne both as a diagnostic and as a therapeutic aid, helping in establishing rapport, promoting catharsis, giving reassurance, and fostering insight. A more active technique was the therapeutic use of conflict. Where certain maladjustments were sponsored by too little concern, conflicts might deliberately be induced. Thus, the patient was provoked to reconsider attitudes in the direction of reality. The patient was then presented with his or her inconsistent behavior in a strong confrontational way in an effort to motivate him or her to resolve it. The extent of directiveness was gauged in each patient and varied from forceful coerciveness to a relatively participating relationship. Thorne, however, recognized that the term "directive psychotherapy" was too limited and nondescriptive of his method, which was of an eclectic nature, and he advocated a comprehensive integrative approach.

Concern with the past, issues of transference, and other dynamic principles are not considered vital or necessary for behavior change in directive approaches. Principles of cognitive behavior therapy are apparently operative in certain forms of directive treatment and may be important in some individuals who are seeking a strong authority who can influence and regulate their lives.

Rational emotive psychotherapy is the name given by A. Ellis (1957, 1958b, 1965, 1973) to cognitive therapy procedures that combine formulations from semantic, persuasive, directive, and behavior therapies. Treatment tactics are organized around the hypothesis that aberrant emotions are controlled by faulty thinking processes, such as illogical "self-talk and internalized sentences." A search is consequently instituted for irrationalities in the patient's ideational stream that result in negative, unrealistic, and self-defeating behavior. Generally, this exploration will reveal the origin of illogical ideas in the attitudes of parents, teachers, peers, and, above all, the credos supported by the culture. The effective therapist must bring the patient's self-defeating verbalizations to his or her attention, show how they cause and maintain disturbance, reveal the irrational links in the internalized sentences, and teach the patient how to rethink and reverbalize these in a "more logical, self-helping way." For example, a commonly accepted misconception is that the individual must depend on, be loved by, and approved of at all times by others. In the patient's upbringing he or she is taught that to be self-sufficient is to be selfish. To reverse the behavior that this distortion produces, one must substitute the idea that universal approval is impossible and that dependency is self-annihilating. Self-sufficiency is by far a much more wholesome way of life, and it is in this direction that the individual must move. There are countless other illogical ideas to which the person falsely subscribes that operate to cause and to sustain neurosis. Release from these ideas can be brought about only by rethinking and reconceptualization. Toward this end, the therapist may employ many relationship-building and expressive-emotive techniques—analytic, persuasive, and behavioral—as long as the patient's self-defeating propaganda is ultimately defeated and a new rational philosophy of living substituted.

A number of other cognitive rational reeducative approaches, such as the

"assumption-centered" psychotherapy of Anderson and the "problem-centered" method of Wertz, have been proposed. In each, the patient is confronted with his or her ideas and behavior that are maladaptive and is offered corrective solutions.

According to Frank (1984) one of the basic features shared by all forms of psychotherapy is that when they are effective they correct the demoralization produced by symptoms. Patients seek help only after their morale has been shattered by symptoms. Such patients are often victimized by an "assumptive world" with distorted ideas about themselves, their future, and the world around them, which leads to symptomatic distress. By altering the meaning or expounding on the function of a symptom through psychotherapy, the "assumptive world" can sometimes be altered or rectified. Corrections in the "assumptive world" can result in changes in thinking and behavior which reinforce the gains produced by any form of psychotherapy. In *programmed psychotherapy* (Young H, 1974) the patient is given a series of significant problems and appropriate solutions to illuminate and revise assumptions. These problems are related to events in the patient's past history and are also taken from the histories of patients with similar problems. Psychotherapy as a form of instruction aimed at reorganization of "assumptive worlds" is considered in the section on cognitive learning, which is focused more on external than internal variables. Concerned with the latter (i.e., with identification of inner forces that create assumptive distortions and impede problem-solving techniques) are approaches such as those described by Brunner (1966) and M. T. McGuire (1968).

Combining the ideas and methods of psychoanalysis, individual psychology, rational emotive therapy, and behavior modification within an existential framework, Harold Greenwald (1974, 1980) has described a useful treatment in individual, group, and family therapy that he calls *Direct Decision Therapy* and that he dates back to 1970. The patient is asked to state as clearly as possible the nature of his or her problems and the goals he or she wishes to achieve. The patient and therapist jointly examine past decisions that created the problems that prevented the patient from reaching the goals. The therapist helps the patient become aware of these faulty decisions as they are expressed in the patient's activities, attitudes, and philosophy of life. The gains ("payoffs") for the decisions

are examined. The original basis for the decisions is explored and is contrasted with its utility in the here and now. Next the patient is invited to examine options or alternatives that could enable him or her to function in a different, more constructive way. Once the patient has made a decision to change, methods are discussed regarding how to do this. Often the patient describes the method that he or she would like to try—Gestalt, hypnosis, rational emotive therapy, behavior therapy, and so on. The therapist obviously participates in making and implementing this choice.

Reality therapy is another directive method organized around the central theme of "identity as a core problem" (Glasser, 1965; Glasser & Zunin, 1972). In therapy the patient is guided away from methods by which he or she avoids reality and is motivated toward success. The first principle is "involvement" by the therapist with the patient to demonstrate "that he cares, that he is warm and friendly … willing, if indicated and appropriate, to discuss his own experiences and to have his values challenged and discussed." The therapist reassures the patient of confidence in him or her and communicates the belief that the patient can become happier and can function in a more responsible, effective, and self-fulfilling manner. Treatment is organized around the relationship with the therapist rather than the content of verbal exchange. The second principle of reality therapy is the focusing "on behavior rather than feelings." Doing is more important than feeling, and the therapist orients the conversation around the patient's daily actions. The third principle is concentration on the present and future rather than the past. If past critical events are mentioned, the patient is asked what was learned from them. Past character-building experiences are reviewed in relation to present success-oriented strivings. Constructive alternatives are explored. The fourth principle is helping the patient arrive at a value judgment about what he or she is doing to contribute to his or her own failure. The fifth principle is evolving a realistic life plan (perhaps put in writing in the form of a contract between patient and therapist) and assuming responsibility for seeing it through. The sixth principle is making it clear to the patient that no excuses for failure to execute the plan are acceptable. If failure occurs, a new plan is jointly made or the old one modified. The seventh principle is avoiding punishment, sarcasm, ridicule, or hostile statements; transference, when it occurs, is

immediately dealt with and dissipated rather than encouraged.

Some therapists have used a form of treatment called *Releasing* to counter a potent source of stress that stems from the frustration that results when one urgently wants to change something that seems immediately difficult or impossible to change. The target of the desired change may be a current or anticipated irritating happening, a past event or memory, a physical need that cannot be fulfilled, indeed almost any stimulus, impulse, emotion, striving, or situation that is upsetting to the person. The consequence of this compelling urge or "wanting" is an overinvolvement with the target and an overpush to rectify it, resulting in further tension and anxiety. Awareness of what is going on, even insight into its dynamics, may not succeed in removing the existing distress. What is sometimes helpful is a cognitive shift that diverts the individual from engaging in self-defeating overpush maneuvers. Recognizing that some people inescapably become locked into cycles of stress, techniques such as the "Sedona Method" have been used in workshops to help people "let go" of their investment in "wanting" (overpushing) to change things, which results in their stirring up troubles rather than resolving them. In this way, one hopes, they are "released" from overinvolvement and achieve peace of mind and freedom from tension.

Releasing techniques have been elaborated by a number of writers and lecturers. Patricia Carrington (1984) has written a textbook on "releasing" and has developed audiotapes that provide step-by-step instructions on how to use this method to reduce stress and enhance the quality of one's experiences. Included in the book are clinical examples of how to use the technique. According to Carrington, the procedures of "releasing" are not designed to replace psychotherapy, which deals with different psychological dimensions. In some cases, however, "releasing" techniques can operate as an adjunct to psychotherapy, particularly during the difficult phase in which insight is translated into action to alter unproductive patterns. There are some similarities between the "releasing" method and cognitive behavior therapy, persuasion, and desensitization; all work toward the same goals in a somewhat different way.

The goal of "releasing" exercises is to "let go" of trying to change whatever it is one wants to change, such as the behavior of another person, unalterable events, or past happenings. Effort or force (overpush) are eschewed. "As we let go of wanting to change any one thing (however insignificant it may seem to us at the moment)," says Carrington, "we simultaneously let go of whole networks of related events which are stored in our memory banks." "Letting go" of "wanting to change something" does not make a person passive or take away the motivation to overcome a problem. This is an important point because some people assume that letting go of the "wanting to change something" means that they have to detach and abandon the *desire* for constructive change. The "wanting" in releasing methods refers to the compulsive overpushing that does nothing to solve a problem. "Releasing," on the contrary is said to clear the mind so that a person can make constructive choices.

What may confuse some persons is the language used in "releasing." The word *releasing* simply means "letting go or yielding compulsive thoughts and behavior and not dredging up buried emotions." Explosive outbursts of emotional catharsis may occur in the course of practice sessions, but this is serendipitous. A good deal of the success of "releasing" is based on the suggestibility of the subject and faith in the guide or teacher who is promoting a different way of thinking. As with any other technique, not all persons are susceptible to "releasing." It is designed to deal with the effects of conflict and with conditioned behavioral patterns and not with their sources. It does not propose to reconstruct personality but merely to redirect patterns of thinking. Understandably, it is not intended as a cure for serious emotional problems that call for more intensive treatment approaches. It may occasionally reduce stress in a subject who accepts its precepts and lacks a masochistic dedication to self-defeating behavior and who does not submit to other obdurate resistances to change.

Jay Haley (1963b) has described a type of directive therapy for the short-term management of patients, as well as for strategic interventions during long-term therapy, during which the therapist enters into an alliance with the patient's symptoms. Assuming that the dynamic function of symptoms is essentially power-motivated, Haley believes that

the operations of the therapist should be pointed toward wresting control from the patient. Once the symptoms are clearly delineated, the therapist instructs the patient to do what he or she would ordinarily do anyway, such as indulge in the symptoms and withhold information.

The object is to encourage the resistances of the patient, but at the same time to bring them under the control of the therapist. Then it is suggested that symptoms will appear, intensify, and lessen under certain circumstances. Finally, the patient is enjoined to execute the symptoms in such a way that he or she cannot possibly continued them or until he or she begs to give them up. For instance, compulsive symptoms may be encouraged by the therapist until the patient requests a change, whereupon "permission" is granted to relinquish them. An obese woman with a yen for rich desserts may be ordered to restrict herself to only this item of food, which she may incorporate to her heart's desire. When she has surfeited herself to the point where sweets repulse her, she may then be given permission to eliminate them from her diet. A compulsive patient who is punishing himself with a distressing symptom is asked to discipline himself whenever the symptom appears—in other words, to castigate himself for treating himself so badly with his symptom. Ways of self-punishment may be worked out that will benefit rather than hurt the patient. Thus, a man who is convinced he must exercise more for his health is instructed that whenever his symptoms are intense, he will get up in the middle of the night and do deep knee bends. The relationship of these tactics to counterconditioning is apparent.

Criticism of Directive Therapy

Criticism of directive psychotherapy is voiced, particularly by psychoanalysts and client-centered therapists, in terms of the imposition on the patient of the therapist's goals and sense of values and the reestablishment of the disciplinary atmosphere of the child-parent relationship. Under these circumstances, liberation from the yoke of one's authoritarian conscience may be impeded, leading to an interference with growth toward assertiveness and independence. A disadvantage claimed is that the patient is kept on a

dependency level longer than is necessary. Where the aim in therapy is to make the patient self-sufficient and capable of finding security within himself or herself, directiveness may inhibit this aim. In looking for security or support from the outside, the patient may be inhibited in developing an autonomous stand in life and in becoming a stronger being through his or her own resources. Another criticism of directive therapy is that hostility is often mobilized by the very nature of the magisterial relationship. This prevents the patient from becoming liberated from a punitive and severe conscience fostered by an irrational attitude toward authority. While the new ways of conduct that are developed may be better than those the patient has followed most of his or her life, they do not alter the intrapsychic structure. The patient virtually remains a child who has merely incorporated the mandates of the new parent-therapist. Critics of cognitive therapy attack the "guiding" influence of the therapist, whose own values and assumptions may not necessarily be pristine and accurate. In this way the therapist functions like a clergyman or educator whose philosophies or viewpoints are sometimes suspect.

Not all of these criticisms are justified. Actually, at certain points in all therapies a cognitive position is taken, as in psychoanalytic interpretations, in which bias is not too unusual. All good psychotherapists probably do a species of cognitive therapy after gaining an understanding of the existing fallacious ideas harbored by the patient.

The therapist's attitude and mode of dealing with a patient's rebelliousness at directive mandates will determine the direction of the behavioral change. Unless their dependency needs are too great, many patients will learn to cope with the directiveness of the therapist and to evolve new ego strengths out of their own spontaneous needs. If the therapist acknowledges the patient's right to criticize and shows respect for the patient's autonomy, the patient may be able to effect some change in concepts toward authority as universally obstinate and punitive. A value of directive therapy is in the techniques that have been evolved, which may be adapted to some aspects of a therapeutic program, particularly during the resistive phase of translating insight into action. Freud himself acknowledged that some patients require forceful mandates when their resistance blocks

constructive action.

CASEWORK THERAPY

Traditionally, social casework is a guidance or counseling technique based on the casework interview and employed by social workers. The aim is to help individuals find a solution to problems of social adjustment that they are unable to handle in a satisfactory way through their own resources. This process is usually divided into three parts: the case study, the plan, and the working out of the plan with the client. Casework, employed in this way, can be either preventive or remedial. In recent years the casework method has been enriched by knowledge from psychoanalysis, psychology, sociology, and other behavioral sciences. This has fostered an interest in broadening the function of the caseworker from management of manifest social problems and the utilization of community resources toward increasing the inherent capacities within the individual to cope more effectively with his or her environment. Interpersonal and social problems are resolved both to help clients meet unfulfilled needs and to adapt more adequately in their relationships with people and society. Toward this end, inner psychological difficulties are dealt with in addition to external vexations. The expanding role of the social worker is dealt with in greater detail in chapter (16) "Who Can Do Psychotherapy?"

In examining modern casework procedure we find that the process of helping is remarkably similar to that of psychotherapy with educational goals. The complaint factor is usually a social or relationship problem, and the motivations that prompt consultation are focused on external rather than internal problems. The ultimate objective is to enhance social functioning, but the means to this usually necessitates some change within the client's attitudinal and value systems as well as the customary modes of problem solving. To reach this goal, the client is encouraged to express feelings about accepting and utilizing help while the caseworker responds empathically to communicate understanding. Basic is a proper diagnosis to determine the nature of the problem, the changes that can or cannot realistically be implemented, and the most expedient means of bringing about these changes. The initial inquiry *(the social study process)* secures

important information about the client, the social situation confronting the client, and the difficulties that bring him or her to the agency. To help in the survey, as complete information as possible is obtained regarding the client's assessments, feelings, and judgments. Information other than that revealed by the client is secured from authoritative sources, such as hospitals, schools, courts, and agencies. Skilled interviewing is mandatory to obtain reliable data that will contribute to a workable diagnosis and the estimate of possibilities of change. Helpful also are planned visits to the client in the family setting. The *social treatment process* is geared toward strengthening the client's adjustment skills as well as reducing destructive environmental pressures. The practitioner must be on the alert to obstacles that block the client's coping capacities and ability to utilize available environmental resources. The amount of active help and support given by the worker varies with the existing strengths of the client. As the latter gains in understanding and problem-solving talents, less and less active help is extended. Reasonable short-term goals are designed with the object of giving the client greater confidence in reaching long-term, more difficult objectives.

It is obvious that what is being described in this process is a treatment that focuses on social change; however, it is one that inherently and inescapably aims for enhancement of growth processes within the individual, a diminution of regressive tendencies, and a more realistic appraisal of inner capacities.

Focus on the individual's capacity for self-direction expands ideal goals of casework from mere solution of the complaint factor to actual intrapsychic change. The means toward this reconstructive end will vary with the theoretical orientation of the practitioner. In the past, social workers, increasing their operations, concentrated largely on the field of psychoanalysis and drew their inspiration from two sources, the theories of Otto Rank and Sigmund Freud.

The school of *functional casework* (Kasius, 1950), oriented around the teachings of Otto Rank, attempted to help people seeking specific services in social agencies in such a way that the use of the services became psychologically constructive for the individual.

The relationship with the caseworker therapist was considered a "helping process," in which the individual experienced a new, constructive way of observing himself or herself and of relating to another person. The relationship served as a kind of laboratory in which the client acted out, with a representative of authority (the therapist), the full range of attitudes and patterns such as belligerency, detachment, ingratiation, and the need to control or to be controlled, that were habitually cherished toward authoritative persons. The therapist handled these projections as a necessary part of the client's accepting help and, in tolerant recipience, reflected back to the difference between the projections and the existing realities. This enabled the client to become aware of his or her characteristic ways of relating and permitted the client to accept in a more realistic manner the kind of help being offered. The client was charged with direction for processes of change; choices and goals were conceived of as his or her right and responsibility. Within the limitations of the structure of the agency, the client was free to move toward self-responsibility and self-acceptance. The relationship between therapist and client was thus believed to serve two aims: first, the solution of a specific problem and, second, the evolvement of a more mature personality.

The school of *diagnostic casework* with theories, drawing largely from the teachings of Freud and his contemporaries, tried to provide a corrective emotional experience for the individual through the medium of a positive relationship with the caseworker-therapist. The relationship was not the central core of treatment as in functional casework, but rather it was a vehicle toward increasing the client's ability to solve problems on a more adult level. The attitudes of the client and the kind of relationship that he or she sought with the therapist were used diagnostically, but they did not determine the direction of therapy. This was geared toward dissipating inner conflict and expanding ego strength as well as reducing, by social planning, existing environmental pressures. Objectives were variably graded to meet requirements of the diagnosis and the specific needs of the client. Techniques, which included emotional catharsis, reassurance, guidance, clarification, and interpretation, were used in whatever ways best served to increase the capacities of the ego. The focus of discussion was on the client's problems, particularly on ways of overcoming obstacles to their solution imposed by inner feelings

and social reality. There was a continued evaluation and reevaluation of the problem from cues supplied by behavior patterns and attitudes, from the client's responses to the therapeutic situation, and from reactions to interpretations and suggestions made by the therapist. Projected irrational feelings and attitudes were recognized and discussed, leading to greater awareness of current patterns of behavior and of their origins in earlier relationships. The client gradually was led to see connections between present attitudes and conflicts and those harbored toward parental and other important personages in the past. The goal was a strengthening of ego capacities, a reappraising of reality issues divorced from anachronistic expectations, a developing of a sense of being valued, and an incorporating of acceptable social concepts and standards. As in functional casework, dreams and other derivatives of the unconscious were accepted, but they were not handled or interpreted unless the caseworker was trained to do reconstructive therapy.

These differential points between the functional and diagnostic schools are not as rigidly drawn now as they were in years past. This is because both systems have not fit into the contemporary practice scene, which is branching off into many areas, including the behavioral field and group work.

Since casework practitioners must be concerned with both intrapsychic and social systems (the family, groups, community), they need several models to understand their interactions, for example, psychoanalytic theory and social system and role theories. Perhaps it was inevitable that analytically oriented practitioners would move from classical theory to that of ego psychology. According to this, the ego is conceived of as the mind's regulating mechanism toward management of needs and feelings. The ultimate aim of casework is toward enlarging the capacities of the ego to select more rewarding aims and objects. Stressed is an assessment of the client's motivations causing resistance to taking help and of utilizing help effectively in the interest of improving healthful adaptive patterns. Immediate and long-term goals are particularized, including situational changes to enhance improved client functioning.

Frances Upham (1973) has outlined a method of ego analysis to influence the

developmental process that has been interrupted by pressures with which the individual in the past was unable to cope. The practitioner serves as an identification model, as a supportive ally to enhance existing strengths, and as an educator to teach new skills in modifying the environment and evolving more constructive coping patterns. Once a helping relationship is established between client and practitioner, a search is made for any resistances. To resolve these, the practitioner attempts to clarify misunderstandings, supply information, outline alternatives, and negotiate differences between expectations and possibilities of fulfillment in the medium of empathic understanding. Positive transference is not interfered with, but negative transference is handled actively by discussion and interpretation. An agreement is reached regarding the kind of help that will be administered and the goals to be attained.

The practitioner in working with the client attempts to assess the available coping strengths and weaknesses that will help or hinder the treatment plan. This estimate is based on a developmental model during which more elaborate ego patterns are progressively evolved on a biological timetable. The practitioner gauges modes of perception that help orient the individual to reality, enabling him or her to relate to other human beings and to play essential roles in the service of adaptation. The practitioner makes an assessment of cognitive capacities, of adaptive and maladaptive patterns, of adequacy in managing drives, needs, and feelings, of maturity in handling relationships with others, of abilities in utilizing executive competence in carrying out goal-directed activities, of sophistication in integrating patterns toward appropriate functioning, and of the sense of identity. Such assessment acts as a basis for interventions to increase the client's capacities and lessen limitations. It enables the recognition of adaptive patterns that require strengthening as well as the recognition of maladaptive ones that necessitate change.

As it will be seen, such a method draws from psychoanalytic, social, and role theories and flexibly accepts supportive, reeducative, and reconstructive goals, recognizing that these must be graded to the motivations, resistances, and adaptive plasticities of the individual. While unconscious motivation and conflict are accepted as key sources of

behavior, and transference is acknowledged as perhaps inevitable, free association and dream analysis are not employed. The focus is on resistances and defenses that operate currently, and there is greater emphasis on the present than on the past.

Behavior theory is also influencing the current dimensions of casework. Some practitioners find in behavioral approaches shortcuts to dealing with specific symptoms and complaints, and some practitioners concentrate on group approaches that they believe are more practically attuned to the needs of clients.

Casework practices are not static but relate to continued advances in the field of the helping processes. In recent years, for economic and other motives, caseworkers have been increasingly entering the field of "clinical social work" and moving into private practice as clinicians, offering increasing competition to psychiatrists and clinical psychologists.

RELATIONSHIP THERAPY AND "ATTITUDE THERAPY"

Relationship therapy was the name given a half-century ago by John Levy (1938) to a process in which the focus of treatment was organized around the patient-therapist relationship. While admitting projection into the relationship of many attitudes and feelings related to the past, interpretations were made in terms of feelings experienced in the present, F. H. Allen (1934) also described a system of relationship psychotherapy with children that acted as a positive growth experience, releasing forces that make for more complete development. The work of Taft (1933) on the relationship aspects of casework may during this epoch be considered in this category.

As the name "relationship therapy" implies, the relationship is the vehicle that both promotes change and serves as a target for an inquiry into basic interpersonal patterns. The therapeutic encounter constitutes for the patient a new experience with a human being, which permits full expression of needs and strivings without retaliatory injury or rejection. The awareness gained in this unique setting helps patients readapt to their situations and achieve some of their potentials. Actually, what has been described as

relationship therapy has been recognized as constituting a vital aspect of all therapies.

In "relationship therapy" the therapist provides a corrective emotional experience for the patient by absorbing the patient's neurotic behavior and not responding to it with expected anger or indignation. Instead, a non-critical interpretation of the behavior is offered, with suggestions of an alternative style for handling oneself. Sometimes the therapist will model a more constructive way of managing the environmental provocations that beset the patient. Relationship therapy may be helpful for individuals who are unable to utilize expressive insight-oriented therapy and yet need to change destructive patterns. This method is embodied, without labeling it as such, in many counseling, educational, and behavioral approaches in which the therapist adopts the stance of a non-punitive, helpful authority figure guiding the patient toward a more productive way of life. It can be helpful in developmental and other crises. Whether it can replace a punitive parental introject with a more tolerant figure and thus lessen hostility and guilt is difficult to say, but over a long-term period we may anticipate a softening of a harsh superego if countertransference is kept under control while the patient doggedly and sometimes brutally tests the sincerity of the therapist.

The term *attitude therapy* was used originally by David Levy (1937a) to describe a process of treating children by working with the disturbed attitudes of their parents. At present, the term is sometimes employed to describe a reeducative procedure focused on the current dispositions of the patient. Distortions in attitudes are examined, their origins discussed, and their present purpose appraised. Following this, attitudes that make for harmonious relationships are introduced as topics for discussion, and the patient is helped to incorporate these as substitutes for morbid habitudes. Thorne (1950), for example, suggests a reeducative method that identifies "core attitudes" that cause varied maladaptive secondary traits and characteristics. The core attitudes, once identified, are neutralized by presenting opposite healthy sentiments to promote a reorganization of attitudinal constellations. Since the patient will not yield old ways of thinking readily, repeated emphasis on a new point of view is essential to achieve desired results. A systematic reconstitution is attempted of the patient's outlook as it affects various areas of

the patient's life. Reinforcement of new attitudes is achieved by providing the patient with a corrective emotional experience within and outside of therapy. Some of these techniques have been utilized in the methods of cognitive therapy.

DISTRIBUTIVE ANALYSIS AND SYNTHESIS (PSYCHOBIOLOGIC THERAPY)

Adolf Meyer (1915, 1948), founder of the psychobiologic school, emphasized that the human being was an "experiment in nature," the product of an integrated fusion of somatic, neurological, and psychological organizations fashioned by social conditionings. It was impossible, he claimed, to isolate any one of the many structures that made up the totality of a human being. They all had to be considered in relation to the living individual and not regarded as detached units. Furthermore, Meyer urged an empirical viewpoint, utilizing the contributions of any of the various branches of science that could shed light on the total behavior of the individual. A person was to be studied as a functioning unit in society and as a part of nature by means of the scientific method. Because a human being evolved from lower forms, it was necessary to investigate human physics, chemistry, biology, embryology, anatomy, and anthropology. Because a human being differed from lower forms, it was essential to examine the more highly developed qualities that distinguished a human from the lower species. The most intricate function was that of mental activity, which Meyer termed "mentation" or "the minding function." This included the ability to sense, imagine, discriminate, communicate ideas, learn, recall, think, and reason.

In studying human behavior it was necessary to take into account everything significant in the life history of the person, including heredity, body build, temperament, developmental history, illnesses, traumatic experiences, and the interaction of the individual with parents, siblings, and other important personages. It was necessary to consider intellectual, spiritual, and sexual development, school, vocational, marital, and community adjustments as well as interests, ambitions, moods, habits, and life goals. Toward this end the therapist was enjoined to exploit all methods of diagnosis. It was vital to understand that each individual had a different capacity for bearing stress. Hence, it

was necessary to evaluate the strength of the personality through an assay of one's assets and liabilities.

The psychobiologic approach, with its emphasis on eclecticism and its consideration of every facet of the individual's functioning as material for inquiry, had a great influence on the mental hygiene movement in this country. It gave rise also to an eclectic therapy known as "distributive analysis and synthesis," or "psychobiologic therapy."

In psychobiologic therapy (Billings, 1939; Kraines, 1943; Muncie, 1948), therapist and patient cooperatively engage in a systematic examination of all forces that go into the shaping of the patterns of the patient, namely, hereditary and constitutional elements, early childhood conditionings, and later experiential influences, including educational, economic, work, marital, interpersonal, and social factors. An initial workup consists of a thorough exploration of both the patient's problem and personality. This usually involves an inquiry into the individual's life history, a physical examination, and psychological testing. A psychiatric social worker, clinical psychologist, internist, and psychiatrist can function together as a team here in making a proper study.

The character of the complaint, the history of its development, and the patient's past and current attitudes toward it are discussed thoroughly. All available sources are explored, with the help of a psychiatric caseworker if necessary, to determine hereditary, constitutional, and experiential elements of importance in explaining the patient's reactions. The patient's social, sexual, work, educational, and recreational adjustments are considered, as are interests, ambitions, habits, cravings, and conflicts. Since the therapeutic objective is the retraining of unhealthful attitudes and the elimination of immature reaction patterns, it is essential to obtain as clear an idea of the patient's personality in operation as is possible.

A physical examination is important not only to detect existing organic conditions, but also to reassure the patient and to inspire confidence in the competence of the therapist. X-ray and laboratory facilities are utilized where indicated. Psychological testing, particularly projection tests, yield data as to personality resources and liabilities,

existing anxieties and conflicts, and the nature of the patient's defenses against anxiety.

The initial workup is invaluable in estimating the best type of therapy to utilize at the start, the prognosis, and the possible duration of treatment. It allows for a much more scientific approach to the patient's problems.

Factors divulged in the initial study, which have operated to mold the individual's personality and to produce the present disorder, are examined systematically in a series of interviews. The past is considered important in providing an understanding of the makeup of the individual. The past is translated, however, in terms of the patient's present attitudes. The formulation of difficulties is couched in concepts consonant with the patient's current capacities for understanding. The therapist always attempts to avoid leading the patient into material that he or she is unable to face, and the therapist tries to circumvent the stirring up of guilt or resentment that may interfere with progress. The manner of thinking displayed by the patient, and general reaction tendencies, are carefully studied. A life history chart may be constructed, detailing important facts in the patient's case, including family background, socioeconomic influences, and significant childhood and adult experiences.

Once a blueprint is obtained of the formative and presently operating influences in the patient's neurosis, the therapist strives to help the patient make constructive use of what has been discovered. This is not done in a mechanistic and authoritative way. Treatment following Meyer's inspiration is a matter of negotiation between patient and therapist for the most favorable solution. In this process the relationship between therapist and patient is important to understand, always implicitly and at times for explicit analysis.

> To the greatest degree possible I rely on the spontaneous contributions of the patient to keep the process going, but I do not exclude my right to bring up new or unfinished topics pertinent to the problem. And always the historical roots of the problem in overt or covert material from the past are used to illuminate the points where education in living went astray. Then comes the effort to discover unused learning opportunities— unused because of emotional blocks. Dependence on the therapist is not denied the patient, but encouragement to assume the risks involved in the reeducation process is given. There is constant feedback—as there must be in

meaningful negotiation. (Muncie. 1976)

Discussions cover in great detail those facts that have influenced the patient and his or her problems. The patient, one hopes, through these discussions, gains insight into the difficulty. During each interview positive and constructive elements are accented, successes are emphasized, and hopeful elements are brought to the fore. This is to counterbalance and to counteract negative, destructive forces and liabilities. The patient's assets are constantly considered against liabilities. A "synthesis" is then made of those factors that can help in adjustment, and the patient is encouraged to deal with life through a healthier perspective. The patient is encouraged to correct disturbing environmental situations and to avoid or to control traits that adversely influence adjustment. The patient is also inspired to develop adequate compensations. As treatment goes on, and more material becomes available, the therapist's initial hypotheses may have to be reformulated.

A number of techniques (such as suggestion, guidance, reassurance, persuasion, and confession and ventilation) may be used jointly toward the goal of a more constructive adaptation. If analytically trained, the therapist may deal with the more deeply repressed material, utilizing psychoanalytic techniques, such as free association and dream interpretation. While the clinical material of psychoanalysis is accepted in psychobiology, psychoanalytic theoretical explanations are considered intuitive and metapsychologic rather than scientific. Therefore, a broader biosociological explanation is attempted for which there is experimental evidence or reasonably assured probability.

Pointed questions are asked and areas of discussion are delineated, but the patient is stimulated to think things through for himself or herself. The focus in therapy is usually on present situations and symptoms of which the patient is aware rather than on unconscious attitudes and mechanisms. The relationship between the patient and therapist is explicitly analyzed only when found to be necessary, and no attempt is made to induce the patient to relieve past experiences, although an understanding of present reactions in the light of past conditioning can be helpful.

These techniques may, in an incredibly short time, help to restore a patient to an emotional equilibrium, symptom free and capable (because of the knowledge that has been gained) of avoiding pitfalls that have hitherto created anxiety. Additionally, the patient may learn to utilize his or her assets to best advantage and to get along in life far better than before. Correcting difficulties in relationships with people may relieve much anxiety, tension, and hostility. Knowledge of his or her character weaknesses may make life more tolerable. Discovering positive qualities within himself or herself help raise the patient's pathologically low self-esteem. The dynamic sources of the individual's emotional problem are sought to the degree necessary to achieve understanding. The relationship with the therapist may inspire curative forces that influence personality growth.

The philosophy and methods of psychobiologic therapy have been incorporated into the body of many, perhaps most, of the current psychotherapies without giving credit to the rich contributions of Adolph Meyer, Wendell Muncie, and other pioneers in this field.

INTERVIEW PSYCHOTHERAPY (PSYCHIATRIC INTERVIEWING)

"Psychiatric interviewing" is the appellation attached to certain interview procedures that attempt to bring the patient to a state of awareness by focusing the interview on pertinent problems. Most types of psychiatric interviewing are forms of insight therapy with limited goals—focused or conscious stresses and conflicts—since deeply repressed elements of personality are not exposed to awareness. Transference material and dreams are utilized rarely, if at all, as foci for interviewing. What is essential is an effective doctor-patient relationship, the employment of goal-directed planning and management, the focusing of content on specific aspects of behavior, and use of minimal activity (Fine-singer, 1948).

The ultimate goals in treatment are formulated in advance, considering the preliminary diagnosis, the patient's needs, and the therapist's clinical experience. Intermediate goals are determined by what is happening in the therapist-patient relationship and by the kind of material that is brought up during discussions. Focusing of

the interview is generally, at first, along lines of an inquiry into existing symptoms, attitudes, and problems. Next, there is a search for repetitive patterns in the patient's behavior. Then, the effect of habitual patterns of current behavior is explored with an investigation of the meaning and function of such patterns as well as their historical origin. Flexibility must be observed in intermediate goals, and there is usually a shift from one to another, determined by the needs of the situation. Interpretations are made for the patient, as required, and, from time to time, there are summarizing statements.

A focusing of the patient's attention on relevant topics is essential to avoid rambling. This may be achieved by exhibiting interest or by displaying disinterest in specific topics brought up by the patient. The therapist employs as minimal amounts of activity as are consistent with therapeutic plans and goals. Only when the patient fails to respond does the therapist become more active. A careful regulation of the relationship is essential, being balanced between emotional support and the stimulation of tension to activate therapeutic progress.

Interviewing procedures consist of studied nonverbal and verbal responses. Included in the former are facial expressions, nodding, glances, gestures, postural changes, and vocal inflections and intonations. Low-activity verbal responses are preferred; they consist of articulate syllables with rising inflection, repetition of the patient's last uttered word, elaboration of a phrase, mild commands, and questions of a general or specific nature aimed at exploring a certain topic.

Greater activity is required only where material is not readily obtained. Technical procedures here include a repetition of the patient's statements with special emphasis, rearrangement, or juxtaposition, statements of a descriptive, elaborative, or summarizing nature, and direct questions in relation to associations. Difficulties in communication may be handled by questions related to the manifest problem and by mild or more active encouragement to talk. Methods of marked activity are used only when absolutely essential. These consist of suggesting reasons for reticence, interpreting the reasons, provoking emotional reactions through rapid probing, focusing on the relationship,

forcing the patient to verbalize material, or displaying affect. Extreme active measures are rarely indicated, such as active reassurance, shared experiences, gratifying the demands made by the patient, and shifting the relationship in the direction of a social experience.

A less structured method of therapeutic interviewing, directed toward goals of insight, has been described by Stanley Law (1948), which he believes can be learned and practiced by general practitioners.

SEMANTIC APPROACHES TO THERAPY

J. Ruesch (1957, 1959) and R. Spiegel (1959) have hypothesized that abnormal behavior is accompanied by physical and social interference with communication. The more intense and repetitious the interference, the more extensive the traces that exist to plague the person. Therapy, focused on improving the patient's communication process, may lead to a better ability to relate interpersonally, and also to acquire a more cogent understanding of oneself, in regard to one's inner life, past experiences, and current interactions.

Formal study of human evaluative processes, particularly in relation to signs and symbols, is the goal of the field of "general semantics." Semantics deals with systems of symbols, including language structures, and the uses made of these systems by individuals and social groups, as well as the influence on the systems of existing social values and individual behavior tendencies (Korzybski, 1941). Therapeutically employed, semantics tries to teach the individual the principles of scientific thinking through a more valid use of communication.

The rare employment of semantics as a therapeutic method necessitates a high degree of intelligence in the patient and requires special semantic training for the therapist. During treatment, a mutual examination of verbal forms used by both therapist and patient is conducted to see whether exact meanings are being communicated. There follows a detailed evaluation of the patient in relation to language efficiency and the prevalence of semantic problems. Finally, semantic retraining is employed to teach the

patient the more exact use of symbols and terms. Adequate problem solving presupposes a sufficient mastery of language and use of symbols to enable the person to state difficulties, differentiate them, make inferences, and draw conclusions from facts. The person must know something about the uses and abuses of symbols. These are the foci of investigation in semantic therapy.

W. Johnson (1946) has outlined the effect of semantic difficulties on adjustment. One syndrome of maladjustment is the product of unrealistic ideals in life which bring about disappointment and frustration. Part of the problem is due to the doubt that governs the individual's ideas, making it impossible for the person to conceptualize clearly what he or she wants from life. The person is, therefore, inevitably disappointed in efforts to gain pleasure in living. Another source of maladjustment is the inability to identify or even state problems coherently because language is poorly organized and lacking in clarity. This vagueness in thinking, embracing faulty notions about oneself and fallacious concepts of the meaning of life, interfere with the formulation of realistic goals.

Semantic distortions include ororverbalization, which may serve the function of avoiding silence, of concealing the truth, or of searching frantically for meanings. Underverbalization is another response, which is often motivated by a fear of failure, demoralization, or perfectionistic strivings. There may be great verbal rigidity involving content, modes of phrasing, and moods. There may also be a defect in the capacity to discriminate levels of verbal and nonverbal abstracting. Other disturbances of communication occur that require careful analysis and diagnosis.

In therapy, once a good relationship with the therapist is established, semantic training and reorganization are practiced. Interpretations are given the patient as the semantic defects become apparent. Training proceeds as rapidly as the patient's resistances will permit. As the patient becomes capable of formulating the problem cogently, he or she greatly expands the ability to communicate with freedom and clarity. Verbal rigidities relaxing, the patient becomes more conscious of the real difficulties, feelings about oneself, and life goals. By being able to put the problem into meaningful

words, the person is helped to achieve greater volitional control over emotional processes.

When we evaluate the semantic approach to therapy, we have to consider that all emotional ailments are associated with problems in communication. These involve, among other things, vagueness in phrasing and defects in conceptualization. As long as there is an unclearness in the use of symbols, the individual is unable to define, differentiate, or think critically about his or her attitudes, values, and life goals. It is likely that a good part of the existing communication difficulty in emotional illness is the product of repression—a purposive attempt to cloud issues in order to keep painful aspects of the personality outside the range of awareness. During any kind of psychotherapy patients, by mastering anxiety, become capable of expressing themselves more and more clearly and of verbalizing in increasingly explicit terms that which they had hitherto merely been able to feel. This restores the patients' ability to deal more adequately with the sources of their problems.

In summary, semantic approaches to therapy put the emphasis on the patient's difficulties in communication. Emotional illness is believed to arise from problems of symbolic functioning. The focus of the therapeutic effort is on defining and clarifying symbols, making the patient's use of them more precise. As the individual formulates ideas more clearly, interactions with others become more meaningful.

REEDUCATIVE GROUP THERAPY

Group therapy may have the reeducative goal of altering attitudinal and behavioral patterns (Pratt, 1907; Slavson, 1944, 1946, 1947; Solomon & Axelrod, 1944; Rome, 1945; Luchins, 1947). The group setting offers the patient a splendid opportunity to relate to others and to observe distortions that develop in such relationships. Benefits accrue to the patient from experiences with other members within the group. A protective as well as challenging milieu fosters the growth and expansion of cooperative attitudes that may eventually replace neurotic strivings.

Dynamics derived from a study of the process of individual psychotherapy do not

seem to suffice for such group experiences. In searching for a comprehensive and operational theory of reeducative groups, we are obliged to enter the field of sociological research. Some efforts here have been made to apply research in group dynamics to therapeutic groups (Bales, 1950; Cartwright & Zander, 1960). In recent years communication theory and systems theory have added some important dimensions (Durkin, 1975).

Group therapists contend that the group experience can liberate and give direction to what is socially significant in the indivdual. A person is by nature a group creature and needs to associate closely with others in order to operate adequately as a human being. Unfortunately, disturbances in relationships of emotionally ill persons eventually alienate them in the group, i.e., society. The therapy group provides an atmosphere for resolution of some of these distortions. An overcoming of neurotic impulses may follow experiences of becoming less defensive toward others. This may lead to greater tolerance of personal lacks and failings.

During the past few decades a great deal of work has been done, particularly by social psychologists and sociologists, on how people relate in groups. Description of the observable variables in a group and delineation of the dynamics of interaction are the contribution of the field which has come to be known as *group dynamics*. This field is distinctive from that of personality dynamics, of which psychoanalysis is the best known representative, which, applying itself to the *why* of human behavior, deals with the motivational determinants. Some of the data from studies of group dynamics are applicable to therapeutic groups. Unfortunately, there is still very little communication between group therapists and social psychologists.

Perhaps the major contribution to group dynamics was made by Kurt Lewin, who, utilizing field therapy, focused attention on the complex and shifting nature of group life (1947, 1948, 1951). Lewin emphasized that in a group there is an interdependence of the individuals, which characterizes the "dynamical whole," and that a change in one subpart can effect change in the state of any other subpart. A group was thus more than a sum of

its parts; it had unique characteristics of its own. Individual psychodynamics could not explain behavior since the individual was subject to social forces in the form of pressures by the group. Such *group pressure* could effectuate changes in behavior. Under Lewin's leadership, experimental studies attempted to delineate the internal structure, processes, phenomena, and laws of group life as well as to apply these data to such practical problems as group productivity, leadership, and cohesiveness, which occurred in industry, education, correctional work, and other fields. The research and bibliography in group dynamics have been substantial, including among others the work of French (1941, 1944), Festinger (1942, 1947), Bavelas (1948, 1952), F. Deutsch (1949, 1951), Cartwright (1950), Homans (1950), Bales (1958), and Hare (1962). The contributions of Bion (1951) have been especially noteworthy. Bion pointed out that members of a group at first look for a leader on whom to depend but soon realize that this is a fantasy and that one must look to oneself for survival. They then form pairing couples, which also leads to disappointment when one realizes that no one can be fully depended on to fill a hoped-for role. This encourages impulses toward fight (quarreling among themselves) or flight (leaving the group). Working through these impulses can have a therapeutic effect.

The concern of psychotherapists with group dynamics is predicated on the basis that behavioral changes are constantly being consummated through the individual's interactions with family, peer, occupational, religious, and other groups of which he or she is a member. Processes may thus be observed taking place within the individual in his or her relationship with others, in the course of which certain kinds of change come about. A study of the dynamics of change illuminates some of the allied operations in psychotherapy. Moreover, it helps differentiate the contingencies that precipitate out in all groups, irrespective of structure, from those that are specifically parcels of the psychotherapeutic experience.

Common to all groups are a number of phenomena: (1) all groups possess some kind of structure, (2) the members assume or are assigned special roles, (3) goals toward which the group strives are implicitly accepted or explicitly defined, (4) a communication network mediates the interactions among members, (5) group norms are applied with

varying pressure to each individual (social control), and (6) both cohesive and disorganizing forces are at all times operative.

Dynamic interaction is the essence of group activity. Never static, the group constellations alter themselves as new fusions, enmities, and alliances allocate different roles for the members. A status hierarchy emerges, which determines the nature and direction of communication. Interacting patterns are evolved that reflect role expectancies.

Observation of different groups in operation discloses a number of consistent processes (Wolberg LR, 1966):

1. Individuals upon entering a new group bring into it all of the distortions and expectancies that are parcels of their personality structure, while attitudes directed toward them by the other members similarly reflect their prejudices. These immediate impressions are rectified as interaction continues, perceptions tending to become more reality-oriented ("consensual validation").

2. A status struggle often occurs at the beginning of group formation during the establishing of leader-follower hierarchies. Members reach out for leadership on the basis of a number of inner needs, such as identification and dependency. Leadership characteristics are not the same for all groups; they depend on the culture and needs of the group. Intelligence, dominance, self-confidence, vitality, the ability to relate to the goals of the group, and the capacity to participate socially have been found to be important in all groups.

3. The norms developed by the group represent rules of behavior designed by the group to achieve its expressed or implied goals. Group norms applied to an individual define his or her role expectations. The individual also possesses norms that are related to personal values and goals, which may or may not conflict with group norms.

4. All groups approach one or more of four goals: (a) the group goal of problem solving in relation to some area of concern involving all members (as in a parent-teacher or industrial group), (b) the group goal of resolving expressed or undefined social-emotional problems, for example, shared

anxieties (as in an executive-training group where group dynamics are emphasized), (c) the goal of supplying an individual in the group with a solution to a personal need (as in a social or educational group), and (d) the goal of solving emotional difficulties associated with personal and relationship disturbances (as in a therapeutic group).

5. The structure of the group, and the activities that it sponsors, will, more or less, be modeled by the goals toward which the group directs itself. Generally, goals relate to resolution of an explicitly defined external problem that concerns the group or to a less well-defined social-emotional problem within the group that is reflected in shared anxieties.

6. Group size influences the responses and movement of the group. As numbers in the group increase, information and suggestion giving become more pronounced. This is accompanied by a diminished request for and expression of opinions and by a lessened agreement among members. Groups of two (dyad) show high tension, avoid antagonism and disputation, ask for opinions (but shy away from giving opinions), and focus on the exchange of information and on reconciliation. The optimal size of a group is five, a smaller or greater number being less satisfactory to members. Discontentment is expressed if the group gets too large. Each additional member expands the potential relationships among the individuals and subgroups. As the group increases in size, members feel inhibited and threatened, and the leader becomes more removed from the members. Greater difficulty exists in reaching a consensus.

7. The superiority of group over individual performance has been tested. It has been found that manual productivity is greatest in groups, but intellectual productivity is not necessarily increased. Problem solving within a group framework is enhanced in some individuals but retarded in others. Group discussion, however, makes individual judgment more accurate. Recall of information is expanded in a group setting.

8. A variety of situations make for greater group productivity. Productive groups are composed of members whose skills are appropriate for the tasks. The most resourceful and accomplished groups are small, are cohesive, are of the same sex, have a satisfactory communication network and feedback, and are led by a skillful leader. Autocratic leadership encourages greater quantitative productivity, while democratic leadership results in optimal morale. In authoritarian settings authoritarian groups achieve greater output; in democratic settings egalitarian groups are more efficient.

Personality characteristics that result in compatibility of individuals in a group and in free communication make for expanded group productivity. Tasks are best accomplished by a group in which rules are appropriate for the tasks. Where cooperation is expected, there is greater individual incentive, friendliness, communication, and productivity; self-oriented needs in a member here tend to disrupt the group. Application of stress, if not too strong, encourages greater productivity; if too strong, the group yield diminishes. Productivity is retarded by any conflicts that develop in the group.

9. Conflict often appears when the roles of two members clash ("role collision"), where an individual plays two opposing roles ("role incompatibility"), and where group members cannot agree as to expected roles ("role confusion"). It also develops where the personality structure of an individual does not coordinate with the role expectation that is dictated by his or her position in the group. Ethnic, status, intellectual, and educational differences among the group members may act as sources of tension and conflict.

10. Cohesiveness is expanded and disruptive forces are minimized where the members know and like each other, where the prestige of the group is stressed, where members are rewarded on a cooperative rather than competitive basis, where they possess strong mutual interests and are democratically led, and where communication processes are facilitated.

11. Both deviance and conformity are present in members of a group. The more highly the individual regards the group, the more he or she needs its prestige, its output, or the friendship of its members—the more he or she will want to conform. Interactive processes in the group are released by a deviant. This has an effect on group morale, group decisions, and group cohesiveness. Every group exerts pressures on its members to conform to accepted norms. Where a member deviates in behavior from the norm, that person is subject to one of four choices: conform with group norms, change norms to align them with those of the group, operate as a deviant, or retire from the group. Deviant members are pressured to yield to majority opinion, which some will accept. Conformity is encouraged where the majority maintaining a contrary view is large, where membership in the group is valued, and where one's opinion must be stated publicly. Yet a minority viewpoint is possible where the minority possesses high status, is considered expert, or is especially popular. Thus, a leader may promote his or her ideas in the group and find them

accepted even though they clash with sentiments of the group majority; yet the leader will also have to abide by group norms once they are solidified.

Membership in a group influences the way an individual perceives reality, his or her decision making, and the nature of his or her values and prejudices. Often the individual will suppress a correct perception or judgment in favor of the majority opinion, particularly from respected sources, firmly convinced that conclusions have been independently reached. Where a person is highly motivated to remain in a group, he or she is more prone to resist arguments, however logical they may be, that are opposed to the group norms. This principle has been found empirically useful and probably accounts for certain dramatic changes, hardly possible in individual therapy, that come about in therapeutic and some social groups (Alcoholics Anonymous, Synanon, etc.).

Group dynamics share with psychotherapy the common goal of altering norms in the individual. The manner in which this change is implemented differs in the two disciplines. Psychotherapy approaches the problem of change by dealing directly with the forces of emotional motivation and conflict; group dynamics operate more peripherally through the influences of group interaction and pressure. Each of the disciplines complements the other. During individual psychotherapy the patient continues to be permeated by pressures from family and peer and secondary groups. In group psychotherapy the individual is in addition subjected to group dynamic vectors.

The pressures of the group for individual conformity are great. A problem posed here is that if group standards are abnormal, it will be difficult for an individual to change a pattern supported or sponsored by the new group. Should behavior be altered in isolation, the deviancy will come under attack when returning to the old group, and one may be forced to assume a previous role. Thus it would seem, as Lewin pointed out, a group change may have to precede transformation in attitudes in a group-rooted individual. One may, however, retain the gains by leaving the customary group for a group whose norms are more consonant with the newly developed ideas. Or one may assume a leadership role and change the norms of the habitual group to coordinate with one's own.

R. Dreikurs (1950) speaks of the "unique social climate" experienced in group psychotherapy. Among its distinctive qualities is the fact that the therapy group acts as a natural testing ground for observation and experimentation with the phenomenon of group values. It has been discovered that the values operating in a therapy group geared toward reeducational objectives are best democratic or egalitarian, as each member, regardless of achievements or deficiencies, is granted equal status and rights in the group. Another value stressed in the social climate of the group is honesty and frankness, the ability to reveal oneself freely without putting up a front. The therapist, too, functions as an equal among equals, who can assume the responsibility of leadership because he or she knows more about human relationships than the other members of the group. Binding the group members together is the need for mutual trust, for belongingness, and for mutual identification.

In addition to the phenomena of group dynamics, which operate in all groups and on which the therapeutic results of educational groups are to a large extent dependent, Slavson (1957) has pointed out that "in therapy groups there constantly occurs verbalized and nonverbalized interpersonal action and reaction, partly as a result of therapeutic projections and partly because of the inevitable effect persons have upon one another, such as contagion, mutual induction, interstimulation, intensification of emotions, sympathy, empathy, and others. These cannot be considered, however, as group dynamics but rather as interpersonal interactions." Interpersonal factors are constantly operative in groups and complement the effect of group dynamics as well as the more irrational transference phenomena that are exploited in analytic groups.

As each patient interacts with other members and behavior is discussed frankly, and often with affect, he or she gains greater self-understanding by allowing feelings to be harbored and expressed in an accepting climate. The group may stimulate destructive patterns in interpersonal relationships, but eventually the members may be able to participate without exploiting their neurotic character drives. For instance, a power-hungry person may learn in time to merge closely with the group without being controlled or hurt. A negativistic individual may discover that yielding to others does not mean

abandoning one's personal rights and freedom. A detached patient may derive positive pleasures from slowly entering into group activities. As group members relate to each other freely, they learn to compromise as well as to give and receive. Thus they begin to develop cooperative participation, helpfulness, and friendliness, which may in time replace destructive interpersonal feelings. H. T. Glatzer and Pederson-Krag (1947) have emphasized the importance of these interpersonal patterns. The group setting provides individuals with a theater in which to play out their impulses and fantasies. It is not uncommon for group members to create surrogates (father, mother, siblings) and to project transferentially onto them archaic needs and defenses. These, when detected, may be interpreted to the patient by the therapist. Immediate emotions are dealt with and handled, particularly those the patient can face without too much anxiety. In this way, the patient gradually becomes aware of his or her feelings and even of some of the origins of neurotic conflicts. The object is to help people come to terms with themselves.

Activity Group Therapy

Slavson (1943) has described a type of reeducative therapy called "activity group therapy," which is used with children in the medium of a social club. Complete permissiveness prevails and the youngsters are free to express all types of behavior. This usually results in a cathartic ventilation of feelings. Arts and crafts materials are supplied, refreshments are served, and outings are arranged. Children's activity groups are usually composed of eight to ten members whose ages are relatively comparable; for instance, children from 6 to 9 may constitute one group, those from 9 to 13 another. The participants are encouraged to be freely emotive and expressive. There is no special focusing on problems, although aggression, destructiveness, withdrawal, and other disturbed kinds of behavior that endanger the child or others are dealt with in a firm but kindly manner. A permissive and understanding environment is the keynote. The setting of limits is essential, for instance, in regard to destroying property, taking things from one another, and persistent fighting. The group functions as a secondary family, with the therapist as substitute parent. Relationships established with the therapist and with others in the group may lead the members to a more realistic conception of the world and

of themselves. This awareness is gained within the action setting, and not through interpretation.

Activity groups with adults have also been developed around special interests and needs of the participants. Thus, sports, crafts, games, photography, painting, sketching, carving, mosaics, and other hobbies and recreations may form the focus around which the group is organized. In hospitals, day hospitals, and therapeutic communities, occupational therapy (see Occupational Therapy), special programs of exercise (Coulter, 1966), and social clubs (Bierer, 1944, 1948) may be the means of bringing together persons who eventually begin to relate to each other. In outpatient set-ups, dramatics, music (see Music Therapy), dance and movement (see Dance and Movement Therapy), poetry (see Poetry Therapy), and social activities (see Social Therapy) may constitute the central diversion that enables the audience to communicate and to release their feelings. Caseworkers have developed a social group work process around the rehabilitative needs of their clients (Hendry, 1948; Konopka, 1947, 1960, 1963; Kunstler, 1955; Lindeman, 1939; M. Murphy, 1959; E. Phillips, 1957; Schwartz, 1959; Trecker, 1955; G. Wilson, 1941; Wilson & Ryland, 1949). This provides enrichment of school-day and after-school programs as well as activities for the handicapped and the aged. Health education, recreation, camping, athletics, dramatics, arts and crafts, social dancing, forums, lectures, and other constructive measures are combined with skilled guidance to meet the various needs of clients. The introduction of an activity provides structure to individuals who otherwise would be too inhibited to interact.

Directive-Didactic Behavioral Group Approaches

Bringing small groups together to discuss matters of special interest to the members constitutes an important reeducative measure. Such topics may concern health, marital relationships, child-parent difficulties, and social and community problems of the widest range. During the sessions the participants bring up subjects for discussion which may then become the central theme. In less active groups the therapist may deliver prepared talks or lectures around which the deliberations may proceed. Even Bible-reading classes

have formed the basis for therapeutic assemblages (Marsh, 1931). There is some advantage to organized presentations in settings where personnel changes are the rule, and relatively little disruption is experienced when the regular group leader is replaced by a new leader who continues with mimeographed or printed material. Books and readings may be assigned as part of the proceedings. A tendering by individual group members of their problems and histories serve as periodic interesting diversions (Pratt, 1953). Sometimes group relaxation (Jacobson, 1938) and group hypnosis (Wolberg LR, 1948, p. 180) precede talks and discussions. These methods have the advantage of calming the group by enhancing the placebo effect and putting the therapist in the role of a benevolent healer. Persuasive arguments may better be received under these circumstances.

Some therapists who work in hospitals have stressed the importance of "will" therapy, which emphasizes self-help and encourages the continuance of group discussions after patients leave the institution. An example of such a self-help group movement is Recovery, Inc. (Low, 1950).

In groups led by a therapist dedicated to behavior therapy, group hypnosis with desensitization techniques may be employed, particularly with phobic patients (Lazarus, 1961). Behavioral groups are usually most effective with patients sharing common symptoms, such as agoraphobia, fear of flying, a smoking habit, obesity, sexual problems, or deficiencies in assertiveness. Behavioral techniques may then be appropriate for all the patients. Subgroups are usually organized on a short-term basis for up to 6 months. Among the group therapy approaches incorporating principles of learning theory (Mowrer OH, 1950, 1953) are those developed by Saslow and Matarazzo (1962) and Small et al. (1963), which regard emotional difficulties as learned disturbances subject to extinction, reinforcement, and reeducation.

In hospital setups didactic groups have been operating for many years, providing special topics and guided discussions for patients who are too detached, regressed, or deteriorated to enter into spontaneous interactions (Marsh LC, 1931, 1935; Klapman, 1946; Low, 1950; Klapman & Lundin, 1952). Persons who have been apprehended or

imprisoned for antisocial tendencies, such as sex offenders, juvenile delinquents, prisoners and paroled convicts, often benefit from guided group conferences. Alcoholics and drug addicts profit from didactic approaches combined with repressive-inspirational measures, such as practiced in some Alcoholics Anonymous and Synanon groups.

nondirective (Client-centered) Group Therapy

Therapists espousing the philosophy that inherent self-actualizing tendencies may be released in an atmosphere of permissiveness, "genuineness," and empathy have applied their concepts to work with groups (Hobbs & Rogers, 1951; Hobbs, 1969; Gordon, 1955; Lifton, 1961). In accordance with client-centered theory, the therapist operates to confront, guide, and clarify feelings and distortions that prevent the group from realizing itself as a constructive body that can release the growth potentials of each member. In an atmosphere in which the free exploration of feelings and communication to other members is encouraged, self-understanding and self-acceptance emerge. The activities of the therapist are geared toward conveying to the clients "through gesture, posture, facial expression as well as by verbal means, the therapist's *congruence,* his sense of acceptance and of confidence in the ability of the client, with the help of the group, to resolve his problems… . The therapist does not interpret, probe, evaluate or reassess… (Smith et al, 1963).

Family therapy

It has been said that a family is an autocracy ruled by its sickest member. Often this member is not the "primary patient" who is sent out for help. What we generally observe within the family structure is an unstable homeostasis maintained through interlocking neurotic roles that the various members play with one another. Such roles are usually concealed from the awareness of the participants by perceptual blocks, and their resolution is staunchly resisted, particularly in families with either a psychotic or borderline member. The evolving network of interlacing patterns is remarkably stable, and sometimes contagious, being passed along in almost pure culture from one generation to the next. Other patterns are constantly being influenced and modified by defenses and

reaction formations. Affectionate, supportive, domineering, submissive, exploitative, punitive, aggressive, indulgent, cooperative, sadistic, masochistic, detached, seductive, inhibited—these and other traits are adopted through identification with parents or are compounded in the crucible of family life in response to the pressures, deprivations, and indulgences brought to bear on the individual. Constantly in play are configurations that operate in the service of both healthy and neurotic adaptation.

The permutations of traits among the parents and siblings become diverse as controllingness is met by compliance or rebellion, overprotection by helplessness or compulsive independence, neglect by defiance or distrust. Incompatibility between father and mother, between parental and social values, between intrinsic family standards and the laws of the prevailing subcultural group generate complex subpatterns in all of the inhabitants in the home. These, derived from the incorporation of and resistance against attitudes present within the family, often act as sources of conflict. Neurosis or psychosis that breaks out in one or another of the members is merely an event in the family drama and may actually constitute a means of helping the constituent members achieve a kind of tenuous balance. Should the developing problems precipitate intolerable symptoms in a member, he or she may be the first emissary (the "primary patient") from the disturbed family group.

It is apparent from this that disabling emotional problems in any single individual must be approached within the context of relations with the family group. The patient's difficulty is usually a symptomatic manifestation of a disorganizing family unit. Only rarely do we find that only one member of a family is emotionally ill; generally several and even all members share the disturbance that manifests itself most dramatically in the "primary patient. "The emotional equilibrium of a subgroup may be maintained by the sacrifice of one member or another subgroup in the home. The "scapegoating" of selected persons is a common phenomenon in establishing a balance, which easily becomes disrupted should the victims begin to emancipate themselves. Thus mother and daughter may war against father, who seeks his peace in alcoholic overindulgence, the latter becoming the grievance around which battles are fought. A father's competitiveness with his son, with subtle

imposition of expectations beyond the resources of the child, may drive the latter into a schizoid retreat, which then marshals further aggression from the father and detachment by the child.

Subgroup splits may be along several lines, varying roles being assumed as the alliances are joined or relinquished by changing needs. New alignments are encouraged by a host of forces, including the maturational demands of growing children as they proceed from the helplessness of infancy through the defiant turmoil of adolescence into adulthood—as well as disintegrative trends in contemporary society itself, expressed in pressures toward conformity, impingement on personal freedom, and social upheavals that interfere with the sense of identity, feelings of security, and the need for belongingness essential for the requirements of a stable personality. Manifestations of alienation and conflict may take the form of minor engagements between parents and siblings, with dogfights and cursory clashes; or they may be expressed in violent prolonged eruptions. Generally, however, a cold war of attrition is waged between family subgroups, open combat being avoided because of guilt feelings or fear of hostility. This subversive warfare is most wearing on the belligerents; eventually the weakest members break down. Encouraging such collapse is a precipitating event, such as the imposition on the individual of demands that require a new role, for example, a change in occupation, death of a family member, sexual maturation, marriage, or the birth of a child. The family pathology may manifest itself either in outright neurotic or psychotic disorganization of one or more members. Or the family itself may fail to fulfill its traditional function of child rearing and responsibility to the community because of such disruptions as abandonment, unwarranted divorce, and delinquency.

The family then, as the cradle of health and illness, must be considered in any appraisal of individual emotional illness. It is both the fount of neurotic contagion and a potential resource for therapeutic intervention. Acceptance of this doctrine has sponsored a systematic family approach, which has proved to be productive in both diagnosis and treatment of individuals and groups. Even though therapy ultimately may be focused on one person, a recognition of the family vectors operating on that individual in the past and

present is vital. Bringing the family together and working with various members who need help has, in many instances, resulted in a better understanding of one another and in an improvement of their mutual relationships.

The origins of family therapy are vague. The field of social work for years dealt with individual problems in a family setting. It was not a coincidence that Nathan Ackerman, who worked with a child guidance social agency over fifty years ago, began exploring the possibilities of the family as a vehicle for growth as well as pathology. J. E. Bell (1953) and Jackson (1959) published some of the earliest ideas on the family as a focus for treatment, and in 1958 Ackerman made a seminal contribution with his book on the psychodynamics of family life.

In the short time of its existence, family therapy has witnessed the evolvement of a surprising number of models (Ackerman, 1954, 1957, 1957b, 1958a, b, 1960, 1961, 1965; Albert, 1960; Bateson, 1959, 1960, 1961; Bateson and Jackson, 1963; Bell JE, 1961; Bell & Vogel, 1960a, b; Boszormenyi-Nagy, 1962; Boszormenyi-Nagy & Framo, 1965; Bott, 1957; Brim, 1960; Carroll, 1960; Ehrenwald, 1963; Elkin, 1962; Ferreira, 1960; Fleck, 1960; Framo, 1962; Friedman, 1962; Fry & Heersema, 1965; Goodman JA, 1962; Grotjahn, 1960; Haley, 1962a, b, 1963a; Jackson & Satir, 1961; Jackson & Weakland, 1961; Kadis & Markowitz, 1963; Lidz, 1958; Masserman, 1959; Parloff, 1961; Rubinstein, 1964; Satir, 1963, 1964; Spiegel, 1958; Watzlawick, 1963; Weakland, 1962). While no specific methodology has emerged from current work in the field, various strategies of relationship and communication have been developed, such as split family, intergenerational, couple, individual as well as conjoint family sessions (Stein, 1966). Flexibility in approach is most helpful (Deutsch D, 1966). Treatment of family members or a spouse may follow individual therapy ("consecutive therapy"). Treatment may be done by different therapists ("collaborative therapy") or by the same therapist who utilizes both group and individual treatment ("concurrent therapy"). Treatment may involve the entire family in the same room ("conjoint therapy") as well as individual treatment for one or more members ("combined therapy"). It may involve the treatment in the same room of more than one family ("multiple family therapy"). It may employ co-therapists or

multiple therapists when necessary. Procedures are improvised in accordance with the clinical perceptiveness, theoretical orientation, inventiveness, and idiosyncratic working methods of the different therapists. For instance, some approaches draw their substance from social and role theory (Murphy G, 1947); communications theory (Watzlawick et al, 1967); general systems theory (Bertanlanffy, 1968); intergenerational systems theory (Bowen, 1978); social learning (Weathers & Liberman, 1978); interpersonal perception (Liang et al, 1966); behavior theory (Patterson et al, 1975); psychoanalytic theory, with an accent on Freud, Adler, Horney, or Sullivan, contingent on the favored school of the therapist; transactional analysis (Berne, 1963); or Gestalt therapy (Perls et al, 1951). Irrespective of orientation, the family therapist seeks to eliminate destructive symbiotic bonds that tie family members together.

The aims of family therapy are not only to resolve current problems and difficulties but to teach the family to solve further impasses by itself, to communicate more clearly with one another, to develop strategies for avoidance of conflicts, to accept one another's handicaps and differences without blaming and scapegoating, and to foster "functional processes for appropriate balancing of competing values such as family cohesiveness and individuation, balanced separateness *and* togetherness, stability and flexibility, to name only a few" (Bodin, 1984). Family therapy is of prime importance in crisis intervention (Everstine & Everstine, 1983). Indeed there is no limit to the conditions for which family therapy may be suited since family relationships affect and are affected by the entire host of afflictions to which people are subject. The essential separation on which maturity rests is usually impeded unless there is a working through of aggressive feelings the members have toward each other (Rubenstein et al, 1966). It is to be expected that the family at first will resist altering its fixed patterns of interaction. Attempts will be made to coerce the therapist into supporting the neurotic cohesiveness and divisiveness that fosters the family neurosis.

Improvement in one member of a family may be resisted and sabotaged by the others who need the identified patient to be ill to maintain their own and the family's homeostatic balance (Lewis JM, 1984). The resistance will be especially great in mother-

child symbiotic patterns, and particularly in overcoming "double-bind" verbal and nonverbal communicative links (Bateson et al, 1956; Jackson DD, 1959). It may be possible to detect in the family relationships how parents communicate their unconscious demands to their children. The therapist will, at first, be enlisted to serve as judge and to allocate blame. As patterns are challenged, new alliances and fusions are sought. The therapist is then promoted to the role of omniscient adviser who can provide answers and gratifications. When these are not forthcoming, new subgroups and pairings organize spontaneously, around which different patterns of conflict develop. The working through of these collusions eventuates in more realistic attitudes. Establishing better communication among the members helps them to allay guilt, to resolve defensiveness, and perhaps to realize that the pressures to which they are exposed are motivated by forces that have little to do with them. More tolerance of and compassion with the problems of the aggressor alleviate resentment and hopelessness. Rebelliousness and other forms of acting-out may be replaced by more wholesome ways of standing up to and relating with the aggressor. Eventually, new values and healthy modes emerge.

There is a tendency to overemphasize the existing family pathology without giving due recognition to healthy elements that are present and that may be mobilized even in the sickest family constellations. Family therapy may activate latent resources not apparent during phases of family crisis when members collide with and withdraw from each other. How effective this can be is illustrated by the experiment of family-oriented therapy in 50 cases of acute decompensation applying for admission to the Colorado Psychopathic Hospital (Pittman et al, 1966):

On the assumption that the suicidal act or psychotic collapse was one manifestation of family disorganization, the therapeutic goal was as rapid restoration of the family equilibrium as was possible while developing new roles among the members. An immediate evaluation of the family problem was made, and absent relatives were summoned to the hospital. The patient's symptoms were considered as efforts at communication and were interpreted to the patient as such. Guilt feelings and reluctance to cooperate on the part of relatives were dealt with firmly. The involvement in the

patient's problem of each family member was demonstrated, responsibilities were outlined, and tasks assigned. The patient and family were faced with the grim fact that the presenting symptoms of the patient were escape mechanisms and that a modification of family roles and rules was the best way to proceed. Role assignments were considered important, and tasks were allotted to each family member. This ended the functional paralysis in the household. A team visited the home in 24 hours to see that the tasks were being carried out. Medications were prescribed when necessary. Any social agencies already servicing the family were included in the planning. Responsibility for the patient's symptoms was imperatively placed in the family to reinforce the need for cooperative task performances. As new rules were made and role assignments set up, daily visits were sometimes necessary to help meet the needs of the different members and to see to it that the treatment plan was being followed. Pressure was exerted on the patient and family to change, their responsibility to change was preemptorily assumed. The success of this experiment was demonstrated by the fact that hospitalization was avoided completely in 42 of the 50 cases; 6 cases required temporary care for an average of 17 days, and only 2 cases needed long-term hospitalization. An average of 6 home or office visits per family was required, and some member in 75 percent of the families was referred to another agency for long-term outpatient services. Ten of the 50 families called again about a subsequent crisis, but this usually required only telephone handling.

In patients who have been hospitalized, conjoint family group therapy has been done with four or five patients and their families meeting together as a group led by a therapist and co-therapist (Laqueur & LaBurt, 1966). The objective of such meetings is not to solve problems or give advice, but to improve communications within the family and to explore attitudes likely to form sources of difficulty in the family that may lead to a relapse of illness in the patient when returning home. The families have an opportunity to learn from each other by analogy, indirect interpretation, mimicking, identification, and objective description. (Techniques in family therapy are described in Chapter 52.)

Conjoint Treatment of Married Couples (Marital Therapy)

The realization that no psychopathological condition exists in isolation, that it is an appendage of more extensive psycho-pathological processes within the family structure and social matrix, has resulted in a recasting of individual psychodynamics in the mold of family and social dynamics. A consequence of this orientation has been to see both husband and wife together as well as individually, or in groups with other married couples, even though symptoms occur in only one partner. Experience persuades that a feedback of pathological processes goes on from one to the other partner and that these must be dealt with definitively before either one can get well. In studying marital alliances, it becomes apparent that in many cases the choice of a marital partner rests on the hope that the prospective spouse will fulfill urgent unconscious needs that have been consciously rejected and repudiated. The most compelling of these needs are transferred by the mechanism of projective identification to a spouse who one hopes will introject and act them out. Reciprocal needs in the spouse follow the same dynamic and result in an interlocking projection-introjection collusion that makes psychotherapy difficult unless both partners are involved in the therapeutic plan. Otherwise, improvement in one spouse can result in disruption in the homeostatic balance of the other, encouraging a sabotage of the partner's treatment.

A variety of treatment tactics have been used in this conjunctive effort, including counseling, casework, small group process, group therapy, and intensive psychoanalysis with a Freudian or neo-Freudian accent. Among the most important intervention strategies, in addition to the psychoanalytic (Abies & Brandsma, 1977; Sager, 1976), are systems therapy (Haley, 1976; Minuchin, 1974a&b), client-centered approaches (Guerney, 1977), behavior therapy (Jacobson & Margolin, 1979), and combined therapies (Paolino & McCrady, 1978). Formats include crisis counseling, collaborative therapy, concurrent therapy, conjoint marital therapy, conjoint family therapy, combined-collaborative therapy, and multiple group therapy. The extensive early writings include Bird and Martin (1956), Boas (1962), Bruyn and deJong (1959), Dicks (1953), Dreikurs (1950), Eisenstein (1956), Ellis (1958a&b), Faucett (1962), Green S. (1954), Greene & Solomon (1963), Grotjahn (1960), Gomberg (1956), Goodwin and Mudd (1961), Harrower (1956a), Hastings and Runkle (1963), Harper (1960), Herbert and Jarvis (1959), Jackson and

Grotjahn (1958b), Kadis (1963), Kohl (1962), Katz (1965), Laidlaw (1950), Leichter (1962), H. E. Mitchell (1963), Mittelman (1944a, 1948, 1956), Oberndorf (1938), Perelman (1960), Sager (1966a&b), Satir (1965), Saul et al. (1953), Sarwer-Foner (1963), Tharp (1963), A. Thomas (1956), A. S. Watson (1963), and Whitaker (1958).

Later contributions include those of Alger (1967a, b), Berman and Lief (1975), Bolte (1970), Fitzgerald (1969), Framo (1973), Greene (1972), Hurvitz (1970), Martin and Lief (1973), Minuchin (1974a), Sager et al. (1968), Watzlawick et al. (1967). The extensive bibliography in the field indicates the wide prevalence of marital pathology.

Couples in trouble often consult marriage counselors, ministers, lawyers, and even friendly people of goodwill to advise them on proper steps to straighten out their entanglements. Where the partners are not too seriously plagued by neurotic drives, where their defenses are flexible and reasonably intact, and where they essentially love and respect each other, they may at least temporarily be held together in marriage by such consultations. Usually, however, the sources of serious marital problems are rooted in inner conflicts and stem from the operation of personality disturbances that resist pressure, education, convention, and the lessons of morality and proper decorum.

The prescription of tasks and exercises that are intended to influence couples to be less abrasive toward each other, to communicate more constructively, and to foster a balanced relationship will therefore not succeed in those couples whose behavior is intractably motivated by urgent unconscious needs and impelling inner conflicts. For example, if a wife transferentially relates to a husband as if he represents a hateful brother with whom she was in competition during early childhood, she may resent being nice to him and continuously fail in her therapeutic assignments. A husband who is struggling with a dependency need, idealizing his wife as a mother figure who must love, nurture and take care of him, may be unable to give up acting irresponsibly, resisting the independent role his wife insists he must assume as a condition for more fruitful living together.

We should not minimize the utility of the various persuasive, behavioral, and cognitive techniques practiced by counselors to expedite marital congeniality. They can be

valuable, but they will miss their mark if one utilizes them while ignoring the enormously important developmentally inspired motivational forces that are constantly maneuvering marital partners to act against their best interests. These more insistently dictate the terms of conduct than any injunctions, maxims, precepts, recipes, prohibitions, and interpretations presented by the most skilled and dedicated marital counselors.

Most therapists dealing with marital difficulties agree that the complex triangular transferential problems inherent in working with a couple make treatment difficult. As Ackerman (1964) has pointed out, the therapist's role is that of a participant-observer, who must be forthright and at times even blunt. As the therapist moves alternately in and out of the pool of marital conflict, it is necessary to make free and undefensive use of oneself. Sager (1964) has suggested five levels of involvement in conjoint sessions:

1. Elucidation of the current source of irritation between the spouses.

2. The working through of role, function, rule setting, and who is in charge.

3. Consideration of how roles intermesh or clash (complementarity).

4. Recognition and analysis of defensive behavior.

5. Understanding and dealing with transferential reactions.

V. M. Satir (1964a&b, 1965) encourages the couple to be authentic and spontaneous and to risk committing themselves to reporting all feelings and thoughts without inhibition. Through what she calls "communication analysis," she attempts to help each partner change so that self-maintenance is substituted for "parasitic operations." An analysis of the respective ideas of the interaction of parents as marital partners is encouraged ("model integration analysis"). Often one finds in such analysis that marital partners attempt to accomplish in their relations with one another what was lacking in the families of their origin. What they assume with each other is not a husband-wife association but a parent-child or sibling relationship ("role-function discrepancy"). A number of processes become apparent in the working through of role discrepancies. First, the individual attempts to perpetuate his or her style of matching current experiences

with previous expectations ("manifesting self"). Second, there is recognition that the individual has separate needs and modes of operation apart from the spouse ("separating self from the other"). Third, accepting the uniqueness of the separate selves, there are attempts at decision making, considering the needs of the partner ("making room for the other"). Fourth, a search is conducted for compromise settlements of life needs, negotiating for what is suitable ("ways in which differentness is acknowledged"). To achieve these goals best, the therapist must report to the couple fully and clearly what he or she observes in the marital interaction. The therapist acts as a "model of communication," asking questions, intervening, giving answers, and demonstrating how to pose questions, and to negotiate for meaning. The therapist serves as a resource person, presenting a delineated structure that encourages change in a way that permits the marital pair to identify and use its own resources.

The advantage of treatment of two individuals connected by blood, marriage, or friendship, together or separately, according to Grinker (1966), are many, such as revelation of new areas of information, a more precise clarification of issues, stimulation of intense affect, mobilization of repressed content, provocation of transferential and countertransferential reactions, increased reality testing, and reduced acting out, all of which provide for a corrective emotional experience and help shorten therapy. On the other hand, there are disadvantages in that the released heightened emotions can be upsetting to both patient and therapist: The divulged material of one or the other partner puts a strain on confidentiality and trust; the atmosphere becomes provocative of intense transference and countertransference, leading to acting out on the parts of therapist and patients; the trap doors to repressed or suppressed feelings and impulses are lifted too rapidly to permit proper control and working through of the material; and the therapist is more easily led into a sadomasochistic triangle.

The actual techniques of marital therapy are detailed in Chapter 52.

Criticism of Educational Group Therapy

There is little question that an educational group, chiefly through group dynamics,

can influence values and behavior significantly. It may provide the individual with opportunities for constructive learning and serve as a means of working through some distortions in the basic personality structure. The benefits of reeducation, however, are too often registered as an overlay, superimposed on unchanged underlying impulses and attitudes that will, in situations of stress, tend to displace the newly acquired characteristics. Unless intrapsychic restructuring has occurred, results may be impermanent. This is not to depreciate group dynamics, nor to say that true cognitive alterations are not effectuated through reeducational groups. They do occur, but they cannot always be relied upon.

Wolf and Schwartz (1962) have pointed out the difficulty of relying on group dynamics as a therapeutic force: "The group dynamic emphasis brings with it a failure to differentiate one patient from the next and occupies itself with phases of group development… . The use of group dynamics in interpretation and as a means for affecting change in the individuals that constitute the therapy group is a misperception and a rejection of both intrapsychic and interpersonal processes." The authors consider that in a group directed toward personality change, one should consider group dynamics as they emerge as resistance phenomena that must be resolved. "A group therapist who occupies himself with group dynamics is catering to the patient's resistance. To contemplate the seeming homogeneity of response is to give undue importance to the superficial and obvious reaction and to disregard the covert and unconscious individual responses."

There are some group therapists, such as Bion (1961), who attempt to circumvent the limitations of reeducational therapy by utilizing group dynamic phenomena, when they appear in a group, as material for analysis of the group as a whole on the basis that resolution of the "group neurosis" will effectuate reconstructive changes in the individual members. This approach is described by Bach (1954) in these words: "The group is a state or projection screen onto which the total repertoire of conscious, pre-conscious, and unconscious needs are internalized, projected, acted out, recognized, and corrected through a group-center therapeutic work process." H. Durkin (1957) has stressed that group dynamic and psychotherapeutic processes are on the whole mutually reinforcing.

Both group dynamics and interpersonal reactions are present in all groups. They may be destructive as well as constructive for the individual. If therapists apply themselves to support the beneficial elements, with analysis and resolution of destructive aspects as they come up, a reeducative group may serve the individual remarkably well in fostering a more wholesome adjustment and in liberating tendencies toward greater self-realization.

PHILOSOPHICAL AND RELIGIOUS APPROACHES

Essential in human adjustment is a salutary philosophy that gives direction to one's needs and substances to life's goals. Philosophical and religious systems abound that lend purpose and meaning to existence. Embedded in these ideologies are ways of adjusting to inequities, of executing obligations to others, of finding peace and contentment. More remotely, they seek to alter the individual's sense of values.

A fundamental goal of psychotherapy is to effectuate a change in value systems through an altered perception of one's inner self. Philosophical and religious approaches aim for and sometimes accomplish the same purpose through a different means, namely, by direct attempts to influence modes of looking at things through entreaty, logic, argument, or authoritative mandate. Such approaches are often embraced in an effort to bring about peace of mind, to bolster personality defenses, and to open up outlets for promptings that could otherwise neither be countenanced nor expressed.

Since psychological needs are diverse, no single religious or philosophical credo appeals to all persons. Variant drives and defenses make for endless protocols that are organized to fit specific designs. Thus, ungratified mothering will open the door to the acceptance of philosophical or religious systems that promise protection, love, and pleasure from some "God-mother" or "earthmother," if not immediately, then in the hereafter. The price of submission, condign obedience, and indulgence in ritual and prayer, is small indeed for the size of the bounty promised. Illustrative of how philosophies may substantiate coping mechanisms are the mystical cults that reinforce detachment and introspection and the stoical systems that put a premium on masochism and self-punishment. Credendas and codes can neutralize a severe conscience that puts an

embargo on impulse expression. For example, acceptance of hedonistic philosophies will in guilt-ridden persons help promote pleasure as a prime purpose.

It is interesting that, in organizing values, modern humankind still exploits philosophical systems that parallel those developed hundreds and even thousands of years ago. Thus, *hedonism* may be commandeered as a credo to give sanction to impulses for unbridled pleasure seeking. In conditions such as psychopathic personality, alcoholism, drug addiction, and sexual perversion, a doctrine that endorses pleasure as a mainstay of life may lend patronage to an irresponsibility that is prompted by uncontrollable inner needs. *Epicurianism* may be espoused as a means of balancing an incubus of guilt in persons with consciences that refuse to lend sanction to life's delectations without restraint. Worries are purged from the mind as wanton waste, with encouragement of (1) regulation of one's life to anticipate unpleasant events so that they may be avoided, (2) arrangement of matters so that as much pleasure as possible may be crowded into each day, (3) elimination of those pleasures for which one has to pay too dearly, (4) the judicious cutting off of thoughts that mobilize pain or create tension, and (5) the banishment of profitless recriminations about the past or anticipated fears of the future. In the canons of *stoicism* the detached soul often finds refuge. *Skepticism,* the philosophy of doubting, serves some obsessive-compulsive personalities in their quest to achieve tranquility. By scrupulous doubting and withdrawing into the self, the skeptic attempts to escape unhappiness. This suspension of judgment ("isosthenia") results in a state of mental balance ("epoche"). We might speculate that the basis for the skeptical maneuver is a defense against a severe, dogmatic, and authoritarian conscience. The skeptic is fired by a desire to avoid the controlling hand of fate. By doubting, the person negates it thus gaining liberation from the shackles of cosmic doom. In this way the person neutralizes anxiety. At the same time the refusal to arrive at definite judgments perhaps falls in with the coexistence of ambivalent value systems often a product of inconsistent disciplines in childhood. Diametrically opposed to the values of skepticism are those of *dogmatism*, which, as a philosophy, may be exploited for inner harmony and peace of mind. This is the sanctuary of a severe and authoritarian conscience that seeks constant control because of a devastating fear of uncertainty and the unknown. The dogmatist

seeks to mold fate to his or her own controlling prospectus. It may be seen, then, that the values of certainty and truth—and the need for a precise structuring of reality in the dogmatist and the value of doubting in the skeptic that negates certainty and structure— are both manifestations of obsessive-compulsive personality structures and constitute different modes of coping with precisely the same kind of anxiety.

Individuals reared in a religious atmosphere, or achieving a decision through a need for personal salvation, may at times become dedicated to the adoration of God, either as a symbol of power and protectiveness or in the form of ethical self-devotion—for instance, as a Christian in the morality embodied in Jesus Christ. They may then conceive that what appeals to their souls as deserving of worship is what they feel their souls may trust, which has the ability to deliver them from evil, sin, fear, and death. In this way they will, according to their interpretation, attempt to conform to the purpose of the life of their Savior, with expressions of devotion to God and love for humanity in accordance with the theological creeds and sacraments and in the church, synagogue, temple, or mosque within which they find their identity. Those aspects of religion that possess greatest meaning will be cherished whether they involve ritual, sacrament, logic, belief, faith, or the privileges of church membership. The values for the individuals will be contingent on their needs and range from the comforts of group belongingness to the enhancement of the spiritual aspects of the self and the enrichment of moral goals. This is not to say that neurotic objectives may not be sought through the exploitation of religion's instrumentalities; for religion, with its Divinities, ceremonials, dogma, and taboos offers the neurotic individual rich resources for the projection of strivings, demands, and defenses that keep him or her in psychological homeostasis. Whatever the motives, belief in God and reliance on prayer, according to a recent Gallup poll, are on the upswing, and more people in the United States today than in the past three decades believe that religion is having an increasing influence on U.S. life. Sixty-one percent of those interviewed feel that religion can answer all or most of today's problems. Even in countries that have tried to abolish religion as "the opiate of the people" efforts have not been too successful.

On the other hand, the values of science may become for some individuals, at least

temporarily, of supreme importance in supplying answers to the ultimate meaning of reality. They will then extrapolate from the data of their observations the functional relationships between pertinent variables in the hope of bringing some order to the phenomenalistic chaos that invests their lives. Through the doorway of empiricism, rather than faith, they will approach purpose and meaning. And yet they will, realizing the limits of reason, attempt from time to time to liberate themselves from the tyranny of their senses by introspection and subjectivism.

Transcending the empirical sphere into the hazardous world of speculation, some people in their quest for meaning, take a journey into arcane zones. Accepting the dictum that "things may not be quite other in themselves than that which by the laws of our thought they necessarily appear," people weld together concepts by the powerful force of faith. In search of experience beyond knowledge, they penetrate into the penumbra of *mysticism.* Justifying their illusions of reality, they argue that humans are limited by the testimony of their senses. Perspectives of reality are always relative to the percipient. No universal standard exists or can exist except that which each person discovers by retreating into the self. Liberated from the fetters of reason, the individual can blend with the Absolute and then perceive the ultimate nature of reality. His or her mind, the individual may believe, is directly linked to the Cosmic Mind, which All-seeing and All-knowing can fashion his or her destiny and direct his or her journey through infinity from gloomy evil toward the luminous fields of spirit, love, and truth. It is to be expected that the mystical path to tranquility is the refuse of some who are unable to brook the harsh realities of their existence, whose coping mechanisms have failed them, or who have lost their faith in the dignity of humanity and the virtue and safety of the material world.

Organization of one's life around philosophical religious, or, for that matter, "scientific" values is an inescapable aspect of mental functioning. These centralizing points are woven into the complex tapestry of adjustment. They may be adapted, changed, or discarded as the shifting needs of the individual dictate modification.

Mysticism

Mysticism possesses properties that have led a number of psychotherapists to explore its therapeutic potentials, some even attempting to blend mystical formulations into their treatment systems, as, for instance, Zen Buddhism (Suzuki, 1947; Watts, 1957; Ben-Avi, 1959). The mystical striving is twofold; first, there is an attempt to achieve communion with the Absolute (the Highest, the One, God, Brahma, the Order of Heaven, Being of beings) and, second, a desire to grasp through introspection the ultimate nature of reality.

The Absolute is conceived of in various symbolic forms as an encompassing, irresistible, indwelling power that can overcome the temporal, the changing, the relative, the impermanent, and other aspects of existential anxiety. The Absolute establishes stability, methodical arrangement, and permanence in the universe. Since it is impossible to approach it through the senses, the establishment of the Absolute is attempted by epistemological arguments, by mandates in sacred writings presumably divinely inspired and enforced through religious discipline, and by mystical experience.

Approach to the Absolute through mystical experience has an old and elaborate history. In such experience there is no need for intermediaries, such as oracles, priests, historical revelations, or prayers; rather direct and personal contact is made, resulting in an identification and fusion with the Absolute substance. Description of the austerity of mortifications suffered, of the rapture of the visions, and of the intoxication of the senses as the soul finds its resting place with the Absolute have produced some of the world's most florid and poetic literature. The mystical experience may become a part of multiform religious or philosophical systems. Historically, it was organized into bodies of practice among dissatisfied adherents of the inflexible, formalistic, and legalistic religions who sought to detach themselves from the ossification of formulas and ceremonies toward a liberating union with a divine spirit.

A search for the Absolute has preoccupied philosophers and theologians throughout the ages. Its most prominent forms have been found in Eastern systems, for example, the Brahmanic and Buddhist religions, which promote the illusory nature of reality and the

goal of absorption in mystical essences toward ecstatic enlightenment ("nirvana," "satori"). Reeducation of the self to plastic passivity as a precurser to the transcendental experience is encouraged by sets of rules outlining contemplative and ascetic rituals that are said to result in an expansion of consciousness and in the promotion of self-control.

In all mystical systems direct personal experience is approached through states of absorption in which the individual becomes aware of oneness with the Absolute. By various stages the mystic achieves this union. Through meditation the student invokes reason, memory, and will, concentrating on some scene or subject. In Western religious systems, the student may employ a preparatory prayer for Grace, focusing on several points in the image he or she creates, then pouring devotion out freely into the Colloquy. In Eastern systems an attempt may be to suspend reason, employing certain aids, such as breathing and body control, as in Yoga; or practice of the arts, like archery or flower arrangement in Zen Buddhism; or indulge asceticism to bring the body under regulation to extinguish desire and reduce the self to submission. Gradually, reason gives way to inner contemplation, and even to hallucination. Excitement, rapture, despair, and varied other emotions may develop within the matrix of a delicious solitude.

A symbolic dialect unites mystics of all persuasions. In different words there is described the same adventure: the "paradox" of existence, the "journey" into the unknown within, the periods of "darkness" and "light," the excitement and enlightenment at achieving the strange and wonderful world of inner reality, and the "marriage" with the Absolute or Divine.

What patients derive from mysticism is illustrated in a letter to me by a professional man who had immersed himself in it.

> For me there is nothing "mysterious" about mysticism. Rather, it gives a clear view of how to best live my life for myself and others. "Mysticism" is a commitment to life and reality, nothing less than a seeking of total conscious awareness and identity with life itself. Not a merging of the ego beyond the cognitive, sensory, and emotional structures which, though they are so necessary for our day-to-day productivity and happiness, nevertheless, can be seen as limits when we set our sights on our relationship to God and the cosmos. (The questions, "Who are we? Why are we here? Where are we going?") The ego and awareness naturally expands as we

progress from infancy to adulthood and finally obtain the perspective of old age. For some, this process occurs experientially, for others—they crawl their way through life still dragging their childhood fears and fantasies behind, creating for themselves in their lives an ensnaring chaos, from which the consciousness longs only for escape, not greater understanding. For me, once or twice a day, meditation, or rather, contemplation, and active fixing of attention, has gone hand-in-hand with my psychotherapy in accelerating my awareness. It gives me the conscious experience of my larger self, or the whole knowing and loving the whole at every point—my awareness being just a point in this sense. It is the realization that I am a lot more than I thought I was.

Eastern Systems

Hindu Philosophical Approaches: Yoga

Historically, Hinduism preceded Buddhism. It was a polytheistic system, with sacred writings (Vedas and Brahamanas) that developed into an elaborate sacrificial and ritualistic movement. Essentially, it conceived of an absolute spirit, the Brahma, as the source and goal of all things. Creative, conservative, and destructive principles were reflected in the divine personalities of Brahma, Vishnu, and Siva, who respectively represented creation, preservation, and destruction. While many forms of Hindu religion have evolved from its early origins, there is generally accepted the doctrine of *Karma,* which makes humans accountable in the present or in their reincarnations (transmigration of souls is a principal belief) for their good and bad actions. Karma of the spirit can drive humans to evil, toward a concern with matter and selfishness, or toward selfless good and love.

Modern Hindu systems of philosophy are employed to help the distressed. These, according to Vahia (1962), conceive of the basis sources of conflict or disturbed peace of mind as threefold:

1. Too intense emotional attachment to external things, such as possessions, status and power, which inevitably produces destructive competitiveness.

2. A delusion that humans with their finite mind can understand cosmic reality, which is actually beyond human comprehension.

3. Inharmonious interactions with other people, such as (a) excessive attachments,

(b) too powerful emotional yearnings, including love, (c) inordinate jealousy, and (d) unreasonable anger.

While these conflicts are universal, the special way in which they operate is unique for each individual.

Measures, valuable for the achievement of peace of mind, will vary with the personality. Three main categories of people exist, and the approach will differ in each. First, there are those who operate on the basis of intellectual understanding; the second are swayed primarily by sentiment and emotion; the third are insistent on a practical solution without analyzing the problem or bothering about feelings.

Those persons who wish to learn the essential techniques may seek the guidance of an expert. No attempt is made at the start to understand the problem. Rather, the person is taught the principles of relaxation. Various postures are tried until the best one is discovered. Voluntary muscles are relaxed; then an attempt is made to bring the involuntary nervous system under control. Once respiration is regulated, heart action and management of other aspects of the cardiovascular system are attempted. By special exercises, the stomach and intestines are also relaxed; the autonomic nervous system is brought under voluntary management. This will require a long period of work under supervision.

Complete muscle laxity enables the individual to proceed to the practice of meditation in order to achieve a void where the intellect is suspended. What is desired is a new objective kind of understanding. Concentration is shifted from the sources of problems to an object of faith and love, focusing on the latter as a way of removing the investment in the conflict. For example, one may focus on the idea of God or a prophet. Hinduism is an ideal religion on which to meditate. The concept of God becomes a concept of "everlasting unchanging cosmic reality… . This, the only Reality, is free from life and death, or pleasure or pain … from love and hatred, pride and prejudice." By identifying oneself with this reality, one may eschew emotional involvement and best be able to study the forces that have led to one's difficulties. A state of mind is achieved "where peace

prevails and turbulence, if any, is only transitory." In this way one can eventually "remain unaffected by any event of stress and strain."

Eastern philosophical systems were not designed as forms of psychotherapy. They were oriented around promoting spiritual growth and achieving a oneness with the Universal. The resulting serenity and tranquility, however, may palliate a mind in turmoil and shift values toward harmony with the world, thus indirectly registering a therapeutic impact.

Appraising what may be accomplished in this approach, we observe a combination of supportive and reeducational modalities:

1. Relaxation helps to resolve tension and to relieve anxiety.

2. Meditation redirects thoughts from anxiety-laden sources toward those that sponsor a more constructive life orientation.

3. Guidance from the helping agency helps to buttress defenses and to insulate oneself from sources of anxiety by (a) encouraging detachment from emotional situations, with avoidance of competitive strivings and a removing of oneself from involvement with other persons, (b) making oneself dependent on a power stronger than oneself through mystical cosmic unity, and (c) promoting independence by means of introspection and self-realization.

Yoga, a form of Hindu mysticism, had its origins in an idealistic monism, the Vedanta philosophy, which conceived of the world as a conscious spiritual principle permeating all things, the *Atman.* "The wise who perceive him as being within their own Self, to them belongs eternal peace, not to others" (Katha-Upanishad, ii, 5, 12). A modification of this philosophy in the *Sankhya* system assumed "the eternal coexistence of a material first cause and a plurality of spiritual elements or Selves, *Puru-sha.*" A schism in the *Sankhya* movement developed that added the concept of God. This, the *Yoga* system, advocated a mortification of the senses, brought about by such measures as prolonged fixation of the eyes on the nose, protracted assumption of rigid postures, to liberate energies, and a new awareness. The purpose was to bring about an ecstatic vision of the Deity and perhaps the

acquisition of miraculous powers.

Hoped for was a permanent union with the Supreme Being.

To achieve the concentration essential for this, eight stages are deemed necessary:

1. Self-control *(yama)* obtained by such devices as chastity, nonstealing, nonviolence, truthfulness, and avoidance of greed.

2. Religious observance (*niyama*) through chanting of the Vedic hymns, austerity, purity, and contentment.

3. Assumption of certain postures C*asana*).

4. Regulation of the breath *(pranayama)* with controlled rhythmic exhalation, inhalation, and temporary suspension of breathing.

5. Restraint of the senses *(pratydhara*) by withdrawing of the senses from their objects.

6. Steadying of the mind *(dharana)* through fixation on some part of the body, such as the nose or navel.

7. Meditation *(dhyana)* on the true object of knowledge, the Supreme Spirit, to the exclusion of other thoughts.

8. Profound contemplation *(samadhi)* with such complete absorption and detachment that there is insensitivity to heat and cold, pain and pleasure.

The "Yogin" who arrives at perfecting the last three stages (*samyana*) achieves an ecstatic mystical state that stimulates ability to have an awareness of the past and future, of what has happened in previous births, and knowledge of "everything that exists in the world and in his own body." Proper application of the *samyama* promises "complete control over everything in the universe," "traversing anywhere at will," and other miraculous powers, including, finally, a complete release of the intellect from the self, purity, and eternal liberation in the form of separation of matter from spirit *(Raja-yoga* or *Kaivalya).*

Modern practices of Yoga essentially avoid asceticism in quest of the mystical experience of "awakening." The ultimate goal is fusion with the Absolute, during which the person experiences the highest wisdom and most profound truth of being, thus gaining possession of his or her real self through expanded comprehension and self-realization (Bagchi, 1936; Behanan, 1937; Yesudian & Haich, 1956; Yeats-Brown, 1958; Wood, 1959; Malhotra, 1963; Majumdar, 1964).

Buddhism and Zen Buddhism

A young prince, Gautama Siddhartha, at the age of 29, during the sixth century B.C., struck with the suffering of humankind, deserted his family to search for the true meaning of life. For years he wandered, attempting in vain to reach the "truth" by fasting, self-torture, and meditation, which were prescribed by the traditional Brahmanistic teachings. One day under a fig tree, known later as the Bo Tree or tree of enlightenment, he suddenly achieved a glimpse of the truth. This was to the effect that the cure for unhappiness was a renunciation of selfish desires and a mastery of the self. He then taught others his discovery of how to find true happiness, and he became known as Buddha, the Enlightened One.

The great popularity of Buddhism was due to its making salvation available to all through personal efforts without the self-torture that existed in the older Brahmanism.

Among the teachings of Buddha were three basic concepts:

1. The soul of a person passes after death to higher or lower animals depending on whether the person performed good or bad deeds in his or her lifetime. The purpose of this transmigration is to overcome all desire. Then the soul no longer has individuality and may enter "Nirvana," a peaceful state of oblivion.

2. Release from conscious existence is hastened by pursuing the Eightfold Path of Right Faith, Right Intention, Right Speech, Right Conduct, Right Livelihood, Right Effort, Right Thinking, and Right Meditation.

3. There is no supreme God.

Over the centuries the teachings of Buddha underwent revision. Buddha, himself, became considered a god who had miraculously come into the world. Sacrifices of flowers and images were made in his honor. Elaborate rites and ceremonies were evolved. Legends were developed about Buddha and his might. Prayers to Buddha began to replace personal effort. Self-mastery gradually became forgotten as the most important goal.

The principles of Buddhism include the following four main ideas: (1) life is imbued with suffering; (2) suffering is the product of desires seeking fulfillment; (3) control of all desire and self-mastery can end suffering, hence celibacy is sometimes encouraged; and (4) pursuance of certain rules of living and of proper attitudes and knowledge leads to the overcoming of desire. The final objective in life is Nirvana, a blissful contemplation and peaceful state of oblivion, characterized by an extinction of the material personality and achievement of enlightenment.

Among the Buddhist sects, that of *Zen Buddhism*, a kind of introspective mysticism difficult to reduce to words, has most attracted Western psychotherapists. It is difficult for the Western mind, oriented as it is around logic, intellectualism, and determinism, to conceive of Zen. Satori ("enlightenment and awakening") experience is predicated on a suspension of the reasoning facilities, which are held to be a hindrance to the release of the intuitive essence of being. Zen is dedicated to the idea that one may solve all problems through intuition and enlightenment rather than through logical abstractions such as constitute the methods of the West. Zen cannot be taught easily since each person finds his or her own path through search and struggle.

A number of excellent books have been written about Zen (Blofeld, 1959; Conze, E., 1951, 1954, 1958; McGovern, 1922, 1923; Rhys-Davids, 1899-1938; Sasaki, 1960; Suzuki, DT, 1949, 1952, 1953, 1957a, b, 1959; Takakusu, 1947; Thomas EJ, 1931, 1933, 1935; Watts, 1957; Yama-kami, 1912). Practically all advocate the achievement of the extraordinary Satori experience (a oneness with Buddha) "which is devoid of emotion and intellectual content" through study with a Zen Master. One method commonly employed by the master is meditation on a Koan, a riddle for which there is no set solution. The Zen

Master operates by posing paradoxes, such as, "What is the sound of one hand clapping?" At the same time the Zen Master puts the student in an untenable situation. For instance, the master may threaten the student with a stick, saying, "If you call this a stick, I will beat you. If you say this is not really a stick I will beat you. And if you say nothing I will beat you." This establishes for the student a paradox that cannot be unraveled through customary modes of problem solving. Somehow the student must work out a reply that will satisfy the Zen Master. In the process of doing this, the student will have developed a unique mode of conceptualizing reality that dissociates him or her from habitual points of reference.

Another means to Satori may be through random activities such as flower arrangement or by practicing archery, as described by Herrigel (1953). What one strives for is an experience of being that cannot be described except in such terms as "free-movement of the spirit" and "an original and nameless essence." This is achieved by "methodical immersion in oneself" leading "to one's becoming aware, in the deepest ground of the soul, of the unmanageable Groundlessness and Qualitylessness—nay more, to one's becoming one with it." The experience cannot be reduced to words ("one knows it by not knowing it"), but it is said to liberate and change the human being. Only by true detachment can one become completely empty of the self and then "become one" with the "Transcedent Deity." In breathing exercises, in practicing archery, "I learned to lose myself so effortlessly in the breathing that I sometimes had the feeling that I myself was not breathing, but strange as this may sound—being breathed." What Herrigel is particularizing are psychological phenomena characteristic of all forms of mystical experience, which is, as has been indicated, the essential substance of Zen Buddhism.

Cultist Movements

A growing number of movements have developed that appeal to alienated young people seeking to dissociate themselves from the values and life styles of their parents and groups with which they are customarily identified. These cults appeal to school dropouts, drug abusers, borderline cases, youngsters with severe personality disorders, and

individuals in emotional turmoil. Many of these youngsters are simply unhappy souls who have been unable to complete their developmental growth to reasonable separation-individuation. On the surface they appear and act normal (Ross, 1983). Rejecting the usual religious and political tenets that are accepted in their families, they seek self-fulfillment through mysticism and a faith in an esoteric leadership onto which they can project their infantile needs and hopes. Heads of such movements are usually charismatic and grandiose gurus, ministers, or exploitative laymen whose pronouncements are sufficiently ambiguous so that the devotees can interpret them however they wish. Participants come to these movements of their own free will, recruited by acquaintances or friends who have become ardent supporters and salesmen. A brief exposure to such dedicated groups convinces the new recruits that they have finally found a resource that alleviates their anxieties and satisfies their search for purpose and meaning. Perhaps for the first time, these individuals feel accepted by their peers and find their dependency needs gratified by submitting to the rules of the leader (with whose grandiosity they may inwardly identify) and the mores of the group members, who become for them a new and more accepting family. Needless to say, these developments are often viewed with horror by a recruit's parents, who may, in their turmoil, seek ways of extricating their child from what they consider a most destructive and bizarre way of life. Should the parents succeed in removing their deviant from the group by kidnapping or legal means, an attempt will often be made to deprogram the presumably brainwashed victim. Such efforts usually prove unsuccessful, unless the deviant is sufficiently motivated to seek help from a professional who has had experience in dealing with his or her problems. Coordinate family therapy is usually essential.

Among the most common cults are the Hare Krishna movement, Arica, and the Unification Church of Reverend Sun Myung Moon. In 1965, A.C. Bhaktivedanta Phapupadha came to the United States to bring to the needy the benefits of his transcendental teachings, including *Bhakti yoga,* which endorses dietary and sexual abstemiousness and various taboos against intoxication, gambling, and aggression. The Hare Krishna movement sponsors community living devoted to the worship of Kirshna, one of the incarnations of the god Vishnu, "to help man in distress." The followers of this

sect in the Western world assume the dress and life style of the ancient Vedic society and devote themselves to a simple religious existence, chanting the glories of Krishna as a way of perfecting their lives. Many other movements, such as the Self-Realization Fellowship of Paramhansa Yogananda, have attracted enthusiastic followers who claim that the Vedic teachings have brought purpose to their lives and harmonized their physical, mental, and spiritual natures.

The Arica Institute was founded in 1971 by Oscar Ichazo a Bolivian. Presented as a course of training, it teaches meditation to obtain a state of liberated consciousness; deep body massage to release mental stress; "protoanalysis" to understand the destructive ways the body seeks to express stress; "psychoalchemy" to transfer physical into psychic energy; "Kinerhythm," in which slow movements help evoke ecstasy and "yantras"; "Pneumorhythm," which combines breathing with rhythmic counting to expand consciousness; "Opening the Rainbow Eye," which provides a state of "satori" in which all internal and external experiences are seen clearly; the "Alpha Heat" ritual to free the mind of worry, regret, rivalry, hatred, envy, pretense, fear, jealousy, and prejudice; "Trialectics," which teaches the logic of unity to permit the analysis of reality; the "Cutting the Diamond" ritual to complete the mystical union; "Hypergnostic Analysis" of internal meanings and connections of things; the "Golden Eye" ritual to observe the voyage of consciousness inside the body and to transfer consciousness; and the "Psychic Shapes" ritual, which sponsors the internal recognition of the Unity of God. These practices and rituals have attracted hundreds of thousands of followers who often gather in communes where Arica is taught.

The Unification Church, founded by Reverend Sun Myung Moon and which has received a great deal of publicity in the press, is intended to rectify the "moral confusion" and "the absence of a clear sense of values" that threaten America's spiritual heritage. Presented as signs of such corrosion are child abuse, prostitution, abortions in girls below the age of 18, fatherless children, juvenile crime, drug deaths, suicide, murder, robbery, assaults, burglary, and divorce. More generally, followers believe there is a universal lack of well-being and a sense of unfulfillment and unhappiness. All these woes stem from

"confusion in the hearts of individuals." What is necessary is a revolution within men and women that only God can bring about through a "new revelation." Reverend Moon claims that this truth, which current religion, philosophy, and ethics have been unable to supply, was personally revealed to him by God, who appeared and selected him for the mission of revelation. Thereafter, Reverend Moon journeyed into the spirit world many times, and God instructed him to teach the revelation, the Divine Principle, in every corner on earth. It is now taught in all languages in 127 nations. Through this revelation, says Reverend Moon, alcoholism and mental illness can be cured, physical healing occurs, and racism and nationalistic prejudice disappear. Fresh hope, love for one's fellow brothers and sisters, and happy marriages are said to become a way of life. These bounties are available to those who join the Unification Church. And thousands upon thousands of people do in order to live the prescribed life and to receive the important revelation (Galanter et al, 1979).

To detail the specific beliefs and rituals of all the different cultist movements would encompass a textbook in itself and would merely repeat what has been written elsewhere (Patrick, 1976; Edward, 1979; Levine & Salter, 1976; Ungerleider & Wellisch, 1979; Levin & Zegans, 1974; Marmor, 1984). Suffice it to say that the psychopathology in some of the leadership and followers is relatively high. Nonetheless, the movements seem to serve some purpose in stabilizing disturbed individuals who otherwise would become drug addicts, delinquents, psychotics, and victims of suicide. It is an indictment of society that more rational group resources have not been made available. It may be that the successes of experiential groups (see Chapter 52) serve the same purpose as religious cults by supplying some populations with avenues for gratification of their personality needs, albeit in more socially accepted and less peculiar ways.

Western Religious Approaches

In the Book of St. Matthew (17:14-18) there is recorded the following miracle:

> ...there came to Him a certain man, kneeling down to Him and saying,
>
> Lord have mercy on my son: for he is a lunatick, and sore vexed: for oftimes

he falleth in the fire, and oft into the water.

> And I brought him to thy disciples, and they could not cure him.

> Then Jesus answered and said O faithless and perverse generation, how long shall I be with you? how long shall I suffer you? bring him hither to me.

> And Jesus rebuked the devil; and he departed out of him: and the child was cured from that very hour.

Religious healing, recorded in the successes of Jesus, is legendary.

> And great multitudes came unto him. having with them *those that were* lame, blind, dumb, maimed, and many others, and cast them down at Jesus' feet; and he healed them.

> Insomuch that the multitude wondered, when they saw the dumb to speak, the maimed to be whole, the lame to walk, and the blind to see: and they gloried the God of Israel. [St. Matthew 15:30-31]

The inspiring effects of divine influence are testimony to the fact that a human being has the potentiality for extraordinary response to the proper authoritative mandates. Faith cures are irrefutable. Under favorable circumstances the ravages of physical and psychological illness may be palliated. Some may even be permanently resolved.

The relief of inner turmoil through faith is dramatically described by St. Augustine:

> How then do I seek Thee, O Lord? For when I seek Thee, my God, I seek a happy life. I will seek Thee, that my soul may live. For my body liveth by my soul; and my soul by Thee.... When I shall with my whole self cleave to Thee, I shall nowhere have sorrow or labour; and my life shall wholly live, as wholly full of Thee. Thou fillest, Thou lifteth up, because I am not full of Thee I am a burthen to myself.... Woe is me! Lord, have pity on me. Woe is me! lo! I hide not my wounds; Thou art the Physician, I the sick; Thou merciful, I miserable.... And all my hope is nowhere but in Thy exceeding great mercy.

A study of comparative religions elucidates the vital role that religion has historically played in the emotional adjustment of people. Its survival as one of the most potent of institutions for the supplying of some vital human needs is manifest; in the face of the most devastating attacks by science on the authenticity of its sacred documents, it continues to function unabated. This, Montaigne claimed, was because religion is "man's only succour from his native state of helplessness and uncertainty." Carl Jung (1933),

denouncing Freud's antireligious attitude, wrote that "man has never yet been able singlehanded to hold his own against the powers of darkness—that is, of the unconscious. Man has always stood in need of spiritual help which each individual's own religion held out to him."

The survey of the Joint Commission on Mental Illness and Health (1960) indicated that, on the whole, persons who regularly attend church have less discomfort than those who do not. Whether religion can be serviceable for a specifio patient will be contingent on the person's special needs and his or her propensity to employ religious principles for healthy or neurotic gains.

There is no doubt that dramatic relief from neurotic suffering is possible after religious conversion. Through conversion the individual may harmonize with the order of the universe and feel a oneness with the world or a union with God. Riddled by anxiety, tortured by self-doubt, the person in anguish is susceptible to the help held out through salvation by the evangelist. A reeducational experience develops as the person moves in the conversion from defeatism to hope. By confessing wickedness, the convert attains both forgiveness and the means to a blessed existence. Feelings of insignificance are replaced with a sense of distinction as one of God's instruments. Competitive strivings are abandoned; hate changes to love, tolerance, and compassion. Remarkable shifts in attitudes and behavior may follow. Such experiences have been reported in detail by William James (1941) in his *Varieties of Religious Experience.* The consequence of these transformations is another matter, since psychic stability is sometimes restored at the expense of general psychological integrity. Many patients come to psychotherapy after extensive efforts of religious devotion have failed them. Other patients who have received psychotherapy find themselves more fulfilled by affiliating themselves with a religious movement.

Religion in some form is employed by many people to bring happiness and solace to an otherwise turbulent existence. It is conscripted as a vehicle for values that fill the person's life with purpose and meaning. It is also utilized to substantiate neurotic

defenses, justifying these by a blind adherence to codes and authoritarian mandates (Conigliaro, 1965). If religious credos serve the individual's personality needs, they may facilitate adaptation and contribute to the social good. If they conflict with the individual's needs, they will interfere with adjustment and militate against social good.

A number of notable attempts have been made to reconcile psychiatry, psychotherapy, and psychoanalysis with religion (Ryle, 1945; Santayana, 1948; Tillich, 1952; Moore, 1953; Toulmin, 1953; Wisdom, 1955; Niebuhr, 1955; McLean, 1959; Zilboorg, 1956, 1962; Lee, 1957; Bartemeier, 1965). Implied in most of these contributions is the idea that even a psychotherapist in search of values may find these in religious experience. Psychotherapy, it is alleged, releases the individual to choose constructive values, while religion is a suitable supply depot for such values.

Conflict between psychiatry and religion, however, still continues, sustained in part by an inability to define religion. If by religion we mean the striving for worthy ideals and values, most scientists would concede its merits. On the other hand, if we mean the acceptance on faith of fixed creeds and beliefs regarding the origin of the world and the ultimate purpose of life and the abiding by ethical standards as absolute in relation to an eternal law, most scientists would register their opposition.

Amidst the conflicts of science and religion many individuals search within themselves for meanings of faith and attempt to define God in their own terms shorn of the dogma and ritual of the church. In the systems that they evolve, ancient ideas of logic and cosmology are discarded and scientific concepts of the material world are accepted in a realm of their own. To some, God continues to be accepted as the essential element, the embodiment of the highest ideal of self-sacrificing love, which can lead humanity to peace and fulfillment. For others, a revision of religious belief prevails that has gone so far as to challenge the essential doctrines of the church of their origin and to make out of the Savior a noble mortal rather than an incarnation of God. God is accepted as a principle of order and goodness, rather than as an extramundane Creator who rules the universe. The highest religious achievement is identification with the principle of goodness and the

achievement of ethical self-realization.

Actually, we have witnessed in official circles of the church a reinterpretation of some of its doctrines and a revision of standard documents. There are many now who are capable, without conflict, of maintaining communion while accepting a scientific conception of the world. We have seen also a softening of the stand of science in the form of recognition that religious fulfillment satisfies a fundamental human need.

Psychotherapy and the newer direction in religion thus share a number of common goals. They both strive to bring about better self-understanding and a full utilization of latent creative potentials. Psychotherapy attempts to do this by bringing the person to a fuller realization in terms of past experiences and the residual distortions that hamper his or her present interpersonal relationships, while encouraging new and more productive behavioral patterns. Religion encourages the search for new meanings by affiliation with the Divine Being and by worship and prayer that can suffuse the human spirit with hope, with strength to resist deviant drives, and with new directions that will lead to self-fulfillment. Both psychotherapy and religion seek to alter destructive values in the individual and to lead one toward humane values that will accomplish the greatest social good, such as honesty, loyalty, charity, love, courage, and compassion for suffering. Both psychotherapy and religion promote salutary family and community relationships as virtuous to the highest degree.

Existentialism

Existentialism is a philosophy that has attracted many psychotherapists in Europe and the United States, who have, on its premises, developed "ontological" or "existential" treatment procedures that attempt to combine existentialist doctrines with reeducative and reconstructive methodologies (Binswanger, 1947, 1956; Boss, 1957, 1963; Frankl, 1948; Havens, 1967; Holt, 1975; Husserl, 1931; Jaspers, 1963; Laing, 1967; May R, 1950, 1959; Minkowski, 1970; Tillich, 1952).

More or less, existentialism is oriented around the writings of Søren Kierkegaard

(1813-1855), who revolted against the impotence of Hegel's philosophy of "pure thought" as a means of coping with the paradoxes and contradictions of human existence (Kierkegaard, 1951). Fruitless, contended Kierkegaard, were faith and coercive divine grace, proffered as a means of salvation; Christ was no substitute for true experience in the world. Nor was science of any greater use, for the human search for facts as an escape from moral decisions was not possible. Haunted by perpetual despair and dread *(Angst,* anxiety), which "eats away all the things of the finite world and lays bare all illusions," a human could not remain a mere spectator, finding refuge in evanescent comforts. He or she was forced to assume responsibility and to make a choice. Duty might dull the person's consciousness; it might, in a romantically optimistic way, enable the person to evade responsibility. It could not, however, eliminate responsibility. Essential was a free choice to which the individual committed as a whole in the recognition that human values were insignificant indeed. In the crisis of existence, the only true refuge was a leap into religion in which a person related to the infinite. Freedom of choice was a fount of anguish because individuals had a limited time in which to act. They needed courage to be. When the immortal soul was at stake, the choice would crucially determine which way to turn.

The phenomenological descriptions of inner turmoil, such as have so vividly been described by Kierkegaard, are of a different order of conceptualization than psychological ideas of drive and defense. Kierkegaard, being a religious man, stressed the choice of religion as a means of surcease from anguish. Later existentialists, however, made other choices, such as agnosticism (as in the writings of Jean Paul Sartre) oraestheticism. Karl Jaspers, in *Man in the Modern Age,* considered that the chief threat to modern humankind lay in our complex technology. *Philosophie,* published in 1932, spoke of the importance of the persistent quest for knowledge as a means by which humans actualized themselves.

These ideas were enhanced by the phenomenological concepts of Edmund Husserl, a German philosopher, who contended that human experience was corrupted by attempting its analysis through the physical sciences. Only through reflection ("transcendental phenomenology") could one best realize essential structures, vital relationships, authentic existence, and "the experiences of phenomena." Science with its focus on causation

contributed to human alienation by crushing individuals' creativity and intuition. Human beings were not puppets upon whom reality could be thrust. They were free agents with freedom of choice and responsibility for their own values. In 1927, Martin Heidegger, a pupil of Edmund Husserl, wrote *Sein und Zeit,* which followed Husserl's feeling, as expressed in his *Logische Untersuchungen,* that human beings needed to focus on their inner experience as a way of apprehending the outer world.

Heidegger detailed some of the important inner experiences underlying our scientific understanding. His description of humans' preoccupation with the inevitability of death had a profound influence on existential formulations.

Periods of crisis in world history, such as during and after war, bring forth the philosophy of protest against the world. Various interpretations of existentialism have been made by different devotees of this philosophy. Jean Paul Sartre stresses the need to preserve human loneliness from the encroachment of others. Karl Jaspers and Gabriel Marcel emphasize the interpersonal communication of "loving conflict," during which each participant retains his or her uniqueness. Other prominent existentialists who have contributed to the theory are Karl Barth, Martin Buber, Emil Brunner, Paul Tillich, Reinhold Niebuhr, H. Spiegelberg (1960), and E. Straus (1963).

Drawing from Kierkegaard's original conceptions, psychiatrists such as Karl Jaspers (1947), Ludwig Binswanger (1942, 1947, 1955, 1956), Viktor Frankl (1955, 1967), and Medard Boss (1963) adapted existentialist ideas within a framework of psychotherapy. Incorporated was Heidegger's conception that concern with others was the key to the optimal development of the self and that endurance of anxiety was more essential than attempts to deny or evade it. According to Heidegger, the basis of existence is a sense of nothingness that vitalizes the self with meaningfulness. This idea borders on mysticism, although existentialism is not a mystical philosophy. Heidegger insisted that the self reached its highest stature in its struggle with anxiety, guilt, and the ubiquitous threat of death. To this idea Binswanger added the concept of the self reaching its fullest development in the experience of love: indeed the keystone of existence, he believed, was

the achievement of "we-ness" through love. But love is threatened and broken down by anxiety and isolated by excessive independence and overidealization of the love object. With the shattering of love, the self suffers damage and returns to nothingness. Frankl introduced the entity of the "existential neurosis," derived from the inability to see meaning in life. Through "logotherapy," he avowed, a search could be organized into the patient's world view with the object of helping the patient to adjust it to an "authentic existential modality." Novel approaches to existential therapy reflect varying interpretations of existential philosophy, blended with the specialized psychotherapeutic techniques of the authors.

Since the conceptual model of existentialism is ontological, it is difficult to understand it in mechanistic terms. We are dealing with frames of reference unlike those that the average therapist has known. It seems futile to describe such phenomena as "being in the world" and "I am" in purely verbal terms. Inherent in these ideas are self-acceptance, tolerance of limitations, the ability to scale down ambitions, acknowledgment of prevailing creativity, self-realization, and self-determination, shorn of neurotic cultural values and demands. These goals are achieved and achievable only in a special kind of empathic relationship, which presupposes a willingness on the part of the therapist to enter into the world of the patient.

While the therapist utilizes habitual psychotherapeutic tools, for example, the various reeducational techniques, they are employed from a perspective of "reverent love" toward the human being "encountered" as a patient, sharing with him or her a common plane of existence. The therapist moves beyond drives and mechanisms in dealing with the person as he or she is. In fundamental "being-togetherness," the patient's and therapist's modes of being are related. In such a climate of "care" and understanding, the patient gets the courage to emulate the therapist's healthy style, and so moves on to "be" in the matrix of a uniqueness of self. There is much in this conception of the therapeutic relationship that resembles the "genuineness" and "empathic understanding" advocated for the "client-centered" therapist. The explication of the phenomenon of self relating to self, however, is much more embellished and particularized.

Logotherapy is a special existential approach, elaborated by Viktor Frankl (1955, 1961a, b, 1962, 1963, 1966), which includes two distinctive reeducative procedures, "paradoxical intention" and "de-reflection." It proposes to fulfill "the innate spiritual drive in man" by exploring the "meaning of human existence." The "will to meaning," according to Frankl, is one of the deepest motivating forces of humanity, even more fundamental than Freud's "pleasure principle" or Adler's "will to power." When human beings no longer question the meaning of their existence, they become ill. This is because they cannot function in an "existential vacuum." A basic conflict precipitates as a result of this inability to "emerge spiritually above the level of his own psychic and physical conditions." This conflict is not rooted in psychological complexes; it is focused in spiritual and ethical issues and produces neuroses of a unique quality, which Frankl calls the "noogenic neuroses." Approximately 12 percent of all neuroses are said by him to be of the "noogenic" variety.

Such "noogenic, spiritually rooted" neuroses require for their solution the existential approach of logotherapy "in contrast to psychotherapy in the narrower sense of the word." In logotherapy, the patient is helped to find new values and to develop a constructive philosophy in life. "The logotherapist is not primarily concerned with treating the individual symptom or the disease as such. Rather, he sets out to transform the neurotic's attitude toward his neurosis." Responsibility is put firmly on the shoulders of the patient to "push forward independently toward the concrete meaning of his personal existence." The patient "must choose it on his own, search for it, and find it."

Logotherapy helps the patient evolve three kinds of values which will lend meaning to existence: "creative values," "experiential values," and "attitudinal values." The patient is shown how to make life meaningful by "the experience of love," which enables the patient to enjoy "truth, beauty and kindness … and human beings in their uniqueness and individuality." The patient is shown that suffering may be useful in helping to change his or her attitudes. For instance, an irremediable situation may have to be endured. "Where we can no longer change our fate by action, what matters is the right attitude toward fate … we must be able to accept it." The goal of the logotherapist, then, is to evoke in the

individual the "will-to-meaning," which is specific and personal for each person. Only when this goal is fulfilled can one survive the most unfavorable conditions. The dimension of helping to find "meaning" is above and beyond what may be done for the individual through exploration of the dynamics of his or her intrapsychic processes and by probing his or her interpersonal relationships through the traditional psychotherapeutic and psychoanalytic techniques. The latter tactics become futile or only partially successful unless there is restored to the person the spark in his or her being that gives life purpose and meaning. In the words of Nietzsche, "He who knows a Why of living surmounts almost every How." The explicit answer to the question of what constitutes the "meaning of his existence" can be answered only by the patient under the guidance of the therapist.

Even in dire distress or under depriving circumstances in which activity and creativity are blocked, a person "can still give his life meaning by the way and manner in which he faces his fate, in which he takes his suffering upon himself. Precisely in this he has been given a last chance to realize values." Frankl agrees with Goethe, who emphasized that "there is no condition which cannot be ennobled either by a deed or by suffering." Thus, "the right kind of suffering is itself a deed, nay the highest achievement which has been granted to man." In this way the patient may be aided in utilizing daily vexations and sufferings as a means toward finding purpose in living. By putting a positive value on suffering, the victim may overcome "trends in our present-day civilization where the incurable sufferer is given very little opportunity to be proud of his unavoidable and inescapable suffering and to consider it ennobling rather than degrading."

Persuasive tactics are employed in logotherapy to get the patient to adopt a more constructive attitude toward his or her difficulties. Frankl illustrates this in a case of a nurse who suffered from an inoperable tumor and who experienced despair centered about her inability to work in her cherished profession. "I tried to help her understand that to work eight hours or ten hours or God knows how many hours a day, is no great thing. Many people can do that. But to be as eager to work as she was and to be incapable of working yet not despairing would be an achievement few could attain." An appeal was then made to her sense of fairness to the patients to whom she was dedicated in her work,

since she was depreciating them when she assumed that a sick person's life had no meaning. "In so doing you take away from all sick and incurable people the right to life and justification for their existence."

A shift in point of view effectuated by the therapist's promptings may interrupt a neurosis. Frankl illustrates this point:

> I should like to quote another case of a colleague, an old general practitioner who turned to me because he still could not get over the loss of his wife who had died two years earlier. His marriage had been very happy and he was very depressed. I asked him quite simply, "Tell me, what would have happened if you had died instead of your wife, if she had survived you?" "That would have been terrible," he said. "Quite unthinkable. How my wife would have suffered."
>
> "Well, you see," I answered, "your wife has been spared that, and it was you who spared her, though, of course, you must now pay by surviving and mourning her." In that very moment his mourning had been given a meaning— the meaning of sacrifice. The depression was overcome.

What Frankl brings out is that he had succeeded in giving a new meaning to the experience of his patient's suffering. What precise dynamics were involved in the patient's attitudinal shift, other than appeasement of his sense of guilt, we do not know; however, the tremendous impact that a respected authority may have on a susceptible patient by a timed interpretation is clearly brought out, particularly in helping the patient face death, suffering, and other disasters in life.

Because happiness can rarely be achieved intentionally, the patient is enjoined by the logotherapist to avoid striving for its achievement. Rather, the patient is shown that happiness will come as a byproduct to the attainment of other values. Nor should "unpleasure" be evaded. Logotherapy contends that intention may prevent the occurrence of an event. This principle may be applied to fighting neurotic symptoms. By the technique that Frankl calls "paradoxical intention," the patient is sometimes "encouraged not only to accept the neurotic symptoms but even to try to exaggerate them. Thus the patient increasingly learns to put himself 'above' the symptom." Paradoxical intention, which mobilizes the "capacity of self-detachment," is particularly suited for the short-term treatment of obsessive-compulsive and phobic patients. The fearful anticipation of an

event often succeeds in bringing on the reactions developing from the event. Patients with strong obsessions tend to fight off their obsessions and compulsions. If they stop fighting their symptoms, and even joke about them, the symptoms may diminish and disappear. The patient is requested to think about or to experience in his or her mind that which is unpleasant, terrifying, or embarrassing. In this way the patient develops, as in behavior therapy, an ability to counteract his or her fears. Paradoxical intention, says Frankl, is contraindicated in psychotic depressions. It is a basis around which more modern ideas of paradoxical therapy have been organized (Borkovec & Boudewyns (1976), Ascher & Efran (1978), Fay (1976).

Another logotherapeutic technique is "de-reflection," which enhances the "capacity for self-transcendence." Here the patient is first helped to an awareness of unused or forgotten capabilities and potentialities. "It is a kind of appeal to the patient's deeply buried values. Once they are uncovered, they assert themselves and give the patient a feeling of uniqueness, of usefulness, and a sense of life." De-reflection is said to be valuable in somatic preoccupations, neurotic sleep disturbances, and such sexual disorders as impotence and frigidity.

Frankl supports eclecticism in method and advocates, when necessary, a combination of logotherapeutic techniques with hypnosis, Schultz's autogenic training, behavior therapy, and pharmacotherapy.

The concept of "responsibility" is a cornerstone in logotherapy, as it is in other forms of existential therapy. This purports that individuals are responsible for making of their lives what they will—a thing of joy or a living hell. The interpretation imparted to his or her experiences is the arbiter; one possesses the means of changing one's destiny by altering one's values. The leading maxim of existential therapy, in the words of Frankl, may be phrased in this way:

Live as if you were living for the second time and you had acted as wrongly the first time as you are about to act now. Once one really puts oneself into this imagined situation, one will instantaneously become conscious of the full gravity of the responsibility that

every human bears throughout every moment of his or her life, the responsibility for what he or she will make of the next hour, or how he or she will shape the next day.

Criticism of Philosophical and Religious Approaches

The utility of philosophical and religious approaches in promoting mental tranquility is evidenced by their universal employment. As a means toward providing institutionalized outlets for inner needs, of bolstering psychological defenses, and of facilitating more congenial relationships among people, they have served humankind from its earliest origins. Where they are supported by cultural sanctions, where environmental stress and inner conflict are not beyond coping capacities, they may sponsor a healthful adaptation. They have serious limitations, however, where they contradict the disposition of a culture, buttress crippling repressions, or endorse neurotic mechanisms, such as retreat from reality.

Once accepted, ideologies tend to be defended by a captious logic or transcendental dialectic that seeks to deny their inherent contradictions. Rationalizations suffuse the individual with the reasonableness of his or her own arguments and attempt to weld together into a completely coherent body that which even superficial examination shows to be spurious.

Many philosophies are predicated on the principle that the human mind, as it is constituted, is unable to understand the ultimate nature of things. Unique attitudes, values, and modes of feeling and behaving are then evolved to provide new meanings for existence. If all thinking, feeling, and striving can be channelized into a unified and unifying system—whether this be mystical, existential, hedonistic, skeptical, or other—emotional stabilization may be achieved, at least so long as the system remains intact. Should the system fail to secure inner peace, however, a search for new and more stabilizing prescripts will then ensue.

Psychotherapists are attracted to philosophical and religious helping practices partly in appreciation of the limitations of psychotherapy and partly because of their

personal emotional needs. Because they have found their own lives enriched by certain points of view, they may adopt these as a basis for an approach that, in their hands, will probably prove to be fruitful. Yet the sponsoring of philosophies will not be useful for all patients; special needs and resistances will enjoin them to modify or reject the therapist's best efforts at indoctrination.

Philosophical promptings in themselves are not sufficient for the struggle with severe personality immaturities and deep neurotic conflicts. Indeed, they are too often used to reinforce neurotic strivings, for instance, to bolster fears of authority, to negate sexual and aggressive impulses, to avert anxiety through obsessive rituals, to pander to self-punitive and masochistic leanings, to remove the individual from the demands of reality, and to identify with omnipotent extramundane forces with the intent of incorporating them within the self. Such ideologies may negate rather than help a constructive adjustment.

Arguments posed by scientists against the serviceability of religious practices are even more stringent (Freud, 1949; Reik, 1951). A good number of devotees of science admit that there are aspects beyond observable experience, but they are not willing to elevate these to a deistic substance or being in whose transcendent vision all phenomena are clear. Religion resents the implication of some scientists that the craving for God is an infantile or neurotic prompting, and it challenges the denial of the validity of an Almighty Being, since science can offer no experimental proof that there is none. What better evidence is there for God, protests religion, than the miracle of creation of living things, the source of which no scientist has been able to qualify, let alone quantify.

On more specific grounds, a point of conflict between science and religion is that the former regards moral deviation as a symptom, the latter as a sin. Science is apt to look on a human being as an irrational entity and on deviations as unwilled and manipulatory of the individual without his or her desire or awareness. Religion considers a human being a rational being and holds deviation to be an act against humankind and God to be judged in moralistic terms. It suspects science of belittling the individual's responsibility for his or

her behavior, appeasing guilt feelings and encouraging the acting out of errant impulses and drives that are morally reprehensible. Thus, science is seen as acquitting anger, covetousness, envy, gluttony, lust, pride, and sloth—the seven deadly sins—as byproducts of an individual's past conditionings, the liability for their present manifestations falling on the shoulders of parents and not patients. Moreover, science is considered by some representatives of religion to encourage a closer relationship to the psychotherapist than to the pastor, hence diverting patients from seeking spiritual guidance. Science counters by pointing out that certain religious precepts contradict the biological nature of a human being and that a literal interpretation of the Bible will cast a shadow over healthy promptings that stir in all persons in the course of personality development, for instance, in relation to sexual and aggressive feelings. Relegating the individual to eternal damnation for sexual drives out of wedlock, for adulterous thoughts and fantasies, for interest in prurient materials, for retaliatory aggression in the face of humiliation or exploitation, for rebellious impulses toward parental agencies—all of this serves merely to mobilize pathological guilt and shame, to sponsor masochistic, sadistic, and other neurotic responses, and even to cripple healthy drives for reproduction and self-defense. The meek, the poor, the sad, the peaceful are not necessarily blessed. Temporary anger, resentment, and bitterness may be justified and need not irreparably violate the spirit of Love. Mutilation is not a worthy punishment for fantasies that oppose monogamy and fidelity. Passive compliance cannot always be the response to those who promote evil, nor can one in the spirit of tolerance always love one's enemies.

There are some scientists who believe that any morality that proposes an absolute code, violation of which brings supernatural punishment, contains within it seeds of conflict, since the definition of what constitutes the proper morality is open to some question. Thus, obedience to authority and unquestioning submission conflicts with self-determination and independence. Un-worldiness, with its abandonment of natural pursuits, leads to passive alienation; shame and guilt in relation to bodily desires may inspire monastic self-torment and degradation of sexual desire with a repression of rage and aggression. Many of the sacrificial rituals in religion stem from this conflict. Religious systems, it is also claimed, may sponsor conflict and bad values, representing the bad in

the form of an inhabitant of the underworld—devil, satan, Baal-Zebub—an evil representative who opposes God for the mastery of the universe. This struggle, recorded vividly in the Talmud and New Testament, and especially in the Apocryphal and Apocalyptic Books, is literally incorporated in the conviction that the devil is constantly on the alert to occupy an individual's body and to pervert that individual to his satanic purposes. This is a potent fount of anxiety, particularly when the religious individual feels incapable of living a perpetually sainted life. More in the form of an abstraction than in a pictorialized image of a cloven-footed, horned monster, the notion of an invasive devil may preoccupy those whose fundamentalist notions are rooted in medieval conceptions that continue to be a means through which they control and discipline themselves.

A conflict in moral values may furthermore be sponsored in religious systems that conceive of the right and ability on the part of the individual to do and think as he or she wishes, as theologically opposed to the idea of predestination. If we conceive of all humankind as "free," we must assume an autonomous morality with self-determinism and unpredictability dissociated from Divine foreknowledge. Science claims that sources of behavior are too often considered by religion to be the product of moral judgments of which the individual is fully aware and which he or she may freely "will" and "choose." Very often, however, the determining factors in behavior are unconscious in nature, outside the awareness and control of the individual. One is frequently driven in one's choices by forces that are not apparent at moments of decision. A view reconciling these disputations, and one that psychotherapy endorses, is that moral choice is still the individual's in his or her freedom to exercise it; however, each person has the nature to misuse it. Awareness of one's unconscious enables the individual better to exercise moral control. Freedom of will does not imply capriciousness or irresponsibility.

Another conflict brews over the matter of fundamentalism. A believer must accept the Divine authorship of the Scripture, since the authors were merely the agencies for the transcription of sacred and unalterable doctrines. Deviation from the sentence and word, in the mind of fundamentalists, tends to discredit God. Science contends that the Bible is a human document, subject to the same kind of study and analysis as any other human

document. Fundamentalists insist that biblical criticism, and the pointing out of discrepancies in the Scripture, are illusions of the devil. Reconciliation of opposing viewpoints is often attempted by the judgment that while the ideas in the Bible are Divine, the canons of Scripture are the product of the church on earth. A strong undercurrent of fundamentalism still exists that may disturb those who have no investment in orthodoxy. Fundamentalist conflict, incidentally, is not confined to the Bible; it invests many fields of thought, even scientific, where allegiance to the omniscience of founders of a movement tends to circumscribe one's thinking to the letter of published text or to interpretations of the text by self-appointed prophets.

We are currently witnessing a softening of the stand of science and religion toward each other. By integrating the findings of science, religion may be able to achieve its highest aims in encouraging values that make for a better world. By studying the forces activated by faith, scientists may be able to release the same healing elements more precisely in the medium of a scientific methodology.

In summary, philosophical and religious systems in the themselves do not suffice to control or rectify severe neurotic distortions. In an eclectic therapeutic framework, philosophical precepts may sometimes be incorporated to develop socially useful values helpful in promoting adaptation.

11
Reconstructive Therapy

An ultimate goal of psychotherapy is to reduce the force of irrational impulses and strivings and bring them under control, to increase the repertoire of defenses and make them more flexible, and to lessen the severity of the conscience, altering value systems so as to enable the patients to adapt to reality and their inner needs. These aims are formidable because the various components of personality are so forged into a conditioned system as to be almost impervious to outside influence. Homeostatic balances are maintained to safeguard neurotic adjustment. Resistances block attempts to interfere with coping mechanisms and defenses. To cut into the neurotic system in order to modify the structure of personality and to expand the potentials of the individual in all required dimensions are difficult and frequently unrewarding undertakings. Reconstructive psychotherapy is aimed at these objectives.

Reconstructive psychotherapy is more or less traditionally rooted in the theoretical soil of a genetic-dynamic model of personality. This purports that past inimical experiences and conditionings have retarded the normal psychosocial growth process and are now promoting in the individual immature strivings and emotions that come into conflict with reality, on the one hand, and, on the other, with the person's own incorporated system of ideals and standards. Resultant are tensions, catastrophic feelings of helplessness, and expectations of injury that in turn invoke protective devices, most common of which is repression, a sealing-off process that blankets offending impulses, attitudes, and memories from awareness. However noble the attempt, repression of unacceptable strivings rarely succeeds in annihilating them, for their expression is sought, from time to time, by powerful motivations of impelling need. The filtering of offensive impulses into conscious life promotes bouts of anxiety and whips up the defenses of the ego, which, while ameliorating anxiety, may be destructive of adjustment. Additionally, repressed strivings may express themselves as symptoms. The direct or disguised operations of repudiated strivings, and the defenses that are mobilized against them,

promote attitudes and values that disorganize interpersonal relationships. Reactions develop that are opposed to judgment and common sense. While individuals may assume they are acting like adults, emotionally they are behaving like children, projecting into their present life the same kinds of fears, misinterpretations, and expectations of hurt that confronted them in their early years, as if neither time nor reality considerations have altered materially the patterns learned in the past. As long as individuals protect themselves from fancied hurt by circumscribing their activities, they may manage to get along; but should they venture beyond their habitual zone of safety, the precarious balances they have erected will be upset.

Were we to treat a patient according to this hypothesis, we would consider that his or her symptoms were manifestations of a general collapse in adaptation, and our therapeutic effort would be directed toward correcting disorganizing drives that were destructive to the patient's total adjustment. The objective, therefore, would be expanded toward personality growth and maturation, toward heightened assertiveness and greater self-esteem, and toward more harmonious interpersonal relationships. In quest of these objectives, we would strive for a strengthening of the patient's ego, which, involved hitherto in warding off anxiety through the marshalling of neurotic defenses, has been unable to attend to the individual's essential needs. Instrumentalities toward ego strengthening are, first, greater self-understanding and, second, the living through with a new kind of authority, as vested in the therapist, of experiences that rectify residual distortions in attitudes, feelings, values, and behavior.

Increasingly, psychotherapists, directing their efforts toward reconstructive changes, have drawn for inspiration on psychoanalytic theories and methods, although some have tended to label the ideas and tactics that they employ with tags that mask their origin. Accordingly, during the past half century, many ingredients of psychoanalytic thinking have permeated into the very fiber of American psychiatry and psychology and have fashioned a good number of its trends. In turn, psychoanalysis has been influenced by contemporary developments in the psychiatric and psychological fields. It has consequently lost many of its esoteric qualities while acquiring a firmer anchoring in

scientific experiment.

Reconstructive psychotherapy is distinguished from supportive and reeducative therapy by the degree and quality of insight mobilized. In supportive therapy efforts at insight are minimal. In reeducative therapy they are more extensive, but they are focused on relatively conscious problems. The traditional objective in reconstructive therapy is to bring the individual to an awareness of crucial unconscious conflicts and their derivatives. Reconstructive psychotherapy strives not only to bring about a restoration of the individual to effective life functioning, through the resolution of disabling symptoms and disturbed interpersonal relationships, but also to promote maturation of emotional development with the creation of new adaptive potentialities.

The methods employed in bringing unconscious aspects to awareness were originally developed and described by Sigmund Freud, who had the happy faculty of illuminating the most obscure concepts with a refreshing verbal simplicity. Included are such techniques as free association, dream interpretation, the analysis of the evolving transference, the use of strategically timed interpretations, and dealing with resistances to the content of unconscious material. An understanding of the genetic determinants of the individual's personality and of the relationship of these determinants to the operative present-day character structure are component aspects of the therapeutic process.

To do reconstructive therapy, the therapist must have received special training, which ideally includes a personal psychoanalysis and the successful treatment of a number of patients under the supervision of an experienced psychoanalyst.

As has been indicated previously, reconstructive personality changes sometimes occur spontaneously during the course of supportive and reeducative therapies or upon completion of these treatments as a consequence of more congenial relationships with people. For instance, the individual may work out serendipitously, in the medium of a relationship with a helping agency or reeducative therapist, such archaic strivings as infantile dependency needs, unyielding fears of rejection or overprotection, intense detachment, and untoward aggression. The patient may even spontaneously connect the

origin of such impulses with unfortunate childhood conditionings and experiences. Any changes developing in this way, however, are more or less fortuitous. In reconstructive psychotherapy, the treatment situation is deliberately planned to encourage change by a living through, with insight, of the deepest fears and conflicts.

There are four main "types" of insight therapy with reconstructive goals: (1) "Freudian psychoanalysis," (2) "ego analysis," (3) "non-Freudian" or "neo-Freudian psychoanalysis," and (4) "psychoanalytically oriented psychotherapy. All of these therapies aim at reconstructive alterations in the personality. They differ, however, as to the methods by which this objective is realized. Freudian psychoanalysis is, more or less, the original technique of Sigmund Freud. Ego analysis, while retaining the classical therapeutic form, focuses on the adaptive functions of the ego. Neo-Freudian psychoanalysis, which includes the approaches of Horney, Sullivan, Rank, Jung, and Adler, is a modified, more active technique. Psychoanalytically oriented psychotherapy is the most active of the reconstructive therapies. In addition to these main types, there are a number of modifications, such as Kleinian and transactional analysis. Derived from Kleinian theory are object relations therapy, therapy oriented around self-psychology, and some forms of transactional analysis.

FREUDIAN PSYCHOANALYSIS

From recorded history it is obvious that there were people in every age and in almost every culture who had some understanding of the significance of people's psychic life in the scheme of things. The Bible and the writings of the early philosophers contain a wealth of psychological wisdom. But none of the insights was integrated into an organized form until a man from Moravia. Sigmund Freud, through his genius for understanding people's inner motivations and his unflagging determination in the face of violent opposition, broke through and laid a foundation for the science of the psychic processes in what is known today as psychoanalysis.

In 1880 Joseph Breuer discovered that when a hysterical girl under hypnosis was induced to speak freely, she expressed profound emotion and experienced relief from her

symptoms. Under the impression that her hysteria originated in certain painful experiences while caring for her sick father, Breuer enjoined her, while she was in an hypnotic state, to remember and to relive the traumatic scenes in her past. This seemed to produce a cure for her hysteria.

Ten years later, in conjunction with Freud, Breuer continued his research, and in 1895 the two men published their observations in a book, *Studien Uber Hysteria* (1936). Their conclusions were that hysterical symptoms developed as a result of experiences so traumatic to the individual that they were repressed. The mental energy associated with the experiences was blocked off, and not being able to reach consciousness was converted into bodily innervations. The discharge of strangulated emotions (abreaction), through normal channels during hypnosis, would relieve the need to divert the energy into symptoms. This method was termed "catharsis."

Freud soon found that equally good therapeutic results could be obtained without hypnosis by permitting the patient to talk freely, expressing whatever ideas came to mind. Freud invented the term "psychoanalysis" for the process of uncovering and permitting the verbal expression of hidden traumatic experiences. Freud found that there were forces that kept memories from invading consciousness, and he discovered that it was necessary to neutralize the repressing forces before recall was possible. An effective way to overcome resistances was to permit the patient to relax and to talk freely about any ideas or fantasy that entered his or her mind, no matter how trivial or absurd. Freud could observe in this "free association" a sequential theme that gave clues to the nature of the repressed material.

Mainly through an introspective analysis of his own dreams, Freud (1938) was able to show how dreams were expressions of unconscious wishes and fears that evaded the barriers of repression through the assumption of symbolic disguises. He perfected a technique of arriving at the meaning of the unconscious material through the translation of symbols.

Freud also observed that when patients were encouraged to say whatever came to

mind, irrational attitudes toward the therapist—such as deep love, fear, hate, overvaluation, expectancy, disappointment, and other strivings that were not justified by the reality situation—were verbalized. He noted, too, that patients identified the therapist with significant personages in their past, particularly their parents, and that this identification motivated the transfer over to the therapist of attitudes similar to those that they originally had toward their parents. This phenomenon Freud called "transference." For example, a male patient with a phobia of being subject to imminent but indefinable injury might, at a certain phase in his analysis, begin to develop an aversion toward and dread of the analyst, expressed in fears of being mutilated. At the same time incestuous wishes for the mother might appear in dreams. Analysis of the relationship with the analyst (transference) would then possibly reveal an identification of the analyst with the patient's father. It would then become apparent that the patient secretly feared injury by the father for his forbidden wish to possess the mother and that his phobia was an expression of this fear of mutilation that had been dissociated from awareness by repression. The hope was that bringing patients' attention to the sources of their fears, and their realization of its irrational nature, would result in an amelioration or cure of their neurosis.

The material uncovered by Freud from his studies of free association, dream interpretation, and analysis of the transference suggested to him that there was a dynamic portion of the psyche, closely associated with the emotional disorder, that did not follow the normal laws of mental functioning. Freud called this aspect of the mind the "unconscious," and he set about to determine the unique laws that dominated the repressed psychic component.[2] To aid him in this task he formulated a topography of the mind by dividing it into three zones or systems: the unconscious (Ucs.), the pre-conscious (Pcs.), and the conscious (Cs.). The preconscious contained thoughts that could be revived into consciousness with some effort, in contrast to the unconscious, which contained material barricaded from consciousness by an obstructive force.

In studying the symbols issuing from the unconscious, Freud noted that they were concerned chiefly with sexual material, and he concluded from this that the unconscious

was preoccupied for the most part with sexual wishes and fears. Consequently, he assumed that the most important traumatic events that had been repressed were sexual in nature. It was largely on this evidence that he evolved his "theory of instincts" or the "libido theory."

In his theory of instincts Freud (1930a) postulated that all energy had its origin in instincts that persistently expressed themselves (repetition compulsion) and were represented mentally as ideas with an emotional charge (cathexis). A fundamental instinct was that of *eros,* the sexual or life instinct, manifesting itself in a force called "libido." Freud hypothesized a permeation of the body by this vital instinctual force, the "libido," which powered the individual's development toward mature sexuality. Libido was, however, subject to many developmental vicissitudes in its destined course to adult genitality. During the first year of life it concentrated itself around the oral zone—the mouth and lips—the child gaining a kind of erotic pleasure by sucking and later by biting. At the end of the first year there was a partial shift in libido to the anal zone, and intense pleasures were derived from the retention and expulsion of feces. During this period the child's interests were more or less concentrated on oneself (narcissism), and satisfactions were localized primarily within his or her own body (autoerotism). Relationships with people were primitive, being circumscribed to only part of the parent (part-object relationships), like the nipple or breast instead of the entire parent.

Around the age of 3, libido was centered around the phallic zone—the penis or clitoris. "Object relationships" were less primitive and were extended to a more complete relatedness with the parent. Yet, fundamentally, the child was ambivalent, responding to parents and other people with a mixture of love and hate.

This stage of psychosexual growth continued into the Oedipal period, during which the little boy developed toward his mother a profound interest, with strong sexual overtones and desires for exclusive ownership. The little girl, envying men for their possession of a penis, created in part by a desire to repudiate her femininity and to become a male (penis envy), and resenting the fact that she had no penis, accused the

mother of responsibility for this deprivation and turned to the father with an intensified sexual interest. In the case of the boy, hostility toward the father, due to a desire to eliminate him as a rival, generated a fear of counterhostility, and particularly a fear of castration, which inspired such anxiety as to induce him to give up his interest in the mother and to make friends with his father. The intensity of fear became so overwhelming and so unendurable that the boy was forced to yield to his more powerful competitor by renouncing, repudiating, and repressing sexual feelings toward the maternal love object. He was obliged also to repress concomitant hostile impulses toward the father. The little girl similarly resolved her enmity toward her mother as well as her sexual interest in her father. This drama, known as the Oedipus complex, was to Freud the crucial nuclear conflict in the development of the personality contributing to both character formation and neurotic symptoms.

The incorporation of parental injunctions and prohibitions and the repudiation of sexual and hostile aims as related to the parents resulted in the crystallization of an aspect of the psyche that took over the judging, prohibiting, and punitive functions hitherto vested in the parents. This aspect became the conscience or superego. The adequate resolution of the Oedipus complex was associated with channelization of libido into the genital zone, with capacities for complete, mature, unambivalent, "whole-object" relationships.

After the Oedipal period was an era characterized by the neutralization of sexual impulses, which Freud called the "latency period." With the advent of puberty, however, increased libido, due to the heightened activity of the genital glands, reactivated the old Oedipal interests. The person then lived through the revived early Oedipal conflict, and the capacity to solve this anew was determined by the extent of previous vicissitudes and the adequacy with which the conflict had formerly been resolved. In "normal" solutions the child transferred his or her sexual interest to extrafamilial persons of the opposite sex. In Freud's pattern of behavior the little girl renounced her boyish interests and accepted a passive female role.

Under certain conditions normal psychosexual development was impeded by a "fixation" of libido onto oral, anal, and phallic zones. The libido, bound down in this way, was unable to participate in the development of full genitality. Freud believed that both constitutional and experiential factors were responsible for this. Most prominent were excessive gratifications or inordinate frustrations experienced at an early stage of growth. Not only did libidinal fixations interfere with the development of mature sexuality, but they constituted stations to which the individual might return when confronted with overwhelming stress or frustration. Under these circumstances the libidinal stream was said to undergo "regression" to pregenital fixation points. When this happened, there were revived attitudes and interests characteristic of childhood, with immature sexual strivings, interest in "part objects," and narcissism.[3]

In addition to the libido theory described above, Freud elaborated the theory of the death instinct to account for phenomena not explicable in terms of libido. He postulated that it was this second instinct that prompted aggressive and destructive drives. This instinct manifested itself in a "repetition compulsion" to undo the forward evolutionary development of the organism and to return it to its primordial inorganic state. The death instinct, though sometimes libidinized (sadism), was totally different from the sexual instinct. Largely because of his studies on sadism and masochism, Freud came to the conclusion that the sexual and aggressive drives could be fused to foster both normal and pathological activities. The aggressive drive was also subject to vicissitudes in its development through oral (biting), anal (soiling and retention), and phallic phases, during which fixations could occur to which regression was later possible.

Freud conceived of the mental apparatus as an organ that prevented the damming up of energy. Pain was related to an increase of energy and pleasure to a decrease. To help understand the operations of the mental apparatus, Freud elaborated, apart from his topographical theory, a structural theory of the psyche. According to this theory, the psyche involved (1) a reservoir of instinctual energy, the *id;* (2) a supervisory area serving a censoring and sanctioning function, the *superego;* and (3) a body that mediated internal and external adjustments, the *ego.* Although recognized by Freud as arbitrary, empiric,

and metapsychologic, these subdivisions were retained by him as a conceptual necessity (Freud, 1930a).

Freud classified the id as the original undifferentiated mind, the repository of inherited urges and instinctual energy. It contained the instincts of Eros—the life or sexual instinct—and Thanatos—the death instinct. It provided the individual with dynamic energy (libido), which vitalized every organ and tissue and sought expression in response to a "pleasure principle," along whatever channels were available for it. Through impressions received by the perceptual organs, the id underwent modifications immediately after birth. Differentiation by the child of himself or herself as an entity apart from the world was in keeping with the evolution of the ego, which increasingly assumed the function of an executive organ, harnessing the id to the demands of reality (reality principle). Important impressions, particularly those related to experiences with parents or their surrogates, and frustrations created by prohibitions of pleasure strivings, registered themselves on the child's psyche and stimulated primitive mechanisms of projection and introjection. In projection, aggression was discharged outward and directed toward parents; in introjection, the frustrating parental agencies were "incorporated" within the child's psychic apparatus. Through these mechanisms, rudiments of a superego developed that later, with the resolution of the Oedipus complex, crystallized and took over the guiding and prohibitive functions of the parents. One aspect of the superego contained constructive ideals toward which the individual felt driven (ego ideals). The superego, oriented as it was around childish concepts of reality, evaluated actions in terms of whether they had approbatory or punitive potentials. It was the guardian of a primitive morality attended at all times by a custodian of guilt. Unconscious disapproval by the superego gave rise to a host of disturbances, including a need for punishment, feelings of inadequacy, and low self-esteem.

Under the lash of the superego the ego created repressions against libidinal strivings and their ideational representatives. Such repressions served to avoid conflict. When, however, for any reason, repression relaxed or proved insufficient, the ego was invaded with some of the content of the repressed. This threat to the individual's security inspired

anxiety, a danger signal that indicated a breakthrough of the repressed material.

As Freud continued his work, he laid less and less stress on strangulated emotions due to early traumatic experiences as the primary cause of neurosis. More and more he became cognizant of the purposeful nature of symptoms, and in 1926 he revised his theory of neurosis drastically, claiming that symptoms were not only manifestations of repressed instinctive strivings but also represented defenses against these strivings (Freud, 1936).

Freud contended, however, that the essence of a neurosis was a repression of infantile fears and experiences that continually forced the individual to act in the present as if living in the past. The neurotic seemed to be dominated by past anxieties that, split off, operated autonomously and served no further function in reality.

The accent on the ego and its responses to anxiety moved the emphasis away from the id. Anxiety, a biologically inherited pattern, appeared under two sets of circumstances: "traumatic situations" and "danger situations." The prototype of the former was the birth trauma. During infancy the influx of stimuli often was too great for the individual to handle and sponsored the development of a stimulus barrier. As the ego developed, recognition of danger situations enabled the child to anticipate them with anxiety ("signal anxiety"). The ego mobilized its defenses in response to such signals. Typical danger situations during infancy were a threatened loss of the love object (breast-mother); around 18 months, loss of love and good will from the love object (parents and other significant persons); around the end of age 3, injury to the genitals (castration anxiety) and deprivation of its gratifications; and after 5 years of age, disapproval and punishment from the superego. These dangers persisted unconsciously throughout the life of the individual.

Three types of anxiety could be distinguished: real or objective anxiety (in which the danger was external), neurotic anxiety (the danger here was the eruption of id impulses that the ego considered harmful), and moral anxiety (in which punishment from the superego was threatened). The sources of anxiety were unconscious in nature and were

usually highly disguised, rationalized, and shielded from awareness. Neurotic anxiety manifested itself in free-floating anxiety (vague and unfixed), phobic anxiety (irrationally displaced to symbolic situations), and panic anxiety (acting out of id impulses impossible to control—for instance, aggressive and sexual drives). The latter could activate moral anxiety with needs for punishment.

The examination of defenses that the ego evolved to cope with anxiety revealed a variety of mechanisms, including:

1. *Repression*—neutralization of cathexis of psychic energy from the id by countercathexis, thus barricading the ego from unacceptable impulses.

2. *Projection*—transferring responsibility for one's own inner impulses to others.

3. *Introjection*—incorporating qualities of others into the self.

4. *Rationalization*—seeking amnesty by disguising motives.

5. *Regression*—reverting to earlier forms of fulfillment and defense.

6. *Isolation*—splitting emotion or thought associations off from a memory, fantasy, or impulse.

7. *Turning against the self*—redirecting aggressive wishes toward others through self-castigation.

8. *Reaction formation*—neutralization of one drive by conscious expression of a diametrically opposite one.

9. *Denial of reality*—distortion of facts to support inner wishes.

A weak ego, due to constitutional defects and/or severe overindulgence or frustration in childhood, could exhaust the psychic energy and stimulate defenses, such as repression, depriving the id of essential gratifications and diverting the ego from an adaptive dealing with reality. This was often complicated by problems in superego formation due to an inability to resolve the Oedipal struggle. Thus, the superego could be excessively harsh and destructive, sponsoring excessive guilt and inferiority feelings, or it

might be underdeveloped, leading to impulsive, psychopathic, amoralistic, and delinquent behavior. A harmonious balance of superego-ego-id led to a character structure that permitted constructive relationships and a proper adaptation. Imbalance led to psychopathology.

Internal dangers were constantly threatened by the efforts of the id to discharge accumulated tension. Such discharge was opposed by the mental force of the superego in the form of repression to prevent the release of tension. Repression was a dynamic force that attempted to seal off internal dangers. The maintenance of repression, however, required an enormous expenditure of energy. The ego derived this energy from the id in a subversive manner. Thus, an idea or tendency invested with libido (cathexis) would be stripped of libido and this energy used to oppose the idea or tendency (anticathexis).

Subtle mechanisms, such as symbolization, condensation, distortion, and displacement, were employed to evade repressive forces and to provide a substitutive discharge of repressed energy and a consequent relief of tension. Fantasies, dreams, and symptoms were expressions of such mechanisms. Where the substitutive expression was in harmony with social values and superego ideals, it provided a suitable means of relief (sublimation). Where it was not in harmony, conflict resulted and repressive mechanisms were again invoked. If repression proved ineffective in mediating tension, a return to earlier modes of adaptation was possible. This happened particularly where the individual was confronted by experiences similar to, or representative of, those that initiated anxiety in childhood. The ego reacted automatically to these experiences, as if the reality conditionings of later years had had no corrective effect on the original danger situation. It responded with essentially the same defenses of childhood, even though these were now inappropriate.

At puberty and at menopause certain instincts became powerfully reinforced and flooded the capacities of the ego. Even normal people could become neurotic at these times when, for physiological reasons, the instincts were too strong. Accidental influences at any other time might also make them too powerful. All repressions developed in

childhood as "primitive defensive measures adopted by the immature, feeble ego." In later years no fresh repressions occurred, but the old ones persisted and were employed by the ego to master instinct.

A retention of a relationship to reality at the expense of an intrapsychic balance produced a psychoneurotic disturbance. The existing conflict here was between the ego and the id. If an intrapsychic balance developed at the expense of reality relationships, the consequence was psychosis. The latter resulted when the ego was overwhelmed by id forces, the conflict being between the ego and the environment.

Freudian psychoanalytic therapy is based on the libido theory described above. It rests on the hypothesis that neurotic illness is nurtured by the repression of vital aspects of the self and its experiences— particularly oral, anal, and sexual (including Oedipal) experiences in relation to important parental agencies. This repression is sponsored by fear of the loss of love or of punishment from the parents, which has been internalized in the superego. Repressed feelings, attitudes, and fears, and the early experiences associated with them, continue to strive for conscious recognition, but they are kept from awareness by dread of repetition of parental loss of love or punishment now invested in the superego. Their removal from the mainstream of consciousness makes it impossible for the individual to come to grips with basic conflicts. They remain in their pristine state, uncorrected by reality and by later experiences. The energy required to maintain repression, as well as to sustain other defenses against anxiety, robs the individual of energy that could be used to nurture psychosexual development.

In his last clinical paper, "Analysis Terminable and Interminable," (1952), Freud emphasized that the essence of the analytic situation was the entry by the analyst into an alliance with the ego of the patient in order to subdue certain uncontrolled parts of the id and ultimately to include them in the synthesis of the ego. Reviewing this, Freud contended that the ego acted as an intermediary between the id and the external world "to protect the id from the dangers of the external world." In the process the ego tended to "adopt a defensive attitude towards its own id and to treat the instinctual demands of the

latter like external dangers...." The child's ego thus learned "to shift the scene of the battle from outside to inside and to master the *inner* danger before it becomes *external*" by elaborating defensive mechanisms, such as repression, to avoid danger, anxiety, and unpleasure. Moreover, a defensive falsification of inner perceptions rendered "an imperfect and travestied picture of the id." Unfortunately, defensive mechanisms, while averting danger, could themselves become dangerous. They consumed enormous expenditures of energy, and they imposed ego restrictions that burdened the psychic economy. The services rendered by the defenses thus entailed too high a price.

Mechanisms of defense were varied, and each individual selected those that satisfied his or her needs. They became fixated in the ego and reappeared as characteristic reactions under situations similar to those that originally invoked them. Even though they had outlived their usefulness, they persistently survived "like outmoded institutions which contaminate a modern society." The adult ego "continues to defend itself against dangers which no longer exist in reality and even finds itself impelled to seek out real situations which may serve as a substitute for the original danger, so as to be able to justify its clinging to its habitual modes of reaction." Thus the defensive mechanisms distorted perceptions of reality and undermined the ego to a point where neurosis finally broke out.

During analysis the individual exhibited customary defense mechanisms, the dealing with which constituted half of the analytic task. The other half "is the revelation of what is hidden in the id. Our therapeutic work swings to and fro during the treatment like a pendulum, analyzing now a fragment of the id and now a fragment of the ego. The mechanisms of defense recur in analysis in the shape of *resistances* to cure. It follows that the ego treats recovery itself as a new danger." The resistances, unconscious in nature, constantly blocked the therapeutic task of making conscious what was repressed within the id. The effect of unpleasurable impulses in the patient "when his defensive conflicts are once more roused may be that negative transferences gain the upper hand and break up the whole analytic situation." The patient regarded the analyst as an alien personality in whom he had no confidence.

Some of the resistances were peculiarities of the ego determined by heredity. Some were acquired in defensive conflicts. Some, such as the ease or stubbornness with which libidinal cathexes were released from one object and displaced to another, were due to "changes in some rhythm in the development of psychical life which we have not yet apprehended." Some of the resistances that prevented a release from illness were manifestations of "the behavior of the two primal instincts, Eros and the death instinct, their distribution, fusion and defusion," which permeated all provinces of the mental apparatus—id, ego, and superego. The sense of guilt and need for punishment, a product of the ego's relation to the superego, which accounted for the phenomena of masochism and negative therapeutic reaction, was only one expression of this resistance.

Freud considered that the etiology of all neurosis "was a mixed one; either the patient's instincts are excessively strong and refuse to submit to the taming influence of his ego or else he is suffering from the effects of premature traumas, by which I mean traumas which his immature ego was unable to surmount." A relationship existed between these two factors; i.e., the stronger the constitutional strength of instincts, the more easily could a trauma lead to fixation and a disturbance in development. If the instinctual life was normal, severe trauma alone might suffice to create neurosis. Analysis had a better chance of strengthening the ego where the traumatic factor predominated. Prejudicial to analysis and fostering its interminability was "a constitutional strength of instinct and an unfavourable modification of the ego in the defensive conflict." Also a reinforcement of instinctual energy at some later period in life made demands on the ego it could not tolerate. It was then difficult to achieve the goal of analysis, the taming of instincts and bringing them into harmony with the ego.

The two themes that gave the analyst the greatest difficulty were penis envy in women and in men the struggle against their passive or feminine attitude toward other men. In women, normally, large portions of the striving for masculinity underwent a transformation. The unsatisfied wish for a penis became converted into a wish for a child and for a man who possessed a penis. Often, however, the masculine wish persisted, repressed in the unconscious, exercising itself disturbingly. In men the passive attitude

often continued to signify castration. Where these drives had not been satisfactorily resolved, they could persist doggedly throughout analysis, frustrating the analyst's most dedicated attempts at resolution. Many resistances arose out of a female patient's refusal to give up the wish for a penis and the masculine protest. When these drives were elucidated in analysis, "we have penetrated all the psychological strata and reached 'bedrock.' " Then the analytic task was accomplished, and analysts could console themselves "that everything possible has been done to encourage the patient to examine and to change his attitude to the question."

All people were bisexual since "their libido is distributed between objects of both sexes, either in a manifest or a latent form." Why conflict developed with a restriction of the love object. Freud attributed to the "intervention of an element of aggressiveness…a manifestation of the destructive or aggressive instinct."

Quite modestly, Freud admitted the reason for "the variable results of analytic therapy might be that our success in replacing insecure repressions by reliable and ego-syntonic controls is not always complete, i.e., is not radical enough. A change does occur, but it is often only partial: parts of the old mechanisms remain untouched by analysis." While "analysis is always right in theory in its claim to cure neurosis by ensuring control over instinct … in practice its claim is not always justified." This is because the instincts continue to be so strong that the ego fails in its tasks, "for the power of analysis is not infinite; it is limited, and the final result always depends on the relative strength of the conflicting psychical agencies."

Adequate criteria for the termination of psychoanalysis were, first, symptom relief with overcoming of various anxieties and inhibitions, and, second, the opinion on the part of the analyst that so much repressed material had been made conscious, with sufficient evidence that that which was inexplicable is now elucidated, and enough inner resistance eliminated, that we need fear no repetition of the patient's specific pathological processes. The latter criterion for the "end" of analysis was ambitious in its scope. "According to it we have to answer the question whether the effect upon the patient has been so profound

that no further change would take place in him if his analysis were continued." This, Freud added, implied that through analysis one could achieve absolute psychical normality, with a lifting of all the patient's repressions and a filling of every gap in the memory. "If the patient who has made such a good recovery never produces any more symptoms calling for analysis, it still, of course, remains an open question how much of this immunity is due to a benevolent fate which spares him too searching a test."

In analytic practice treatment had to be carried out "in a state of abstinence" to bring the "conflict to a head" by increasing the "instinctual energy available for its solution." Yet, "a prophylactic treatment of instinctual conflicts" was not to be fostered by subjecting the patient to cruel experiments, since "in conditions of acute crisis it is, to all intents and purposes, impossible to use analysis." Fresh conflicts "will only make the analysis longer and more difficult." During analysis the strengthening of the ego permits a review of old repressions "with the result that some are lifted, while others are accepted but reconstructed from more solid material ... they will not so easily give way before the floodtide of instinct." Sometimes analysis counteracted an increase in the instinctual strength; sometimes it raised the resistances so they could take a greater instinctual strain.

The Technique of Classical Psychoanalysis

It is generally accepted that classical psychoanalysis is useful only in persons who have reached a relatively mature state of personality development. They must have experienced the traditional triangular (Oedipal) conflict that in resolution has enabled them to sustain a reasonably meaningful relationship with both their parents. If the pre-oedipal relationship with the mother was too severely ambivalent, the regression during psychoanalysis will provoke anxiety and depression so great as to interfere with the management of the transference neurosis.

Not all persons are capable of establishing an initial therapeutic alliance, which is the preliminary requisite for psychoanalysis. Defensive mistrust and frustration at the lack of immediate gratification of needs and demands may block progress. The therapist's

seemingly cruel and unfeeling behavior may be looked upon as a sign of a harsh perversity, and the patient may be unwilling to give up his or her detachment and need for control. The analytic situation may therefore never get off the ground. Those patients who are capable of establishing a therapeutic alliance have an opportunity to be helped through the next phase of regression, in which infantile conflicts are revived and a transference neurosis develops that enables the patient to work through and resolve the conflicts. The techniques of free association, lying on the couch, passivity on the part of the analyst, are purposely designed to encourage passive dependence and regression. The inevitable resistance of the patient is managed by timed interpretations. Unresolved conflicts emerge in the transference, and their understanding is helped by proper interpretation. Slowly the original infantile conflict emerges and is definitively resolved. The termination phase involves an ability to separate from therapy and the analyst and to assume independence and autonomy.

Freud's formulations are more or less accepted as the basis for present-day classical psychoanalysis. It is believed essential that the patient recognize the derivatives of the repressed since these represent, in an attenuated form, the warded-off material. To minimize the distortion of these derivatives, the obtrusion of current situations and other reality influences must be kept at a minimum.

The core of Freudian psychoanalysis lies in what is perhaps Freud's most vital discovery—that of transference. As has previously been indicated, Freud found that patients, if not interfered with, inevitably projected into the therapeutic situation feelings and attitudes that were parcels of their past. Sometimes transference manifestations became so intense that they actually reproduced and reenacted with the therapist important conflictual situations and traumatic experiences (transference neurosis) that had been subject to infantile amnesia. By recovering and recognizing these repressed experiences and conflictual situations that had never been resolved and by living through them with a new, less neurotic, and non-punitive parental agency, the superego was believed to undergo modification. The individual became tolerant of his or her id and more capable of altering ego defenses that had crippled adaptation. There occurred,

finally, a mastery of early conflicts and a liberation of fixated libido that could then enter into the development of a mature personality.

Since the Oedipus complex is considered to be the nucleus of every neurosis, its analysis and resolution in transference constitutes a primary focus. Where the Oedipus complex is not revealed, where its pathologic manifestations are not thoroughly analyzed and worked through, and where forgotten memories of early childhood experiences are not restored, treatment is considered incomplete.

Because Freudian psychoanalysis is transference analysis, all means of facilitating transference are employed. These include the assumption by the therapist of an extremely passive role, the verbalization by the patient of a special kind of communication—"free association"—the analysis of dream material, the maintenance of an intense contact with the patient during no less than four or five visits weekly, and the employment of the recumbent couch position.

Passivity on the part of the therapist is judiciously maintained even through long periods of silence. The therapist also refrains from reacting emotionally or responding positively or negatively to any verbalized or nonverbalized attitude or feeling expressed by the patient. Strict anonymity is observed, and no personal information is supplied to the patient irrespective of how importunate he or she may become. A nonjudgmental, non-punitive, non-condoning attitude by the therapist is adhered to, dogmatic utterances of any kind being forbidden.

The chief "rule" the patient is asked to obey is the "basic rule" or "fundamental rule" of verbalizing whatever comes to mind, however fleeting, repulsive, or seemingly inconsequential it may seem (free association). This undirected kind of thinking is a most important means of tapping the unconscious and of reviving unconscious conflicts and the memories that are related to their origin. Most important, free association, like passivity, enhances the evolution of transference. As long as the patient continues to associate freely, the therapist keeps silent, even though much time may pass without a comment. The therapist fights off all temptations toward "small talk" or impulses to expound on

theory. The therapist interferes only when resistances to free association develop and until the patient proceeds with undirected verbalizations.

Dream analysis is used constantly as another means of penetrating the unconscious. By activating repressed material and working on defenses as they are revealed in dream structure, the therapist aids the development of transference.

The frequency of visits in Freudian psychoanalysis is important, to encourage transference, no fewer than four or five visits weekly are required. Fewer visits than this encourage "acting-out" and other resistances to transference.

The use of the recumbent couch position enables the patient to concentrate on the task of free association with as few encumbrances of reality as possible. It helps the therapist, also, to focus on the unconscious content underlying the patient's verbalizations without having to adjust to the demands such as would exist in a face-to-face position. Concentrating on the patient's inner life, rather than on external reality, helps to bring on the phenomenon of transference.

During the early stages of analysis the main task is to observe—from free associations and dreams—manifestations of conflicts and the types of defenses employed, which form a kind of blueprint of the unconscious problems of the patient. This blueprint is used later at the stage of transference. Since repression is threatened by the operation of exploring the unconscious, anxiety is apt to appear, stimulating defensive mechanisms. These function as resistances to productivity, and even to verbalization. Free association may consequently cease, and the patient may exhibit other manifestations that oppose cooperation with the treatment endeavor. Such resistances are dealt with by interpretation. Through interpretation the patient is brought to an awareness of how and why he or she is resisting and the conflicts that make resistance necessary.

Sooner or later the patient will "transfer" past attitudes and feelings into the present relationship with the analyst. Observance of the "basic rule," the attack on resistances through interpretation, and the consideration of unconscious material in dreams and free

associations remove habitual protective devices and facades that permit the patient to maintain a conventional relationship. The patient is most apt to express strivings toward the therapist rooted in past experiences, perhaps even reproducing the past in the present. Thus, a revival of pathogenic past conflicts is instituted. Unlike supportive and reeducative therapy, in which transference may be used as a therapeutic vehicle, the transference is interpreted to the patient in order to expose its nature. This is the chief means of resolving resistance, of bringing the individual to an awareness of the warded-off content, and of realizing the historical origin of conflicts.

The development of transference may occur insidiously and manifest itself indirectly, or it may suddenly break out in stark form. It often shows itself in changes in the content of free associations, from inner feelings and past relationships with parents to more innocuous topics, like current events and situations. This shift is evidence of resistance to deeper material activated by the erupting transference feelings. Sometimes free association may cease entirely, with long stubborn silences prevailing that are engendered by an inability to talk about feelings in relation to the therapist. The purpose of superficial talk or silence is to keep from awareness repressed emotions and forgotten memories associated with early childhood, particularly the Oedipus complex. Until these can be brought out into the open, the emotions relating to them discharged, and the associated memories reclaimed, the conflictual base of neurosis will survive. The transference neurosis offers an opportunity for this revivification since, in the relationship with the therapist, the patient will expose loves, fears, and hates that were characteristic of his or her own experiences during the Oedipal period.

Transference, however, acts as a source of powerful resistances that impede therapeutic progress. Once the patient is in the grip of such resistances, he or she is usually determined to cling to them at the expense of any other motivation, including that of getting well. On the positive side, transference is important diagnostically since it reveals a most accurate picture of the patient's inner conflicts. Additionally, it induces a coming to grips with and a working through in a much more favorable setting of those unresolved conflicts that have blocked maturation. The resolution of transference is felt

by Freudian psychoanalysts to be the most powerful vehicle known today for producing structural alterations in the personality.

Active interpretations of the transference are essential to its resolution. These include the interpretation of its manifestations, its source, and its original and present purposes. The working through of transference is accompanied by a recollection of forgotten infantile and childhood experiences—a recounting of distortions in relationships with parents or parental surrogates. The accuracy of interpretations will usually be denied at first as part of the resistance manifestation. Acknowledgment of the unreal nature of transference is usually opposed by the patient because this either constitutes too great a threat or because the patient does not want to relinquish transference gratifications that are deemed essential to life itself. As long as he or she continues to deny transference, the analysis will remain interminable, unless forcefully terminated by either participant. With persistence on the part of the therapist, interpretations usually take hold and the patient is rewarded with greater insight, an increased sense of mastery, liberation from neurotic symptoms, and genuine growth in maturity.

The therapist must also constantly guard against manifestations of destructive countertransference, which, disguised and varied, are mobilized by unresolved problems and pressing needs within the therapist. Common forms of countertransference are subtle sadistic attacks on the patient, impulses to be pompous and omnipotent, or desires to reject the patient or to detach oneself from the relationship. Because of countertransference, a personal analysis is considered essential for analysts so that they can deal with their own unconscious tendencies and resistances precipitated by contact with their patients.

As the ego of the patient is strengthened by an alliance with the therapist, it becomes more and more capable of tolerating less and less distorted derivatives of unconscious conflict. The continued interpretation by the therapist of the patient's unconscious feelings and attitudes, as well as the defensive devices that the patient employs against

them, enables the patient to work through problems by seeing how they condition every aspect of his or her life. In the medium of the therapeutic relationship the individual is helped to come to grips with early fears and misconceptions, resolving these by living them through in the transference. The patient is finally able to resolve libidinal fixations and to liberate energy that should originally have gone into the formation of a mature sexual organization (Freud, 1920, 1924, 1930b, 1933, 1936, 1937, 1938a, b; Jones E, 1924; Glover E, 1927; Strachey, 1934; Balint, 1936; Bibring-Lehner, 1936; Glover et al, 1937; LaForgue, 1937; Schmideberg, 1938; Zilboorg, 1939; Sterba, 1940; Fenichel, 1941; Lorand, 1946; Berg, C, 1948; Nunberg, 1948; Kubie, 1950b).

A number of additions and modifications of Freudian theory have been introduced, especially as they relate to sicker patients. Most notable is the focus on object relations during the pregenital period and residues of existing distortions in adult life. Interferences with instinctual development brought about by difficulties with the parenting objects have been especially explicated by Anna Freud and Margeret Mahler. According to Mahler (1971), children who fail to resolve the rapproachement aspect of the separation-individuation process may incorporate "bad" introjects laden with derivatives of aggressive drive that encourage a splitting of the object world into "good" and "bad" objects. This splitting is characteristic of the transference experience in most borderline cases. Mahler (1958) contends that during the first three months of the life of the infant, in the "presymbiotic" or "normal-autistic" phase, the mother acts as an "external executive ego." At the end of this stage the infant enters the "phase of symbiosis," during which the mother is dimly perceived as a "need-satisfying-quasi-extension-of-the-self." The infant's and mother's body-ego boundaries seem fused. Mother and infant are "an omnipotent symbiotic dual unity" (Mahler et al, 1959). Toward the end of the first year, coincident with locomotion and the beginning of language, the process of separation-individuation takes place; at 18 months ego boundaries begin to crystallize; and during the second year reality testing consolidates toward a "clear distinction between the self and the object world." A disturbed mother-child relationship during these early phases disrupts the normal progression toward separation-individuation and reality testing.

E. Jacobson (1967) has further expanded on the dynamics of the psychotic process. She states that whereas both the neurotic and psychotic possess pre-Oedipal narcissistic fixations and are subject to pregenital and ambivalence conflicts, the relative stability of these defenses in the neurotic (particularly the repressive capacity and the intactness of boundaries between self and object representations) help prevent not only drive defusion and drive deneutralization but also flooding of the ego with sexual, destructive, and self-destructive forces. These forces in the poorly defended psychotic lead to a regressive dissolution of the psychic structures. In the latter case, an increase of free aggression weakens the ego's ability to resist the assault of the instinctual forces, particularly outward destructive and self-destructive impulses. The basic intrapsychic conflict in the psychotic relates to the "struggle between active and passive, sadistic and masochistic, destructive and self-destructive tendencies, and in general between sexual and aggressive impulses," which may at varying times be employed as defenses against each other.

Many psychoanalysts today have attempted to incorporate in their thinking and practices some of the new advances in the behavioral sciences. A survey conducted by Hofling and Meyers (1972) of the opinions of 90 American psychoanalysts of the most important information and technical advances made in their field since Freud's death indicated that, although there was some doubt as to the value and originality of most of the work, substantive contributions had been made by Hartmann (on ego autonomy), Erikson (on identity and psychosocial development), Mahler (on separation-individuation), Kohut (on narcissism), Anna Freud (on early infancy and lines of development), and Jacobson (on object-relations theory). Kernberg (1973) has written extensively about problems of the borderline patient.

Disagreement with certain psychoanalytic concepts is common among contemporary psychoanalysts. Even those analysts who consider themselves to be "orthodox" Freudians are not in complete accord with Freud in theory and method. Many analysts challenge the death instinct hypothesis, for instance. Insofar as technique is concerned, practically every analyst implements psychoanalytic methods in his or her own specific way. Many years ago an extensive questionnaire distributed by Glover (1940)

to a representative group of practicing psychoanalysts demonstrated that deviations from orthodox techniques were extensive even then. There were differences in the form, timing, and amount and depth of interpretation. The degree of adherence to free association varied, as did the assumption of passivity and anonymity, the use of reassurance, and the management of transference. Variation in methods of doing psychoanalysis was indicated by the fact that out of 82 questions, there was general agreement on only 6, and even here there was not complete conformity. Glover (1964) has emphasized repeatedly that established principles of psychoanalysis are difficult to delineate even for avowed classical analysts. T. W. Mitchell's (1927) contention that a psychoanalyst can be defined as one who accepts the ideas of the unconscious, infantile sexuality, repression, conflict, and transference would not be considered adequate for a British Kleinian, who would insist on explorations and analysis in depth through the 3-to-6-month-old "depressive position" and the later infantile "paranoid-schizoid" phases.

Drawing inspiration from Levi-Strauss's structuralism, Lacan (1953, 1964, 1977, 1978; Leavy, 1977; Miel, 1966; Wilden, 1973; Muller, 1985) attempted a mating of linguistics with psychoanalysis. The amalgam resulted in writings notable for their obscurity of meaning. Nonetheless, Lacan's dedication and energy resulted in the development of a popular school of analysis. According to Lacan, psychopathology is rooted in developmental defects, particularly around the "mirror stage," which occurs between the ages of 8 to 18 months and consists of visual perceptions of one's body form as seen in a mirror at an early stage in life (Lacan, 1949). Disturbances in this perception may result in a false recognition of the self and the assumption that there is another being shadowing the self (the "other"), which is principally responsible for self-alienation. An ego structure develops that is defensive and maladaptive, and the self becomes increasingly identified with the "other." Therapy consists, through language, of clarifying this distortion and liberating the true self from the "other," which manifests itself in many ways, including identification with the analyst.

Lacan resigned from the Psychoanalytic Society of Paris to found his own school and popular training institute, the "Freudian Cause." His methods, which include shortening

the traditional 50-minute session, and his writings, which are difficult to understand, have made him a controversial figure. Some consider him a genius; others, such as members of the International Psychoanalytic Society, which expelled him for "deviant practices," believe that he is grossly incompetent. Except for using the couch position in the treatment of a majority of his patients, Lacan deviates from practically all other accepted Freudian methodological principles, although he pays homage to the greatness of the master and calls himself a *true* Freudian. The shortening of the session is perhaps the key issue around which clinicians organize their criticism. Lacan provides a rationale for the abbreviated therapeutic session (which is sometimes as short as 3 minutes) by avowing that dismissing a patient before the end of the hour is an effective way of dealing with verbal resistances and that such dismissal actually solidifies the therapeutic relationship. It is difficult to say how much of Lacan's success was due to his charisma, or to disagreement of his followers with classical psychoanalytic theory and method, or to the validity of his developmental theory of the "mirror stage." Because Lacan's explanations are too obscure for one to be certain of their true meaning, his concepts have been subject to many interpretations. Many of his statements are revolutionary, such as that good therapy should strengthen not overcome the ego, since it is a distorting organization. It will be interesting to observe how many of his theories and practices survive Lacan's death.

Some analysts still practice classical psychoanalytic technique, but, by and large, many, perhaps most, analysts employ a modified psychoanalytic technique that differs from the orthodox form. Questionnaires sent out by the Research Committee on Psychoanalytic Practice of the American Academy of Psychoanalysis (Tabachnick, 1973) to a sizable number of therapists indicated that only 6 percent of the patients being treated by the respondees were seen four times a week and a mere 1 percent were seen five times a week. The great majority of the patients were treated in the sitting-up rather than the recumbent position. Group, family, and marital therapy were occasionally used, and *94 percent of those polled sometimes prescribed drugs.* We might speculate from these findings that either the majority of patients were not suited for intensive psychoanalytic work, or that the analysts in the survey believed that psychoanalysis could be done with

less than the classical four to five sessions per week, or that most patients could not afford to pay for more frequent visits, or that the members of the American Academy of Psychoanalysis were less rigorous than their colleagues in the more orthodox American Psychoanalytic Association. If this survey truly reflects what is going on in contemporary psychoanalysis, most therapists who call themselves psychoanalysts are not using the classical technique for most of their patients. One would conclude that a sizable group of psychoanalysts of various schools are providing a psychoanalytically oriented treatment rather than the classical type, irrespective of what the analysts themselves say they are doing. Whether we can apply the term "psychoanalysis" to these modifications is a matter of opinion.

Criticism of Freudian Psychoanalysis

Perhaps no branch of psychotherapy has created so great a furor among professionals and laity, or is as responsible for so great a polemic, as Freudian psychoanalysis. "Superlative," "finest," "unique," "peerless," "incomparable," "insipid," "senseless," "absurd," "inconsistent," "prejudiced"—in these words, from the mouths and pens of its devotees and critics, psychoanalysis is qualified in both transcendent and opprobrious terms. While the brilliance of Freud's clinical observations is acknowledged by even his sternest critics, the theoretical cement that binds his concepts together is considered by many to be fragile (Bieber, 1958). Such concepts are considered by some to be rooted in nineteenth-century physics and biology. Objection is voiced to the thesis (1) that a human being, frustrated by the sexual impasse imposed by inimical events in childhood, spends the rest of his or her life fruitlessly trying to repair this damage, (2) that, blocked in this quest by a false friend, the mechanism of repression, the individual aimlessly wanders through the circuitous by-paths of life, seeking vicarious and infantile satisfactions, and (3) that, while constantly casting in the present the shadows of the past, the individual defends himself or herself with capricious maneuvers, relentlessly marching on to inevitable psychological doom. A person's destiny, it is claimed, is not so dismal. Neo-Freudians and existential analysts particularly, stress one's "responsibility" for one's own fate and future. They have also accused Freud of minimizing the social

determinants of psychic phenomena. A scientific approach to the study of personality must consider that the basic biological forces of humanity are shaped and fashioned through the social environment. Freudians counter with the explanation that although Freud did not elaborate too fully on them, he did not neglect cultural influences while stressing instinctual processes. Fenichel (1945, p. 6), for example, has pointed out that Freud was fully aware of how instinctual attitudes, objects, and aims were constantly being altered as a result of social experience.

A search through Freud's voluminous writings easily reveals passages that can sustain almost any variant version of psychodynamics. As is so often done with Shakespeare and the Bible, the practice is common of plucking of statements out of context and exploiting them for prejudiced purposes. One may in various volumes find contradictory passages among Freud's contributions, in the form of contrasting sentiments and revisions. Such amendments are in the highest traditions of science, which demand alteration of old conclusions as new hypotheses are advanced.

In the richness of his contributions Freud developed a variety of theoretical configurations. In some quarters, however, obsolescent models have been retained even as more functional ones evolved. This superimposition of model upon model makes for a certain grotesqueness of concepts. In the main, Freud's dynamic theoretical premises have been accepted more enthusiastically than either his topological constructs of the mental apparatus or his economic theories, which relate intrapsychic and interpersonal transactions to energy distributions issuing from libidinal and aggressive instincts.

Dealing with so many disparate aspects, psychoanalysis has suffered by the tendency to judge its whole by the weakness of some of its parts. For instance, its theoretical inconsistencies have led to a minimization of its therapeutic potential. Conversely, the fact that it fails as a treatment procedure in certain problems has tended to devalue psychoanalysis as reflecting a reasonable theory of behavior. Its limitations as a model for the interpretation of anthropologic, historical, educational, religious, and literary data have invited the repudiation of psychoanalysis as a whole.

Some of Freud's ideas have gained a wide acceptance and continue to ring as true today as they did when he originally formulated them. Others are outmoded, and like any other human concepts have undergone revision and reformulation. Freud framed many of his notions in a tentative and speculative mood, and he preferred them with the cautious warning that they would undoubtedly later be altered or discarded. "Psycho-analysis," he wrote, "has never set itself up as a panacea and has never claimed to perform miracles" (Freud, S, 1959).

One of the problems in the evolution of a school is the resistance of the founder to countenance changes in his formulations by any person other than himself. Freud was no exception. While he took great liberties with his own postulates, transforming and discarding many of his pronouncements, he was not so generous with innovations introduced by his contemporaries. The abandonment of anonymity and passivity by Ferenczi with assumption of a "caring" and loving attitude toward his patients, the active involvement in therapeutic maneuvers by Stekel, the concern with mystical philosophy by Jung, the drift away from infantile sexuality toward inferiority feelings by Adler, the elaboration of the birth trauma and separation anxiety by Rank all brought forth the sternest criticism from Freud. This tendency of denying validity to approaches that deviate from formal doctrine has continued in psychoanalysis to the present day.

It sponsors the commonly voiced criticism of Freudian method that analysts insist upon wedging their patients into a preconceived theoretic structure. When the patient does not produce appropriate material that substantiates accepted notions of dynamics or refuses to accept interpretations, he or she is credited with being in an obstinate state of resistance. A sentiment expressed by non-Freudians is that, in their eagerness to smuggle "deep" insights into patients, certain "orthodox" analysts make dogmatic interpretations that patients feel obliged to accept. This practice may mobilize intense anxiety that can disorganize patients with weak ego structures. Another criticism is that many classical analysts are intolerant toward those who practice therapies other than Freudian psychoanalysis, considering these to be superficial and of little real value. Accordingly, they are inclined to depreciate treatment by non-analysts as well as by analysts of non-

Freudian orientation.

What is interpreted as a lack of flexibility, however, is actually a staunch defense of a theoretical position that "psychoanalysis" is a specific mode of treatment in which the focus is on the unconscious, revealed through the transference, uncovered by resolution of resistance, and centered on the bringing to the surface and working through of buried childhood conflicts. Obstinacy in retaining this position is derived not from cantankerousness but from a passionate conviction that this is the most effective way of achieving extensive restructuring of the psychic apparatus.

Opinions vary about the effectiveness of classical psychoanalysis because countless characteristics of patients and therapists influence outcome. It is often avowed that current pessimistic impressions of the potential of psychoanalysis as a therapy result from the inclusion of reports of outcome made by inexperienced practitioners (Gedo, 1979). Are there any reliable reports of experienced analysts? Summarizing his own work of two decades as an experienced full-time analyst, Gedo is convinced of the effectiveness of the method. His data are drawn from a total caseload of 36 people treated over 20 years of practice, 28 of whom terminated analysis with a "consensus about the satisfactory outcome of the enterprise." The patients were primarily in the higher socioeconomic class. The technique was classical psychoanalysis four or five times weekly, for 600 to 1000 sessions in three to seven years. There was no systematic follow-up study, but the author estimates that failure to contact him "argues for the probability that those who have not been heard from are not simply withholding unfavorable tidings." The author cryptically concludes with the statement that an analyst should not approach clinical work with a personal need to be a healer since "to require patients to improve is an illegitimate infringement on their autonomy."

In reviewing the presented statistics of 28 out of 36 patients improved over a period of 20 years of practice, one would estimate that, irrespective of whether the results justify the conclusion of a "matchless usefulness of the analytic method as a means for personal growth," the classical technique, for economic reasons, is definitely not designed for the

great majority of patients seeking help for emotional problems. This does not in any way invalidate the incorporation of analytic principles in a lesser than long-term program.

My own impression is that, given a carefully screened patient and a well-trained analyst, the results with classical analysis can justify the expense and effort. On the other hand, the great majority of patients can be effectively helped by less intensive and costly methods. Where poor results have been obtained with classical psychoanalysis, the chances are that it was employed with patients who were unsuited for the technique or that the therapist was by training or personality not capable of working with the method.

A discreet appraisal of its therapeutic merit indicates that classical psychoanalysis constitutes a serviceable, though by no means exclusive, insight-oriented approach to problems of an emotional nature. In some cases, and in the hands of qualified and experienced psychoanalysts, it may be the most consummate of all treatments. In other cases it may fail miserably to benefit patients in the least. It is useful in individuals who are not too sick emotionally, whose conflicts are severely and obstinately repressed, who are capable of understanding abstract concepts, who have the time and money to invest in long-term therapy, and who are willing to expose themselves to the rigors of the method. This limits the number of patients to a small percentage of those who require psychotherapy. Accordingly, therapists trained in the classical method often adopt techniques from other approaches (somatic, group, family, active interviewing, etc.) when they are obliged to treat patients who are not suited for the formal analytic procedure. Its qualification in transcendent terms is not only undeserved, but contrary to the spirit of its founder, who cautiously wrote in one of his last depositions: "The future will probably attribute far greater importance to psychoanalysis as the science of the unconscious than as a therapeutic procedure" (Freud, 1926).

The homage paid Freud is, nevertheless, truly deserving. Despite his intolerance of nonconformity, his was a truly great mind, reflected in his pioneer writings by his sparkling prose, his brilliant wit, and his unique and penetrating insights into human behavior. Humanity owes this extraordinary man an enormous debt for opening up new

psychological vistas and for bringing to science of the mind the same dignity and grandeur that Darwin brought to biology and Harvey to physiology. The concept of the unconscious, the dynamic nature of repression, the importance of psychic determinism, the goal-directed nature of behavior, the relation of psychosocial development to personality evolution, the consociation of abnormal mental symptoms and normal mental processes, the meaning of anxiety, the role of symbolism, the significance of dreams, and the phenomena of transference and resistance—these have proved themselves to be of revolutionary importance and have provided us with tools for the investigation of intrapsychic and interpersonal activities. One may easily understand the esteem in which his contemporaries and students have held Freud and why those who have known him personally and from his writings talk about him with such love and reverence. While many of Freud's findings have been challenged and some altered, his discoveries have paved the way to a better understanding of human beings' psychological nature. They have stimulated independent and productive research for the benefit of all humanity.

Freudian psychoanalysis is practiced extensively throughout most of the world, especially in the United States and England. The parent organization is the International Psychoanalytic Association, which publishes the *International Journal for Psychoanalysis.* The American Psychoanalytic Association, which sponsors the *American Journal of Psychoanalysis,* is composed of a number of local societies throughout the country.

KLEINIAN PSYCHOANALYSIS

By analyzing the free-associational play of young children in the 1920s, Melanie Klein developed a biological theory that has gained a great deal of prominence among English psychoanalysts. She has a large following in South America, Spain, and Switzerland. Some authorities believe that an understanding of Kleinian principles is basic to a dynamic conception of child psychology as well as adult psychopathology, particularly the phenomena of schizophrenia and manic-depressive psychosis.

Freud contended that the superego of children was evolved by taking over (introjecting) the parental attitude at the time of the resolution of the Oedipus complex,

around the age of 4 years. According to Melanie Klein's theory (1932, 1946, 1948, 1952, 1955, 1957, 1960, 1961, 1963), the Oedipus complex emerges during the first year of life. The superego, too, is organized soon after birth. In the initial contacts with reality, the child fuses emotional feelings in relation to objects (mother, breast, nipple, etc.) with the objects themselves. Thus objects that inspire pleasure are "good objects"; those that provoke pain are "bad objects." The first object within the infant's perceptual range is the mother's breast ("breast" is used as an inclusive term—for breast, nipple of a bottle, mother's body, and her closeness). Since hunger is an unbearable tension state for the infant, the breast and everything associated with it become a chief means of allaying the child's discomfort. But the breast is not always forthcoming on demand. The infant does not have the knowledge "that loss, frustration, pain and discomfort are usually temporary and will be followed by relief." The slightest change in the tension-alleviating state, such as a less easy grasp of the nipple or diminution in the flow of milk, will suffice to change the pleasant stimulus into an unpleasant, dissatisfying one. The child will then love and hate the breast and mother simultaneously on the basis of an all-or-nothing principle. The world for the child is peopled with good objects that satisfy and bring relief and with bad objects that frustrate and provoke suffering.

Among the child's earliest concepts, incorporation (taking in milk) and expulsion (giving out feces) are most prominent; these processes come to play a vital role in ideas of oneself and the world. A rudimentary sense of the world and objects (breast of mother, bottle and nipple, mother's body, his or her own feces and urine, genital organs, the closeness and absence of mother) surrounds the child, along with dim phylogenetically determined images of the penis, vagina, coitus, and childbirth. Reacting to the Oedipus complex, the infant fears destruction by the Oedipal rival. The infant conceives of coitus as an act of biting, with oral incorporation of the penis by the mother. Penis and vagina are regarded as dangerous weapons; the penis equated with breast, the vagina with a biting mouth. The infant desires to take in (incorporate, introject) "good objects," such as the pleasurable and satisfying breast, and in doing so conceives of himself or herself as good and whole. The assault on the breast (around the sixth month passive sucking is replaced in part by active biting) enables the infant to react to anxiety with attack. This oral sadism

is vital to personality development, and rage issuing from frustration serves to strengthen the sadistic instincts. Operation of the death instinct inspires active aggression against the self; in self-protection there is a projection outward against the breast, or "persecutors." Introjection of the breast is also a means of controlling and destroying "bad objects." This leads to guilt and to efforts to deal with aggression by projection or destruction. The infant's notion of aggression is at first centered around the oral function. Fantasies of sucking and biting tend to be externalized, as are the hatred and "envy" of the mother. These return as fear of the mother destroying, tearing, and eviscerating the child. A persecutory "paranoid-schizoid position" prevails when the bad objects, the product of the child's own aggression, in being projected, come back to torment the child ("projective identification"). The "paranoid position" that occupies the first 4 months of life makes for the first active relationship with the world. A primitive form of the adult paranoidal persecutory delusion, it is usually outgrown, though remnants remain in the psyche to be affiliated with a later developing sense of guilt.

Such conceptual formulations are concocted during a stage in the child's mental life when ideas are diffuse and undifferentiated. The incorporated desires toward the part object "good breast" and aggressive wishes toward the part object "bad breast" are soon directed toward the whole object, the mother, the person the child needs and loves. The mother is conceived of as being both good and bad; if one attacks the bad mother, one also destroys the good mother. The "whole object" is at this time introjected. The fear that the child has destroyed or may destroy the mother leads to guilt, fear of loss, and feelings of depression. This "depressive position," which occurs at about 6 months to a year, is so painful that the child tends to regress to the "paranoid position" of separate good and bad objects. Eventually the child realizes that the aggressive wishes have not and will not destroy the mother, and the depression ceases, though residues of the depressive position remain in the form of guilt feelings. Defenses against the depressive conflict bring about a return of paranoid-schizoid phenomena, and the individual may fluctuate between two states. The paranoid-schizoid position gives way to the depressive position, particularly when external reality provides a preponderance of good experiences. This enables the ego of the child to acquire belief in the prevalence of ideal objects over persecutory objects.

The introjection of these ideal objects also helps to modify the internal persecutory objects and death instinct. As the ego of the child strengthens, it can cope with internal and external anxieties more easily without recourse or violent mechanisms of defense and extreme splitting.

Under favorable conditions, the infant feels that his or her ideal object and libidinal impulses are stronger than the bad object and bad impulses, and he or she will be able more and more to identify with the ideal object. The child is less frightened of bad impulses and less driven to project them outside. Integration proceeds, and finally a phase of development takes place during which the infant recognizes and relates to the whole object. Originally this is the mother; later there is cognizance of other people in the environment. In contrast to the infant's perceiving the mother only as bits and pieces— breast, hands, and eyes— she is conceived of in her entirety. She is also accepted as the same mother who can at times be good, at times bad; present and absent; loved and hated. The infant begins to see that good and bad experiences do not proceed from two sources but rather from the same mother. Thus, ambivalence develops. The child will also realize at this time that the mother is an individual with a life of her own and with other relationships. This leads to feelings of jealousy and painful feelings of dependency. As the mother becomes a whole object, the infant's ego becomes whole and fragmentation diminishes.

In the paranoid-schizoid position the main anxiety is that the ego will be destroyed by bad objects; in the depressive position, anxieties spring from ambivalence and from the fear that the child's destructive impulses will destroy or have destroyed the object he or she loves and depends on. Mourning occurs, despair is felt, and guilt arises connected to destructive feelings toward the good object. As the depressive position is worked through by the child, the relationship to objects alters and the child acquires the capacity to love and to respect people as separate and differentiated individuals. The child has concern for objects, which helps to control impulses and to regulate activities toward self and objects. Regression supersedes splitting, and neurotic mechanisms rather than psychotic ones take over. Symbol formation also begins as the infant inhibits the instincts and displaces

them onto substitutes.

The development of the child is influenced by both internal and external factors. External deprivations, physical or mental, clearly influence the child in various ways, but even when the environment is bountiful and should be conducive to satisfactory growth, development may still be modified or prevented by internal factors.

Melanie Klein describes one such factor as "envy," which she believes operates from birth and affects the infant's earliest experiences. While Freud recognized and paid a great deal of attention to penis envy in women, other needs of envy, for example man's envy of females and both sexes' envy of one another, were not so specifically recognized and described. There has been a strong tendency, both in the literature and in everyday practice, to confuse "envy" with jealousy. In her book *Envy and Gratitude,* Melanie Klein (1957b) makes a distinction between the emotions of "envy" and jealousy. She considers "envy" the earlier of the two, and she believes it to be one of the most primitive and fundamental emotions. She differentiates it clearly from jealousy and greed:

Jealousy is based on love; it aims at the possession of the loved object and the removal of the rival. It always exists in a triangular relationship and therefore occurs at a time when objects can be clearly recognized and differentiated from one another.

Envy is a two-person relationship in which the subject begrudges the object for some possession or quality. It may be experienced in terms of part-object as well as whole-object relationships.

Greed, on the one hand, aims at the possession of all the goodness that can be extracted from the object. It may result in the destruction and "spoiling" of the object, but this destruction is not directed at, and is only incidental to, ruthless acquisition. Envy, on the other hand, aims at being as good as the object, and, if this is not possible, at blemishing the goodness of the object.

It is this spoiling aspect of "envy" that is so destructive to development, since the

very source of goodness that the infant depends on, i.e., the breast in the first instance, and the good things to be achieved from it, is turned bad by envious attacks. As the source of good things is spoiled, so the capacity to obtain good things from the source, i.e., by introjection, is seriously interfered with. The infant is really attacking the very source of life, and this phenomenon can be considered to be the earliest direct externalization of the death instinct. It stirs as soon as the infant becomes aware of the breast, and, paradoxically, the better the good experience has been, the more powerful the envious attacks that may be levied at the breast. Sometimes the infant will attack the "goodness" after it has been incorporated, envying what has been obtained. Envy operates mainly by projection, and the fantasy of attacking the breast is supported by such physiological processes as spitting, urinating, defecating, the passage of wind, and penetrating looking. Even the Oedipal situation may be dominated by envy rather than jealousy, the child attacking the parents and their relationship out of envy of what they have rather than the love that the child feels has been lost (jealousy). Strong feelings of envy prevent the child from differentiating good and bad things because the good things are attacked and turned bad. This leads to confusion between good and bad and often results in despair. Because no ideal object can be found, there appears to be no hope of love or help.

It is apparent from Melanie Klein's theories about child development that aggression is regarded in large measure as hereditary and that mistrust, fear of attack, and depression are inevitable, irrespective of the upbringing the child has experienced. "The repeated attempts," wrote Melanie Klein, "that have been made to improve humanity—in particular to make it more peaceful—have failed, because nobody has understood the full depth and vigour of the instincts of aggression innate in each individual." The only means of resolving infantile anxiety, and of socially modifying the aggressive impulses, she concludes, is by universal child analysis. Any adult analysis, she insists, that does not deal with and resolve infantile anxiety and aggressiveness is incomplete.

Clinical Implications

Kleinian theory holds that neurotic difficulties that occur during and beyond

childhood are manifestations of paranoid-schizoid or depressive patterns. Neurotic defenses are evolved around paranoid-schizoid or depressive personalities, i.e., the determining way in which object relations are integrated, part or whole. An important mechanism in Kleinian theory is called "projective identification," in which parts of the self and internal objects are split off and projected into an important external object for the purpose of possessing and controlling it. Projective identification is also aimed at avoiding separation from the ideal object by uniting with it. Bad parts of the self may be projected to get rid of them and good parts to keep them safe or to avoid separation. At certain times when normal mechanisms fail to protect the ego from anxiety, the ego may disintegrate as a defensive measure and then project the fragmented pieces. Extensive use of this mechanism is made in more severely disturbed children and in psychotics. The use of projective identification produces its own anxieties, i.e., the fear that the object will retaliate and also that the parts of the self that are projected will be imprisoned and trapped inside the object, thus leading to claustrophobic anxieties.

One of the main features of the paranoid-schizoid position is "splitting," which allows the ego to order its experiences and begin to integrate. This process usually starts by differentiating objects into good and bad. Splitting is the basis of what later is called repression; providing it is not excessive and rigid but an important mechanism of defense it functions in a modified form throughout life.

An example of projective identification is provided by Albert Mason (1966), a Kleinian psychoanalyst. The patient was a 25-year-old nurse who had recovered from two schizophrenic breakdowns. Though she was not acutely psychotic at the moment, her dreams and fantasy material showed marked psychotic mechanisms.

> For example, one dream was of her being at a party when she caught site of an Arum Lily. She screamed and fainted and a tall, slim carpenter with a pot-belly came out of the water to comfort her. The dream then changed to her seeing a baby sitting at one end of a carriage. The baby had a huge penis. The mother of the baby, and Indian lady, was wrapped in a white sari. The breast of the mother had a purple engorged look like a genital. It appeared that the mother had just finished feeding the baby. The patient's feeling in the dream was of overwhelming frustration.

> Her associations made it fairly easy to interpret confidently that the tall slim

pot-bellied man stood for the penis of her father that she extracts from the parental intercourse (Arum Lily—associated with marriage) by her scream. The scream, which is an evacuation of part of herself, is the equivalent of the child's angry evacuation of excretia, which is felt to get into the mother and push out the father. The man comes out of the water. The baby (baby part of herself) then feels it possesses the father's genital and can push it into the mother's breast (Indian woman in sari = pigmented nipple surrounded by white breast) in an infantile representation of intercourse. She screams with frustration because although she fantasizes that she possesses the mother sexually, the baby part of herself gets frustrated because it will not be fed by this kind of relationship.

One can see clearly in this dream how father is really a part object, a tall, thin man with a pot belly representing a penis and scrotum. Mother likewise is a breast, merely a pigmented head surrounded by a white sari.

During the session with me the patient felt that her stomach was distended (confusion with pot-bellied man) and felt on occasion that I was cutting her sentences short and thrusting my opinions down her throat. She cuts off the penis and appropriates it (baby with penis) and now feels that I cut off her speech. She feels I push my analytical penis into her violently, just as she pushed the penis into the mother's breast in the dream. At one moment in the session my interpretations excited her and made her lose track of an association that she thought was helpful to me. Here she is confused with [i.e., identifies with] the breast that she excited by thrusting sexuality into it and seducing it away from the feeding situation, i.e., I am felt to be putting things into her which excite and seduce her mind away from the thought which could feed the analysis.

One sees over and over in this kind of relationship how she becomes confused with her objects and how *she* feels the feeling that her objects—breast and penis in this instance—are experiencing in her dreams and phantasies. At one point in the session she remembered testing urine for sugar and noticing the doctor looking at her, as she thought, sexily. Again the confusion with me is clear. She becomes the analyst of patient's material who is being penetrated by a doctor's sexy look. (In the dream she penetrates me as the mother, with the genital).

Another patient, a paranoid homosexual of twenty four, continually feels that his words are dirty and excite me, i.e., dirty my mind. This is then followed in the session by intense irritation and preoccupation with his anus with a mixture of pain and excitation. This he feels I cause by interpretations which he feels humiliate him, penetrate to his core, and get on top of him. He continually makes jokes and quips in the session, i.e., he buggers the analysis about and immediately feels my interpretations are aimed at making him small, exhibiting my skill (penis) and in fact buggering him rather than nourishing and feeding his mind. He often gets claustrophobic on these occasions and feels in despair because he is not sure whether he is not telling me the truth of whether my interpretations are true or just a load of "phoney crap" as he puts it.

One can see here how he projects parts of himself into me and immediately becomes confused with me and feels penetrated and projected into by me. He also feels trapped inside me and the mess he produces which he pretends is exciting (faeces presented as something sexual or good to eat) become hopelessly confused

with my analytical food, so that that is suspected of being phoney, i.e. not true food but disguised "crap." This kind of confusion which is based upon the infant's envy of the breast and feeding qualities of the mother, and which are then confused with its own excretory activities, is a common and persistent characteristic of many homosexuals and needs careful analysis for any resolution of the homosexuality to become possible.

The primitive emotion of envy is often said to be the root of negative therapeutic reactions and interminable treatment; the patient is unable to tolerate help from the analysis and destroys it outside or inside his or her own mind. Good interpretations, felt to be like the nipple putting good food in to nourish the patient's mind, or like the potent father's penis, which can satisfy or create, are both attacked and destroyed when envy is strong.

A frequent defense against envy and one that makes itself felt very commonly in the analytic situation is contempt, which is an effort to defend the patient against unbearable envy and hostility. Envy is very often unconscious, and considerable working through of it is needed before it appears in awareness. "The making of the unconscious envy conscious," says Mason, "will usually result in the mobilization of more love and concern for the attacked object and therefore some diminution of destructive envious attacks."

The further understanding of early mechanisms in the mental life of the child brought about by Melanie Klein's work has encouraged several of her followers to apply her findings to the treatment of psychotics. Notable among these is Herbert Rosenfeld, whose book *Psychotic States* (1965) outlines some of his work. What emerges most clearly is Rosenfeld's strict adherence to classical analytic procedure and principles. The understanding of the psychotic transference is considered essential to maintain contact with schizophrenics and to analyze them without resorting to artificial means. Freud (1953) and Abraham believed that schizophrenics were incapable of forming a transference to the autoerotic level of development because they were regressed. Nurnberg (1955), O'Malley (1931), Barkas (1925), LaForgue (1937), and later Sullivan (1962) (1962) (1939) (1954), Fromm-Reichmann, Knight, and their collaborators have, however, described the importance of the transference in schizophrenia.

Rosenfeld demonstrates that the acute schizophrenic patient is capable of forming both a positive and negative transference, which may be interpreted and can produce clear responses from the patient. He states that in all schizophrenics whom he has observed one particular form of object relationship appears very clearly: "As soon as the schizophrenic approaches any object in love or hate, he becomes confused with this object (projective identification). This is due not only to identification by introjection, but to impulses and fantasies of entering the object with the whole or part of the self in order to control it." Agreeing with Melanie Klein, Rosenfeld believes that this is the most primitive type of object relationship and that it begins at birth. He contends that the withdrawal of the schizophrenic is not simply an autoerotic regression; it may be a defense against external persecutors, or it may be due to identification with an object involving both introjection and projection. In a state of projective identification, which may be experienced by the patient as confusion, the patient is aware of being mixed up with someone else (his or her object). Rosenfeld believes that in the analysis of acute psychosis the psychotic manifestations attach themselves to the transference and a transference psychosis develops. The transference phenomena can be interpreted to the patient only when they are comprehended. The full understanding of projective identification enables one to do this.

In his book Rosenfeld also has interesting chapters on drug addiction and hypochondriasis. He believes that drug addiction is closely related to manic-depressive states but is not identical with them. Drug addicts use manic and depressive mechanisms that are reinforced and consequently altered by the drugs. Drugs have both a symbolic meaning, relating to unconscious fantasies, and a pharmacotoxic effect, which increases the omnipotence of the prevailing impulses and mechanisms. The use of such mechanisms as idealization, identification with ideal objects, and denial of persecutory and depressive anxieties is associated with a positive or defensive aspect of mania. Also, the destructive phases in drug addiction are closely allied to the destructive aspects of mania. An important feature of drug addiction is the projection of good and bad parts of the self. Rosenfeld reveals that crises of severe drugging may occur when a drug addict is making progress in analysis and a splitting of the ego diminishes. This leads to aggressive acting-

out and can be regarded as an envious attack on the therapist. On the surface, the Oedipal conflict and homosexuality play an important part in the psychopathology of the drug addict, but the overwhelming force of these conflicts can be understood only by examining their basis in the very earliest conflicts and mechanisms of the infant.

Rosenfeld considers the hypochondriac state as constituting a defense against schizophrenic or paranoid conditions and confusional anxieties. The ego seems to be unable to work through the confusional state that it projects, including internal objects and parts of the self, into external objects. These are then immediately reintrojected into the body and body organs. A characteristic of the chronic hypochondriac is the inability to obtain proper oral gratification. This frustration is displaced into and complicates the genital sphere of activity. The anxiety created by the patient's genital frustration increases the tendency to regression and mobilizes early confusional anxieties. As a defense against this, the hypochondriac state becomes manifest.

Another of Klein's followers is W. R. Bion (1962, 1963, 1965, 1967, 1970). He has made certain contributions, especially in the field of thinking and thought disorder. His first book, *Experiences in Groups* (1961), has become a standard work among group therapists and demonstrates his use of Kleinian theory in the group process. He notes in detail the use of omnipotent fantasies present in groups and how these fantasies are used to deal with the frustrations concomitant with contact with reality. These omnipotent fantasies are similar to those Klein described that she observed in the infant and its responses to the outside world. Bion also made important observations on the effect of the "genius" or "Messiah" in a group and described how this genius could enlarge or improve the group and be enlarged and improved by it or, conversely, how they could destroy each other.

Bion's work on psychoses essentially supported that of Klein and Rosenfeld, and he demonstrated that a strict analytic and interpretive technique could be utilized successfully with psychotics, as Rosenfeld had also done. He linked the phenomenon of projective identification with the development of thinking. He also described certain

pathological forms of projective identification and postulated that these produced a failure of development of verbal thought and thus played a part in the development of schizophrenic illnesses. Klein's concept "that the infant treats the absence of the good breast as the presence of a bad breast to be evacuated" was explored and expanded by Bion and was the central theme in many of his papers. He also believed that this fantasy plays an important part in the development of psychosis. Bion examines the nature of thoughts and thinking in several of his books and has written extensively about the nature of hallucinations and hallucinosis. He has described the problem of the patient who cannot learn from experience and, therefore, cannot grow, and he has linked this phenomenon with Klein's work on envy.

Donald Meltzer has worked extensively with children and, from his experience, has written several books (1973a & b, 1975). He sets out to revise the psychoanalytic theory of sexuality as formulated by Freud. In so doing, he contends that the original nebulous formulation of the infantile polymorphous-perverse disposition (and genetic concepts of stages of psycho-sexual development and erogenous zone primacies, eventuating in a genital primacy) is shown to resolve itself. Through delineation of the distinction between adult and infantile structures of the mind, criteria of a purely psychoanalytic variety are evolved for assessing the significance of sexual states of mind and consequent behavior. Meltzer discusses the nature of autism and the specific technique of obsessional dismantling of the sensory apparatus of the ego that brings it about. He also examines the origins of mutism as part of the natural history of the disorder and the implications of all these findings for psychoanalytic theory and practice in general. His understanding and clarification of the perversions and their link to perverse states of mind are believed by some to be an important synthesis of the work of Freud, Abraham, Klein, and Bion and a major contribution to the understanding and treatment of psychoses, perversions, and addictions.

Elliot Jaques has written eight books on the implications of Melanie Klein's work to the fields of industry, sociology, and law. In addition, he has written papers about social justice, art, and creativity and is one of the leading applicants of psychoanalytic theory to

everyday life. Other Kleinians whose works have dealt with art and anthropology, as well as the treatment of patients, are Roger Money-Kyrle and Hanna Segal. Bion, Rosenfeld, Meltzer, Jaques, Money-Kyrle, and Segal were all analyzed by Klein.

Criticism of Kleinian Analysis

Both Freudians and non-Freudians believe that the concept of phylogenetically determined images of the genitals, breasts, and primal scene and the description of incorporative and projective symbolic thought processes in infancy are fanciful projections of a theoretically biased therapist. They insist also that focusing all psychopathology on distortions developed during the first year of life is too limiting. There are some who accept aspects of Kleinian theory, for example, the basic paranoid and depressive positions, while rejecting such aspects as pregenital Oedipal conflict and formulations related to the death instinct.

In spite of the criticisms levied against Melanie Klein, her contributions have had a great impact on analytic theory and practice. She was instrumental in showing how the superego formed itself from environmental rather than biological sources, the vitality of intrapsychic struggles between introjected good and bad objects, how object relations were prejudiced by projections from these objects, and the impact of aggression on pathological development, the infantile precursor of structural entities. Most important, her work acted as a basis for present-day ego analysis and object relations theory.

EGO ANALYSIS

Fairbairn (1946a & b; 1954) was one of the pioneers in emphasizing the importance of the ego. He developed an *object-relations theory*, patterned after some of the conceptions of Melanie Klein, which posited a splitting of the ego in early infancy as a consequence of reciprocal action of introjected good and bad objects. While the ego was whole at birth (rather than incomplete as in classical theory), unfortunate relationships with the mother fostered this splitting. The function of the instincts (libido) was to seek good objects. This was needed to promote ego growth. Aggression was a reaction to

frustration of the libidinal drive in this quest. Aggression, therefore, was a defense rather than an instinct (as in classical theory). Loss of ego integrity through the process of splitting and evolvement of internal ego-object relations created pathology. The developmental process was thus bracketed to vicissitudes of objects rather than vicissitudes of instincts. Early interactions of mother and child as a basis for ego development was also emphasized by Winnicott (1958).

Among the contentions of these early adherents of ego psychology such as Fairbairn was the idea that objects were not casual figures who served merely as conduits for infantile need gratification, but rather an integral part of the infant's nature and instinctually sought out from the start. In this way Fairbairn anticipated what later researchers in human development demonstrated, namely, that the newborn child was object-related from the moment of birth. Instead of considering structure (the ego) and energy (the id) as distinct entities, Fairbairn contended that they were intimately bound together. Libido was not pleasure-seeking as much as object-seeking, and this was a biological survival mechanism. A so-called primary narcissistic objectless initial stage of development was an empty abstraction, because object-seeking, albeit disorganized at first, was the primary aim of the infant. Relations with an object were the key to survival of the individual (mouth to breast) and later to the survival of the race (genitals to genitals). Adaptation was the product of a good relationship between individual and object; psychopathology, the consequence of a poor relationship.

The conviction that human behavior is too complex to be accounted for purely in terms of instinctual processes gradually turned a body of Freudians toward the focal consideration of dimensions of personality other than the id, particularly the ego, while retaining fidelity to the dynamic, structural, economic, topographic, and other basic psychoanalytic concepts, including the libido theory. Among the first of these "ego analysts" were Anna Freud (1946), Erikson (1946, 1950), Hartmann (1950a & b, 1951, 1958), Rapaport (1950, 1951, 1958, 1960), Kris (1951), and Loewenstein (1953). The direction of the ego analysts has been less introspective and speculative than it has been empirical, based on factual investigations, the systematic gathering of data, and organized

experiments. Attempts have been made to avoid philosophical issues and implications in order to deal more scientifically with facts. This has led to intensive studies of the child and particularly responses to various child-rearing practices, interactions within the family, as well as the influence of the community. Sociological and anthropological vectors have accordingly entered into some of the emerging formulations, although the orientation is definitely a biological one.

Although primary psychological drives are considered basic and important, these are dealt with in the context of the molding and modifying influence of the environment, which is believed to play a decisive role in eliciting behavior independent of instinctual forces. Building on Freud's conceptions of instinct, ego analysts regard behavior as undifferentiated at birth, at which time the infant possesses certain response potentials, innately derived but requiring the influence of environment to arouse and consolidate them into adaptive sequences. Among the groupings of responses are certain internal and external elicitors of behavior that are distinctive from instincts— those that deal with responses to perceptual stimuli and those that serve organizing, integrating, and controlling functions. Response patterns serve to adjust the individual to the particular environment. Responses such as awareness and thought, which serve to control and direct behavior, are also innately determined. Learned responses soon displace instinctual and automatic reactions. Behavior is more than a means of reduction of sexual and aggressive energies. Ego functions can be pleasurable in their own right. Among the most important ego functions are those that mediate perceptions and sensation and support operations that maintain contact with the external and internal environment; there are those that deal with awareness and attention (which can help delay or inhibit impulses), those that govern thinking and communicating (verbal response), and others that control action and motility, enabling management of one's environment. The ego in its synthetic, integrating, and organizing operations fosters a controlled, thoughtful, planned, and efficient mediation of behavior directed at consciously selected goals.

Though psychosocial development is crucial during the first five years of life, laying down patterns that will determine behavior throughout the remainder of an individual's

existence, these patterns are not as completely fixed and unmodifiable as the earlier Freudian theorists supposed. Nevertheless, at certain stages of growth environmental experiences can have a decisive influence on the total personality structure.

Ego development occurs immediately after birth as the child discriminates between inner responses and the influences of the environment, for instance, in feeding. Gradually the child differentiates self from the environment and anticipates future events. Frustrations encourage self-control. The child develops the ability to recall past situations in which delay in gratification was followed by fulfillment. Habitual response patterns are developed in relation to surrounding objects enabling the child to win their approval and to control feelings from within. A sense of personal continuity and identity emerge. Problem solving and coping are aided by imitation (identification). The social milieu becomes incorporated within the individual, seducing the child, as Erikson has put it, to its particular life style. Self-esteem is built from exercise of different skills and the fulfilling of interpersonal experiences. Defense mechanisms are evolved to control fear and the situations in which it becomes conditioned. The signal of anxiety serves to mobilize defenses in the repertory of the child, and although the early conditions that fostered them no longer exist, the individual may continue to employ them throughout life. Learned patterns of behavior are established as "hierarchial structures" from the base of the earliest patterns to the apex of the latest responses, the original ones never being completely ablated but merely replaced by the later ones. This applies also to thoughts, at the foundation of which are primitive "primary-process" thought patterns concerned with instinctual drive reduction; these are replaced gradually by logical thought. Furthermore, the mechanisms of defense are in hierarchial arrangements. Their antecedents reside in physiological responses, and their latest representations are in the form of creative thought.

Behavior is considered to be neither the by-product of instinctual energies nor the result of situational events. Rather, it is a mode that reflects and yet gradually achieves relative independence from both through the development of autonomous stable response structures. Healthy behavior is under conscious control. When the ego loses its

autonomy from the id or from reality, behavior is no longer under conscious control and pathology may ensue. This is particularly the case when residual stable behavior patterns are insufficient to deal with an existing stress situation. A variety of circumstances contribute to the formation and maintenance of learned adaptive structures, and a consideration of these is vital to the understanding of behavior pathology.

In therapy that is conducted under orthodox Freudian rules, an added goal is an attempt at expansion of the repertory of learned patterns to enhance conscious control of behavior in relation to both inner impulses and environmental pressures. Hartmann has speculated that eventually a technique system will be evolved that can keep abreast of new theoretical developments. Under such a system an effort would be made to understand not only pathological but also adaptive behavior patterns and to examine the interrelationship between the conflict and nonconflict aspects of the ego while tracing the antecedents of neurotic anxiety. There is an implication in some of the writings of ego analysts that therapy should embody more active procedures than the orthodox techniques employ. For instance, interpretations should be couched in terms of specific events rather than in abstract concepts. A focus on immediate problems in the current life situation and on character defenses that influence interpersonal relationships can be productive.

In summary, the basic contributions of the "ego analysts," as these analysts have become known, are the following:

1. Behavior is determined by forces other than instinct in the form of response sequences encompassed under the classification of "ego."

2. The ego as an entity has an autonomy separate from both instinct and reality.

3. The ego supports drives for environmental mastery and adaptive learning that are divorced from sexual and aggressive instincts.

4. The adaptive aspects of learned behavior are as important as instinctual behavior and lead to important gratifications in their own right.

5. A greater emphasis must be put on the environment and on healthy, as opposed

to pathological, behavior than is found in orthodox Freudian approaches. An understanding of pathological behavior in relation to normal behavior is vital.

6. Personality is more plastic and modifiable, even beyond the period of childhood, than is traditionally supposed. A more hopeful prognosis is consequently forecast.

7. The human being is the master of his or her destiny and can control and select behavioral patterns to achieve differentiated goals.

8. Society is a force that does not necessarily emerge from a human being's expressions of instinct; nor does it always thwart the biologic nature of a human being. It can exert a constructive influence on the individual while modifying primitive instinctual drives.

9. Conscious and learned responses are basic to a person's adjustment.

10. Technical innovations in the direction of greater activity are sometimes necessary.

Criticisms of Ego Analysis

Many non-Freudians contend that ego analysts essentially have not really abandoned the archaic classical model. They have merely altered it to fit into a more palatable framework of development and learning. While the structural hypothesis of id, ego, and superego conceptualizes some aspects of behavioral function, by no means does it encompass all aspects. The mechanisms of adaptation are so complex and involve so many facets of behavior that simplistic models cover only limited areas of operation. There are also flaws in the related epigenetic theory that identifies sequential stages of learning in the developmental process and organizes a diagnostic system around these stages. Of course, assessment of development levels and existing fixations is a convenient way of looking at pathology, but inferences drawn from this regarding coping capacities are not always correct, and in fact may be misleading.

Freudians, on the other hand, insist that Freud in no way minimized the importance of external objects and their function in molding the inner organization. They believe that

putting the ego at the helm of the entire psychic structure neglects other important and perhaps more determining components. The ego should be considered a substructure, a part of the total apparatus, emerging from the original primary narcissism, gradually evolving as an aggregate of functions.

NEO-FREUDIAN AND NON-FREUDIAN PSYCHOANALYSIS

Classical psychoanalysis as a specialized form of psychotherapy, devised by Sigmund Freud, consists, as indicated previously, of a group of organized procedures whose objective is to activate in the relationship with the therapist (transference neurosis) the conflicts experienced during the early formative years (infantile neurosis) that, sealed off in the unconscious by repression, dissipate energy and foster an unrealistic adaptation. By interpreting and "working through" the regressive transference neurosis (that embodies distortions in relationships with parental agencies), an attempt is made to resolve the infantile neurosis, liberating the individual from fixations in personality growth toward greater self-actualization.

As a technique, classical (Freudian) psychoanalysis is applicable to a class of patients who are able to devote themselves to and tolerate the rigors of a long-term intensive exploratory process. In essence, therapeutic results depend upon the replacement of unconscious mental acts by conscious ones through the overcoming of internal resistances in the patient's mind. The vanquishing of resistances is brought about by the use of special techniques that are employed with the object: first, reviving memories of past experiences, particularly those of childhood, which, due to their painful content, have been repudiated and repressed; and, second, activating and transferring over to the analyst the early "infantile neurosis" responsible for the unconscious conflicts that continue to blight the patient in the here and now.

These conventional characteristics of therapeutic psychoanalysis have been disputed by some factions of the psychoanalytic fraternity. Operating under the rubric of "neo-Freudian psychoanalysis," these analysts challenge the economic, dynamic and topographic formulations of Freud, including the instinct theory, the significance of

infantile sexuality, and the ubiquity of the Oedipus complex. The very existence of the unconscious itself is questioned by some. These deviations have sponsored combinations of orthodox techniques with more active and supportive measures, such as shifting the focus from the past to the present, reducing the number of weekly sessions, veering from free association to more structured interviewing, and minimizing the need for transference neurosis. Understandably, some consecrated Freudians have responded to these adulterations with consternation, insisting that neo-Freudians, in removing the pillars of psychoanalytic structure and in altering the orthodox procedure, have no right to call their therapeutic maneuvers "psychoanalysis."

Rigorously speaking, psychoanalysis in its "pure" form consists of the creation, by a professional person thoroughly trained in the method, of a transference neurosis through the maintenance of neutrality, anonymity, and passivity in the relationship with the patient. As already noted, this method includes frequent sessions (four to five times weekly), the use of the couch, the adoption of the "fundamental rule" of free association, the employment of dreams, the focus on early significant memories, and the detection and interpretation of resistance. Patients are thus afforded an opportunity to experience, to understand, and to resolve in a dynamic, protected atmosphere conflicts of which they were previously unaware.

Contaminations of the purity of psychoanalysis have been fomented by an increasingly large body of psychoanalysts who have introduced ideas from social theory, role theory, group dynamics, cultural anthropology, field theory, and even philosophy. Deviations from Freudian psychoanalysis vary from minor divergences related to one aspect of theory to major disagreements in which substitute hypotheses or therapeutic methods appear to depart radically from commonly accepted definitions of psychoanalysis.

Among the propositions of the neo-Freudians are the following:

1. Personality is fashioned principally by cultural rather than instinctual forces; the value systems of society are incorporated in the individual's character structure and determine the individual's action tendencies;

conflict is a product of diverse factors within and outside of the person and involves both conscious and unconscious factors.

2. The myriad elements—social, interpersonal, intrapsychic—entering into character organization necessitate a comprehensive and holistic view of personality theory, together with a concern for healthy as well as abnormal adaptation.

3. The libido and death-instinct theories are formulations that cannot explain either normal or abnormal behavior; infantile sexuality alone cannot account for an individual's basic conflicts or for the lines along which character structure develops.

4. Female sexuality is an entity on a parity with, rather than inferior to, male sexuality.

5. The classical topography does not explain the structure of the psychic apparatus.

6. The therapeutic encounter is more than a means of repeating and working through early traumatic experiences; it is an experience in a relationship, containing positive growth potentials that can lead to greater self-actualization.

7. Activity and flexibility in the therapeutic approach are essential; this encourages eclecticism in method.

8. An optimistic, rather than pessimistic, viewpoint is justified regarding a human being's potentials as a creative, loving, and peaceful being.

Primacy of Cultural Factors in Personality Development

The concept, in the words of Geza Roheim, that "culture is the creation of a substitute object" embodying solutions for pre-Oedipal and Oedipal conflicts has not gained too wide acceptance among sociologists and anthropologists. While Freudian ideas about individual development and the unconscious are considered credible, those that apply to cultural theories and social process are more or less rejected. Interesting accounts of how society, particularly through its child-rearing practices, molds personality structure are found in Kardiner's writings (1939). Elaborated is a delineation from

comparative studies of a number of different societies that reveals personality characteristics as reflective of, and congenial with, the total range of institutions within a culture, although an individual character structure may show certain variations in response to personal experience. Ruth Benedict (1953) and Margaret Mead (1939, 1952) in extensive field studies, have shown that stages of personality development that have been accepted as universal are not applicable to certain cultures. For example. Mead (1939, 1952) in studying adolescent girls in Samoa observed that the traditional tumultuous adolescent upheaval did not exist, possibly because few restraints were put on self-expression and sexuality. Personality characteristics usually credited to male and female are shown to be more the product of social role than biological forces. Disturbances of society, such as delinquency, crime, drug addition, and sex offenses, as L. K. Frank (1957) has pointed out, should not be regarded as distortions of the instincts or signs of human wickedness but as manifestations of disintegrating forces in the environment.

Stressing concepts from field theory, neo-Freudians do not regard the environment as a projection vehicle that is molded by instinctual needs and demands. Rather, they look on it as a cardinal force in itself that shapes personality. Behavior is conceived as the product of many vectors, both biologic and social. Constitutional and hereditary elements, while present, do not determine an individual's destiny. This is mediated principally by experiences in life. Attention must be focused, therefore, not on the unconscious—on instincts and their vicissitudes—but on the relationship of the individual with the significant persons in the early and later development who are carriers of the value systems of his or her culture. Personal values reflect these systems. Distortions in relationships and in values are registered in the character structure, disparate operations of which act as a potent source of conflict. Though there is general agreement among the various neo-Freudian groups who hold these ideas, there are discrepancies as to the most important cultural determinants, the specific effects that are registered on character structure, and the consequences of such impacts. The existence, role, and content of the unconscious are also matters about which there is disagreement.

The Holistic Viewpoint in Abnormal and Healthy Adaptation

The concept of character as fashioned by the culture has directed attention to the institutions and values of society that foster healthy and unhealthy adaptation. Instead of viewing healthy aspects of personality through the lens of pathological distortion, neo-Freudians have tended to investigate what goes on in the "normal" or healthy individual, drawing inferences from data dealing with adaptive rather than sick behavior. Abnormal behavior is considered within the framework of understanding "normal" behavior rather than the reverse. This has widened the horizons of progressive personality research to include pertinent areas of sociology, social psychology, ecology, anthropology, ethology, and philosophy. The focus of inquiry is on the intricate network of organizational units—interpersonal, familial, group, national, and international—as well as the sum total of institutions that constitute society as a whole. Behavioral studies are encouraged that scrutinize the interaction of individuals and groups in a variety of settings. The habits, manners, mores, and customs of people in primitive and civilized organizations are surveyed, and cross-cultural data on child-rearing practices are analyzed. Modes of reacting to aspects of the environment that constitute the individual's life space and ecological patterns of such phenomena as crime, delinquency, poverty, and insanity are examined. The behavior of animals in their natural habitat is observed to determine the relative roles of instincts and social learning. Finally, studies of aesthetic, moral, ethical, and spiritual promptings, of social values and how they are internalized and influence behavior, bring the behavioral scientist into the fields of philosophy and religion. Scientists from diverse fields, cooperating together in interdisciplinary research, foster a better integration of the biological and social sciences. By considering the human being as a totality, neo-Freudian approaches support a holistic and Gestalt point of view. The individual is considered to be a tapestry of biochemical, physiological, psychological, sociological, and spiritual systems, each of which has a feedback onto the others.

Shortcomings of the Instinct Theory

The libido theory as a developmental as well as therapeutic model, ingenious as it is, is considered by neo-Freudians to be inadequate in explaining what goes on in all

personality operations. It is believed to be highly overgeneralized, extending itself into zones of energy exchange that cannot possibly deal with the complexities of human relationships. For instance, pregenital instinctual drives are not considered to be the basic elements involved in character organization. Parental attitudes and practices, on the other hand, do have a determining effect upon feeding, excretory, assertive, aggressive, and sexual patterns—indeed a greater impact than forces of maturation. Experiences in the family are the cradle of faulty conditionings. Personality functions are best conceived of in an interactional or transactional framework. This calls for a different perspective on such phenomena as infantile sexuality. All bodily activities should not be regarded as manifestations of sexuality. For example, pleasure in feeding and excreting cannot conceivably be sexual even in the broadest sense of the word. Evidence of the sexualization of certain bodily activities during analysis does not necessarily prove the case for pansexual development in childhood. Even frank genital exploration and manipulation in childhood may be less a sign of true sexuality than a mark of curiosity and the seeking of knowledge of how the body is constituted. Where childhood sexual aberrancies develop and persist, this is evidence of a disturbed upbringing, precocious erotic stimulation, and response to anxiety rather than anarchical sexual instincts.

The presence of the Oedipus complex during psychosocial development is not disputed, but its universality and ultimate destiny are questioned. Some neo-Freudians accept firmly the ubiquitous biological nature of the Oedipus complex, but they contend that its form is influenced by the particular culture in which the child is reared. Others believe that the Oedipus complex is not a biological phenomenon but rather the product of provocative conditioning, particularly in families in which strong dependent attitudes are encouraged in the children or in which the child encounters excessive sexual stimulation through the overfondling activities of the parents. Cultures in which such dependency or sexually seductive attitudes do not exist do not foster the Oedipus complex in children. When the Oedipus complex develops, it may be a manifestation of discord and distrust between the parents, resulting in their utilizing the child as a vehicle for frustrated love needs. Emotions of jealousy and hostility emerge in the child as a by-product of the conflict that is engendered in the child. The child selects the "strong" and dominant parent

—mother or father—as an identification vehicle, and when mothers play the dominant role, the child will, for security's sake, tend to identify with the mother. This can create problems in sexual identification for the boy. The Oedipus complex may accordingly be understood in cultural terms as a reaction to anxiety, and not necessarily as a manifestation of the libido.

The death instinct also is labeled a metaphysical concept rather than a plausible theory to account for aggression, masochism, and sadism. It has little theoretical or clinical usefulness. Aggression is not a primary drive but, as has been repeatedly pointed out, a secondary reaction to drive frustration. Masochism is a special kind of defensive response to anxiety marshalled by certain interpersonal conflicts.

Dualistic formulations regarding sexuality and aggressiveness are not considered adequate in explaining the complexity of these drives. For instance, bisexuality is not universal as some authorities insist. Though physical rudiments of the opposite sex are present in an individual, this does not justify the notion that they must influence the individual's mental life (Lillie, 1931; Rado, 1956). The idea of universal latent homosexuality has led to therapeutic nihilism in treating homosexual problems. Placing a higher biological value on the aggressive quality of the male genital is also unjustified; the crediting of superiority to the penis as compared to the female genital is a cultural phenomenon that can easily shift with a change in social values.

A Positive Approach to Female Psychology

Male-oriented concepts of female psychology that regard women as arrested males, frustrated by their biological inferiority, are alleged to be a product of the cultural consideration of women as an inferior species. Under these circumstances penis envy, when it develops, is a manifestation of the underdog philosophy foisted on females by the dominant males. By possessing a fantasized penis and masculine strivings, a woman compensates for her feelings of social inferiority. Similarly, the designation of passivity, dependency, and masochism as female characteristics does not reveal their true nonsexual dynamic qualities. Female psychology, therefore, can be explained purely in

cultural rather than biological terms. On the other hand, there are biological differences between males and females, and there are variant social roles that they must assume. For instance, motherhood imposes certain demands on women that makes for characteristics distinct from those of males.

The Structure of the Psychic Apparatus

While convenient for categorizing broad groups of mental activity, the structural conception of the mental apparatus in terms of superego, ego, and id is not believed to be adequate for explaining psychic functions. Overweighting of the superego and id in conventional analytic formulations has left the ego a barren area. Moreover, breathing life into the id-ego-super-ego trinity, giving it substance and location, and charging it with human lusts, fears, hostilities and jealousies are both animistic and clinically untenable. The id is not the core of all human energy and activity. The concept of the superego is a confusing one since it incorporates both the healthy elements of the conscience and the neurotic, compulsive qualities. The values embraced by the superego are not a mere facsimile of standards incorporated from parental agencies, but reflect a variety of other conditionings.

The Therapeutic Encounter as a Positive Growth Experience

The therapeutic relationship is a two-way transaction in which there is a feedback of feeling between therapist and patient. What is effective in therapy is not the expulsion from the unconscious of material that results in startling insights, but the emotional experience of two individuals relating to each other in a productive way. The therapeutic interpersonal relationship has a healing effect that mobilizes the patient's capacities to solve his or her own problems. The therapist is never neutral during this process. Values and prejudices filter through irrespective of how much the therapist tries to act as a neutral screen. Nonverbal responses, the emphasis on certain kinds of content, and the nature of interpretations all reflect personal standards that will influence the lines along which the patient thinks, the kinds of ideas that will be retained, and the direction the patient will follow in revising his or her life style. This has led to a deliberate

abandonment of anonymity on the part of the neo-Freudian analyst, interpersonal spontaneity, and the ability to reveal personal values that are proffered as potential contingencies rather than as absolute mandates.

The expression of hostility by the patient during analysis is not always considered necessarily an index of good therapy, marking the release of repressed, transferential energy. It may be a manifestation of provocations inspired by the therapist's rejecting and detached attitude. Aggression is regarded as a secondary reaction to frustration and a defense against anxiety. When it occurs in therapy, it is usually being mobilized as a response to conflict within the immediate interpersonal relationship. Rather than helping, it may be a detriment to therapeutic progress. There is a tendency among neo-Freudians to regard conscious aspects of experience as important, if not more important, than unconscious operations in the formation of conflict. Indeed, some neo-Freudians depreciate the value of probing into unconscious ideation. Also important to many neo-Freudian theorists is the question of "responsibility" of a patient for his or her own actions.

"Eclecticism" in Therapeutic Method

The realization that most patients cannot avail themselves of the opportunity of coming to sessions four to five times weekly, and that, of those who can, many are not suited for intensive probing and the rigors of a transference neurosis, has led to a reduction in the number of sessions, greater activity and flexibility in the therapist's tactics, relaxation of the fundamental rule of free association, and the introduction of a variety of adjunctive procedures within the framework of treatment. Without arguing the points as to whether such stratagems convert the gold of psychoanalysis into a baser metal, whether results of this "eclecticism" are more superficial because they are based on suggestion, or whether reconstruction of personality is bypassed in favor of symptom relief and the expediency of environmental adjustment, the amalgam has, it is claimed, proven helpful to more patients than could otherwise be reached (Abroms, 1969).

A Constructive Philosophy Toward Humankind

In minimizing the fixity of behavior in instincts, a different philosophy toward humankind is encouraged. A human being is more than an animal whose biological heritage chains him or her to the limitations of inner strivings. A human being is not basically lecherous or destructive. These characteristics, if they occur, are environmentally nurtured. Emphasis on the essential goodness of humankind, not as a reaction formation to aggressive and destructive instincts but as a quality in its own right, emphasizes positive values as determining forces in the creation and molding of personality. It substantiates the human being as a creature who has needs to receive and to extend "tenderness," "care," and "love" for others.

Discussion

Little uniformity of opinion exists among the different neo-Freudian groups and even among members of the same school regarding the above points. Ideas range from a practically complete acceptance of the basic Freudian tenets, differing only slightly in how they are formulated, to extensive deviations, which include denying the existence of the Oedipus complex and even of the unconscious. Some analysts believe in a treatment process focused around the mobilization of a transference neurosis (although the explanation of the nature of the infantile neurosis is more inclusive than the Oedipus complex), and hence they employ the traditional tactics of frequent sessions, therapist anonymity and passivity, free association, concentration on infantile and early experiences, dream analysis, and interpretive focus on transference and resistance. Others depreciate the rationale of transference neurosis and contend that dealing with conscious material focused on the present is more effective than delving into the past with discursive explorations of the unconscious.

The introduction of supportive procedures and activity in the relationship, the abandonment of free association and the couch position, the breaking up of transference before it gets out of hand, and the violation of the most traditional rules of psychoanalytic technique constitute the methodology employed. To the consternation of orthodox analysts, there is insistence on the part of some apostates that their instituted

modifications be accepted as legitimate variations of psychoanalytic techniques. In some instances, even substitution of philosophic precepts for analytic techniques are presented under the title of "psychoanalysis." A number of neo-Freudian groups have dedicated themselves to "exploring more scientific approaches to psychoanalysis." To support an interchange of ideas they have organized a rival group to the Freudian American Psychoanalytic Association called the American Academy of Psychoanalysis and publish their own journal, *The Journal of the American Academy of Psychoanalysis.*

The technical modifications employed by many of those who have deviated from orthodox Freudian theory and method include the following:

1. Passivity in the relationship is superseded by activity in order to deal more adequately with resistance and to subdue the development of neurotic transference. Anonymity of the therapist is, for the same reason, not completely observed.

2. Free association is abandoned as a "fundamental rule," and the interview is focused in nature.

3. The couch position is replaced completely or partly by a sitting-up, face-to-face position.

4. The number of visits may be reduced to as few as three sessions weekly, sometimes to even two or one.

5. The therapeutic relationship is handled in a manner so as to resolve transference as soon as it begins to operate as resistance. An attempt is made to minimize the development of a transference neurosis. Positive elements in the relationship may be encouraged as a catalyst to therapy. The relationship is regarded not only as a mirror that reflects unconscious strivings, but also as a vehicle that has values in itself as a growth experience.

6. The focus in therapy is on both unconscious and conscious aspects of personality. Current problems and situations are stressed as much as past experiences.

7. There is a blending of analytic techniques with methods derived from supportive and reeducative approaches.

The most notable non-Freudian contributions to dynamic psychiatry have been made by Adler, Jung, Ferenczi, Rank, Stekel, Reich, Rado, and members of the "dynamic-cultural school," including Fromm, Horney, and Sullivan. Though the followers of these schools generally subscribe to the basic principles of the movement with which they affiliate themselves, wide degrees of difference exist among members of the same school as to interpretation of these principles. This is to be expected since each therapist will introduce individual unique ideas, many of which may deviate from the classical tenets of the founders of his or her school. More significant, each therapist will practice with his or her own style, often blending orthodox techniques with those of other schools of thought, sometimes to a point where an impartial observer may not be able to identify the professed ideology.

THE "INDIVIDUAL PSYCHOLOGY" OF ALFRED ADLER

Alfred Adler was the earliest contributor of ego psychology. He is rarely given credit for his pioneer work in child guidance, group therapy, family therapy, community psychiatry, social therapy, and a host of original theoretical ideas that have been widely adopted by the various schools. About 1910 Adler broke with Freud over the importance of infantile sexuality and the validity of the libido theory. He insisted that human development was conditioned by the social environment rather than by biological forces. Because each person was unique, his or her psychology was an "individual psychology." Adler propounded a theory of neurosis based on the idea that behavior must be examined, both historically from the viewpoint of past causes and teleologically from the standpoint of goals. Body and mind were a unity, indivisible and goal-directed, without separation of id, ego, and superego. This biosocial-psychological approach did not ignore the importance of cause but viewed it in the service of life's objectives.

According to Adler's theory (1917a & b, 1929, 1930, 1938), the basic helplessness of the human infant, magnified by existing body or organ defects, by the child's interpretation of his or her inadvantageous ordinal position in the family, or by parental neglect or rejection, creates feelings of inferiority. Since inferiority feelings oppose

security and a sense of well-being, the individual attempts to cope with them by elaborating compensatory attitudes and patterns of behavior. One extreme neurotic compensation is a "will to power" characterized by irrational strivings for power, dominance, and superiority. This, the "aggressive" way of dealing with inferiority feelings, in the minds of both males and females is equated with "masculinity." A "submissive" way of handling inferiority is to conceal, deny, or escape from it through fantasy and rationalization. Unable to gain self-esteem or power through other means, the individual may attempt to achieve objectives by a "flight from reality" and the development of neurotic symptoms. Since the feminine role is associated with inferiority, both men and women exhibit a "masculine protest" to compensate for their feminine characteristics, either by trying to subdue the other or by denying their own sociosexual roles. Sexual symptoms, including the Oedipus complex, are comprehensible only as manifestations of an inferiority-superiority continuum.

Adler rejected the concept of "penis envy." He regarded women's "masculine protest" often as objecting to their subordinate economic and social roles. The present-day feminist movement is in accord with Adler's view that cultural rather than biological trends have created inferiority feelings in women. Adler acknowledged the importance but not the primacy of sex roles. The neo-Freudians are in agreement with Adler in the lesser emphasis on the libido.

The constellation of impulses, attitudes, and strivings marshalled to overcome inferiority and to achieve power, originally elaborated in relation to significant persons in the environment, are organized into an elaborate "life style" or "life plan" that influences the individual in every dimension. In accordance with the "concept of unity and purpose" there is a total involvement in pursuit of one's "life style." This "personal purposive pattern" has for its goal power and social significance that may be crystallized in (1) successful compensation and a good adjustment, (2) overcompensation with various kinds of faulty adjustment, and (3) "Active goals," such as retreat into illness as a means to power. The improper operation of one's "life style" may interfere with the healthy growth of the person and with good social and community relationships.

Adler fostered the idea that the school is the extended arm of the family, and he founded child guidance clinics in the schools of Vienna, instituting a type of family therapy. His pioneer ideas on child guidance and family therapy have not been fully acknowledged.

The technique of Adlerian therapy is organized around the exploration and detection of the "life style" of the individual, including the aims, motivations, and compensatory strivings that operate in both negative and positive ways. The past, while considered of historical interest is relegated to a position less important than the present or the future, except for the "earliest recollections," which are used to identify the source of the "life style." Once the "life style" is identified, the patient is guided into more effective ways of functioning in order to aspire to greater potentialities through "normal" means. In the course of this educational process, strivings for power diminish and are replaced by social feelings and interests that lead to healthier attitudes toward the self and the community. Social integration is one of the most important facets of Adlerian theory (*Gemeinschaftsgefuehl).*

The basic tools are interpretation of early recollections, the family constellation, and recurrent and recent dreams (Deutsch, D, 1966). Early remembrances help to detect the point at which the biased apperception originated. Family constellation offers a clue to the individual's perception of his or her role within the family and other social settings. Recurrent dreams expose and reinforce the patient's self-doubts and vulnerabilities as well as strengths; recent dreams serve as indicators of the amount of insight gained and the degree of therapeutic progress. The healthy aspects of the patient's personality and strivings toward improvement are emphasized.

The relationship of the therapist to the patient is considered to be of great importance. The therapist ideally should represent to the patient a benevolent, empathic, trustworthy person, making up for real or imaginary disappointments in early childhood. A cooperative exploration into the past is encouraged, during which the therapist endeavors to correct the patient's distorted views of past happenings and relationships. Adler warned against fostering too intense a relationship, finding it more beneficial for the

patient to keep the interaction on a reality level.

Adlerian concepts can be applied to short-term or long-term therapy, depending on the nature of the disturbance. The therapist may utilize analytic, active, passive, directive, and nondirective methods. The course of therapy can extend from counseling and the solving of acute situational problems to a more extensive reconstruction of personality that is intended to lead to self-actualization.

The functioning of the individual in major life areas is used as the yardstick of improvement and readiness for termination. Termination by the patient, however, even if seemingly premature, is not necessarily interpreted as resistance. It is accepted that some individuals can change without continued treatment by utilizing on their own the therapeutic insights that they have already gained. The door is left open, however, so that they can return at any time they feel it is necessary. In this way people may return to therapy at different critical periods in their lives, beginning with problems in nursery school and continuing through marriage and parenthood. Thus, therapy serves as a *support* for life, avoiding the danger of becoming a *substitute* for life.

Adler's theory, according to H. Papanek (1966), "is based on carefully observed clinical data from which he abstracted broad generalizations. He was less interested in constructing a tightly fitting system of speculative thinking than Freud. His aim was to bring together, to achieve a synthesis of the multitude and variety of psychological facts. This creative thinking and intuitive understanding of the living organism has resulted in a theory which anticipates many viewpoints and hypotheses of present-day psychology: to mention among others Gestalt and Field psychology."

Criticisms of Adler's theory and method are organized around the following contentions: first, that only one of manifold human strivings is stressed—that of feelings of inferiority; second, that not enough credence is given to deep unconscious forces; and, third, that goals in therapy tend to be reeducative rather than reconstructive in nature. Adlerians answer these criticisms by insisting that Adler used terms like inferiority in the broadest sense, including connotations of insecurity and anxiety. Moreover, results of

therapy are often reconstructive.

At present, "individual psychology" is practiced by a multidisciplinary group, who, like the Freudian group, are strongly loyal to their founder. Adlerian associations in New York, New Jersey, Washington, D.C., Chicago, and Los Angeles maintain training institutes and mental hygiene centers. There are also important Adlerian groups in Oregon and Wilmington, Delaware. The parent organization is the American Society of Adlerian Psychology, which conducts annual meetings and publishes *The Journal of Individual Psychology* as well as *The Individual Psychologist.* Adlerian groups in Austria, Italy, England, France, Holland, Switzerland, and Israel, together with the American Society, form the International Association of Individual Psychology.

Alexandra Adler and Kurt Adler, both psychiatrists and the children of Alfred Adler, contributed to the growth of "individual psychology" through teaching, writing, and leadership in the above organizations, as had their associates Danica Deutsch and Helene Papanek. Among the better-known contributions to the Adlerian literature are those by Alexandra Adler (1948), K. Adler and Deutsch (1959), Ansbacher and Rowena (1956), Bottome (1957), Dreikurs (1957), Farau (1962), Orgler (1963), E. Papanek and H. Papanek (1961), and H. Papanek (1965). Rudolf Dreikurs made a major contribution introducing Adlerian psychology to American educational institutions.

THE "ANALYTICAL PSYCHOLOGY" OF CARL JUNG

Freud contended that each individual in childhood repeated in an abbreviated form the whole course of evolution of the human race. In psychological development each person acted out the racial tragedy of incest and retaliation. This conflict, being biologically ordained, occurred universally. It constituted a psychological hurdle that suspended the individual inexorably between passion and reason. Primary congenital variations, Freud explained, existed in the ego. "Indeed, analytic experience convinces us that particular psychical contents, such as symbolism, have no other source than hereditary transmission…there are other, no less specialized, deposits from primitive human development present in our archaic heritage."

Carl Jung (1916, 1923) expounded these areas in great detail, while rejecting the general phases of Freud's biological and genetic approach for a teleological point of view. Although he acknowledged the existence of bodily libido, he contended that it is issued, not from the sexual instinct, but from a universal force or "life urge." He recognized that neurotic parents promoted neurosis in their offspring, but he minimized the effect of sexual intimidation as well as the general importance of infantile sexuality.

Observing that the symbolic productions of neurotics and psychotics bore a resemblance to those of primitive people, Jung speculated on the existence of a collective unconscious—a hereditary portion of the mind that contained the imprints of ancestral experience. A study by Jung of associations, dreams, fantasies, and drawings seemed to substantiate the presence of instinctive thought processes. These appeared in the form of primordial images, which Jung called "archetypes." Prominent, for instance, was the quadruple "mandala" symbolism, which throughout recorded history appeared as a "magic circle" in legend, art, literature, and religion. Repetitive configurations of a circle in a square, or a square in a circle, containing groupings of radial or spherical components, the mandala symbol was viewed by Jung as an archetypal manifestation of the collective unconscious that, not based on tradition or model, was determined by archetypal ideas unknown to their creators: "Mandalas are symbols of order, unity, totality. As magic circles they bind and subdue the lawless powers belonging to the world of darkness, depict or create an order that transforms the chaos into a cosmos." Among the archetypes that emerge in myths, legends, dreams, and other symbolisms are the *earth-mother* or *witch-mother;* the *old wise man;* the *hero figure* (such as Hercules, Siegfried, and St. George); the *night journey under the sea* (appearing in such forms as Jonah and the whale); the *Anima,* the mate ideal of the male psyche, and the *Animus,* the mate ideal of the female psyche. Human beings are influenced not only by values and motives acquired through personal experience (residing in their personal unconscious) but also by the collective experience of the human race embedded in their neural structure.

Jung compartmentalized the psyche in different terms than Freud. He divided it into a superficial part, the *persona,* which was a social mask assumed by the individual, made

up of social interests and sanctions; a less superficial aspect, the *ego,* which was only to some extent conscious and reflected pastpersonal experiences; and a deeply unconscious part, which had within it the *collective unconscious* and contained archetypes.

Difficulties developed when an improper balance of masculine Animus elements and feminine Anima elements prevailed. Difficulties also occurred when there was a lack of harmony among the persona, the ego, and the collective unconscious. Jung conceived of the idea that baser elements of the soul were present in the collective unconscious, and he characterized these as "the Shadow." He believed also that the collective unconscious contained creative founts of energy. Primitive fears and other untoward manifestations of the unconscious invaded the patient's conscious mind and created tensions and various neurotic symptoms that were attempts at self-cure. The collective unconscious, unleashed, constituted a source of danger for the person.

Another area of conflict was residual in the way personality structure functioned. Jung evolved a theory of character, dividing people into two types: introverts and extroverts. The introvert's interests centered on himself or herself; the extrovert's interests were on the external world. Each type was further subdivided into feeling, thinking, intuition, and sensation subtypes. Problems developed when an individual pursued his or her own personality type or subtype too thoroughly, with extreme inhibition of other reactions. Complexes were formed by a blending of innate dispositions with external circumstances. Charged with affect, they influenced the individual for the good or bad. Only when they became autonomous and operated like separate egos did they threaten the ego-supremacy.

A human being, said Jung, had an innate religious craving which powered the need for self-realization. There was, he explained, no retreat from life's burdens other than to find refuge in spiritual strivings with "acceptance of the irrational and unbelievable." By experiencing the collective unconscious, an individual no longer would experience personal sorrow "but the sorrow of the world, no longer a personal isolating pain, but pain without bitterness, binding all human beings together." We are brought "back to ourselves

as an existing, living something, stretched as it were between two worlds of images, from which forces proceed that are only dimly discerned but are all the more clearly felt. This something, though strange to us, is yet so near, it is altogether ourselves and yet unrecognizable, a virtual middlepoint of such a mysterious constitution that it can demand anything, relationship with animals and with gods, with crystals and with stars." These ideas were elaborated by Jung (1961) in his last book, *Memories, Dreams, Reflections*, a fascinating autobiographical document that explains his relationship with Freud and gives us a broader understanding of the essence and meaning of his work.

Jungian psychoanalytic therapy presupposes a basic attitude toward neurosis that is regarded as an attempt by the organism to promote growth as well as illness. The Jungian process is essentially nonsystematic, although Jung stated that analysis consisted of four stages: catharsis, explanation, education, and transformation. Therapy involves an exploration, with the help of dream interpretation and art analysis, of various aspects of the psyche, including elements of the personal and collective unconscious. Particularly, an effort is made to explore "archetypes" in order to determine how these imprints contaminate the patient's present life and interfere with self-development and self-realization (individuation). Bringing the individual into contact with his or her collective unconscious is said to help liberate creative forces that will have a constructive effect on adjustment. Once nonconscious elements are recognized, an attempt is made to guide the patient actively into a productive relationship with the unconscious. In this way, a balance of masculine and feminine components is restored within the personality. Regressive impulses, such as desires for return to the womb and impulses for rebirth, become dissipated. For instance, Jung cites the case of a man with panic attacks who produced mandalas in dreams and waking fantasies. Jung consulted a 400-year-old book which contained a woodcut that was an exact duplication of the patient's symbol. Explained Jung, "You see, your dream is no secret. You are not…separated from mankind by an inexplicable psychosis. You are merely ignorant of certain experiences well within human knowledge and understanding." It may be necessary to help patients work through a long series of mandalas until they stop following an ideal from the past and move toward the world of reality. Neurosis is related to the hold on the individual of archetype processes.

As individuals grope for wholeness and fulfillment, they are said invariably to come upon the ancient geometrical designs and symbols of their evolving selves.

Emphasis in treatment is not only on the unconscious but also on current difficulties. Dreams, for instance, are regarded as reflecting present strivings as well as future plans of action. Activity is the keynote in therapy, and the relationship is kept on a positive level, transference neurosis being avoided as much as possible. Free association is secondary to a focusing of the interview along specific lines. The therapeutic approach varies with the personality type. The introvert is presumed to need elaborate coherent interpretations, while the extrovert is said to achieve adjustment on a much more pragmatic basis. The development of an intellectually satisfying religion is often considered an essential part of therapy, since religion is believed capable of reconciling existing "archetypes" with an ethical system.

In their actual working with patients, modern Jungians proceed along transactional lines, minimizing theory. A great deal of variability reigns in the way modern Jungian analysis proceeds, with session frequency ranging from one to six times weekly. Group therapy is commonly employed. Some Jungians follow the format of classical Freudian analysis and use the couch. Others use face-to-face interviews. Artistic productions, sometimes via a sandtray, paintings, drawings, sculptures, and especially dreams are freely utilized for exploration of the unconscious. The dream is regarded as a vital means not only of approaching the past but also of understanding complexes in the present through a synthesis of the inherent images and associations. Archetypal motifs are discerned through transference as well as through "amplification" of personal productions with mythological, religious, and anthropological themes. Countertransference is often considered a positive force that can help in the transformation process, which ultimately is directed toward greater individuation.

The abandoning of therapist authoritarianism and the use of the vis-à-vis position, as opposed to the couch, expedite rapport and even reactivity on the part of the analyst. The effectiveness of therapy stems "from the reality-based interpersonal exchange between

analysand and therapist. This also means that the two people in the transaction are partners, jointly engaged in a struggle to explore and dispel the neurosis that affects the patient, including the resolution of the transference. It involves making an alliance with the healthy aspects of the patient ... [which] need to be activated and encouraged throughout the therapeutic procedure. ... It seems to me important to hold theory in abeyance so that nothing will stand between patient and therapist, and interfere with the immediacy of contract" (Wheelwright, 1956).

Criticisms of the Jungian approach relate to its metaphysical content, to the religious-like elements with which therapy is imbued, and to a tendency for some patients to become preoccupied with a mystic philosophy toward life and with speculations of "archetypes" and other manifestations of their racial past. On the whole, however, Jungian therapy achieves results comparable to those of other analytic treatments.

Jungian principles have recently gained great popularity in the United States, possibly because of the enhanced interest in mysticism. Jungian centers exist in New York City and on the West Coast. Jungian therapy is practiced in various parts of the world, drawing its inspiration from the writings of its founder (Groesback, 1983).

THERAPEUTIC MODIFICATIONS OF SANDOR FERENCZI

Sandor Ferenczi (1950a, b, c, & d, 1952), while remaining loyal to Freud's theories, introduced certain modifications of method. Finding that transference did not develop readily in many patients, Ferenczi advocated "active" therapy in the form of an embargo on physical and sexual gratifications. He believed that this restriction would block libido and make it available for projection into the transference. The patient was consequently enjoined to abstain from sexual satisfactions of all kinds, and even to limit toilet activities. The release of resentment and aggression directed toward the therapist was felt to be of therapeutic importance. Experience soon proved the method to be of little value, however, and Ferenczi himself abandoned it. Instead, he substituted a completely permissive atmosphere by acting as a tolerant "good" parental figure who acceded to many of the patient's wishes and demands. He urged that the therapist admit his or her own faults and

shortcomings to the patient in order to convince the latter that all authority was not harsh, intolerant, nor incapable of admitting to failings. A mutual analysis often resulted.

To help patients to an awareness of their past, Ferenczi also encouraged them to relive it by dramatizing childhood situations, while he remained tolerant to the patients' "acting-out." Thus patients would relive their childhood, play with dolls, and engage in baby talk, while Ferenczi joined in the play. He regarded relationships as a two-way interaction, and his writings stimulated interest in what later was expanded by Sullivan in the concept of the interpersonal relationship. Ferenczi recognized that the analyst's personal feelings about the patient and attitudes toward the patient often determined the nature of the latter's reactions. He advocated that the therapist consider the patient's responses as being conditioned both by transference and by reality provocations for which the therapist should admit responsibility. Collaborating with Rank (1925), Ferenczi advised setting a time limit to analysis as a means of accelerating the end of treatment.

Ferenczi's technical innovations are still employed by some therapists, some of whom chance upon identical methods and then claim originality for them.

THE "WILL THERAPY" OF OTTO RANK

Otto Rank was responsible for a number of important technical innovations, and, with Stekel, may be considered an innovator of short-term psychoanalytic therapy. He advocated a flexible, active, patient-oriented treatment process, with the patient determining the particular mode of reaching self-direction and self-determination. Some of the present-day transactional approaches draw their tactics from Rank, while client-centered therapy appears to have absorbed much of his philosophy regarding "self-realization." The functional school of casework was also oriented around dynamic concepts of what Rank called the "helping process" (Taft, 1933, 1948; Allen, F. 1942; Kasius, 1950; Karpf, 1953).

To Rank (1929, 1947), Freud's original idea that the process of birth, with forceful separation of the child from the mother, constituted a trauma from which the individual

never recovered was of crucial importance. Two sets of strivings resulted from the "birth trauma": the first, an impulse to return to the womb in order to restore prenatal conditionings of security; the second, an impulse for rebirth or separation from a maternal object so as to achieve independence. The first group of impulses stimulated the establishment of relationships of a dependent, infantile, and clinging nature. The second group appeared as a "will" to grow, to achieve "individuation," and to separate oneself from confining relationships. The life of the person was governed by these contradictory strivings to unite and to separate.

The primordial anxiety of separation from the mother, rooted in the original birth trauma, was revived at all subsequent experiences of separation, such as weaning, castration threats, and removal from close relationships with people. The need to restore unity with the maternal figure was contained in a desire to submit oneself in human relationships, including sexual relationships, while the need for assertive individuality was residual in an impulse to fight off the desire to unite with another person. Separation anxiety manifested itself (1) as the "life fear," when "the person recognized creative capacities within himself which would threaten to separate him from others lighting up the fear of having to live as an isolated person," and (2) the "death fear," manifested by terror of losing one's individuality and being swallowed by others.

Rank classified personality into "normal," "neurotic," and "creative artist" types. "Normal" people subordinated their own will to that of the group in contrast to "neurotics" who refused to yield their will to the group. This reluctance, coupled with an inability to break out of the trap between dependency and individual autonomy, made it impossible to utilize their will in the direction of developing into "creative artists." Thus, unable to achieve latent creative aspirations and the will to be themselves, they were forced to evolve their own standards and to stand alone if necessary.

Rank emphasized that the analytic hour offered the patient a unique opportunity to live through with the therapist past experiences, particularly the birth trauma, and to move toward a more complete individuation. Psychotherapy was thus essentially a

therapist-patient relationship during which the therapist as a helper mobilized the patient's "creative will impulse" for positive self-realization. The relationship itself served as a corrective experience for the patient, revelation of unconscious material and insight being secondary. Patterns of reaction rather than specific content were to be studied. The therapeutic situation was to be adapted to the unique and individual needs of each patient.

Rankian analysis, according to Karpf (1957), "must be patient-centered, not therapist-centered; it must be flexible, adaptable, alert to the new and unexpected—a genuinely creative experience for both patient and therapist. ... In essence it is a view which has a special appeal to non-authoritarian therapists who respect patients as self-reliant and self-responsible persons... ." The process of therapy was entirely centered in the patient-therapist relationship, the focus being on the patient's feelings toward the therapist. The analysis was an experience from which the patient would eventually separate and then go on to a new experience. The reactions of the patient to the inevitable circumstance of separation were studied carefully, with the object of working through fear of, and guilt toward, the separation as well as needs to control and to be controlled. The struggle of the will was also studied as it was reflected in the desire to continue therapy and to be dependent as well as to discontinue treatment and to separate oneself from a dependent relationship.

The emphasis in therapy, thus, was on the present rather than the past. Activity in treatment was the keynote, the patient being encouraged to assert himself or herself in order to develop and strengthen his or her own will. An effort was made to mobilize constructive elements in the personality and to transfer the negative expression of will into positive and creative will. A time limit to therapy was usually set. This was believed to act as a catalyst to the union-separation conflict. No effort was made to bring out sexual material. Resistance was accepted as an inevitable expression of the will. It was not met with counterresistance or explanatory interpretation. Transference was also accepted as an aspect of the growth process in which there was a strengthening of the "will" to be oneself.

Guilt and fear were gradually resolved through this experience in the relationship, which liberated the will from its one-sided expression and resulted in a "utilization of its own contrariness." The acceptance of responsibility for one's ambivalence reduced guilt and fear to a point compatible with living. The patient eventually learned to tolerate separation from the therapist and with strengthened will achieved independence and growth.

Certain Rankian principles have been incorporated into a number of psychotherapeutic approaches, including psychobiological therapy, client-centered therapy, neo-Freudian analysis, short-term dynamic psychotherapy (Mann, 1973), and psychoanalytically oriented psychotherapy. The theory of the birth trauma is not as generally accepted as are Rank's concepts of therapy, particularly those that deal with the importance of the patient-therapist relationship as a positive growth experience.

An Otto Rank Association exists in Doylestown, Pennsylvania, under leadership of Virginia Robinson and Anita Faatz, and a biannual *Journal of the Otto Rank Association* is published. As social work has shifted from clinical to community work, the once prominent functional casework method, drawing its inspiration from Rank, has lost its appeal. His ideas on short-term therapy, however, are undergoing a revival.

Criticisms of Rankian analysis are expressed by those who object to the activity involved and to the focus on union and separation to the neglect of other personality aspects. The abrupt insistence that the patient stand on his or her own feet under any circumstances is said to have an unfortunate effect on persons with weak ego structures who may require a great deal of support in early phases of treatment.

THE "ACTIVE PSYCHOANALYSIS" OF WILHELM STEKEL

Wilhelm Stekel (1950) is responsible for a number of original techniques in analytic psychotherapy that have been assimilated in many current systems of short-term psychotherapy (Lowy & Gutheil, 1956). Possessed of an uncanny intuition as well as an active personality, Stekel related himself perceptively and rapidly to the immediate

problems of his patients, and he utilized himself forcefully to bring them to an awareness of their conflicts. He was particularly interested in sexual disorders ("paraphilias"), and his volumes on sadomasochism (1929), fetishism (1949), impotence (1927), frigidity (1926), and exhibitionism (1952) are best known. His book on psychopathic behavior, which he called "impulsions" (1924), is also popular.

While Stekel retained Freud's basic concepts of unconscious conflict, transference, and resistance, he believed that the libido theory did not explain the multiform conflicts of the human mind, and he felt that the castration complex was not nearly as ubiquitous as Freud had assumed. He declared that current life conflicts were as important as past conflicts and that absolute unconscious elements were not the only foci of neurosis; rather, aspects of the conscious mind might be repressed and transformed by a wide variety of symbols. Stekel emphasized certain formulations, such as the "central idea of the neurosis," which varied in each person, and the inevitable anchoring of mental conflict in the immediate life situation. Emotional disturbance was often a product of competition of inharmonious "motives." Glimpses of these might be captured from dreams and free associations. Anticipating later characterologic approaches, Stekel remarked that the future of analysis was residual in an analysis of character.

The chief contributions of Stekel, however, were in the field of technique. Perhaps the greatest of these was in the area of dream interpretation, his studies on symbolism being acknowledged by Freud as unique. In employing dreams, Stekel enjoined his patients to bring them recorded to each session. At first, resistance elements were discussed in terms of the patient's desire to remain ill or to avoid facing reality. Then the therapist applied himself to the patient's past involvements and unconscious designs for the future. His flair for symbolism enabled him to pinpoint important conflicts that, sooner or later, were brought to the attention of the patient.

Stekel often remarked that it was not the particular method that cured but rather the personality of the therapist employing it. He stressed what we now call "countertransference." The general therapeutic formula propounded was this: "Recall

what originated your trouble, recognize your morbid attitude, and surmount it." Stekel alleged that resistance prevented the patient from recognizing morbid attitudes, from recalling their origins, and above all, from surmounting difficulty. Resistance, however, could not be resolved by the orthodox analyst's manner of remaining a passive spectator to the patient's free associations and dreams. This was the fallacy of passive psychoanalysis. The therapist must actively interfere in breaking up repression. It is necessary to collaborate actively with the patient in the interpretation of free associations and dreams. Through "sympathy" and "imaginative insight" (qualities Stekel subsumed under the term "intuition") the therapist must be alerted to repressed complexes and must intervene actively to make the patient aware of them. The intuitive facility with which the symbolic meaning of the neurosis was determined and the skill with which interpretation was offered influenced the speed of therapy. The therapist's main function, then, was as an intuitive artist probing his or her way into the psyche. Stekel admitted that active analysis presupposed that the analyst was endowed with an intuitive faculty, but he avowed that this faculty was more widespread than had been presumed.

Abandonment of the analyst's passive role was associated with activity and directiveness, even to the point of advice giving and exhortation. While free association was utilized, the patient could not be permitted to ramble along into blind channels; instead, selection of pertinent topics for discussion was in order. The use of the face-to-face, sitting-up position was also advocated. Emphasis was put on the interpretation of dreams, but the therapist's intuition had to be relied on in order to divine what eluded free associations to the latent content. The use of adjuvants in therapy was also indicated; Stekel insisted that it was essential to adopt methods to the particular case rather than to force the patient to abide by a particular method. With active methods Stekel believed that it was rare for more than 6 months to be required for analysis. This short period avoided interminable analyses and prevented the development of untoward, ill-fated, unmanageable reactions.

The importance of transference was recognized by Stekel as an essential part of every analysis. Indeed, he felt that analysis was impossible without transference.

Transference, however, could serve two functions—that of expediting therapy and that of acting as resistance to therapy. Only when transference functioned as resistance was its handling justified.

A frequently heard criticism of Stekel's system of psychotherapy is that the activity of the therapist may sponsor an excessively disciplinary, prohibitive, and punitive attitude toward the patient. Objections are also expressed in regard to the maximal 6-month time limit to therapy on the basis that character reconstruction is long-term. The few followers of Stekel who remain have revised his temporal limitation and often do long-term therapy.

The "intuitive" aspects of active analysis may also come under questioning. Many observers would contend that what makes a therapist intuitive is a high degree of sensitivity that enables the therapist rapidly to perceive nuances in the interpersonal process and, on the basis of extensive experience, to translate these into valid deductions. Not all persons, however, would be capable of doing this, irrespective of the extent of training and experience. The intuitive aspects of the Stekelian system, therefore, would be limited to a restricted number of "intuitive" analysts, who could hypothesize constructs with a high degree of probability. A less intuitive analyst who tried this would indulge in guesswork that might be disastrous to the therapeutic objective because it would foist faulty interpretations on the patient. To use Stekel's system effectively, then, the therapist required an extremely high degree of analytic training, an extraordinary flexibility in personality, a deep sensitivity that would enable the perception of nuances, and, above all, good judgment, which would permit the judicious employment of active procedures.

At the present time, Stekelian analysts are not organized into a special analytic school. There have been many modifications of the Stekelian method as Stekelian analysts have introduced into their work contributions from various other psychiatric groups.

THE "CHARACTER ANALYSIS" AND "ORGONE THERAPY" OF WILHELM REICH

The basic theoretic orientation of Wilhelm Reich at first followed along the lines of Freud's earliest formulations of the libido theory. This contended that neurosis was due to

a conflict between repressed instinctual desires—usually infantile sexual desires—and ego-repressing forces. The resulting conflict produced a stagnation of libido that was converted into anxiety and that subsequently engendered neurotic symptoms or neurotic character traits. Therapy involved the making conscious of unconscious conflict in an effort to liberate strangulated libido. Defensive forces of the ego, however, acted as resistance to the return of the repressed. Before unconscious elements could be restored to awareness, it was essential to eliminate resistances. Through interpretation, patients were helped to see how their resistances operated, their nature and purpose.

Character formation was conceived of by Reich as a kind of psychic armor that protected the individual from the disturbing stimuli of the outside world and from inner libidinal strivings (Reich, 1927, 1928). During psychoanalysis the patient's character served the interests of resistance against the repressed. Before one could tap the unconscious, therefore, it was essential to break down "character resistances" until the individual was denuded of defenses that barricaded repressed material. Character resistance revealed itself in attitudes and behavior toward the analyst and the analytic situation. Reich, in his book, *Character Analysis* (1949), described the analysis of resistance, including character resistance, and he insisted that this was necessary before the patient could accept and integrate the content of the unconscious.

Four main types of character defenses were apparent. First, the *hysterical character,* fashioned by a defense against incest, was manifested by a passive-feminine orientation with subversive expressions of sexuality at the same time that an open avowal of sexual interest was avoided. Second, the *compulsive character,* determined by a defense against sadistic and aggressive impulses, displayed a penchant for orderliness, cleanliness, and thriftiness. Third, the *phallic-narcissistic character,* conditioned by a defense against passive-feminine tendencies, exhibited a cold, arrogant, and derisively aggressive manner; active homosexuality and schizophrenia could develop in such individuals. Fourth, the *masochistic character,* which was sponsored by a defense (substitutive punishment) against fantasied recriminations from the conscience, avoided anxiety by forcing others to treat him or her badly so as to be able to reproach them while experiencing self-damage

and self-depreciation. The masochist wanted to be loved but disguised this in grandiose provocations of the love object.

Reich also classified character types according to how they managed to resolve the problems existing during earlier stages of their development. In terms of libido, an *oral-receptive character* existed as a sublimation of the earliest sucking stage; he or she was friendly and optimistic and looked upon the world and people as mothering objects. The *oral-aggressive character,* a sublimation of the oral biting stage, manifested itself in aggressiveness, envy, ambition, and a need to exploit others. The *anal character,* a sublimation of the anal period, was pedantic, overly clean, and miserly. The *phallic character* sublimated the phallic stage through cold, arrogant behavior. The *urethral character,* often showed symptoms of bed wetting and a burning ambition and was boastful about his or her achievements. The *genital character* was mature and capable of relating in an adult way to others.

Reich, like Trigant Burrow, pointed out that body tensions were evidences of emotional states and reflected characteristic ways of reacting. Posture, gait, facial expression, and other muscular manifestations revealed certain resistances and had to be attacked by calling attention to them before formal analytic procedures could be effective.

Although the theoretical basis for Reich's method has been discounted by many analysts, the techniques of character analysis have proven themselves to be invaluable. Followers of the "dynamic-cultural" school, particularly, find the analysis of character vital, apart from its resistance-disintegrating virtues. Emphasis is placed on the neurotic nature of character trends, analysis of which constitutes a chief objective rather than a means to deeper repressed material.

Reich, however, coincident with his reported discovery of a "cosmic substance, orgone" tended later to depreciate his contributions on character in favor of a newer "physiological" orientation to therapy (1942). The establishment of orgastic potency was felt by Reich to be the most important goal in therapy. He described the therapeutic process as a consecutive loosening of the character armor, a breakthrough of repressed

and affect-laden material released by activation of infantile sexual conflicts, a working through of infantile genital anxieties, a dealing with orgasm anxiety, and, finally, a developing of full orgastic potency. Character analysis in itself, however, he claimed was incapable of achieving the desired goal of orgastic potency. This was because another form of armor besides character armor shielded the unconscious. This was "muscular armor," which, in the form of chronically fixed muscular attitudes, increased tonus and rigidity and shielded components of sexuality and aggression from awareness Therapy, to be effective, had to provide for a loosening of the muscular armor.

These new ideas made necessary a reformulation of his hypothesis. Character was developed from a binding of "bio-energy." Therapy remobilized "bio-energy" from character armor through character analysis, and from muscular armor through "vegetotherapy." The resulting liberation of emotions produced a mobilization of "orgone energy," which vitalized orgastic potency. This was "orgone therapy," and it reached the biological depths of the human being, bringing an awareness of both organ sensations and muscular armoring, with an eventual destruction of the armor, a reestablishment of "plasma motility," and an appearance of "orgasm reflex."

In orgone therapy the muscles of the patient's back, chest, jaw, abdomen, and extremities are pressed firmly by the therapist to elicit emotional reactions and to liberate associations and memories. The patient's reactions are then interpreted. Sometimes the therapist imitates the patient's mannerisms of behavior or encourages "acting-out" tendencies. Verbalization of fantasies, memories, and feelings associated with the "muscular armor" is said to dissipate the armor and to allow the patient to deal with direct impulses, of which the muscular manifestations are defenses and resistances.

Although character analysis has gained wide acceptance among many analysts, the validity of the theory and technique of orgone therapy is generally considered controversial; it is currently practiced under the term "vegetotherapy" (Konia, 1975). Alexander Lowen (1958), while breaking away from some formulations of Reich, has elaborated his own techniques of releasing energy through muscle activity ("bio-

energetics") and thus relating character disturbances to muscle armoring.

ADAPTATIONAL PSYCHODYNAMICS AND PSYCHOANALYSIS

A biologically oriented theory of human behavior has been developed principally by Rado (1939, 1949, 1950, 1956, 1962), Rado and Daniels (1956), Kardiner et al. (1945), and D. Levy (1956). It deals with the functions of the ego and the mechanisms that are involved in the process of adaptation.

Essentially the theory purports that the individual is constantly in a state of shifting homeostasis. Physiological drives and social needs must constantly be satisfied in order for the organism to survive. Unfulfilled strivings generate tensions and upset the homeostatic balance. This gives rise to a series of mechanisms, which Kardiner calls "action systems," conditioned by past successful activities toward satisfying the same drives and needs. As gratification takes place, emotionally charged memory traces are recorded that will later be activated when homeostasis is again upset. At the same time, feelings of mastery bolster the self-image. "Perception of the sources of stimulation changes according to the degree of gratification and comfort which has been achieved" (Karush, 1961).

Rado's structural model of adaptational psychodynamics introduces several gradations of psychological defense associated with different levels of nerve integration. The most primitive, the "hedonic" level, which phylogenetically antedates all other levels, deals with pain and pleasure and is activated by physiological and instinctual tension states. The second division is the "emotional" level, which registers itself in four basic effects: rage, fear, grief, and love. This is a more advanced phylogenetic level and is associated with greater capacities in the organism to alter his or her environment. The next stage of integration incorporates the cerebral cortex and replaces emotion and "emotional thought" with higher-thought "self-attributive" processes. This supports the ability to anticipate and organize means of attack or withdrawal. The emotional and thought levels constantly intermingle. Feedback occurs among all three levels of defensive integration. Stimulation of pain thus arouses the hedonic level, but it also activates the

emotional and thought levels. This permits anticipatory and adaptive reactions.

According to Rado, neurosis is the product of faulty responses of the organism to danger registered as "failures in emergency adjustment." A signaling arrangement, evoked by any kind of pain threatening the organism or by the anticipation of pain, is the basis for the development of "emergency behavior." Of all motivations, emergency behavior is the strongest: it takes precedence over any other motivation. In disturbed emotional states, however, this rule may be violated.

On the "hedonic" level of organization, pain evokes the "riddance response" in the form of physiological reactions to rid oneself of offensive agents. Vomiting, diarrhea, spitting, sneezing, and coughing are manifestations of these reactions. The psychic correlate of the "riddance principle" is the mechanism of repression. Fear and rage are conditioned by an anticipation of pain. They warn of impending damage, and they inspire protective responses of flight (in fear) and of fight (in rage). On a social level, flight may be into dependency relationships with, and submission to, authority; fight may be expressed in terms of defiance of authority. On the level of "emotional thought," emotions are tempered to some degree with ensuing apprehensive and angry thought patterns. Discrimination and analysis promote greater flexibility of performance. The person is still subject to escape and combat mechanisms, however, in response to painful stimuli. Basic emergency reactions on the level of "unemotional thought" are controlled to some extent by the intellect. There is an advance detection of threats to the organism with an appraisal of its powers to cope with the threats. On the highest or "self-attributive" level, heightened pride accompanies rage responses or awareness of self-strength, while diminished pride follows fear reactions or awareness of self-weakness.

The development of the individual's conscience issues out of disciplinary rewards and punishments in relation to parents. Fear of punishment and the restraints it inspires become automatized, and in adult life continue in force. Obedience and the moral pride consequent to it also persist as adaptive patterns. Fear of one's conscience is a residue of fear of parental punishment.

Temptation may release rage and defiance, however, which, by overwhelming the fear of one's conscience, may drive the individual to disobedience. A fear of condign punishment may then eventuate for such defiance. This may lead to a desire to reinstate oneself. Defiant rage, consequently, may be turned inward with self-reproach, confession, remorse, and pleas for forgiveness. The hope is to be restored to the good graces of the parents. This expiatory pattern may become fixed so that the individual seeks forgiveness by self-punishment. More pernicious are the phenomena of self-punishment for imagined guilt and of advance painful punishment as a release for gratification of forbidden desires. Sometimes rage breaks loose with an abandonment of self-reproach and an attack on the person who is feared.

Failures of emergency control may be caused by an overproduction of fear, rage, and pain. Resultant are overreactions to existing danger and emergency responses in the absence of real danger. An overproduction of emergency emotions may express itself in an outflow of emotions. To stop the overproduction, the organism may have to resort to repression and other automatic "riddance" mechanisms. All disordered behavior is the consequence of such failures in emergency adjustment.

Rado, in his later contributions, has continued to stress that the human being is by nature equipped with a survival mechanism that operates through patterns of adaptation. These change with age in both strength and form. Schematically, the period of youth is characterized by dependent patterns; the adult period, by patterns of self-reliance; the period of aging, by patterns of declining adaptation. In early life survival dictates subordination of inner desires to parental demands. Tactics to mollify or to deceive or to coerce, and expiatory and aggressive modes of coping with actual or anticipated rejection, may be evolved. Cravings for magical fulfillment of dependent needs occur with refusal to accept the reality of limitations in parental powers. Civilization dictates a taming of the child's rage response, and disciplines are imposed by the parent to contain the child's reactions and to bring them under control. The mechanism of conscience is built up on the basis of these conditionings, and it helps in fostering the development of responsible independence. This sponsors emergency control, realistic thinking, and behavior replacing

emotional thinking and activity; self-reliance displaces dependency.

The implications of adaptational psychodynamic theory for treatment stem from its stress on ego functions. This supports the contention that all material uncovered in analysis must be related to current problems of adaptation. In an emotional matrix of "welfare emotions" (love, compassion), controlled by reason ("adaptive insight"), therapy is directed toward supportive, reeducative (reparative), or reconstructive goals depending on the patient's level of motivation. Four categories of motivation are apparent that will determine what kind of technical processes are best adapted to the individual. These motivational forms are allied to stages of personality development (Rado, 1965). The first level, "magical craving" for an idealized parent, will make possible such suggestive techniques as hypnosis. The second level, characteristic of a somewhat higher stage of development, "parental invocation," also addresses itself to limited goals, permitting persuasive and educational measures. The third level, that of "cooperative striving," and the fourth level, of "realistic self-reliance," permit techniques geared toward reconstructive objectives.

It is possible through therapy to bring patients from a limiting motivation to one that is more mature. When the patient is motivated to develop, reconstructive therapy, which deals with inner conflict, may be employed with the objective of bringing the patient to the highest degree of self-reliance. A prime focus here is recognition and resolution of the patient's rage, expressed or repressed, as well as excessive fear of punishment. Awareness of how rooted present-day behavior is in childish experience and misconceptions is an essential ingredient in reconstructive therapy, although the value of memory probing and the focus on insight is questioned. During treatment the therapist constantly must be on the alert for regressive thrusts toward dependency, helping the patient return to a self-reliant motivation. Indeed, advantage is taken of the patient's dependency needs to promote emotional learning through educational tactics. The therapist constantly interprets the difference between realistic and infantile aspects of the patient's behavior in and out of the treatment situation. Rather than considering transference as a manifestation of the repetition compulsion as in classical theory, it is regarded as arising

from the patient's reacting regressively (through a parentified relationship) to faulty emergency responses as a result of a present failure in adaptation (Ovesey, 1954, 1965). The tracing of the origins of faulty emergency reactions and the "emotional redefinition" of memories are aided by proper interpretations. Transference is handled by helping the patient to recognize that helplessness and anger in relation to the therapist are really directed toward past personages. The patient is encouraged to reproduce in memory the actual rage-provoking scenes "with the original cast," to be self-reliant, and to expand a realistic adaptation. Dreams are considered to be compensatory reactions to unresolved conflicts from the previous day, a "pressure gauge of the patient's latent emotional tensions." Activity by the therapist is encouraged, particularly in an educational role.

Critics of adaptational psychodynamics contend that, in their attempt to reinterpret Freudian formulations, adaptational theorists have succeeded merely in introducing further metaphysical concepts into the literature rather than in contributing to a greater understanding of psychodynamics. The active handling of transference is exprobated with the contention that self-reliance can be brought about more readily by a noncontributory and nonstructuring therapist. "Priming" the patient's reactions toward operating on a more mature motivational level is also disputed as more ego reinforcing than analytic and hence more in keeping with reeducative rather than reconstructive goals. On the whole, however, there is a general consensus that adaptational psychodynamics has introduced a fresh way of looking at the phenomenon of adaptation. It has also evolved some special techniques for helping the patient arrive at distortions in ways of relating. Particularly interesting is its approach to sexual problems such as homosexuality, cravings for omnipotence, and strivings for power and dependency (Ovesey, 1954, 1965). Rado's adaptational theories have been utilized as a means of approaching studies on the brain physiology of behavior (Heath et al, 1974).

The theoretical concepts of the adaptational school of Rado have been taught at the Psychoanalytic Clinic for Training and Research at Columbia University.

THE "DYNAMIC-CULTURAL" SCHOOL OF PSYCHOANALYSIS

Freud's theoretical speculations were originally based on the investigation of symptoms and other "ego-alien" phenomena. During psychoanalytic treatment the consideration of resistances and the mechanisms of defense focused investigations on certain "ego-syntonic" transpirations, such as character manifestations. Concentration on dynamisms employed by the ego in its adjustment led to the development of "ego psychology." The contributions of Reich (1949), Fromm (1932, 1936), and Anna Freud (1937) have been utilized by sociologically minded professionals, who, forming what has come to be known as the "dynamic-cultural" school, have made a significant contribution to ego psychology.

This school is characterized by a shift in theoretical emphasis from biological to sociological events, from concern with past experiences to the patient's present-day contacts with people, from consideration of the vicissitudes in sexual development to character patterns that, though of early origin, influence current interpersonal relationships, from preoccupation with fixations of libido to concentration on growth and maturation.

It is the contention of the "dynamic-cultural" school that Freud (1947) confused cultural phenomena with biological instinctual manifestations. Challenged also is the sexual nature of infantile urges. Orally centered activities of the newborn infant, for instance, are believed to stem not from an urge for erotic satisfaction, but rather from the fact that the mouth and the cortical area governing the mouth are more highly developed at birth than any of the other bodily areas. The oral zone, consequently, serves as a primary means of contact with the world. The shift of interest to the anal area is regarded not as a biological transfer of libido to this locality, but as a pattern characteristic of the emphasis put on toilet training in Western civilization. Instead of pleasures in fecal retention or excretion, the focus is put on struggles with parental disciplines. The phenomena of the latency period are also said to be culturally determined, in that field studies of anthropologists demonstrate the absence of a latency period in some societies. The Oedipus complex is regarded as a neurotic reaction, a consequence of incongruities in a monogamous patriarchal society. Sexual feelings in the child for the parent are excited

when neurotic needs cause the parents to overstimulate and overfondle the child. The child's responses are provoked by attitudes of the parents, punitive or disapproving reactions precipitating exaggerated fear of the loss of love and terror of castration. Penis envy is explained not by a craving on the part of the girl for a penis, but rather by the desire for privileges that masculinity awards the individual in our culture. The child's reactions during puberty are also determined by cultural factors. For example, homosexual interests are much less where boys and girls are freely allowed to relate to each other. The resentment a girl feels at accepting her femininity is stimulated not by a need to renounce interest in being a girl or in transfering clitoral to vaginal pleasures, but rather by pressures and demands put on her by the environment because she is a girl. Experiential and sociological factors, rather than biological influences, are thus regarded of prime etiological importance in conflict formation. Fundamental to a human being is an inner urge to fulfill potentialities and thus achieve "real self." The individual is blocked, however, in reaching his or her goal, both by destructive factors in personal upbringing and by repressive elements in the environment that put a taboo on certain traits, such as lovingness and tenderness, and that encourage other traits, such as hostility and aggression, that may alienate the individual from others and from self.

The "dynamic-cultural" school accents character structure above all other aspects of personality. Character, the fusion of conditionings with the constitutional makeup, is organized in complex behavior tendencies that regulate one's relationships with other people and the environment. Most character strivings pattern themselves around the demands of the culture as vested in the disciplines, prohibitions, and commands of the parents. Among their aims is propitiating needs for security and self-esteem. Tension and anxiety may result should a character drive fail to function or should one important drive conflict with another. Distorted character drives make for defects in interpersonal relationships and oppose normal biological and social needs. In this way, they are considered by the dynamic-cultural school to be the core of the neurotic process.

Erich Fromm (1941, 1947, 1950, 1955, 1959a, b, & c) contributed to the dynamic-cultural school a view of human behavior from the perspective of social psychology.

Unlike Freud, he did not believe that there was an essential disparity between the individual and society, that human nature was evil in essence, or that civilization was the product of the sublimation of instincts. Personality, though circumscribed by human biology, is not created by it. Individuals, according to Fromm, reflect the values of their society. Since their needs are economically dependent for fulfillment on interaction with others, individuals must pattern themselves by, and their character structure then reflects, the conditions under which they have to live. They must give and take, "buy and sell" by the rules of their social system. Modern industrial society resists any attempt to impose on it a rational order. This mobilizes aloneness and helplessness in the individual that forces the adoption of such psychic mechanisms as destructiveness, sadism, masochism, and conformity, through which the individual attempts to relate to people and to the world. A person's relationship with society, the basis of one's conflicts, is never a static one: it is constantly changing with the social process. Traits, such as drives for power and puritanism reflect this change. This is why "human nature" has shifted in its form at different historical epochs. A person, Fromm insisted, is not an innocent victim of sociological forces: his or her energies are constantly molding society to the special needs of one's personality.

Inherited behavior patterns are present in lower animals, but such behavior has been replaced in higher animals by learned patterns. Inherited drives, such as hunger and sex, are present, but the extent and means of their satisfaction is determined by the culture. Moreover, the culture creates new needs that may be more powerful than biological needs, for example, loyalty to one's country or religious piety. Unlike other animals, a human being is both blessed and burdened by a sense of awareness. The capacity for symbolization enables a person to store past experience and to project beyond the range of the senses into the future. The environment is so complex that one cannot be bound by the fixed solutions of instinct; reason and imagination are the chief means of adaptation. Yet awareness of one's helplessness in the massive universe and the inevitability of death imposes on existence a sense of futility and adds an "existential dichotomy" to the "historical dichotomy" (war, poverty, disease, etc.). One may rebel against contradictions of our society, or one may try to adapt by rationalizing or denying

them, soaking up the ideologies of the ruling classes who have a stake in maintaining the status quo. To establish one's equilibrium in the face of conflict stirred up by this inescapable dilemma, the individual reaches for a frame of orientation in some philosophy or for devotion to some religion, supernatural or secular. This enables the individual to relate more easily to the world, to people, and to self. Instead of religion being a universal neurosis, as Freud believed, neurosis becomes a kind of personally designed, disorganized, and potentially disorganizing religion.

Social forces thus encourage irrational mechanisms in a person's relationships with the group and promote the isolation of the person from others. A primary need is for closeness with, and approval from, a significant individual. Fear of disapproval from this individual, as originally was the case with the parental agency causes the person to deny or to repress any feeling, impulse, attitude, or reaction that inspires disapproval, no matter how constructive or important it may be. A number of character strivings are elaborated to cope with the reactions of the significant parental figure. Fromm conceives of character types as rooted in certain fundamental attitudes, such as dependent, masochistic, exploitative, (aggressive, sadistic, power-driven), hoarding (meticulous, pedantic), marketing (opportunistic), and productive (loving, mature), conditioned by experiences with parents who exerted a specific influence over the child that led one to develop these attitudes as security mechanisms. Basic anxiety issues form a conflict between a need for approval from a parental figure and a need for independence.

Fromm emphasizes the value in therapy of discovering what healthy aspects of self have been eliminated as a result of environmental restriction or condemnation. The therapist helps the patient to understand and to rectify the need to cling to irrational authority, with the end result of encouraging a character organization that permits the patient to relate to the group in a healthy and productive way. Learning the difference between rational and irrational authority through the relationship with the therapist is the essence of the therapeutic process. This releases the patient's potentialities for fulfillment through relationships with other human beings; it resolves neurotic strictures on productivity and creativity. The goal of psychotherapy is not too different from that of a

constructive religion. The latter, an affirmation of a human's faith, which is a basic requirement for human existence, like psychotherapy encourages self-actualizing tendencies. Psychotherapy and religion are thus mutually compatible rather than antagonistic, since they both strive to remove blocks to loving and to being loved.

School of Karen Horney

Karen Horney played a unique role from many standpoints in the history of psychoanalysis. While appreciating Freud's contributions, she was among the first psychoanalysts to organize and present her theoretical objections based on her dissatisfaction with clinical results. She led the way for the first expansion of American psychoanalysis beyond the orthodox view into other schools of psychoanalytic thought.

Horney viewed neurosis as a special form of human development that, because of the resulting waste of constructive energies, made it antithetical to human growth. Growing in a healthy way meant to Horney the liberating of those evolutionary constructive forces inherent in every human being that urge each one forward to realize given potentialities (the "Real Self"). No matter how impressed we may be with evidence of pathology, we must never forget, however buried or inactive they may be, these potentials for healthier growing.

This optimistic, positive, life-affirming approach led to Horney's concept of "a morality of evolution." Rather than seeing humans as by nature sinful or ridden by primitive instincts that must be tamed, each person is seen as neither good nor evil but with the moral obligation and privilege of evolving toward self-realization by ever-increasing awareness and understanding of oneself, by being truthful to oneself, active and productive, relating to others in the spirit of mutuality, and assuming responsibility for oneself (Horney, 1950).

In her early emphasis on the role of culture, Horney felt that neurosis must be viewed sociologically as well as psychologically since each culture determines its norms, which vary within the culture temporarily and according to sex and status. People are

considered neurotic to the degree to which they deviate from the pattern common to their culture. At the dynamic center of neurosis is anxiety, much of which is generated by the culture. The four principal devices that we use to escape anxiety are rationalization, denial, use of narcotics and the avoidance of thoughts, feelings, and impulses that produce anxiety. Since the latter are so frequent and dangerous, they must be repressed, which leads to more anxiety (Horney, 1937).

The evolution of the neurotic process begins early in infancy as children begin to sense that they are not being accepted for themselves. The actions and attitudes of the parents arouse a basic hostility that has to be repressed. This leads to an insidiously increasing all-pervading feeling of being isolated and helpless in a hostile world. This "Basic Anxiety," one of the essential concepts in Horney theory, is inseparably interwoven with the basic hostility and lies unconsciously at the core of the neurotic process (Cantor, 1967).

The child's normal experience of immediacy leads the child to organize behavior by moving *toward* others, *against* others, or *away from* others. How these functions are used depends on the shifting way the child feels about himself or herself. Healthy children who feel loved and accepted are able to move flexibly toward another person when they want contact or support. They are also able to oppose others when they feel their attitudes are respected. And they can move away to be alone (but not lonely) when they feel they can depend on themselves while alone, while depending on others being there for them when they return. These fundamental ways of relating can be spontaneous and interchangeable. They allow for a sense of integration and genuine satisfaction within oneself and in relation to one's environment.

To the extent that the child is operating under the lash of basic anxiety satisfaction based on inner needs, wishes, and feelings cannot be freely fulfilled. Directions for safety are pursued in ways that are compulsive, indiscriminate, and insatiable. These become rigidified into characterological attitudes (trends), each related to a specific aspect of the basic anxiety that is being overemphasized. Healthy moving toward people now becomes

"compulsive compliancy" as the child accepts helplessness and tries to cope with it by clinging, submitting, and obeying. Healthy moving against others now becomes "compulsive aggressiveness" as the surrounding hostility is taken for granted and the child has to defy, attack, and rebel against others. Healthy moving away from others becomes "compulsive detachment" in which isolation is accepted as fact and the child tries to avoid either belonging or fighting by secrecy, uninvolvement, and distancing.

Since these ways of relating are no longer spontaneous or freely interchangeable, the child is now caught up in an interpersonal "Basic Conflict" between mutually exclusive, contradictory, compulsive drives, each absolute in their demand for fulfillment. Horney (1945) saw four kinds of automatic, unconscious attempts at solution of this conflict. First, the child may repress two of the drives while streamlining the third in order to become predominantly organized around this one set of needs, qualities, sensitivities, and inhibitions in an attempt to achieve a sense of value and identity. This entails radical changes in personality, the development of a Gestalt, which, although Horney described it in specific detail, for purposes of simplicity, she cautioned was not an attempt at typology since there are no "pure forms." There are differing unique degrees to which one trend may be in the foreground. The other two, although in the background, subversively exert their influence. While the child attempts to deny the repressed trends, they continue to affect operating, manifested by contradictory thoughts, confusion, acting-out, physical, or psychological symptoms.

A second way of dealing with the "basic conflict" is to withdraw as much as possible from relating to others so as not to have to confront the conflict. To do away with the feelings of being divided, weak, and confused, a third attempted solution is unconsciously to create an "Idealized Image" of oneself. Through imagination the child becomes a conglomerate of an idealized person (the predominant trend). Compulsive submissiveness may become saintliness; compulsive disparaging of others becomes strength and honesty; compulsive detachment becomes independence. Glorifying the aspects of interpersonal conflict makes it temporarily possible for the child to combine the incompatibles into one apparently harmonious whole so that he or she can feel spuriously self-confident,

superior, meaningful, and, above all, unconflicted: In her last book. *Neurosis and Human Growth* (1950), Horney expanded on the consequences of the "idealized image" as the essential intrapsychic process within the development of the neurotic; this will be discussed shortly.

The fourth attempted solution of the "Basic Conflict" is "externalization," the experiencing of inner processes as if they were external ones. This is more comprehensive than the term "projection," which refers to shifting blame and responsibility for subjectively rejected qualities. In externalizing, *all* feelings, including positive ones, are seen as externally derived. Externalizing is essentially an active process of self-elimination that creates further conflicts between the individual and the external world.

This unstable equilibrium designates what Horney called *"auxiliary* approaches to artificial harmony." These include

1. "Blindspots" to avoid seeing obvious contradictions

2. "Compartmentalization or psychic fragmentation" so that the differences in how the person lives simply seem to be parts of himself or herself that are not contradictory

3. "Rationalization"

4. "Excessive self-control" to hold back being flooded by contradictory emotions

5. "Arbitrary rightness" to eliminate doubt from within and influence from without

6. "Elusiveness"

7. "Cynicism" to deny and deride moral values so that nothing counts but appearances and not getting caught

Since conflicts can be resolved only by changing the conditions within the person which brought them into being, all the aforementioned attempts at developing a protective structure ultimately lead to further unsatisfactory consequences, for instance, to a multitude of fears that the tenuous equilibrium of the protective structure will be

disturbed. These fears manifest themselves in fears of exposure, ridicule, humiliation, and, above all, of changing things within oneself. Further consequences of unresolved conflict are the impoverishment of personality through the waste of human energies, indecisiveness, ineffectualness, and inertia.

In addition, there is moral impairment as the person becomes less sincere and more egocentric. Substituting for authentic ideals are unconscious pretenses of love, goodness, interest, knowledge, honesty, and suffering. Along with this is unconscious arrogance in that the person may not be aware that he or she feels entitled to act demanding and derogatory toward others. Moral impairment makes it difficult for the person to take a definite stand. The person may become undependable since he or she has no appreciation of genuine responsibility. An ultimate product of unresolved conflicts is hopelessness, deeply rooted in the despair of ever being wholehearted and undivided. A person without hope may become destructive and at the same time make an attempt at restitution by living vicariously through others. This Horney saw as the basis of sadistic trends. Such a view of moral problems in neurosis and sadism is quite different from Freud's views.

The culmination of all Horney's previous works was contained in her volume *Neurosis and Human Growth* (1950). She focused on the "Real Self" as that central inner force common to all human beings, with a uniqueness in each that is a deep source of growth, sponsoring free healthy development in accordance with the potentials of one's individual nature. Homeostatic equilibrium is avoided by maintaining the imbalance of an open system that moves the person toward higher forms of order and organization. The "Real Self" is not a concrete entity but an abstract approximation, a direction toward which one can move to varying degrees were it not for the obstructive internal and external forces, past and present, affecting the individual.

In an attempt to find a sense of wholeness and identity, the person's idealized image becomes an "Idealized Self," which becomes more real to the individual than the "Real Self," not primarily because it is more appealing, but because it seems to answer all the person's stringent needs. The energies driving toward self-realization are shifted to the

aims of actualizing the "Idealized Self," which molds the whole personality and may be entirely unconscious. Because it becomes a total plan of behavior around which a person organized all functions of life compulsively, Horney referred to it as the "comprehensive solution of the search for glory." With self-idealization as its nucleus, the search for glory has three essential elements: (1) the need for perfection according to the special features of one's "Idealized Image," (2) neurotic ambition, the drive toward external success, and (3) the drive for vindictive triumph to put others to shame or defeat them through one's success. The motivating force for the vindictiveness stems from impulses to take revenge for humiliations suffered in childhood that are augmented during later neurotic development.

To reinforce the search for glory, needs become "neurotic claims" that are irrational because they assume an entitlement that does not exist in reality. Demands are made without regard for the possibility of their fulfillment (e.g., claims to be exempt from illness, old age, and death). These claims are expected to be fulfilled without the individual making adequate efforts and must be asserted as one's guarantee for future glory. Vindictiveness is the response to their frustration.

Whereas neurotic claims delineate the search for glory in terms of the outer world, the person is simultaneously trying to become an image of perfection by a system of "shoulds" and "should nots," which Horney called "the tyranny of the shoulds."

For all these efforts, the neurotic does not get what is needed most—self-confidence and self-respect—and is left with "neurotic pride," which is very vulnerable as it is based on spurious premises. Reality (the individual's "Actual Self" and how that person is empirically existing in the world) is always threatening to prove the falseness of the neurotic's "Idealized Self." The inevitable consequence here is "self-hate" with merciless self-accusations, self-contempt, self-frustration, self-torment, and self-destructiveness. Neurotic pride and self-hate belong inseparably together as one process, which Horney called the "Pride System."

Everything involved in the neurotic search for glory involves "alienation from self,"

something much more pervasive than feelings of unreality and states of depersonalization. All that is compulsive in neurosis moves the person further away from his or her "Actual Self," the material self (the body, and possessions), and especially the "Real Self." As long as neurotic pride dictates what one should and should not feel, one loses the capacity to be aware of real feelings, to direct life rather than be driven, and to assume responsibility for oneself. Alienation from self is also an active process to relieve the tensions created by the disruptive conflicts and unbearable tensions.

Alienation and the previously discussed approaches for artificial harmony are still only partial solutions. Something of an encompassing character is necessary to give form and direction to the whole personality, to deal with the *intrapsychic* conflict of how the person identifies with his or her glorified self or despised self. There are three *major solutions* to this conflict. These are to be differentiated from the three trends (compulsive compliancy, aggressiveness, or detachment), which attempt to solve the *interpersonal* "Basic Conflict." Here again Horney cautioned against the rigid usage of "types" since what we see are mainly mixed types. The major solutions are more properly directions of development that determine the kinds of satisfactions attainable, what is to be avoided, the hierarchy of values established, and how the person will relate to himself or herself and others.

Horney felt that curative forces are as inherent in the mind as they are in the body. The analyst's task is to give the patient a helping hand in sanctioning constructive forces of the "Real Self" that support an opportunity to grow. It is essential to help the patient identify on an experiential level the neurotic character structure, the complex defensive mechanisms, and underlying psychodynamic conflicts, as well as talents, capacities, and assets that have evidenced themselves in past and present life, including in dreams.

In the early phase of analysis the Horney analyst first addresses the patient's original motivations for therapy, which may be to remove a symptom, to dissolve the anxiety resulting from a conflict the patient is unable to resolve and that thus prevents living comfortably.

In quest of bolstering the Pride System and perfecting the Idealized Self the patient may have to be helped to build up healthy pride and to manage self-hate. Constant reminders enjoin that there is no magic cure, that intellectual "knowing" will not automatically dissolve difficulties, and that immediate relief cannot be obtained through "answers". Efforts are made to promote basic trust in the therapist in order to facilitate progress. The immediate objective is to deal with what is of most immediate concern to the patient. The ultimate objective is to consolidate emotional security, a functioning without pretense, and the putting of the whole of oneself into feelings, work beliefs, and relationships. The therapist engages the patient in diagnosing, prognosticating, sensing and measuring motivation and availability of resources for moving forward (Kelman 1971). How much one can do depends on the patient's ability to "let go" of some externalizing, rigid self-idealizing, and self-hate (M.B. Cantor 1976).

At the time of her death in 1952 Horney was still in the process of further formulating and extending her concepts about psychoanalytic therapy. Her colleagues and students at the American Institute for Psychoanalysis, which she founded, have continued her work along her basic lines, adding more current developments from recent findings in the biological, social, and physical sciences. Noteworthy have been contributions by Muriel Ivimey, Harry Gershman, Frederick Weiss, Alexander Martin, Jack Rubins, Harold Kelman, David Shainberg, Joseph Vollmerhausen, Ralph Slater, Morton Cantor, and Sara Sheiner.

School of Harry Stack Sullivan

By reporting on observable events in human interactions, Harry Stack Sullivan (1947, 1948, 1949, 1953, 1954, 1956) attempted to take psychoanalysis out of the realm of fanciful speculation and establish it in the empirical sciences. In fulfillment of this goal, Sullivan contributed original ideas about normal personality development, a theory of psychodynamics, and a body of technical procedures, particularly in the field of interviewing.

Emotional illness, Sullivan stresses, is both nurtured by and manifested through

disturbances in interpersonal relationships. These develop out of frustrating early experiences with parents and other significant adults. Their effect is registered in interference with proper assessment of reality and suitable communication patterns. Aberrant reactions (parataxic distortions), which are elaborated to maintain security, bear upon all later reactions and lead to other accumulated distortions. Rejecting the libido theory, Sullivan tends to regard sexual disturbances as one aspect of interpersonal disorganization.

A basic factor that molds personality is the need to maintain a sense of well-being or "euphoria," loss of which is associated with tension and anxiety. Early in life the continuance or loss of "euphoria" becomes conditioned to approval or disapproval from parental agencies. To preserve "euphoria," the child imbibes the attitudes, values, and standards dictated by parental sanctions (these become personified as the "good me"), while inhibiting and dissociating traits and tendencies that meet with parental disapproval and punishment (which become personified as the "bad me" and especially an anxiety-provoking "not me"). Demands for social conformity cause the child to respond compliantly to avoid hurt, even though the child is confused as to the meaning of such demands. The "self-system" that is eventually established contains special anxiety-provoking aspects that, repudiated as alien to the self, are either tentatively suppressed or actually barricaded from awareness by repression. Reverberations of the "good me," "bad me," and "not me" influence everyday behavior and become exaggerated in neurosis. Startling personifications of these entities often become apparent in the psychoses.

An important function of the self-system is to reduce anxiety. This would presuppose a repudiation of the "bad me." When an activity charged with pleasure becomes equated with being "bad," however, the individual, to retain gratification, may become resigned to accepting the "bad me" as a worthy penalty for indulgence. The "not-me" personification is, however, too devastating to permit acknowledgment; experiences that relate to it are dissociated or repressed, appearing only in dreams or during the dislodging of repression, as in psychosis. In our culture sexual behavior is especially forbidden in childhood and becomes a "not-me" experience, producing inhibitions in functioning. A vulnerable self-

system hinges on opinions of persons significant to the individual ("reflected appraisals") or what the individual imagines their attitudes to be. While productive relationships later in life may alter some attitudes toward the self, a constricted self-system does not permit such rectification readily.

The various stages of development are characterized by the emergence of new aptitudes that increase the repertoire of the child's capacities, particularly those that regulate relationships with other human beings. Maturation, contingent on the inherent ripening of motor, sensory, and physiological functions, is stimulated by the need to avoid anxiety. Provided it is not too strong, anxiety, consequently, is to some extent a positive stimulant that encourages personality growth. Intense anxiety, on the other hand, paralyzes learning and fosters neurotic defense mechanisms. While a human being is an animal at the mercy of biological needs, human development is shaped almost exclusively by cultural forces. Unlike other animals, humans participate in cultural interchange with their fellow creatures. The vehicle of such interchange is communication. The communicative process, to a large extent nonverbal, begins immediately following birth when the child experiences the closeness and tenderness of the mother. A milieu of empathy embraces both mother and child.

Being both a biological and cultural creature, the child is motivated to pursue biological goals in gratifying such demands as for food and freedom from pain as well as cultural requirements and satisfaction of personal security needs. These become increasingly complex with the growth of the child. They have to do not only with disposing of anxiety, but also with maintaining self-esteem, status, and approval. Sexual needs are secondary to the need for acceptance. Need tensions give rise to goal-directed strivings that, if successful, result in "integrating" or "conjunctive" activities ("dynamisms"); if they are not successful, they result in "disintegrating" and "disjunctive" solutions that augment tension and create conflict and anxiety, particularly when security needs are frustrated. Integrating dynamisms may employ bodily zones (eyes, mouth, ears, anus, urethra, genitals) through which the individual interacts with the environment. During infancy the child, not recognizing himself or herself as separate from the environment, experiences a

kind of cosmic identification ("the prototaxic mode"). Later the child relates events serially rather than logically ("the parataxic mode"). For instance, thunder occurring simultaneously with the closing of a door creates the idea that the door caused the thunder. Parataxic reasoning, while present to some extent in adjusted people, may become pathological, as in autistic and paranoid thinking. The last stage of development is that of logical and rational thinking ("the syntaxic mode"). Residues of the prototaxic and parataxic modes persist in all persons, contaminating rational thinking.

When anxiety is not adequately controlled, it may disrupt the learning process. The self-system becomes constricted through concentrating on reducing anxiety rather than on expanding the potentials of the individual. Anxiety is always generated in an interpersonal frame, usually because of feelings of low self-esteem and fear of disapproval from real or imagined personages. It may not be reality determined but be conditioned by prototaxis or parataxic modes of thinking. When it occurs, it sets into motion operations toward its reduction or elimination. To forestall anxiety, the individual develops techniques of gaining approval and avoiding disapproval, for instance, by recognizing and responding to cues such as "forbidding gestures" as anticipatory to disapproval. Anticipatory cues, in neurotic conditions, may be generated from within when prototaxic or parataxic modes come into play. The individual may consequently react as if self-esteem is vitiated or as though he or she has incurred disapproval, even when apparent reasons are lacking. An aura of disapproval often invests certain childish exploratory and pleasure activities, for instance, thumb sucking (an important means of gaining self-satisfaction as a substitute for the nipple) and genital and anal exploration. Disapproving gestures from the parent may imbue these operations with anxiety and lead to their inhibition. The self-system operates to reduce anxiety by defensive processes of selective inattention and dissociation, distorting awareness and blunting reactions to events and people. In this way the self-system circumscribes the creative potential of the individual and fosters the neurotic process.

As the child matures and is expected to adapt to the demands of society, the integrity of self-system and the degree of anxiety harbored will determine the measure of how he

or she adjusts, sublimates, subdues fear, manages anger, and handles contradictory standards in the culture. When anxiety is not too great and opportunities are propitious, much constructive learning and relearning can occur. This is particularly the case during the juvenile period (5 to 9 years of age) when the child is exposed to compeers, with whom one competes, and teachers whose attention he or she must learn to share. Experiences of cooperation, compromise, belonging to an in-group and out-group, and competition expand the self-system, increase facilities for dealing with people, and promote greater introspectiveness and self-criticism. Around the preadolescent period (8V2 to 12 years) there is a blossoming of the capacity to relate and love. Nonsexual intimacies with members of the same sex are the rule, and an interchange of ideas, experiences, and values in the medium of a warm relationship expands the child's horizons. With the maturing of the sexual organs, minor discursive explorations of the opposite sex occur, but the child returns to same-sex friends for safety and companionship. Toward the end of the preadolescent period there is characteristically experienced a strong emotion of loneliness as feelings of separation and distance develop toward friends who are also in the process of breaking away from their preadolescent ties.

With genital maturity the stormy period of adolescence begins. New and complicated adjustments are required. For one thing, the upsurge of sexual feelings ("lust") may drive the youth to express them with or without true interpersonal intimacy. Emergent are a host of responses— fulfilling, frustrating, productive, neurotic—that reflect residual patterns. Masturbation with all of its attending associations becomes a way of relief, indeed, it may become a chief means of dispelling tension. When relationships with the opposite sex are invested with anxieties that are too strong for resolution by the self-system, the youth may retreat to the safety of same-sex intimacies, releasing sexual drives in homosexual affinities. A chief reason for such anxieties is conditioned disgust and shame related to one's own genitals, which produces loathing and fear of opposite-sex genital organs. Homosexuality is thus more than a sexual problem: it is a disturbance that invests the total personality, making relationships with the less frightening genital equipment of the same-sex members more palatable. Other sexual deviations may similarly be regarded as selective responses to anxiety.

Complementing the need for sexual adjustment is the ubiquitous adolescent struggle for independence in an economic world that necessitates dependency on parents. Conformity and a need to please alternates with rebellion and a need to disobey. Insurgency, though punished, serves the end of imagined personal freedom. Obsequiousness, however humiliating, fulfills security needs. Caught in this conflict, the youth begins to question the values and standards of society to which he or she has been dedicated. Bursts of religious and philosophical interests, concern with ethics and morality, persistent questioning and self-searching constitute the stormy process of growing up, a goal unfortunately that many adolescents never reach, although physically they may mature into adults. Such "chronic adolescents" travel through life as discontented rebels, constantly trying to find peace and the meaning of existence in a world of frustration that provokes feelings of being misunderstood. Adolescents who are successful in attaining maturity display harmony between their inner selves and the demands of their group. Self-respect and the ability to relate intimately, lovingly, and cooperatively with others are the end result of successful group interactions.

Interpersonal relationships are determined by the many characterological traits that the individual has elaborated as consonant with or alien to the self. Some "parataxic distortions," reflecting attitudes toward significant past persons, are automatically projected into all interpersonal relationships.

The psychotherapeutic interview is an interpersonal experience in which the therapist as a "participant observer" engages with the patient in a joint effort to examine difficulties in relating as they are reflected in the therapist-patient encounter and in the patient's interactions in general. In his volume *The Psychiatric Interview* (1954) Sullivan delineates a variety of techniques. Essentially what is important is to help resolve the patient's anxieties in order to overcome avoidance patterns and to release learning potentials. Learning requires that the patient understand his or her behavior in conceptual terms in order to evaluate it accurately. Patients come into therapy with a number of assumptions that may block their effective use of the therapeutic situation; for example, they may assume that they should not need help, that they should be at all times

governed by logic, that they should not be ruled by the difficulties of their early life; and that they must at all times be self-sufficient and independent. These assumptions will require clarification. A wide range of problems may be reviewed: areas of "selective inattention," dissociations, parataxic distortions, false personifications, and inaccurate perceptions of one's behavior or anxiety. The area of focus will be the particular complaint that concerns the patient most. The therapist is alert to inappropriate self-evaluations, inaccurate identification of events, perceptual distortions, and other neurotic patterns that come out during the interview. Once patients commit to therapy and agree to report on their thoughts, they are encouraged to talk about their perceptions, ideas, feelings, and acts in relation to people and to themselves. Areas of difficulty (anxiety and anxiety avoidance) are spotted by the therapist and are bracketed to customary interpersonal reactions. An attempt is made to establish a consociation of events in order to conceptualize them as accurately as possible. On the basis of this understanding, the patient eventually will discuss plans and make appropriate changes in behavioral patterns outside of therapy.

The initial phases of therapy are concerned with the establishment of a diagnosis and the estimate of the tentative prognosis to determine whether therapy can have a constructive influence. Rather than establishing a sterile diagnosis, the therapist appraises the existing problems in living and the assets of the patient in contrast with liabilities. An estimate is then made of what may be accomplished by psychotherapy. Once the probable effectiveness of psychotherapy is decided, a systematic inquiry follows. The developmental history is examined in relation to current areas of anxiety, the prevailing anxiety-avoidance responses and security operations, and the circumstances that bring these about. The therapist is sensitive to manifestations that appear within the therapeutic interpersonal relationship. When convinced that these reflect basic patterns, the therapist focuses the patient's attention on their nature and origins. A variety of questions probe pockets of anxiety. Hypothetical situations are posed, such as "How would you feel if your employer depreciated your services?"; and tentative interpretations are made, such as "I wonder if this doesn't make you want to run away?"

In the therapeutic encounter, as in any other situation, the patient acts out "parataxic distortions." Bringing these to the awareness of the patient helps the patient separate the present from the past and appreciate the attitudes and values that are a part of a self that he or she tends to repudiate. The origins, manifestations, and consequences of the patient's defenses are actively explored. The patient experiences emotionally what has been dissociated, and in this way is enabled to evaluate, toward their possible reacceptance, aspects of himself or herself that have been split off from awareness. While the current situation is actively considered, childhood experiences and conditionings are also constantly prospected in order to expedite separation of the past from the present. In these ways new and healthier interpersonal relationships may be constituted.

The management of patients in therapy is more flexible and active than in Freudian psychoanalysis. Thus, patients may assume a sitting or recumbent position; may use free associations or deal with specific aspects of their experience; and may work with present reality problems as well as early childhood memories and productions from the unconscious, such as dreams. The emphasis is on the character structure and problems in interpersonal relationships, although genetic origins are not neglected. Relaxation of the "basic rule" permits a focusing of the interview on significant material. The therapeutic situation is considered a real relationship that has values in itself in addition to serving as an arena for transference. The manner of the therapist, Sullivan believes, should never be stilted or blank; it should reflect the therapist's inner feelings, even though annoyance, irritation, or pleasure are mobilized. The skillful use of satire may be employed, where indicated. Even provocatively inaccurate statements may be presented to stimulate corrective responses from the patient. Exploited also may be a strategic shifting of the stream of thought into an unexpected area before the patient's defenses are mobilized.

Skill in interviewing, Sullivan insists, is dependent on the therapist's drawing the patient out by pointed questions, identifying parataxic distortions in the relationship, demonstrating the unreasonableness of the patient's reactions in view of what actually has been going on in therapy, speculating on whether feelings of a similar nature occurred in the past, examining the assumptions the patient is making through transference

reactions, and exploring important past relationships associated with the origins of the patient's trends. Particularly important is the uncovering of dissociated systems that have been repressed because of their anxiety content. Here a frontal attack is useless since the patient's defenses can easily ward this off. Rather, slow and indirect interviewing may eventually uncover these systems. Skill is required in dealing with and circumventing the patient's verbal defenses, such as rambling about irrelevances. Sullivan recommends only brief questions and brief comments by the therapist while encouraging lengthy responses from the patient; long dissertations by the therapist are not in order. Clarification of communication is mandatory as is activity as a "participant observer, the therapist utilizing his countertransference in a constructive way" (Crowley, 1971).

Much of the theory and method of Sullivan are at present adopted by the William Alanson White School for Psychiatry, Psychoanalysis and Psychology, which is located in New York.

Criticism of the "Dynamic-Cultural" School

Criticism of the "dynamic-cultural" school stems mostly from Freudian psychoanalysts who regard the diversion into the sociological field a form of resistance against the biological-sexual hypotheses of Freud. This revolt against classical thinking is considered by some to be a manifestation either of unresolved transference in the "renegade" analyst, a product of an incomplete personal analysis, or a manifestation of an entrenched narcissism that spawns the evolvement of ambitious, albeit faulty, new systems. Others attack neo-Freudian concepts along conceptual lines. For example, Franz Alexander questioned Horney's attack on the libido theory on the basis that it substituted for the mystic biological substance of libido an equally empty sociological slogan of culture (Alexander F, 1940).

There is a general feeling among Freudians that sociological-cultural approaches are loose and myopic preconscious generalizations that deal with only one facet of human experience and do not consider the basic infantile sexual conflicts, which are the nuclei of neuroses. While analysis of character is said to be helpful, it does not eradicate the deepest

sources of conflict. Freudians contend that distortions in interpersonal relationships and defense mechanisms as a whole cannot be understood or helped unless we deal with their unconscious roots, a formality often overlooked or not considered essential in the methodologies of some of the neo-Freudians. Therapy conducted in accordance with principles of the dynamic-cultural school is, therefore, considered "superficial" and of reeducative rather than reconstructive influence. Particularly deplored is the discrediting of sexuality as a vital force in personality development by assigning it to its traditional place as a manifestation appearing with the maturation of the genitals. This retrogression to an atavistic conception of sexuality denies clinical findings that indicate that infantile sexual drives are present, powerful, and persistent, shaping not only the expression of adult sexuality, but the individual's personality as a whole.

Divergencies, it is claimed, are often more apparent than real; certainly this is so in technique. But even in theory, once the semantics are clarified, differences are more a matter of emphasis than of explicit contrast. A fine line of distinction may reside in the elaborateness of description by the neo-Freudians of the phenomenological nature and consequences of defenses and character traits. The generalizations drawn from these variances, however, are often expanded into global doctrines that seek to account for the whole of life. But what is even more confounding, it is claimed, is that some deviants from Freud tend to utilize the hypotheses and terminology of Freud whenever it suits their convenience. Indeed, there is a tendency to recast Freudian formulations in novel, excruciatingly complicated neologisms and to concentrate on nuances, torturing these into broad theorems that cannot possibly explain the complexities of behavior, while ignoring those psychopathological areas that do not fit into the renovated scheme of things. There is also a tendency on the part of some neo-Freudians to attack an orthodoxy that no longer exists, particularly among the younger psychoanalysts.

Criticism is also leveled at those, such as Harry Stack Sullivan, who decry the delving into the inaccessible and unobservable, insisting that the material for study be purely that which is apparent and demonstrable, such as interpersonal relationships. Yet such concepts as "self-fulfillment" and "self-actualization" border on the metaphysical and

require postulates that remove them from the zone of science. To the charge of the neo-Freudians that classical hypotheses are farfetched, it is obvious in studying them, say the Freudians, that some of the concepts of the neo-Freudians vie for absurdity with the most fanciful contentions of the orthodox school.

To the neo-Freudians these charges are considered as further evidence of the basic intolerance of the Freudians. They are also branded as rationalizations for clinging to an outmoded theory that has lost its clinical usefulness. On the contrary, they insist, neo-Freudian theories support methodologies that expand the therapeutic spectrum to a wide group of patients not suited for classical techniques (Wolman, 1967; Marmor, 1968).

EXISTENTIAL ANALYSIS

Existential "analysis," a more depth-oriented approach than existential "therapy," is, as is the latter, rooted in the precepts of existentialism. This philosophy attempts to solve a human's apparently insoluble quandary through a search for the meaning of one's existence. It posits that only by finding purpose in one's life, even in the face of catastrophe, can one experience that true sense of "being" that fuses the physical, psychological, and spiritual natures. Such elements operating individually isolate humans from their selves and from the world; they sponsor a profound contradiction. For the spiritual self demands freedom, unlimited choice, and responsibility, while the psychological and physical selves dictate finite restrictions, restricting one to one's own endowment, past history, and conditionings. Although anxiety and despair are inescapable products of this "existential predicament," a human being has the capacity, responsibility, and the freedom of choice to deal with the disruptive forces that tend to unbalance an individual. The crisis in one's existence urges the individual onward toward some solution that is generally registered in terms of greater "self-realization." A human being cannot approach problems of existence solely through objective means, for example, the methods of science; what is required is a search for ultimate values that may be achieved only through moral, ethical, and spiritual means. Only then can one cope with one's ever present anxiety or resolve some of the riddles of one's identity, adapt to life's purpose, and

accept the inevitability of death.

These concepts have been expressed in various ways over and over again as far back as the first philosophical speculative conceptions about the meaning of life. They were most clearly organized into a system by such philosophers as Søren Kierkegaard, Edmund Husserl, Martin Heidegger, Karl Jaspers, Jean-Paul Sartre, Martin Buber, and Paul Tillich, each contributing his own unique mode of viewing the nature of existence and the means by which a human being may solve its ambiguities. It was Husserl (1962) who was principally responsible for the "phenomenological method" of viewing the behavior of a person without preconceived theories or notions of causation while describing phenomena as they were observed. This, with Heidegger's contribution (1962), served as foundations for the existential analytic approach which rapidly advanced in Europe largely because of the influence and writings of Ludwig Binswanger (1942, 1947, 1956) and Medard Boss (1957, 1963) and in this country Rollo May (1950, 1960). These authorities concede that, while biochemical, neurophysiological, and psychological mechanisms are important in describing the functions of the human organism, they cannot be dissociated from the existence of the experiencing individual and from the understanding of his or her ontology. Nor can one, as Buber (1937) has emphasized in his "I-thou" duality, conceive of humans as separated from other humans or apart from their world. Humans are shaped by their world and in turn fashion their world to bring it into focus with their needs.

By applying a phenomenological approach to the technical problems of psychotherapy, existential analysts claim to go beyond conventional ways of managing neurotic problems. This is not because their methods are different from, or superior to, those of other psychotherapists (since the techniques employed are essentially the same), but rather because they feel that they approach their patients from a more constructive and comprehensive standpoint.

Patients are generally encouraged to perceive of their behavior in the context of the "what" it is that one is experiencing rather than the "why." While the genesis of the

individual's problem is considered important, as are the mechanisms of defense, they are regarded as only one aspect of the patient's "being-in-the-world." The crux is the functioning, experiencing person in the present. "Therapy, then, is not primarily an uncovering process, but a creative one. It is the self-making aspects of being that are in the foreground—one's decisions, commitments, and responsibility. The existential therapist is not content with the elimination of undesirable aspects of functioning, such as inhibitions, frustrations, and symptoms, but has the larger goal of the creation of positive values" (Basescu, 1963).

The patient-therapist relationship, unlike that of Freudian psychoanalysis, is predicated on activity. It is in essence an "encounter" in which both participants extend their "full being in the world of the other, without treating the other as an object subordinated to some purpose of one's own." This means complete freedom in mutual self-revelation and an openness in the therapist's approach to the patient, in which the therapist exposes himself or herself as a real person, not as the traditionally tolerant authority. Unconditional acceptance does not preclude criticizing the patient for "self-imposed limitations on being. Patients are not innocent victims of circumstances. They have a responsibility for their own destinies, even to overcoming self-limitations. This requires resolution and fortitude, for if one loses one's courage, one loses one's being (Tillich, 1952). The active "encounter," in which the therapist engages with the patient without assuming an artificial and studied role, releases the "courage to be." As Tillich has remarked, "A person becomes a person in the encounter with other persons, and in no other way. This interdependence of man and man in the process of becoming human is a judgment against a psychotherapeutic method in which the patient is a mere object for the analyst as a subject."

In the conduct of therapy no preconceived theories are admissible. "There is nothing other than a person's definition of self for which that person alone is responsible. The work of therapy is the illumination of the person's view of the way things are (the personal myth) and the way in which that person's suffering incarnates that cosmology" (Ofman, 1985). The patient describes his or her "world of being" and the therapist shows

nonjudgmental interest. What the patient does as a consequence of gaining increasing understanding is entirely left up to him or her. No pressure or manipulation is admissible. As the patient gains an awareness of personal myths that control his or her existence, modes of self-deception, and means of denial of personal autonomy and freedom, in short of the "self-created world of perpetual crises," he or she is helped by authentic relating with the therapist to avoid self-rebuke and spurious ploys and to assume complete responsibility for the distortions.

Essential, then, is a complete acceptance of the patient who is in the process of "becoming," irrespective of his or her behavior and problems. In the words of Martin Buber (1948), "conforming the other" means accepting one's potentialities as well as the person that he has been and is now, in the light of the capacity to develop, for "when something, no matter how imperceptible, happens between two men so that each becomes aware of the other and his world is related to him in such a way that he does not use him as his object but as his partner in a living event, the fact of this encounter can never be entirely eliminated" (Buber, 1957).

In the medium of such unadulterated acceptance various techniques may be employed, including psychoanalytic techniques. What is necessary at all times, however, is a unique kind of phenomenological observation during which the therapist comes to terms with the patient's (as well as the therapist's own) problems of being human without preconceived and structured formulations. The therapist goes beyond *what* patients believe and perceive about themselves to *how* they experience themselves in the world.

The neurotic patient, sick as he or she is, first needs to be "cared for" by the therapist. Only as one grows strong in the relationship does one develop the courage to move toward ontological self-realization. The patient is helped by the therapist's extending to the patient a "humanness" in the relationship, a "being-togetherness," and a "standing-on-the-same-level-of-existence" through meaningful communication. During this process repressions blockading the sense of being are gradually lifted.

The existential system of analysis is oriented around the uniqueness of each

individual and is not impeded by adherence to scientific determinism or the search for systematic regularity (Holt H, 1965). An understanding of human experience, including the human commitment to independence, freedom, and "being-in-the-world," is acquired most fruitfully by recognizing three types of basic experience: the biological body world ("*Umwelt*"), interpersonal relationships ("*Mitwelt*"), and self-recognition ("*Eigenwelt*"). A unification of these three is essential for a complete feeling of authentic existence (May et al, 1958). Unity in these three modes of existence is lost as a result of inescapable basic "ontological" anxiety (Burton, 1965). Integration of the different elements of self, essential for what Iago Galdston (1963) has described as a "healthy ontological thrust toward maturity," is achieved as the therapist moves into the patient's life and helps one experience oneself in terms of the universe around one, including the biological substance and instincts, the world of meaning in relation to others, and the private area of self. Binswanger implies that psychoanalysis deals with the first dimension, partly with the second, but not with the third, i.e., how the self relates to the self. On the other hand, existential analysis applies itself to all three modes and, in their liberation and harmonization, brings to the individual a true alteration in the sense of values and more positive purpose in relationships with people.

Essentially, existential analysis is an approach to *how* the therapist applies himself or herself to therapy rather than a technique in itself. The therapist conceives of the goal in treatment as the restoration of the patient to "bodily-togetherness-with-others-in-the-world."

The cornerstone of existential constructs are embedded in concepts of *will* and *decision* (May, 1960). The patient is at all times aware of free choice in perceiving wishes and in "willing" their fulfillment toward doing something about them. "This is the level of accepting one's self as having a world. If I experience the fact that my wishes are not simply blind pushes toward someone or something, that I am the one who stands in the world where touch, nourishment, sexual pleasure and relatedness may be possible between me and other persons, I can begin to see how I may do something about these wishes" (May & Van Kaam, 1963). In moving toward a better integration, the patient is

helped to appreciate the forces of *decision* and *responsibility* "within a nexus of relationships upon which the individual himself depends not only for his fulfillment but for his existence."

The application of the existential philosophy to therapeutic process will vary with the therapist (Holt H, 1968, 1972b: Havens, 1972; Wenkart, 1972). In a number of important ways, however, we can detect a similarity in operation. First, there is a focus on the inner experience of the patient. Second, there is recognition that the therapist cannot remain aloof and detached from this experience, that the therapist is privileged to emote and to feel torments and dilemmas, many similar to those of the patient. In the ensuing encounter the therapist's feelings are bound to be communicated. This will foster engagement in sympathy, challenge, and confrontation at the same time that the relationship is exposed to investigation. What eventuates is the humanness of the therapist, the therapist's "being-where-the-patient-is," and empathy sharing the inner experiences and desperation of the patient. An emotional clash often occurs as empathy and understanding temporarily recede, and in the ensuing struggle new understandings occur and change is brought about both in the patient and the therapist.

Entering the patient's world and communicating with him or her deeply and humanely help to penetrate the defenses of sicker patients, such as schizophrenics. Experiencing the dissociated elements of the patient's personality is a potent force in their reuniting. "Because the existential therapist tries to stay with the patient, he must be willing to 'encounter' or confront aspects of the patient not so comfortably assimilated" (Havens, 1972).

Existential analysis has not been formalized into a special school, but it has attracted a number of followers, particularly those oriented toward the theories of Jung, Horney, Sullivan, and Fromm. The "third-force" movement of humanistic psychology is oriented around existential analytic ideas.

Criticism of Existential Analysis

A rift is inevitable between existentialism and traditional Western psychotherapeutic approaches that promote both objective scientific naturalism and subjective human psychology. Existential analysis "tries for insightful, intuitive and cross-sectional *descriptions* of the experiencing self," a kind of ontological unfolding (Opler, 1963a) sponsored by intuition, which is foreign to the training and ideologies particularly of the American psychiatrist and psychologist. Criticisms are consequently directed at existential analysis as being a "subjectivist melange" that avoids regularities in process and hence does not help us in arriving at a scientific understanding of how human beings function, get ill, and get well again. Western psychotherapists express irritation at the language of existentialism and accuse its practitioners of diffuseness in concepts and of depending for their therapeutic effects on faith and the profits of a helping relationship. Existential analysis is not considered to be "analysis," but merely a descriptive exploration of problems in self-realization. There is a feeling that existential approaches constitute a regressive movement, a throwback to a prescientific era from which the mental health field has painstakingly tried to liberate itself.

To an extent this intolerance is stimulated by an inability on the part of existential analysts to communicate adequately; the coining of new words and phrases without appropriate definition and clarification has been particularly confounding. To an extent the prejudice is due to sectarianism and a need to defend personal theories against all external assaults. We must remember that most of the therapists who have become attracted to existential analysis have been trained in dynamic and other systems with a scientific pretension. Ludwig Binswanger, for example, was a psychoanalyst and a close friend of Freud. A principal reason why therapists have turned to approaches different from those in which they have been schooled has been that they were disappointed with therapeutic results. In exploiting the existential method, many therapists claim to have found their work more successful and rewarding. This, of course, may be due to the affinity they feel with existentialism because of personal needs. A methodology that has significant meanings for a therapist will enable the therapist to relate more sincerely to patients, who will sense genuineness and then respond appreciatively to the therapist's efforts.

Therapists who practice existential analysis continue to utilize their old techniques on the basis that traditional and existential methods are not mutually exclusive: they influence different aspects of the psyche, hence they actually reinforce each other. Whether or not therapists need to introduce into their modes of working stratagems from different systems is contingent on the systems' helping or hindering their functioning. All progressive psychotherapists incorporate into their operations techniques that yield for them the best results. Somatic therapies, tactics that expose the unconscious, maneuvers in interpersonal relationships, and devices that influence spiritual strivings and alter moral values are often blended into an eclectic framework that is applied flexibly to patients in accordance with their needs. If any approach enhances results, therapists may pragmatically incorporate it into their therapeutic armamentarium. Danger arises, however, from the tendency to overvalue any of the systems, including existential analysis. Many therapists cannot be taught maneuvers and attitudes essential for their functioning as existential analysts. They will then do better with approaches with which they feel more comfortable.

Actually, when we cut through the semantic persiflage and consider the goals and methods of existential analysis, we find that they differ little from those of other forms of psychoanalytic psychotherapy in which patients are encouraged to observe thoughts, feelings, and behavior in the context of their immediate experiences, not merely in terms of whence and why they arise. There is a focus on the present, which is regarded of primary importance in serving as a repository of the past. The patient's mechanisms of defense are considered to be aspects of the total behavior and meaningless in themselves. The objectives are not solely the relief of symptoms and intellectual insight into one's problems, but the utilization of understanding in the direction of change, particularly toward the altering of value systems to promote the greatest possible self-actualization. The relationship with the patient is predicated on measured activity. The therapist on occasion may reveal that he or she has some personal difficulties or that the therapist has made mistakes. Like other therapists, however, most existential analysts do not purposefully display their neurotic distortions or act out destructive feelings that emerge from countertransference. They do not consider their patients helpless puppets

dragooned to everlasting suffering by an inimical past, but rather as active participants in perpetrating their neuroses. Patients have a responsibility in making constructive choices and in getting well. The presence of some anxiety is an inevitable consequence of personal and social conflict, even in healthy people, but existential analysts and seasoned therapists of other schools differentiate between grades of anxiety— between productive and neurotic reactions to anxiety.

In short, a properly working psychotherapist incorporates into his or her system of therapy essentially the same essences of "meaning" and of method as a good existential analyst, or a good Freudian psychoanalyst, or a good neo-Freudian analyst. This presupposes flexibility in approach and full intelligence in the use of oneself in the therapeutic relationship. The language that therapists employ in describing what they do, and the theories they invent to explain why they do it, do not alter the fact that essentially the same healing processes will have to be implemented, or will spontaneously come into operation, if a patient is to get well.

OBJECT RELATIONS APPROACHES

Freud's early drive theory viewed psychopathology as revolving around the nebulous orbit of psychic energy. This explained some of the phenomena encountered in clinical practice, particularly in hysterical and phobic disorders. In working with pre-Oedipal problems, however, the limitations of the drive model became apparent. Attempts were then made to fill in the gap by appending to the instinct hypothesis theories of interpersonal relations. Finding this combination troublesome, some authorities dissociated themselves from Freud's early formulations while retaining his dynamic view that a multitude of motivational forces, originating in prior experiences and conditionings, operating harmoniously or in conflict, consciously or outside of awareness, express themselves in relationships with other human beings.

The direction of psychoanalysis shifted from the capriciousness of instincts to the regulatory operations of the ego and its defenses. The early work of Nurnberg (1955) on the synthetic functions of the ego, of Waelder (1936) on its multiple operations, of Anna

Freud (1937) on its ingenious maneuvers to contain primitive drives, and of Heinz Hartmann (1958, 1964) on its transactions with the total personality, as well as of Fairbairn and other ego analysts, led to the enhancement of ideas about the ego and to what has become known as "object relations theory."

Fairbairn (1954), for example, evolved a developmental model that included many of the components of present-day object relations theory. His contention was that during the first two months of life a child was emotionally fused with the mother. This "primary identification" with the internalized mother figure (the "object") had to be resolved and renunciated in the course of development if mature growth was to be achieved. Otherwise the ego (or "self") would not evolve from infantile dependence to normal conditional dependence with differentiated objects. The relationship with the mother had gratifying and enticing aspects, as well as ungratifying components. Internalization of the relationship into the "ideal object" (gratifying), the "exciting or libidinal object" (promising and enticing), and the "rejecting anti-libidinal object" (depriving and withholding) was accompanied by a threefold split of the ego from its binding to each aspect. Ego and object became inseparable.

If too much was incorporated of the "bad" exciting or rejecting mother, efforts to control and preserve relations with the real mother were prevented and the ego was unable to bind satisfactorily with the "ideal object." There was thus a splitting and fragmentation of the ego, interference in relationships with people, and tendencies toward psychopathology. The battle with the rejecting, depriving antilibidinal mother and the enticing, exciting libidinal object was carried on internally. The frustrated antilibidinal ego hated and attacked the libidinal ego as well as the exciting object, in this way perpetuating self-destructive, self-punitive behavior. As a result of this battle, hateful attitudes were produced that through transference were extended outward toward maternal representatives, including the analyst. Adjustment was thus compromised by the conflict between object-related libidinal desires, object-related antilibidinal, hateful impulses, and object-related idealizations. The threefold splitting of the ego helped the child maintain a good relationship with the mother but created a disunity that continued throughout the

life of the individual. The "splitting" paradigm established with the mother followed through also with the father, and to complicate matters the resulting internalized paternal object was fused with that of the mother and the combination was then projected onto both parents. The continued need for nurturance fostered persistent dependency, which might be sexualized as a defense. The basic conflict that underlined all psychopathology, therefore, was dependency and not through the classical Oedipal situation. Failure in object relations in the early oral phase produced frustrated love and schizoid withdrawal; failure later during the oral biting phase contributed to one's hating one's parents and resulted in depressive manifestations.

Somewhat later, Fairbairn modified his ideas about how internalized objects were developed. He added the notion that since children had to maintain an illusion of the "goodness" of parents for their own security needs, realization of parental seductiveness, rejection, nongivingness, or cruelty was repudiated or repressed by blaming inherent "badness" on themselves. The resulting "bad" internal objects, with which the ego identified (primary identification) to a greater or lesser degree, were repressed with the elaboration of such defenses as splitting and guilt to protect the ego. Attempts to work through painful memories and past experiences with the parents fostered a choice of love objects with similar bad qualities, encouraging disappointing outcomes. The individual through his or her own character distortions provoked rejecting and sadistic behavior on the part of parental surrogates, further aggravating the distress and convictions of hopelessness and despair.

The contributions of Winnicott (1965) revolve about the evolution of the self with speculations of what must be on the infant's mind during this process. The mother is conceived of as a physical and emotional "holding" environment for the child, who, if she has sufficient devotion and provides demonstrable caring, serves as a means of satisfying the child's illusions of power and sense of omnipotence, which in being gratified become the foundation for building of the healthy self. The mother also acts as a mirror, reflecting the child's own "personalizations." Inability of the mother to provide a reasonably "perfect" ("good-enough-mothering") environment usually interferes with the growth of

self. Once a nucleus of "hallucinatory omnipotence" is established, further development of the self necessitates coping with limitations and frustrations in the environment and adapting to a loss of control. This is the second stage of development and encourages separateness from the mother. The use of "transitional objects" (blanket, teddy bear, etc.) over which the child can execute control and that allows the child to experience other people for what they are proceeding from "object relating" to "object usage," helps to ease the transition from total involvement with the mother to separation from her. Serious failures in this process of evolution encourage fragmentation and splitting of the self into a "true self" that becomes impoverished and a "false self that is artificially compliant and provides an illusion of security. The essential shifting from dependence to independence, from omnipotent fantasy to realistic thinking, is thwarted. Life thereafter is spent in searching for the missing parental provisions that should have existed in one's early development. The curative factor in psychoanalysis is that it can be conducted in an environment that can supply these missing emotional ingredients. Unlike classical analysis, in which the analyst does not allow regressive gratifications, Winnicott alleges that to liberate the self the therapist must function as a maternal caretaker.

In these early excursions in object relations theory there was no intention of abandoning the biological orientation of drive theory. The ego, though predominant, was considered a derivative of fundamental biological forces concerned with the maintenance of homeostasis. The Freudian dynamic, economic, and typographic models were in large degree retained while crediting to the ego greater autonomy from the id and better control over forces in reality (Hartmann & Kris, 1964).

This swing toward the ego was abetted by such developmental researchers as Margaret Mahler (1941, 1975). Early developmental theorists conceived of the infant as a helpless blob of palpitating flesh totally bent on needs gratification ("autoerotism," "primary narcissism," "absolute dependence") through an emotional umbilical cord. Severance of this cord was resisted desperately, and, because of maternal immaturity and faulty child care practices, sometimes never occurred. This accounted for the survival into adulthood of chaotic traits that seriously interfered with realistic adaptation. The road

from autoerotism to full genital maturity was paved with many stumbling blocks, not the least of which was failure to resolve the Oedipal complex. This anchored the individual symbiotically to archaic objects and blocked proper separation-individuation (Mahler et al, 1975).

According to Mahler, the first weeks of the infant's life are occupied autistically with hallucinatory wish fulfillment and obliviousness to external stimulation. At three to four weeks there is some response to external stimulation (e.g., smiling in response to the mother's face), indicating some awareness of the environment. This constitutes a normal symbiotic phase when there is no differentiation between the self and the object (the mother). There is some registration of "good" and "bad" environmental happenings. From 4 or 5 months to 10 months a "hatching phase" initiates early differentiation, marked by discrimination between self and object and between perceptual and inner sensations. At the end of this phase a "practicing" subphase is initiated, characterized by bodily movements such as crawling and thrusts into the environment away from the object. This aids initial separation-individuation. There is interest in one's body ("secondary narcissism") as well as in the world around. This subphase is encouraged when the mother is willing to accept the child's independence; it is discouraged when the parent refuses to grant her child autonomy. During this period there are indications that the child does not consider the mother a distinctive entity. Between 15 and 18 months, the child begins to realize his or her own helplessness as the child sees the mother as a person separate from himself or herself. This is a "rapprochement" subphase that around 18 to 24 months of age leads to a crisis in separation and individuation with ambivalent clinging to the mother (symbiosis) and resistance of her efforts at separation. Resolution of this ambivalence is crucial to the child's development since failure leads to splitting of "good" and "bad" object representations. The mother's role during this period is vital, and how she deals with the child's shifting between symbiosis and separation will crucially influence what happens. Coincident with this individuation struggle is the refinement of verbal communication, cognizance of sexual differences (eventually leading to gender identity), and greater awareness of the father. During the third year of life, self and object become more separate and their internalized representations become more unified

("libidinal object constancy"). Differences in the degree of resolution of symbiosis and separateness can occur so that the one is much more advanced than the other, complicating adaptation.

A derivative of object relations theory has emphasized self-representations as distinguished from object representations (Hartmann, 1964; Mahler & McDevitt, 1982). This has encouraged explorations into "self-psychology," of which the most prominent contributors have been Edith Jacobson, Otto Kernberg, Heinz Kohut, and Joseph Sandler. According to Jacobson (1964), the desire of the infant and child to relieve tension (unpleasure) and to secure gratification of needs with resulting pleasure leads to the internalization of the object in the form of bad (frustrating) and good (gratifying) images toward which the child responds as variantly and as intensely as if they existed in reality. Frustrated and aggressive feelings are liberated toward the bad object; a desire to possess and merge with it toward the good. The representational worlds of the self and the object are intricately intertwined and lead to the establishment of a sense of identity and the building of the intrapsychic structure, whereas the mature ego resists fantasies of merging with the object. Situations within the representational world may weaken reality testing and tempt a return to earlier, less differentiated ego states. Retaining some of the elements of drive theory, Jacobson has fused them with a phenomenological approach that makes for a rather complicated structure.

Drawing some substance from the ideas of both Mahler and Jacobson, Otto Kernberg (1976, 1980) has contributed some interesting ideas to contemporary object relations theory while retaining a fidelity to classical metapsychology. From the stormy transferences of narcissistic and borderline personality disorders, the chaotic nature of self and object representations, the use of primitive defense mechanisms, such as splitting, projective identification, and archaic ambivalences, assumptions are made by Kernberg that early object configurations have not been properly "metabolized." This is the reason why they precipitate out rapidly in the transference. The original self and object images as well as the affective colorations of drive derivatives constitute the "internalization system." The representatational world consists of bad and good self and object images, as

well as components of the ideal self and object. As the ego consolidates through the employment of such devices as introjection, the defense of repression relegates unacceptable representations and identifications along with their affective charges to the unconscious. Splitting separates ambivalent introjects. These processes are accompanied by strengthening of the superego, formed from hostile object internalization, the ego ideal (combined ideal self and object representations), and realistic parental introjections (commands, values, etc.). The "self," an intrapsychic structure originating from the ego, consists of the total of self-representations that connect with the total of object representations (Kernberg, 1982). In working with sicker patients during psychoanalysis, one consistently has to deal with transference paradigms, the product of unmetabolized early relationships, as well as with such surviving primitive mechanisms as splitting and ambivalent self-object configurations, with the hope of achieving a better integration.

Heinz Kohut (1971, 1977), a former president of the American Psychoanalytic Association, avowed that severe narcissistic personality disorders, which ordinarily have not been considered susceptible to psychoanalysis, could be treated analytically. What was required, he insisted, was a revision of classical theoretical and methodological concepts, while retaining fundamental premises of the drive theory. Leaning toward a relationship model, Kohut promoted a "self-psychology" that subordinated the structures of id, ego, and superego to the active manipulations of the self. The self evolves out of participation with others ("selfobjects") with whom the child merges and whose feeling states (empathic responsiveness) the child incorporates. The child's fundamental narcissistic needs (omnipotence and grandiosity) require that the child be admired for his or her capabilities by the idealized selfobject (a kind of "mirroring" phenomenon), which enhances fusion of the self-image with the idealized selfobject ("you are perfect, and I am part of you."). Disappointments in "mirroring" by the selfobject hamper idealization but contribute to the development of the self structure ("transmitting internalization"). In one line (pole) of self-development the grandiose exhibitionistic anlage becomes expressed as healthy assertiveness and ambition; in a second alternative line (pole) the idealization of the selfobject results in healthy ideals and values. Failure to develop adequately along either pole impairs self-development, with resulting damage to the self-image and self-

esteem. If, because of parental pathology, proper empathy is not displayed, self-development in the child is thwarted, with psychopathological consequences. The theoretical premises of Kohut have provided a rationale for empathic activity in treatment. Since deficits exist in the constitution of the self, transference in either mirroring or idealizing modes provides an opportunity to rectify these deficits. By acting empathically, the therapist gives the patient a second chance to incorporate healthy structures and thus overcome the original selfobject failures. Gradually, the narcissistic elements are resolved as the therapist slowly adopts a decreasing empathic role and the patient needs the therapist less and less as a selfobject. What is responsible for character reconstruction, according to Kohut, is a fruitful experience with an empathic and idealized therapist (the transferential selfobject) rather than interpretation, the touted classical agency that presumably brings about change.

Instead of conceiving of the development of the psyche in terms of the conflict between primary drives within the individual and the socializing demands of parental authority, self-psychology thus focuses on the vicissitudes of the self and object representations in their archaic and mature forms. Agreeing with Kohut, Ornstein (1984) conceives of the first pole of the bipolar self as the grandiose exhibitionistic self, which becomes the nucleus of later self-assertive tendencies, regulation of self-esteem, enjoyment of mental and physical activities, and successful pursuit of goals and purposes. The second pole involves the idealized parental image incorporated in the selfobject matrix, which becomes the basis for values and guiding ideals, helps regulate inner tension, contains and channels drive needs and affects, and fosters enthusiasm and idealization of one's values and edifying principles. Psychopathology is the product of developmental arrests or derailments that produce disturbances in the bipolar self and failure of maturation. Resultant is a continued dependence on archaic selfobjects and an inability to harmonize one's directive values and ideals with innate skills and talents toward satisfaction of one's self-assertive ambitions. The psychoanalytic cure consists of mobilizing the regressive transference neurosis in the usual analytic way and of employing it to "break the bondage that formerly tied the archaic self to the archaic selfobject" and then establishing "empathic in-tuneness between self and selfobject on

adult, mature levels."

A growing number of analysts have climbed onto the bandwagon of object relations theory. Utilizing some of the formulations of Sullivan, Klein, Mahler, Fairbairn, Winnicott, Kernberg, Kohut, and others, they have expanded on and enriched certain elements of the theory. Some contemporary theorists have seemingly forgotten the contributions of the earlier workers who presented the original formulations. Others have paid proper tribute to the innovators who preceded them. Among these contemporaries are Joseph Sandler, who has elaborated on how the child's representatational world evolves, develops, and forms the basis for the organization of later experience (Sandler & Rosenblatt, 1962) and (Sandler & Sandler, 1978). His formulations are clearly expressed and possess a clinical utility. The phenomenological viewpoint of Stolorow and Atwood (1979) and the work on developmental arrests by Stolorow and Lachman (1980) are of interest. Greenberg and Mitchell (1983) have done an excellent job of showing how object relations theory evolved from ego psychology and of integrating the contributions of the various authorities in the field.

There is some evidence that an object relations orientation adds a dimension to classical structural analytic theory, particularly in relation to self and object representations and to the identification in borderline cases of such pathological defenses as "splitting" and "projective identification." The value of modern object-relations theory is obscured, however, by the use of confusing language that lends ambiguity to its inherent concepts. Some, but by no means unanimous, agreement exists that an object relations approach is better designed for problems that date back to early ("pre-Oedipal") life and that classical methods are more applicable to difficulties originating around a later ("Oedipal") period. There is a difference of opinion as to whether the improvement achieved with borderline, narcissistic, and other serious personality problems may not be due to the greater activity and empathic involvement of the therapist with the patient rather than to the insights emerging from analysis of the transference. Moreover, conflicting claims continue to be made that narcissistic problems are actually variants of the Oedipal neurosis. Thus the introduction of object relations and other theories of

personality beyond classical metapsychology is felt by many orthodox analysts to be unnecessary.

In clinical practice most object relations analysts play a more active role than do their classical counterparts. Instead of operating as a blank screen onto which displacements from the past are projected, they actively participate in the relationship, and some actually play the role of the patient's previous objects or of aspects of the patient's self. In this way they influence the nature of the transference. Countertransference is actively watched and used, providing a keen view of the projective activities of the patient. Except for the repetition of old patterns, the relationship in object relations therapy possesses a momentum of its own.

There is agreement that a regression occurs so that patients live over early developmental stages. At first there is repetition in the transference of the state of fusion with the protective mother figure in the form of projection onto the therapist of the need for total need fulfillment. Separation anxiety is apt to emerge. As therapy progresses, ambivalence develops and the "good breast"-"bad breast" duality emerges toward the therapist or, as in group therapy, a dissociation of the opposing attitudes, one focused on the therapist-leader, the other on the group. The therapist must have the ability to tolerate and "contain" the products of the patient's "projective identification." The hope is that the patient will eventually be strong enough to reabsorb and tolerate disavowed aspects into the self-image. As the "good-bad" split becomes absorbed into the self, the "depressive position" develops. Soon concern about how the patient affects others and guilt feelings emerge, and jealousy replaces envy. Earlier identifications become integrated into the self, which in becoming consolidated enable the person to perceive others more clearly.

A number of attempts have been made to apply object relations theory to group work with children (Soo, 1985) and adults (Alonso & Rutan, 1984).

Criticism of Object Relations Approaches

Some therapists consider the contributions of object relations theorists advanced

and brilliant. On the other hand, a gathering group of dissenters, while admitting the ingeniousness of the developmental theories, question their validity. Perhaps the most extensive criticisms have come from Heimann (1966) and Calef and Weinshel (1979), the latter expressing reservations about the clarity of the theoretical conceptualizations and the usefulness of the advocated technical procedures. Others have branded current ideas about object relations pejoratively as a jerrybuilt structure of metaphor upon metaphor compounded out of a pseudo-synthesis of Kleinian, Bionian, ego-psychological, object relations, and other theories. These criticisms, it seems to me, are altogether harsh, for if the authors under criticism have done nothing else, they have challenged the sanctity of some existing metapsychological credendas and opened the way to a reassessment of their value. This does not certify concepts that modern researchers on development would consider questionable, such as some ideas about infantile development and ideation. Object relations theory is perhaps more tenable than tripartite structural theory in accounting for some phenomena of the borderline state, but it still does not embrace the multiple variables that enter into borderline personality formation.

Although some object relations theorists continue to pay homage to classical drive theory, there is a feeling among classical analysts that most tend to replace fundamental concepts with an overlay of secondary and derivative issues. The focus on "good" and "bad" maternal qualities, on basic dependency, and on developmental deprivation as the principal if not exclusive dynamic is considered myopic since it minimizes other crucial factors in the evolution of personality. Substitution of an innate need for attachment to an object (Bowlby, 1964, 1969; Bulent, 1968) for an instinctual libidinal drive is merely another way of saying the same thing with different linguistic terms. Similarly, Melanie Klein's challenge of primary narcissism, that the infant is involved with inner objects rather than oriented toward the self, is felt to be merely tautological. Repudiation of instinctual aggression by such theorists as Fairbairn evades the findings of neurophysiologists of subcortical centers for aggression. Reinterpretation of the Oedipus complex as less instinctually derived but rather rooted in loving and hateful attitudes toward objects, or due to conflict between warring aspects of the self, are labeled exercises in circumlocution and operations of verbal legerdemain. Kohut's emphasis on

infantile grandiosity and idealization as developmentally normal characteristics, rather than regressive and defensive operations, and his justification of playing an active empathic role to make up developmental deficits have been considered by classical analysts as an abandonment of some basic psychoanalytic tenets. The clinical data are interesting, but some therapists find the language and descriptions of self-psychology complex and confusing. They contend that Kohut has evolved a dynamic to justify his use of activity in his relationship with his patients. Since activity and empathy are very helpful in the treatment of sicker patients, such as those with borderline and narcissistic personality disorders, modifying the conventional passive psychoanalytic stance is helpful but does not require a modification of the classical developmental theory. Doing this has not endeared Kohut to the hearts of many orthodox believers.

The severest criticism has been leveled at the additions to developmental theory of ideas related to representational differentiation and integration of self and external objects. Here it is presumed that neonates cannot differentiate themselves from others nor discriminate between their own and their object's sensations. The first task of development, according to this idea, is to distinguish and separate self from object representations (usually the mother). This common notion is believed by certain authorities to be speculative and not in keeping with their opinions of child development, decidedly substantiated by modern developmental research (Kagan, 1971, 1978a, 1978b; Kagan et al, 1978) who point out that object relations theory comes from observations of psychotics and of patients in deep regression (as during a transference psychosis) who are *presumed* to be repeating what the normal person goes through in infancy. Studies of development, they contend, indicate that neonates are highly capable of differentiating themselves from objects. They downgrade the notion that infants are unable to integrate contrasting emotions as related to object representations (i.e., positive affects associated with the "all good mother" and negative affects associated with the "bad mother") or that infants are at first unable to synthesize "good" and "bad" affects into a combined representation of the total mother figure.

The second developmental task, according to object relations theorists, is to effect

synthesis of the "good" and "bad" mother, as well as the self-representations that issue from the developmental incorporation of the mother figure (the maternal introject). Under favorable conditions, this synthesis occurs with the evolvement of "object constancy" and the valuing of other persons for their true positive and negative qualities. This makes for consolidation of the self-image, acceptance of "good-bad" qualities within oneself, and a solid sense of identity and positive self-esteem. Failure in such integration is presumed to result in "splitting," an absence of self-object differentiation and delusional merging of self and object images predisposing to psychosis (Kernberg, 1975; Kohut, 1971; Searles, 1966). Causes of such failure are variantly attributed to constitutional predisposition, severe maternal deprivation, inconsistencies in care, mishandling, and cruelty. Milder difficulties in self-representation other than psychosis are said to occur where the damage is not so serious, resulting in (1) narcissistic personality disorders, who will require special kinds of management therapeutically (Kohut, 1971), and (2) borderline personality disorders (Kernberg, 1975) in whom "allgood" and "all-bad" self and object representations alternate and who also need special techniques. Again, these concepts derive from work on borderline and psychotic adults and have not been substantiated by modern researchers in child development (Bower, 1977; Condon and Sander, 1974; Dunn, 1977; Kagan et al, 1978; Le-win, 1975; Thomas and Chess, 1980).

Alternative explanations have been offered founded on empirical studies. For instance, detailed observations of infants have shown the presence of a need for investigation and exploration as a means to task mastery. The urge for social relationships seems also to be basic, and this is satisfied by mutual interactions of the infant and mothering figures, not as a fused image, but as separate and individually functioning beings. This does not detract from the ingenuity of the object relations formulations and even their usefulness in giving the therapist some model around which to organize interventions and to enhance confidence in what he or she is doing. Attempts that have been made, however, to explicate these ideas in "metapsychological verifications of psychic structures, cathectic shifts, or fusions and defusions of drive-energies" (Stolorow and Atwood, 1979) are extremely confusing.

PSYCHOANALYTICALLY ORIENTED PSYCHOTHERAPY

The utilization of supportive and reeducative tactics within a psychoanalytic framework has come to be known by a number of designations, such as "dynamic psychotherapy," "psychoanalytically oriented psychotherapy," and "insight therapy." Conceptually and operationally, psychoanalysis and psychoanalytically oriented psychotherapy are distinguishable (Gill, 1951, 1954; Bibring, 1954; Greenson, 1967). Nevertheless, there has been a tendency to lump them together under the banner of psychoanalysis, some analysts quoting Freudian scripture to justify this amalgamation (Fromm-Reichmann, 1950, 1954). Much debate and controversy has crystallized around these issues (Glover E, 1931; Alexander, 1954; Bibring, 1954; Fromm-Reichmann, 1954; Knight, 1954a & b; Rangell, 1954; Waelder, 1960; Tarachow, 1963; Wallerstein, 1966; DeWald, 1964). Nevertheless, the clinical usefulness of modified approaches is conceded since classical analysis is contraindicated in certain conditions. Uncovering and exploratory techniques that do not penetrate into infantile genetic sources or sponsor a regressive transference neurosis are considered helpful in patients with circumscribed symptom and character neuroses who possess sufficient ego strength to endure probing procedures. Here the therapist does not fully present as an object through whom gratifications are sought and obtained, as in supportive therapy; nor does the therapist stimulate the patient's unconscious fantasy system by posing obdurate therapeutic interpretation barriers to all transferential demands until a transference neurosis erupts, as in Freudian psychoanalysis. Rather, the therapist takes an intermediate position, offering himself or herself as a projective vehicle for some transference gratification while doing as much analytically interpretive work as the patient can tolerate.

Psychoanalytically oriented psychotherapy is thus the most active of all analytic therapies and maintains the greatest flexibility in the techniques employed (Stewart, 1985). By focusing on pertinent data, using active means of dealing with resistance, and bringing unconscious conflicts to awareness without resorting to deep regression to invoke a transference neurosis, much unnecessary time is claimed to be saved. The relationship is accordingly actively manipulated, transference is controlled, and certain

aspects of the relationship are stimulated. The focus is generally more on the present than the past and deals with limited rather than complete aspects of the personality. Recent conflicts more than past ones are in the forefront. Frequent weekly sessions, the couch position, and free association are only occasionally employed, if at all. Practical goals of bolstering defenses, promoting enhanced adaptation, and encouraging more effective interpersonal relationships are considered adequate, and a complete overhauling of the personality structure is considered a fortunate but serendipitous happening. Psychoanalytic psychotherapy therefore has a broader range of application than formal analysis and is adaptable both to problems of relatively healthy individuals and to sicker patients with whom psychoanalysis cannot be employed. The use of adjuncts, such as drugs, family therapy, and behavior approaches, is often resorted to as indicated by the immediate needs of the patient. Flexibility of operation is the keynote. Consequently, there is no accepted format, the design of treatment being determined by the therapist based on what is indicated at the time and his or her expertise with special adjunctive methods.

Perhaps the best known system of psychoanalytically oriented psychotherapy has been set forth by Alexander, French, and other members of the Chicago Institute for Psychoanalysis (1946). The therapy described, though of a short-term nature, is believed by the authors to yield results comparable to long-term standard psychoanalysis. Alexander and French stress the fact that they utilize the therapeutic situation as a corrective emotional experience. It provides a new and more favorable medium in which the patient is exposed to, relives, and finally masters the conflicts and emotional problems he or she was unable to handle as a child. This is achieved either in the transference relationship or outside of therapy in real life. Not only does the patient overcome unresolved childhood conflicts by reliving them—which makes them less acute—but the therapist also responds to the patient and to the patient's behavior in a manner totally different from that of the parent. This gives the patient an opportunity to revive his or her past and to face conflicts over and over again under the guiding aegis of the therapist. Activity in the therapeutic situation is said to accentuate the corrective experience.

The authors recommend such modifications in technique as direct interviewing, in

addition to free association; the regulating of the number of sessions each week; the offering to the patient of advice and suggestions about certain aspects of his or her life; the interrupting of therapy for a variable period prior to ending treatment; the manipulating of the transference in each patient in accordance with the needs of the patient; and the employing of real-life experiences as a part of the treatment process. Flexibility in method is advocated with a change of technique periodically to suit the patient's personality as well as problems. While the transference relationship is believed to be important, extratherapeutic experiences are considered of equal importance. Positive transference is encouraged to establish rapport and to enhance therapeutic progress. Negative transference is analyzed when it blocks the process of therapy. Emphasis is more on the relationship than it is on the transference neurosis. The experience of mutual frankness and sincerity in relationship to the therapist makes it possible for the patient to reorient to other human contacts.

F. Alexander (1965) has reemphasized that psychoanalytic psychotherapy acts as a restitutive medium that the therapist actively manipulates, scrupulously avoiding repeating the traumatizing circumstances of the patient's childhood no matter how provocative he or she may be. Once the therapist becomes alerted to the nature of past hurtful experiences with parental figures, the therapist may, by design, act in a way completely opposite to that of the parent so as not to bring to pass the patient's expectations. Control of transference is vital. Another technique is to change the frequency of interviews at certain phases of treatment to make the patient conscious of dependency needs by frustrating them. Experimental temporary interruptions in therapy are also useful. Overtreatment, with its regressive dependency, should be avoided by reminding the patient that treatment will be made as short as possible. This discourages procrastination in facing up to important issues. The search for early memories is not as important as dealing with the present and with immediate life problems. Avoidance of a "parentifying" transference so as to enable the patient to take over his or her own life management as rapidly as is feasible is urgent. While these techniques are not applicable in all cases, the majority of patients, according to Alexander, can benefit from them. Results justify the modification of formal psychoanalysis in many patients.

Psychoanalytic psychotherapy supports many different modes of operation unique to the personalities and styles of therapists. These are sometimes unjustifiably described as revolutionary, but almost invariably they are merely adaptations of earlier forms of treatment. For example, many have drawn inspiration from the "sector therapy" of Felix Deutsch (1949a & b; Deutsch & Murphy, 1955). This is a goal-limited therapy "conducted so as to work on the unconscious factors that influence the reality situation rather than the reality situation itself." Focus is on a limited portion of the total problem, the object being to adjust the patient to an aspect of life that hitherto he or she has been unable to master. An "induced positive transference" is employed, and "associative anamnesis used in lieu of free association." Here the technique essentially involves a focusing of the interview on symptoms and conflicts by accenting key words and phrases that the patient has used and that reflect basic problems (Deutsch, 1939). The therapist picks a few of the most frequently employed words or expressions, incorporates them into the conversation, and observes the reactions of the patient. The key words and phrases uttered by the therapist usually stimulate associative ramifications in the form of free associations. The associations are guided, however, and their continuity is maintained. Through this means, manifest symptoms and current problems are linked with underlying conflicts. The constant confrontations by the therapist serve some of the purposes of interpretation. Memories are revived; associative chains are broken up and replaced with new ones. Through this form of interviewing, the patient purportedly learns to discriminate the past from the present and his or her ego is induced to alter its defensive attitudes.

Illustrative of the many innovations that have been introduced into psychoanalytically oriented psychotherapy is the "objective psychotherapy" described by Karpman (1949). He assigns to the patient a series of written questions dealing with the patient's history, attitudes, and feelings. The patient is requested to write out detailed answers to these questions. After reading them, the therapist picks out pertinent points and formulates new questions to which the patient is expected to reply. Reading material may be given to the patient that is related to his or her problem, and the patient's reactions in writing are requested. Dreams are written by the patient, and interpretations to these are handed in written form back to the patient for leisurely study. Formulations of

the dynamics are made in writing from time to time by the therapist, and the patient is requested to study these and to turn in written comments. *Focal therapy* is the name given by Balint et al. (1972) for a concentrated short-term form of insight therapy. To qualify for this treatment according to the authors, a patient has to be able to establish a reliable therapeutic relationship with the therapist, the illness needs to be ego-dystonic and not a valuable part of the patient's personality, interpretations made by the therapist must be acceptable to and acted on by the patient, t.nd both parties should agree on a suitable specific focus (a "meeting of two minds"). The focus often is on crucial unconscious conflicts, the resolution of which will, one hopes, make at least a limited impact on the patient's character structure. Occasionally, as therapy proceeds, the focus has to be modified and even changed. The technique calls for greater manipulativeness than is customary in psychoanalysis, although interpretation is still the basic intervention. The theory of treatment and of the involved psychopathology are psychoanalytic, but the method is distinguished from true psychoanalysis by its inherent activity, the abandonment of free association, and the avoidance of a transference neurosis. Since its early presentation, the term "focal therapy" has been appropriated by therapists of various orientations as a label for short-term treatment targeted at various foci (symptoms, behavior difficulties, personality problems, situational crises), and psychoanalytic techniques are commonly employed.

George Goldman (1956) has written on "reparative psychotherapy," which is eclectic in nature, utilizing various supportive and insight approaches depending on the needs of the patient. The external manifestations of the problem are first handled in dealing with the disturbed behavior and reality situation. Gradually there is a working toward emotional factors, including the defenses. The primary aim of "reparative therapy" is the modification or relief of symptoms. A secondary goal is improvement of adaptive functioning. A hoped-for objective is growth of the individual toward greater maturity or capacity. Deep-seated characterological change is not considered a target in reparative therapy, although reconstructive successes may on occasion be scored.

An interesting psychoanalytically oriented "humanistic" "third force" approach is

that of *Gestalt therapy.* Drawing from gestalt theory and employing concepts from psychoanalysis, Perls, Hefferline, and Goodman (1951) evolved a transactional form of therapy that proposed to bring fragmented elements of personality into a unified whole. Ideally, it was theorized, an object ("figure") and its field ("ground") should blend into a harmonious assemblage (Gestalt), the interplay constituting a balanced unit of emerging and receding "figure" and "ground." According to this theory, neurotic and psychotic individuals, because to their rigidity (fixation) or imperfect "figure" formation (repression), are burdened with defective split-off Gestalts. These make for confusion, anxiety, and the various symptoms of emotional illness. It follows that the psychotherapeutic focus must take into account both the individual and the environment as well as their subtle interaction with one another. This task necessitates a search for repressed material, the mechanisms through which repression is maintained, as well as the specific needs for repression. To organize a mature figure-ground Gestalt, which is the essence of maturity, it is essential that the individual restore to his or her total being the split-off and dissociated aspects of himself or herself. Guidance in bringing these to awareness is indispensible. More important, an adjustment to the present situation is fostered by presenting actively to the patient a series of "therapeutic experiments" that provide a dynamic educational experience. Not only does the patient learn through this about the repressed and repressing self, but he or she is also faced with graded challenges that help in mastering fears and blocks. The creative resolution of elements of unawareness, which is fostered by the experiments, is said to restore the individual to personality integration and constructive contact with reality.

The function of many of the experiments is to integrate alienated aspects of the self. One technique is to animate and hold conversations with parts of one's body that feel tense or people and objects in dreams, or one with fantasized parents and other important personages. During this dialogue, the patient acts, feels and talks as if he or she is actually the object or part object. Sometimes the "empty chair" technique is used, the patient being urged to imagine a parental or other important figure sitting in a nearby empty chair and then to talk to, upbraid, or question the visionary occupant. This may be followed by changing seats and acting the part of the person or object with whom there has been a

dialogue. A great deal of emotion may be liberated in the process. The therapist in the meantime questions, challenges, and confronts the patient about the behavior and evasions, at all times insisting that he or she take responsibility for his or her actions. Group work may be an integral part of therapy, and many of the techniques of psychodrama, such as role reversal, are employed. J. A. Greenwald (1972) has outlined a number of useful ground rules for Gestalt therapy.

During the last years of his life Perls was active at Esalen Institute in California, elaborating on a number of active techniques and gathering around him a large number of followers who enthusiastically worked with his methods, the flavor of which may be gathered only from reading recordings of his interviews, listening to his cassettes, or watching his films. An interesting conversation with Perls is published by Clements (1968).

Gestalt therapy enjoys a great popularity among younger generations of psychotherapists principally because of its dramatic techniques. Gestalt Therapy Institutes have been organized in various parts of the country offering workshops in the method. Some of the Gestalt techniques are utilized periodically by therapists of various schools as a means of stirring up activity in treatment when movement is deemed necessary. Not all therapists are capable of doing this, however, particularly if they have no confidence in the methods or believe that they are too contrived and artificial. Not all patients can handle the challenging and confronting manner of the Gestalt therapist. A good working relationship is required for this, and if attacks on neurotic ego-syntonic behavior are launched prematurely, the patient may be driven out of treatment. Borderline patients particularly cannot tolerate the attacks. The anti-intellectual stance of Gestalt therapy has as its emphasis the undiluted, direct experiencing of emotions. The gimmicky quality of the techniques have come under attack by more conventional therapists. Some of the Gestalt techniques have nevertheless been incorporated into other therapies. Such therapies draw from the inventiveness of the leader in devising interventions toward integration of split-off aspects of the self. Responsibility for one's actions is constantly stressed with the need to resolve the "unfinished business of the

past," to abandon "phoniness" for true self-awareness, to liberate oneself from the "computer" within one's mind which delivers false messages, to discard useless hoped-for illusions and goals, to stop looking for the "why" instead of the "what" and "how," and to give up banking on help from others (including the therapist) rather than oneself since that is a "sick game."

Used by qualified professionals, selected Gestalt techniques may, during individual therapy or in groups, help break through resistance in rigid, guarded individuals who are then provided with opportunities to work through their liberated memories and emotions. Rigid adherence to the theories of the founders of the Gestalt movement may tie the therapist into a bind, however, particularly in relation to the management of the ubiquitous transference and countertransference eruptions encouraged by the great activity inherent in the treatment process.

Other analytically oriented approaches have been designed, limited only by the originality of the authors, that employ various degrees of activity. These range from a mere pointing out by the therapist of destructive coping mechanisms (which may be helpful to some patients with a strong readiness toward change) to interpersonal provocations within the therapeutic relationship that are calculated to mobilize defenses and resistances. Instead of responding to these in traditional ways, the therapist challenges and even opposes them. Deliberately created by the therapist in some cases is a state of crisis to which the patient will react with frustration, bewilderment, rage, and other reactions which are superimposed on his or her habitual defensive operations. It is at this point that the skill and stability of the therapist are taxed to the limit. If a working relationship and good communication with the patient has been established, with appropriate management of any countertransference, the therapist may be able to support the patient through the upheaval, firmly standing ground, while manifesting empathy and understanding. The patient is confronted with two situations: either he or she leaves therapy or changes. One hopes the latter contingency will prevail.

Criticism of Psychoanalytically Oriented Psychotherapy

The marriage of non-analytic and analytic techniques has, in some circles, not been too happily received, non-analytic therapy being regarded as a kind of ravenous cormorant who eventually swallows, digests, and destroys its marital partner (Waelder, 1960). The progeny of this wedlock, too, in the form of specific procedures, are regarded by some analysts as monstrosities conceived through the mating of opportunism with clinical expediency. Criticism is expressed to the effect that transference is watered down by the active techniques employed. The consequence of avoidance of a transference neurosis is said to be a limitation of the extent of insight achieved. The inevitability of circumscribed goals in treatment is also presented as an objection. Additionally, the concentrated short-term techniques employed are believed to be dangerous in the hands of any other than the most highly trained and experienced psychoanalysts. They are unfortunately apt to appeal to therapists who, while not trained in psychoanalysis, are searching for dramatic unrealistic psychoanalytic shortcuts. To these criticisms adherents of psychoanalytically oriented psychotherapy reply with accounts of greater effectiveness in the management of patients, over a relatively brief period, who would not be suited for the classical approach, which is applicable to a limited number of individuals.

TRANSACTIONAL MODELS OF PSYCHOTHERAPY

In recent years a form of psychotherapy has come into prominence, the therapeutic focus being the ongoing transactions that take place between patient and therapist. The elicitation of defenses that the patient employs, the understanding of the roles that he or she plays, and their "working through" within the relationship have been credited with influencing various dimensions of personality, including interpersonal and intrapsychic components. In establishing the theoretical foundation for transactional therapy, concepts have been adapted from field theory, communication theory, game theory, and role theory, especially the latter two.

Game theory, which was developed by Emile Borel, John von Neumann, and Oskar Morgenstern for the study of competitive economic behavior, attempts to analyze conflict in mathematical terms by abstracting common strategic elements controlled by the

participants. The theory is applied to various kinds of conflict situations, including neurotic behavior and patient-therapist transactions, conceiving of the maneuvers as chosen strategies employed by the "players" under established "rules" that will bring about a favorable outcome ("payoff"). Rationality is stressed, the players presumably taking into account in their "bargaining" situations various calculations of risk.

In role theory society is regarded as an aggregate of persons with common goals whose positions enjoin them to assume specialized roles. The individual, constituted of values, traits, and attitudes (including "self"), develops action systems as a result of the interplay of self and role. Role theory deals with reciprocal relationships that go on between people. It also embraces the interaction of self and role. It contemplates personality as a tapestry of role behavior, of role perception, and of self-perception in the matrix of role.

The conventional definition of role as employed G. H. Mead (1934) regards it as the pattern of attitudes and actions an individual exhibits in social situations. This is molded by one's status or position in the social structure, which obliges one to behave in certain ways. Special actions are expected of persons occupying certain roles ("role expectations") that meet some need in the social system (Parsons & Shils, 1951). The individual consequently organizes behavior in order to fulfill role expectations. Thus the student assumes with the teacher the role of learner; the teacher, the role of educator. The child learns that under set circumstances behavior in certain ways is expected. Conformity brings rewards: revolt results in punishment. The little boy finds that his roles in society, his privileges, and his liberties differ from those of a little girl. As he matures, his role expectations and behavior change. Juveniles, adolescents, and adults perform differently both through intentional instruction and through incidental learning.

The individual ("ego") utilizes many roles at various times and under varied situations with different people ("alters"). When a role coordinates with that which the individual is expected to play, he or she is in relative equilibrium (a state of "complementarity"). When role complementarity is upset, disequilibrium follows with

ensuing tension and anxiety that nurture neurotic disturbances in self-evaluation and difficulties in interpersonal and group relations. Roles may be conscious and explicit or shunted from awareness and more or less implicit. In the latter case the roles usually reflect early identifications, such as mother-child, teacher-child relationships. These identifications are only partly expressed in social roles; some are neutralized and locked in. The expressed roles force the individual to repeat compulsively time-worn and habitual pathological patterns.

Ambiguous role expectations lead to conflict and to socially invalid role enactments. For example, many women in our culture, tending to equate some aspects of the feminine role with inferiority, resist complying with certain role expectations. Indeed they may seek a solution to their conflict by assuming a masculine role in some areas of adjustment. Role conflicts in such instances are inevitable. To some extent role conflicts encompass all human beings, since in certain areas of functioning every individual occupies two or more positions simultaneously and is unable to live up to all of his or her role expectations. The degree of role conflict and the inability of the individual to evolve adequate defenses to the dilemmas posed by one's ambivalencies will determine their pathogenicity.

The role an individual believes must be played in a social context is a product of perceptual and conceptual fields, which involve past experiences and embrace many intrapsychic processes. The overt factors of role perception (for instance, the acts and appearance of others) are colored and even distorted by internal needs and conflicts. Thus, when excessive dependency is a lingering impulse not resolved in the course of maturation, the individual will implicitly assume the role of child with any person whom he or she perceives as an actual or potential parental substitute. The specific position assigned to the parental symbol will be that of authority. When the symbol does not come up to the demanded role expectation of being and acting as the authority, conflict may ensue.

Though the unconscious is not acknowledged by some role theorists, its operations are present, prompting motivations that dragoon the individual to act out roles in

opposition to traditional role expectations. Role enactment then may not validate the expectations of the person or persons with whom the individual is relating. This can give rise to conflict leading to mutual retaliation and other defenses. Multiple roles are the rule: the richer the repertory of role potential, the more flexible and integrated the individual (Gough, 1948; Cameron & Margaret, 1951).

Role theorists regard the self as an intervening variable that can be approached through role concepts. The elusive entity of the self is an aspect of the total cognitive organization, an inference derived from interaction with other persons, objects, and events. The self evolves as an organization of qualities, the result of maturational and personal-social experiences. Its formation is involved with the principle of "constancy," the need for homeostasis in the child bringing about responses that invoke the aid and intervention of other individuals. Awareness by the child of the "somatic self" that embraces tensions is the basis of the differentiation of self from noneself. External events become associated with tension reduction, and the child's perception that certain motor activities on his or her part in relation to others lead to events that eliminate tension acts as further support for the foundation of self. Toward the end of the first year a new cognitive structure is laid down in the form of gestures and other forms of communication that enable the child to differentiate persons and objects from the acts of persons. At the same time there is discrimination between self-acts that are approved or disapproved. Perceiving, identifying, and conceptualizing of roles and role expectations are elaborated as symbolic development expands. The self-concept in role theory is thus intricately related to the socialization process and to reciprocal role playing with many significant persons. Out of such interactions there evolves the "social self." Difficulties in development result in "fixations" of the self concept on primitive or less mature levels than the "social self."

An interesting finding issuing from psychoanalysis that relates to the development of role expectations is that the child will divine, by uncanny perception, the verbally unexpressed but, nevertheless, obvious unconscious designs of the parent with whom he or she identifies. There is an acting out either as a child or later in life, some of the

unconscious parental needs and demands. Antisocial tendencies are often a reflection of the unconscious urges of parents, who, in their eagerness to conceal these promptings, give them undue emphasis in the form of warnings, reaction formations, defenses, and symbolized expressions of repudiated drives. The parent may also confuse the child as to roles by alternately encouraging (seducing) and punishing (rejecting) the child.

Harmony between the self and role enactment is one of the measures of adaptation. Performances to satisfy role expectations that are incongruent with the self (self-role conflicts), or two or more role expectations that clash with one another (role-role conflicts), will interfere with adjustment. Ego-defense mechanisms are elaborated to reconcile such differences and to maintain a constancy of the self in the face of expressing such discordant role expectations. Many self-maintaining mechanisms, such as the evolvement of a rationalizing philosophy, are implemented to support incongruent roles that are regarded as essential for adjustment. When self-maintaining mechanisms fail, neurotic defenses may be exploited to bolster the self. If "constancy" (homeostasis) is still precarious, autistic and desocialized role enactment may come about. When two or more roles are incompatible, and institutionalized forms are not available to reconcile opposing role enactments, conflicts may also ensue with eventuating defensive and disorganizing tendencies. A number of transactional models have appeared. Illustrative are those elaborated by Berne, Grinker, Haley, J. Rosen, and Whitaker and Malone.

The Transactional Model of Grinker

A transactional approach is described by Roy Grinker (1961) that consists essentially of focusing on the roles the patient and therapist are playing with each other while taking into account the current environmental influences.

Posing the question as to whether it is possible to set up a model of psychotherapy based on empirical operations rather than on a theory of psychodynamics or diagnosis, Grinker contends that personality cannot be understood through intrapsychic processes; rather, it is best considered as a system of interactions among human beings within a social organization. In therapy both explicit and implicit roles constitute the transactions

between therapist and patient. Complementarity of roles is evidence of stability and permits communication of information. Noncomplementarity may lead to disequilibrium, which then promotes the establishment of a new system and modification of roles. During the therapist-patient transaction old roles, preconscious and unconscious, are revived and their origins in past experiences come up for discussion. Both therapist and patient are involved in this transactional process, each acting on the other with a constant feedback of respective roles. As the patient reveals through communication the desired relationship with the therapist, the latter interprets the designs of the patient in the hope that this learning will generalize to other relationships. In the communication with the patient the therapist freely discusses his or her positive and negative feelings. Refusal to play the role demanded by the patient will mobilize defensive reactions in the patient. But if the therapist stands firm, new solutions will be sought. Among the techniques are the following: focusing of the interview on the ongoing transactions in therapy rather than past experiences; the use of pointed directiveness, confrontations, and challenges; a firm curbing of acting-out; avoidance of silences; employment of dreams only as a source of information without interpretation; the extension of support when needed; and avoidance of a transference neurosis. The patient is discouraged from using childish and immature forms of communication by interpreting their function and is encouraged to experiment in relationships outside the therapeutic situation. This orientation, writes Grinker, "facilitates a vivid, current understanding of the patient without recourse to reified variables, of unconscious, transference, countertransference, resistance, topological foci, processes involving energy, or any past functions of the human being in behavior."

The Transactional Model of Haley

Another approach is that of Jay Haley (1963b), who considers the therapeutic process a communicative transaction between the therapist and patient. According to Haley, the essence of what happens in all forms of treatment is the determined struggle for control between therapist and patient. Each of the participants is bent on winning this contest: the patient, through the ploys of symptoms; the therapist, through varied contradictory confrontations ("therapeutic paradoxes") presented to the patient

adversary.

Human beings relate through an interchange of messages that define the nature of their relationship. A "symmetrical" relationship is one in which each person initiates action, criticizes, offers advice, and otherwise shows essentially the same type of behavior. Such a relationship tends to be competitive. A "complementary" relationship is one in which different types of behavior exist, interlocking with each other: for example, one teaching, the other learning; one giving advice, and so on. Relationships are never completely stable; they keep shifting as people grope for a definition of their relationship. Maneuvers in a relationship consist of requests, commands, and suggestions that another person think, say, feel, and act in certain ways, as well as comments about the partner's communicative behavior. Relationships become pathological when one person attempts to circumscribe the other's behavior while denying that he or she is doing this. For example, a directive may be delivered, then qualified with the statement that it does not have to be followed. Out of this conflict a series of paradoxical communication patterns evolve.

Psychopathology may be viewed as a set of maneuvers to gain an advantage, namely, the control of a relationship. Psychiatric symptoms offer the patient advantages by setting the rules for relationships and by making the social world more predictable. Under these circumstances therapy must aim at preventing this usage of symptoms while encouraging other ways of handling relationships. Exposing himself or herself to therapy, however, poses for the patient the threat of giving up his or her habitual control over relationships. A duel for control can be expected, therefore, though this may be vigorously denied by both patient and therapist. It is vitally necessary, however, that the therapist deal successfully with the question as to who will control the relationship—the therapist or the patient. The resolution of this question is the basis for therapeutic change. If the patient wins, he or she will perpetuate the problems by governing the relationship with the symptoms. If the therapist gains control, the patient will have an opportunity to change. The stratagems that the therapist must employ in winning control are, therefore, the crux of treatment.

Stratagems are used in all therapies. In directive approaches, for instance, the therapist may tentatively align with the resistances of the patient and his or her need to retain symptoms. Permission having been given the patient to embrace the symptoms on the therapist's terms, the patient is then extorted into yielding them by various devices. In deconditioning techniques the principal agency is not desensitization, but the therapist's taking control over the patient's behavior and the patient obeying the prescriptions of the therapist and operating under the latter's terms. In nondirective therapy, therapists, even though they imagine themselves to be uncontrolling, do not give in to the controllingness of the patient and actually establish themselves as the agency in control. Insight leading to self-awareness is not essential; transference interpretations need not be made; and connections established between the patient's past and present are dispensable.

Thus, in evaluating the effects of psychoanalysis, Haley suggests that exploration of the human psyche in quest of insight is irrelevant to change. It is not self-awareness that promotes health; interpersonal transactions alone are responsible for any transformation that develops. Emphasis on internal processes (such as the unconscious), resistances, and mechanisms of defense are diversionary from what is more significant, namely, that in silence and nondirectiveness the therapist is subtly demonstrating that the patient cannot control the analyst's behavior. From the start the analyst gains the upper hand, though there is denial that the patient is being directed, thereby facing the patient with a paradox. Another way of establishing control is for the analyst to interpret that which the patient ostensibly knows nothing about—his or her unconscious. Any disagreement is classified as resistance. Moreover, crediting the patient's symptoms to deep symbolic forces within the patient prevents the patient from manipulating the therapist through the symptoms. Even philosophical therapies, such as Zen Buddhism, operate through the principle of changing the student's conception of reality by controlling the student's thinking through the setting up of paradoxical situations.

In summary, Haley contends that what causes change in psychotherapy is not self-awareness brought about through the divulging of the operative dynamics, conscious or unconscious, or deconditioning, or any of the other factors commonly ascribed to the

healing process, but the resolution of the therapeutic paradoxes that appear in the relationship between psychotherapist and patient. During therapy a number of paradoxes are presented to the patient in the form of contradictory demands (these are deliberately planned therapeutic strategies that generally take the form of wresting control from the patient) to which adjustment will be required with completely different problem-solving tactics than are customary for him or her. Cure is registered when the patient does not really care whether the therapist is controlling or whether the patient is at the helm. Effectuated then are new and healthier strategies in interpersonal relationships. In the process of resolving the paradoxes in therapy the individual stops employing symptoms as modes of control. The first paradox that confronts the patient during treatment is that he or she enters "voluntarily" into a therapeutic relationship that, at the same time, is actually compulsory in terms of the rules that are being set. The second paradox is that the therapist who professes an interest in the patient actually is performing a paid service. Is he or she seeing the patient because of desire or because of discharging a duty? Why, if as interested as the therapist seems to be, will the therapist not socialize with the patient? The focus of the therapeutic process is the relationship with the therapist. Regardless of the theoretical system and the techniques employed, the real drama is shifting the balance of control from the patient (by symptoms) to the therapist. Gradually the balance tilts from a helper-recipient (complementary) relationship to a cooperative (symmetrical) one. It matters little, according to Haley, what particular brand of therapy one practices so long as strategies employed wrest control from the patient. Diverted from customary modes of manipulating relationships through the perpetuation of symptoms, the patient progresses toward different and more realistic approaches to problem solving.

The Transactional Model of Berne

Eric Berne (1961), utilizing concepts from psychoanalysis, communication theory, and game theory, has succeeded in developing a system of "transactional analysis" that delineates some of the processes operating in interpersonal relationships in simplified terms, which makes them palatable to the average person. By restricting and focusing transactional operations on several common and universal groupings, it is possible with

this technique to bring patients to an awareness of certain basic characterological defects in themselves and others in a rapid and dramatic way. Because the transactions between people are described as "pastimes," "games," and "scripts," and because they are tagged with humorous, salty, and quippish labels, the patient develops a tolerant and understanding attitude toward the frivolities of other human beings, while becoming critically understanding of his or her own histrionic interplay with people. Ego-syntonic attitudes, ordinarily difficult to acknowledge, are then isolated as playful absurdities that yield a dubious "payoff." The patient learns to laugh at himself or herself and soon to inhibit various operations as ego-alien. As a short-term process, practiced individually and particularly in groups, easily taught to professionals, "transactional analysis" may serve a useful purpose for some patients, provided that it is not blown up as the ultimate answer to all the problems in psychotherapy.

Berne conceives of human relationships as repetitive sets of social maneuvers that serve a defensive function and yield important gratifications. Such maneuvers take the form of "pastimes" or "games" that people play. These may be simple stunts, or they may be elaborate exercises that follow an unconscious life plan or "script."

Manifested in all persons are three different "ego states": first, the *child* within the person, a regressive relic of the individual's archaic past, hence an aspect of his or her "archaeopsyche"; second, the external parental agency *(parent)*, whom the person has incorporated through identification, the "exteropsyche"; third, the grown-up, mature, reasonable "data-processing" *adult* self, the "neopsyche." Each of these aspects of the person perceives reality differently: the child part, prelogically and distortedly; the parent part, judgmentally; the adult part, comprehensively on the basis of past experience. The three states are constantly operating in response to the needs of the person and the kinds of pastimes and games that he or she is indulging at the time. For example, in response to a story about embezzlers, the *parent* acts moralistically (i.e., plays the game "Blemish"), the *adult* is interested in how the embezzlement was managed (i.e., plays the game "Accountant"), the *child* acts naively and thinks of how interesting it would be to perpetrate the embezzlement (i.e., plays the game "Cops and Robbers"). The three ego

states may come into conflict with each other, symptoms being the consequences of relics of the *child* struggling with relics of the *parent,* both "contaminating" the *adult.*

During therapy, the three ego states, displayed in the relationship with the therapist, are interpreted to the patient. The function of *child* and *parent* within the patient and the origin of these states in the life history are ventilated. The irrational defenses the patient employs to justify them as adult operations eventually become clear. Ultimately the *adult* becomes stronger and displaces the *child* and *parent.*

Prior to engaging in transactional analysis, the therapist makes a diagnosis through "structural analysis," by becoming sensitized to the patient's demeanor, gestures, vocabulary, and voice in order to determine which ego state is exhibiting the symptom or is responsible for disturbing characterological features. Psychopathology is designated and rephrased in terms of the *parent-adult-child* trilogy ("the cathexis of anthropomorphic precipitates"). Thus, hallucinations are usually exhibitions of the *parents,* utilizing the audience of the *child* and sometimes the contaminated *adult.* Delusions are generally exhibitions of the *child,* which contaminate the *adult.* Depersonalization is a manifestation of somatic stimuli, distorted by the confused *child,* which are incomprehensible to the *adult.* If the stimuli become ego-syntonic to the *adult,* they are transformed into delusions of bodily change. In hypomania the *child* excludes the *parent* with the cooperation of the contaminated *adult.* If this changes to mania, the *adult* as well as the *parent* become overpowered by the "hypercathected" *child.* Conversion hysteria is an exhibition of the *child* that has excluded the *adult* through repression. Character disorders and psychopathies are manifestations of the *child* living in agreement with the *adult.* Impulse neuroses are eruptions of the *child* without the cooperation of the *adult* or *parent.*

The therapist also operates with maneuvers from his or her *parent, adult,* and *child.* It is presumed that these will act in concert for the benefit of the patient. Often the *child* in the therapist will be able to perceive aspects of the patient's *child* and *parent* intuitively and subconsciously. The function of the therapist depends on the problem being considered; for instance, the therapist may, where repression dominates, have to break

down the barrier to enable the *child* in the patient and therapist to talk together in the presence of the acting *adult.* The internal operations of the patient are regarded as akin to those of a multiple personality, the patient eventually learning to view personal maneuvers through the lens of whichever of the three ego-states are active at the time.

The preliminary "structural analytic work" of the therapist (which incidentally is usually accomplished in two or three individual sessions), in addition to making a diagnosis, consists of "decontamination," "boundary work," and "stabilization" to enable the *adult* to control the personality in the face of stress. Thereafter "transactional analysis" is employed, often in a group setting, to help the *adult* maintain social control despite the activities of other people who seek to stimulate the patient's *child* or *parent.* Transactional analysis in a group is usually followed by "game analysis" and, ultimately, by "script analysis" in which complicated life plans exist. In the group the transactions among the constituent members, consisting of a transactional stimulus and transactional response, are analyzed. A stimulus from one *adult* may be made to another *adult,* but the *response* in the latter may be that of the *child* or *parent* ("crossed transaction"). The stimulus may be from *child* to *child* or *parent* to *parent.* As long as the vectors are not crossed, the conversation will proceed smoothly ("complementary transactions"). Crossed transactions may be interrupted by the intervention of another member of the group or by the therapist, who attempts to bring the transactions back to the *adult* level. In this way the group members learn to diagnose each other's ego states as well as their own.

The engagements within the group (indeed in all social intercourse) are in the form of pastimes (when transactions are straightforward), games (in which dissimulation is introduced), and scripts (complex sets of transactions). Pastimes are generally *parental* or *adult.* For instance, a *parental* type of pastime is "PTA" in which projections ("Isn't it awful?") of delinquency by others are mouthed, such as delinquent juveniles, delinquent husbands, or delinquent wives; or they may be adult, in which introjections of "Me too!" are admitted ("Why can't I be a good mother, father, hostess, whatever?"). Other pastimes are "psychiatry" ("Here's what you're doing") and its introjective parts ("Why do I do this?" and "Which part of me said that?"). The "Small-Talk" pastime consists of bits like

"General Motors" (comparing cars), "Who Won" (man-talk), "Grocery," and "Kitchen" (lady-talk). Pastimes are indulged for a variety of reasons, for instance, as a way of diversion, getting satisfactions, warding off guilt, and easing quiet desperation. In group therapy pastimes are considered a waste of efforts, although they are a preliminary means through which the group members size each other up before the "games" begin.

Transactions are of several types: complementary (well structured) and "ulterior." Games are ulterior transactions, containing a concealed motivation ("gimmick"). A common game played in a group is "Why don't you ... yes, but." *(Parent:* "Why don't you go to school if you want to be better educated?" *Child:* "Yes, but then I won't have time to bowl.") The "gimmick" in presenting an adultlike request for information or for solutions here is to gratify the *child* who presents himself or herself as inadequate to meet the situation. Other games (which are infinite) are "Schlemiel," "Alcoholic," "Wooden Leg," "Uproar," "Ain't it awful," "If it weren't for you," "You got me into this," "There I go again," "Let's put one over on Joey," "Do me something," "Gee, but you're wonderful, professor," "Harass," "Rapo," and "Now I've got the son-of-a-bitch." Each game involves a goal-directed set of exploitative complementary transactions. Patients may enter into various alternative roles in the games that they play. Complex sets of games (scripts) are transference phenomena, manifestations of infantile reactions and experiences derived from the need to repeat in acts the transference drama. For instance, women whose fathers were alcoholics often follow the script based on the "rescue fantasy" of marrying one alcoholic after another. Pastimes, games, and scripts are played out and analyzed as integral parts of the group process.

In summary, transactional analysis is a technique felt by Berne to be superior to current supportive and insight therapies, helping the patient rapidly to tolerate and control anxieties and to circumscribe acting-out, while retaining the values of rational therapy. Moreover, he believes it to be applicable to problems that are difficult to reach by conventional therapies, for example, psychopathic personality, borderline cases, mental retardation, and manic-depressive disorders. The technique is easy to grasp. (Berne claims it may be learned in 10 weeks and perfected in a year of supervision.) In addition, it

is well accepted by many patients. Its claim of universal applicability is, however, challengeable.

Several major schools of transactional analysis exist at present, most importantly (1) the Berne approach, (2) the Schiff "Reparenting" approach, (3) the Asklepieion approach, and (4) the "Redecision" approach, the latter three introducing modifications in emphasis and techniques in the original Berne method (Goulding, 1976).

Experiential Therapy

Experiential approaches downgrade experimental, technical, and intellectual methods as nonmeaningful in the treatment process. What is considered important is bringing up and expressing feelings. According to its exponents, only through this means can one actualize one's potential and thereby cure emotional illness. The traditional therapeutic doctor-patient alliance is rejected as the basis for personality change. Instead of anonymity, manipulativeness, or detached noninterference, the climate of the therapeutic relationship is one of empathic warmth, friendship, expressed emotion, and regard for the patient. Neither the problems of the developmental past nor the promulgation of present insights are considered important. The emotional encounter between client and therapist is the basis for significant movement, and defenses against proper relating are dealt with by confrontation and the assignment of tasks. Experiencing the encounter as a different mode of relating eventually leads to self-actualization.

The role of the therapist, it is proclaimed, is to liberate the affects of the patient that have been frozen and cause paralysis. This is best accomplished, not by interpretation, but by establishing a meaningful, deep, affective relationship through the therapist's playing a role with the patient that is different from the conventional "You need me; I don't need you" role. Toward this goal the therapist does not set himself or herself up as a "healthy authority," a paradigm of personality virtues who is falsely "objective" (usually a cover-up for the therapist's neurotic omniscience and omnipotence), a pose that is rejecting of the patient and demeaning to himself or herself as an adult. There is no reason, it is claimed, why therapy should not be a mutual growth process, the therapist exhibiting his or her

sickness and relating to what remains of the patient's healthy soundness, as well as the reverse. Such sincerity, it is presumed, can be remarkably ego-building for the patient.

Important exponents of this point of view are Whitaker and Malone (1963), who insist that the roots of psychotherapy are embedded in the matrix of the individual's biological being. Penetration to this dimension requires a unique management of the transactions between patient and therapist in which heightened emotional tension is maintained. Attitudinal and behavioral change are secured by a modification of the customary interpersonal relationship during the therapeutic hour. This experience incorporates emotional penetrations into the therapist's own child-self, which, projected onto the patient, results in self-treatment of certain aspects of the therapist through the patient. In the course of this complex interaction, the patient is said to liberate himself or herself from socially restricting reality-inhibiting roles. Acting-out by both therapist and patient is accepted and even encouraged, releasing energies previously entrapped in emotional conflict. An interlocking of the unconscious (id) aspects of the participants reflects itself in a joint fantasy experience characterized by mass body sensations and a primitive level of communication. In depth, this encounter is believed to be of the profoundest therapeutic advantage. The patient's acceptance of his or her unconscious fantasies and their unification with the conscious self is encouraged by the role of the therapist as a "good" parent who sees the patient as part of himself or herself. The techniques employed by the therapist are not as important as the activities in facilitating symbolic unconscious meanings. This is accomplished by the therapist's dissociating as many of the realities as possible from the immediate therapeutic experience.

At the start of treatment the therapist may respond to the patient with silence and nonverbal communication as a way of promoting transference and of understanding the symbolic meaning of the patient's communications and behavior. The therapist encourages the patient's plunge into fantasy by pointing out to the patient the therapist's own limitations and immaturities.

Various forms of physical contact, including aggression, may be executed by the

experiential therapist. Such objects as clay and rubber knives may be used, and sleeping during the session may take place, with a reporting of any dreams by therapist and patient as a way of promoting the mutual fantasy experience and "clearing things up." Out of the mutual encounter at the "gateways of unreality," therapist and patient are presumed to arrive at a better understanding of themselves and to achieve a heightened capacity to cope with reality.

Experiential therapy is often conducted in a group setting (see "Encounter and Marathon Group," Chapter 52) and may include many ordinary or unusual nonverbal interchanges.

In "direct psychoanalysis" J. M. Rosen (1947, 1962, 1964) has introduced a means of entering the private world of the psychotic and of interrupting the deeply neurotic or psychotic regression (pregenital and neoinfantile) in which the patient is seeking a hallucinatory or symbolic representation of the indispensable, exalted but deadly mother that he or she knew. Instead of evading the parental role thrust on the therapist, as in conventional analysis, the "direct psychoanalyst" accepts it, functioning as "a loving, omnipotent protector and provider" for the patient. With a psychotic person, the analyst acts like an idealized patent who has the responsibility of bringing up the child again. With a neurotic person, the therapist guides him or her parentally to maturity. Observing Rosen working with patients, a number of therapists have followed his methods and have attempted to detail in their writings the techniques of direct analysis (Brody, 1959; Scheflen, 1961; English, et al, 1961). While Rosen's technique in the hands of skilled, trained therapists establishes rapid communication with regressed patients, its advantage as a form of reconstructive therapy has been challenged. For example, a controlled follow-up study at the Psychiatric Reception Center of the Philadelphia General Hospital showed that the percentage of improved patients treated by direct analysis was approximately the same as the control groups (Bookhammer, et al., 1966).

Criticism of Transactional Therapies

The greater activity inherent in transactional methods, as in other

psychoanalytically oriented approaches, is believed by some observers to sponsor reparative and hence goal-limited tendencies that are more reeducative than reconstructive. A more passive approach, on the other hand, is said to permit the patient more readily, from his or her own growing resources, to appreciate transferential distortions and develop different ways of relating to others as a product of personal experience. Censured, also, is the minimization of insight as a constructive therapeutic force. Social insights acquired through manipulatory procedures rarely effectuate permanent change. The strongest criticism has been directed toward those transactional therapies that advocate a free, spontaneous interaction between therapist and patient, characterized by unrestrained physical and symbolic communication (aggression, physical contact, long periods of silence, joint fantasy), verbal and nonverbal. The emerging irrational experience, which may reach a psychotic level, is presumed to get at the core of problems. Since both the patient and therapist are encouraged to regress, there is said to issue out of this interaction mutual growth and maturity.

It is the "letting oneself go" and acting in an unrestrained way in the therapeutic relationship that have brought forth the greatest cries of disapprobation. This is because some transactional therapists have interpreted freedom in the relationship as an invitation to play the kind of role with patients that they need transferentially to project onto them. Thus, they assume the identity of the father, mother, sibling, God, devil, lover, persecutor, or whatever other figure is dredged up from their own or their patient's imagination. The more inventive and histrionic-minded the therapist, the keener the fantasy life of the patient, the more the eventuating drama takes on the aspect of a folie-a-deux. While the patient may register benefits from such tactics, as one can from any other kind of relatedness, and though better rapport may be established, particularly with psychotic individuals (such as occurs in Rosen's direct psychoanalysis), one should not be deceived regarding the depth and permanence of changes effectuated by such play acting.

Freedom of participation without control can give the therapist with neurotic problems a license for personal emotional catharsis and acting-out. This release has positive values for detached therapists who otherwise may find it difficult to relate and

who therefore respond more genuinely and spontaneously if they are able to express themselves verbally or to act with few or no restraints. Some patients are willing to accept the unconventional behavior of therapists on the basis that they are now dealing with new, easier, more genuine kinds of authority who can admit to certain weaknesses: some patients tolerate a therapist's unconventional acts because they feel sorry for or protective toward the therapist. They may even assume the role of "helper," considering the therapist as as patient, fulfilling in this way their own neurotic needs for control and dominant status. As long as a working relationship exists, patients seem to be able to adjust to an astonishing variety of provocations. In their eagerness to get well, they will make capital out of almost any kind of relationship. This criticism, of course, is not directed at all transactional therapists, but only at those whose personal problems are such that they interpret behaving naturally as meaning undisciplined expression of their feelings and impulses.

ANALYTIC GROUP THERAPY

The spectacular growth of group psychotherapy throughout the world attests to its general acceptance as an effective treatment method. Where its proposed objectives are toward reconstructive changes in the personality structure, methods are introduced that purportedly release growth potentials.

Among the earliest dynamic formulations was a paper by Lazell (1921), which described group work among schizophrenics in terms of psychoanalytic theory, and the studies by Burrow. In the early 1930s Trigant Burrow (1926a, b, c, & d, 1927) organized a group of "participant observers" as part of a research project to investigate human basic motivations, particularly destructive and pathogenic impulses. Observing his own and the reactions of his colleagues, Burrow (1924) evolved ideas about the "social neurosis" or "mass neurosis" (1926b), and he concluded that human beings were faced with phylic defect that fostered autistic self-reference (Burrow, 1933, Syz, 1957). The study of this ubiquitous defect he called "phyloanalysis" (Burrow, 1930). Since emotional prejudices prevented the individual from fully scrutinizing his or her own processes, Burrow

believed that these could best be approached through mutual interaction and self-disclosure in a group ("consensual observation"). A group, he found, helped to orient and resolve "man's unacknowledged self-centered and socially disruptive trend" (Syz, 1963). This was rooted in a preconscious primary identification with the mother, the basis for later stages in the child's development. Obsessive libidinal strivings were the product of an intrusion on this primary identification by objectification and cognition. Awareness of psychosomatic accompaniments of emotional blocking, in the form of oculofacial tensions, sometimes produced unexpected behavior changes, with a resolution of affect images (Burrow, 1941a & b). "The drive for self-justification and social approval gave way to an inclusive feeling attitude, to enhanced communication and a more direct application to immediate tasks, which outlasted the consciously induced attentional shift" (Syz, 1963). The focus on how attentional behavioral shifts could influence endo-organismic tension patterns differentiated Burrow's organismic from other group therapeutic approaches (Syz, 1936, 1957).

An integration of psychoanalytic theory into group process was to be expected as soon as psychoanalytically oriented psychotherapists became interested in groups. Among the earliest group analysts was Paul Schilder (1936, 1939, 1940), who, in working with criminals, described a method that combined autobiographical material with free association and dream interpretation. Wender (1940) employed a group analytic procedure in a hospital setting, and Sarlin and Berezin (1946) also reported an uncovering approach in group therapy.

Among the pioneer efforts to amalgamate psychoanalytic and sociological concepts were those of Moreno (1957), who very early in his career used the group method, and Wender (1940, 1963) and Slavson (1943), who outlined an analytic group process that they considered equivalent in every respect to psychoanalytically oriented psychotherapy. Slavson brought out that transference in the group was multiple, being directed toward various persons at the same and at different times. It could be positive or negative, but if progress was to occur, positive transference toward therapist and group members had to develop after analyzing and disposing of negative feelings. The group, essentially

patterned after the original family, fostered transference that was of parental, sibling, and "identification" types; in the latter case the therapist and certain group members served as identification models. The effect of the group was to dilute the transference, although the total consequence to the individual was a heightening of emotional feeling.

Shortly before the end of World War II Alexander Wolf (1950), applying himself to the "psychoanalysis of groups," endorsed the use of free association, dream analysis, exploration of transference and resistance, and the search for those early memories and experiences that were the forerunners of current characterological and symptomatic disturbances. Countertransference was also to be considered. Wolf advocated hetergenous groups of approximately the same age with a balancing of males and females. He believed this facilitated resolution of problems on the heterosexual gregarious plane. Excluded were psychopaths, alcoholics, stutterers, mental defectives, hallucinating psychotics, and hypermanic patients. The groups, which had eight to ten members, met two to three times weekly for 90 minutes. So-called "alternate sessions" were also introduced by Wolf; i.e., scheduled meetings of a therapeutic group without the therapist present were alternated with regular sessions held with the therapist. A number of individual interviews might be required before the patient was ready to enter the group. This, the first stage of therapy, was diagnostic. The patient was also prepared for group analysis by explanations regarding its theory and practice.

The second stage of therapy, conducted in the group setting, consisted of free associations organized around the dreams of the group members. Once good rapport developed, the third stage of therapy began. This consisted of each patient spontaneously free associating about the next, which resulted in a bombardment of the patient's defenses and exposure of conflicts. The patient learned which of the characteristics pleased the group and which disturbed them. In the fourth stage of treatment, resistances mobilized by the free associations of the group members came up for analysis. The fifth stage of treatment was concerned with analysis of transference—its identification and resolution. Recreating his or her original family in the group, each patient learned how he or she projected parental and sibling images toward members and therapist. Wolf claimed that

identification and resolution of transference proceeded more thoroughly and rapidly in a group setting. The sixth and final stage of treatment was characterized by planned conscious responses in the interests of the group and the individual. These replaced strivings of an irrational or compulsive nature engendered by the person's habitual character structure. More penetrating analytic explorations were possible in groups than in individual analysis because the "group ego," with which each member identified, supported an impoverished ego and heightened tolerance of anxiety.

In his later contributions Wolf, in conjunction with E. K. Schwartz, expanded the advantages of group over individual analysis (Schwartz & Wolf, 1960; Wolf & Schwartz, 1962). An important feature of group, they wrote, was the replacement of the omniscient ego ideal of the single therapist by the group ego ideal with which the patient could align. In this way the group enabled the patient to face social reality and "to become aware that his fulfillment can only be realized in a social or interpersonal setting." At the same time the authors depreciated the impact on the individual of group dynamics, considered by some other therapists to be a potent force in a therapeutic group. They considered group analysis essentially the psychoanalysis of the individual within a group rather than the analysis of the group.

Other psychoanalysts also experimented with methods that drew on psychoanalytic theory. Sutherland (1952), for example, stressed that psychoneurotics could be helped adequately in group therapy only if a change was brought about in them through the resolution of their unconscious conflicts. He contended that group therapy could be conducted along strictly analytic lines in order to achieve this purpose. Somewhat similar points of view were emphasized by S. H. Foulkes (1948) and Ackerman (1950). Ezriel (1950, 1952) listed three hypotheses related to a method of applying psychoanalytic theory to group therapy. The first was that unconscious feelings toward past authoritative personages were projected onto figures in the social environment. The group provided an opportunity for such multiple transferences. The second was that a common group tension developed that involved all group members and elicited in each person unconscious fantasies that had a common denominator. Each member assumed a role in a

"drama," enacted in the session by the group. This brought out the individual's particular defense mechanisms. The third hypothesis dealt with interpretations that were made to the group members. These were given in relation to the unconscious content of the area of common tension and to the specific defenses the patient employed. Spotnitz (1952b) discussed the enhancing of ego functioning of the individual in the group setting. Where selection of group members included a scattering of problems and personality types, an opportunity was afforded patients to experience and to observe a variety of reactions that helped them scrutinize their own reactions more objectively. Individual resistances were handled rapidly by the group, and this resulted in symptomatic improvement. Spotnitz believed that the instinctual forces at work in group could be understood in terms of the life and death instincts as outlined by Freud.

In England, as in the United States, fruitful investigations of analytic group therapy have been ongoing. Bion and Rickman, around 1943, instituted group discussions among army personnel in an atmosphere stripped of the traditional authoritarianism. Bion's work at the Northfield Military Hospital was particularly outstanding and was adopted as a model for psychoanalytic group practice in various parts of England. All groups, Bion (1948—1951, 1961) claimed, operated on the basis of certain cultural assumptions that gave rise to heightened emotional states. Contributions to the group were in accordance with whether individuals resisted or accepted the existing cultural standards. Valences of pairing, dependency, or "fight-flight" developed with shifts in the emotional culture of the group. Operating in a relatively nondirective way and purposefully avoiding structure, Bion utilized the initial resentment or confusion of the group members as material for analytic exploration. Throughout the group process interpretation was focused on the total group rather than on individual behavior.

Expounding on the importance of group factors as distinctive from individual phenomena. Foulkes (1948; Foulkes & Anthony, 1957) considered the group matrix the essential element. The group analyst, he insisted, had to deal, as a participant observer, with all communicative and relationship processes as aspects of the total interactional field. Substantive regressive, infantile manifestations were, according to Foulkes,

minimized by the presence of the group. Maintaining some Freudian concepts, Foulkes felt his approach drew largely from Gestalt and field theory, particularly from the ideas of Kurt Lewin (1945). Analytic group therapy, he insisted, must concern itself with the "deep aspects of social interaction," which is "preeminent in the uncovering of the deep unconscious group phenomena." Though transference occurred in a group, it was not of paramount importance for the therapeutic trend of the group. "The group is not the most suitable place to analyze a transference neurosis... . Psychoanalysis provides the ideal solution for this…. It is not that group-analysis does less; it does something different…. It is consequently unprofitable to confuse the scope and field of the two therapies."

Due to the present-day rapid growth of group psychotherapy, methodologies, as M. Rosenbaum (1965) has pointed out, have moved far ahead of theoretical explications. Conceptual clarity of the process operative in groups is particularly lacking. In this void it was to be expected that each school of analysis would project postulates regarding group phenomena, attempting to delineate in its own terms what happens to people in groups and how they best may be helped to achieve personality growth. Thus, Freudian analysts conceive of the group as a family in which the individual acts out repetitively and compulsively infantile neurotic tendencies. Catharsis and regression are accordingly considered to be significant therapeutic agencies, although Scheidlinger (1968) has emphasized that therapeutic usefulness rests in how well ego functions can overcome resistance to face warded-off infantile drives and accept and master them. Psychoanalysts with an inclination toward "ego analysis" regard the group as a medium that supports mutual exploration of defensive characterological factors and healthy adaptive functions. Horney analysts believe that a group helps to modify exaggerated self-idealization and other distorted concepts of the self and world. In an atmosphere of mutual cooperation a healthy feeling of belongingness may be restored. Sullivanian analysts look upon the group as a laboratory in which neurotic interpersonal patterns may be detected and constructive models elaborated.

Superimposed on adumbrations of unconscious mechanisms are group dynamics, held by some (such as Bach, 1954; Thelen, 1954; Thelen, et al, 1954: Whitaker &

Lieberman, 1964) to be, not an accessory, but a primary factor responsible for change. Postulates from field theory and role theory are borrowed liberally by analysts who subscribe to group rather than patient-oriented methods (Bales, 1950, 1958; Bavelas, 1952; Cameron, N. & Margaret, 1951; Cartwright, 1950, Deutsch, M, 1949a, 1951; Festinger, 1942, 1947; French, J, 1941, 1944; Gough, 1948; Homans, 1950; Lewin, K, 1947, 1948, 1951; Lippitt, 1948, 1952; Mead, G, 1934; Parsons & Schils, 1951).

These concepts, some of which were discussed in the last chapter in the exposition on reeducational group therapy, are combined with psychoanalytic formulations and make for a confounding diffuseness in ideas. Accordingly, group dynamically oriented analysts have been subject to virulent attack. Indeed, the most vocal antagonists consider group processes to be obstructive rather than helpful during analytic group treatment. In another direction are group analytic activities that are wedded to existential concepts, exploiting the "feeling" and "experential" components of the group process (Mullan & Sangiuliano, 1958; Hora, 1959a & b; De Rosis, 1964). A total involvement by the therapist in the group is a primary aim with communication of all of his or her authentically perceived experiences and reflections.

Innovations introduced into the field of analytic group therapy include the use of multiple therapists (Spitz & Kopp, 1957; Rosenbaum, M. 1963), of family members in groups (Ackerman, 1958b; Grotjahn, 1959; Bell, J. 1962), of marital couples (Whitaker, C. 1958; Perelman, 1960; Leichter, 1962; Grinker, 1966; Sager, 1966a) and of videotaping (Berger, 1970, 1971; Alger, 1972; Melnick & Tims, 1974).

The literature in group therapy reflects a paucity of substantial contributions in research and follow-up and a diffuseness of regard for the boundaries of group psychotherapy per se in relation to other types of group experience, such as group counseling, small-group interactions, family therapy, marital therapy, and the therapeutic community. There is particularly a tendency to amalgamate reeducational with analytic groups. This is understandable in that group dynamics operate in all group interactions; however, it tends to confuse issues relating to group theories and techniques. Excellent

reviews of the yearly literature are found in annual issues of the *International Journal of Group Psychotherapy,* the official publication of the American Group Psychotherapy Association, under the title "The Group Psychotherapy Literature." Overviews of the literature in group psychotherapy for a ten-year period are included in the books *Group Therapy* (Wolberg and Schwartz, 1973-1975; Wolberg and Aronson 1974-1979, 1980—1983). An excellent historical account may be found in the paper by Durkin (1974). The books by Yalom (1975, 1980, 1983), Sager and Kaplan (1972), Grotjahn and Freedman (1983), and Kaplan and Sadock (1983) continue to enjoy deserved popularity. Among the important past articles and publications are the reviews written by Taylor (1958), M. Rosenbaum (1965), and Durkin (1974). A coordinated bibliography has been compiled by R. Thorne (1966) and Strachstein (1965). As may be expected, the writings reflect many cause controversial issues, not only in relation to theory, but also in regard to the organization and direction of the group, including the participation and role of the therapist, the therapist's relative activity or passivity, the value of alternate sessions, pre-sessions and post-sessions, the management of acting-out, and the handling of resistance and transference.

The most important older general readings include the following: Ackerman (1957), Bach (1954), Berne (1961, 1963), T. Bieber (1957, 1959), Bion (1961), Brock-bank (1966), Cartwright & Lippitt (1951), Cartwright and Zander (1960), Corsini (1957), Durkin (1954, 1957, 1964), Foulkes (1948, 1957, 1964), Foulkes and Anthony (1957), Glatzer (1964), Hinckley (1951), Hobbs and Rogers (1951), Hulse (1960), J. Johnson (1963), Kadis (1963), Klapman (1946), Locke (1961), Moreno (1957), Mullan (1962), Powdermaker (1951, 1953), Rosenbaum and Berger, (1963), Scheidlinger (1952, 1960), E. Schwartz and A. Wolf (1957, 1960, 1961), Slavson (1943, 1947, 1956a & b, 1960, 1964), Spotnitz (1952a & b, 1961), Wender (1963), D. Whitaker and Lieberman (1964) and A. Wolf and E. Schwartz (1962). Recommended literature on topical problems subsume the following references:

> 1. *Special technical management*—M. Berger (1958), Hulse (1950) Markowitz and Kadis (1964), Munzer (1964), Scheflen (1964), Winick and Holt (1961)

2. *The alternate meeting*—Kadis (1956, 1958, 1960), A. Wolf and E. Schwartz (1959, 1960)

3. *Selection of patients for groups*—M. Freedman and Sweet (1954), Furst (1950), Glatzer (1956), Leopold (1957), Slavson (1955), Stein (1963)

4. *Combined and joint therapy*—Aronson (1964), Lipschutz (1957), H. Papanek (1956), Sager (1959)

5. *The use of co-therapists*—A. Gans (1962), L. Lundin and Aranov (1952), Solomon et al. (1953)

6. *Transference*—Bach (1957), Belinkoff (1964), Beukenkamp (1956), Chance (1952), Demarest and Teicher (1954), Ezriel (1959), Farrell (1962), S. Foulkes (1961), Fried (1965), Glatzer (1952, 1965), Grotjahn (1953), Hadden (1953), Horowitz (1964), Loeser and Bry (1953), Mullan (1955), Slavson (1950), Spangaard (1959), A. Wolf (1950)

7. *Countertransference*—R. Cohen (1961), Flescher (1953), G. Frank (1953), Grotjahn (1950, 1953), Hadden (1953), Hora (1956), Mullan (1953b), L. Rosenthal (1953), Schindler (1953), E. Schwartz and A. Wolf (1964), Shaton et al. (1962), Slavson (1953), Stroh (1958)

8. *Resistance*—Arsenian et al. (1962), Belinkoff et al. (1962), Bry (1951), Durkin (1951), Flescher (1957), Gadpaille (1959), Geller (1962), Glatzer (1953, 1959a & b, 1962), Goodman and Marks (1963), M. Goodman et al. (1964), Greenbaum (1957), Heckel et al. (1962), G. Hill and Armitage (1954), Hulse (1950), J. Jackson and Grotjahn (1958), Kotkov (1957, 1958), Krause (1961), E. McDonald (1951), R. Menninger (1949), Morse et al. (1955), Mullan (1953a), Ormont (1962, 1964), Redl (1948), J. Rosen and Chasen (1949), L. Rosenthal (1963), Spotnitz (1952b, 1958), Spotnitz and Gabriel (1950), A. Stein (1952), Stock (1962), J. White (1964), Wolman (1964)

9. *Acting-out*—Abt (1965), Aronson (1964), Bry (1953), Burke and Lee (1964), Drukin (1955), Durkin et al. (1948), Eaton (1962), Slavson (1956), Vass (1965), A. Wolf et al. (1954), Ziferstein and Grotjahn (1957)

10. *Dreams, fantasies, and early recollections*—Chalfen (1964), Kadis (1957), Klein-Lipshutz (1953), Locke (1957)

11. *Special clinical issues*—Abrahams (1953), S. Brody (1961), Durkin (1954),

Ginott (1961), Godenne (1964), Grotjahn (1959), J. Krasner (1959), L. Kubie (1958a & b), S. Kubie and Landau (1953), L. Rosenthal and Nagelberg (1956), Slavson (1945, 1950), C. Whitaker (1958), A. Wolberg (1960), Wolman (1964)

Criticism of Analytic Group Therapy

There are those who insist that individual therapy is doomed. Some analytic group therapists have become so completely involved with their specialty that they forecast a bleak future for the dyadic model. Because no person is an "island" and each individual is propelled by a feedback of stimuli from others, some predict that psychotherapy of the future will be experiential and concern itself exclusively with the "here and now," with clusters and not single entities, with the "what" and "how" and not the "why." History taking and ransacking childhood memories in search of "significant traumas" will be relegated to "the archives of psychological history" (Kempler, 1969).

This dire augury probably reflects the sentiment of therapists whose working styles are more attuned to groups than to individuals, and in all likelihood it refers to those patients whose learning patterns and cognitive modes synchronize with group interactions. There are patients, however, who are inflexibly unmotivated to resolve their problems in groups, and there are some whose defenses operate against benefits accruing from therapeutic group experiences. Such persons do very much better in individual therapy. Moreover, the verdict of many therapists who do both group and individual therapy points to the fact that if the patient has a desire and capacity for reconstructive change, there is no substitute for intensive individual treatment. Intrapsychic alterations, reflected in depth transformations of the character structure, may occur in patients in group therapy who possess a readiness for change. In my opinion, however, there is a greater likelihood that this will happen with properly administered individual therapy or with combined therapy.

Individual therapy is here to stay despite the adaptations that undoubtedly will need to take place with massive programs for the delivery of mental health services.

Criticisms of analytic group therapy are not so much levied at the concept of working with a group but rather at the theories of the different group therapists and the global claims that they make for their methods. The controversy in group therapy between adherents of the regressive-re-constructive and the experiential-affect approaches (which interpret analytic group therapy as a blend of psychoanalytic and group dynamic processes) is as heated as the Freudian-neo-Freudian polemic in individual psychoanalysis. Controversial also is the tendency on the part of some group analysts to consider the analytic group by itself an adequate substitute for individual analysis. Indeed, in the opinion of a dedicated few, group analysis *is* psychoanalysis. This idea has been disputed by other group analysts who differentiate analytic group process, irrespective of theoretical direction, from psychoanalysis; rather it is classified as a form of psychoanalytically oriented psychotherapy.

The group process, nonetheless, stimulates powerful projective and identification mechanisms in both patients and therapists that operate in the interests of cure as well as of resistance. In a group setting, say the critics, it is more difficult to detect the resistance manifestations, since patients are capable of concealing themselves better behind vocalizations of more active members. It is particularly inconvenient to unmask transference as it assumes the regressive form of claiming the right to a symbiotic tie with the mother. In groups transference is often displaced from the therapist to the group members, undergoing such sharp splitting, "dilution," and distortion that it loses its therapeutic potential. Defenses against transference are more easily elaborated in the group than in individual analysis. The resolution of the regressive transference resistance, one of the most important elements in therapeutic change, may, as a consequence, be completely blocked. This failure is abetted by the propensity of the group to sponsor the acting out of members with each other, particularly in alternate or post-therapy meetings, where pairings drain off transferential tensions and leave the neurosis exactly where it was. The therapist is put in an anomalous role here since to forbid interaction outside of the formal group places the therapist unhappily in the position of a punitive and nonneutral authority; to sanction it invites further acting-out. Moreover, the nature of the group situation makes it arduous for the therapist to identify with each patient and then

to objectify the identification in the form of appropriate interpretations. Some therapists try to overcome this by seeing patients in combined individual and group therapy or by avoiding placing patients into groups until they are well into the middle phases of therapy.

Reconstructive change presupposes intrapsychic restructuring. This is often impeded in the group, it is claimed, by alliances that members make with each other, by encouragement of hostile verbal exchanges, and by interpersonal interlacings through which neurotic regressive gratifications are derived at the expense of mature growth. Analysis of interpersonal operations, continue the critics, is important but often done on the sacrificial altar of true intrapsychic exploration. The engaging of members in verbal combat as an outlet for "sibling-rivalry" hostility serves too readily as defensive resistance. Complicating matters also are the reassuring, advice-giving directives that the reincarnated "family-members" extend to those undergoing stress who are seemingly in need of support. Such tactics, critics allege, water down the reconstructive potentials of treatment. Analytic group therapy also poses a strain on the therapist, since the multiple impact of the group members will exaggerate the therapist's countertransference and interfere with objective interpretations.

A great deal of criticism is extended toward experiential therapists who abdicate their role as therapists and become themselves patients in the group. This is said to play into their patients' defensive needs for omnipotence and control.

These criticisms, while authentic, do not really negate the value of analytic group therapy. They merely accent the need for great experience and maturity on the part of the analytic group therapist. If therapists are able to manage the resistances of their patients, they will have in analytic group therapy a most important, even indispensable, therapeutic instrument. Most therapists endorse a combination of group and individual therapy (combined therapy) during which the benefits of both forms of treatment are used to advantage (Caligor, Fieldsteel & Brok, 1984).

12
Miscellaneous Therapies

Throughout the world a brotherhood of distraught people in search of peace of mind constantly exploit miscellaneous therapies held out to them as recipes for mental health. Feeding this ever-increasing quest is a supermarket of psychotherapeutic methods that are designed to suit the most diverse tastes. Some of these are carefully thought-out interventions, drawing their substance from established supportive, reeducative, and reconstructive therapies, put together into creative constellations. Others exploit unconventional and dubious methods, sustaining these with fanciful theories, exploiting an uncritical eclecticism on the basis that "anything that works is acceptable" (Grinker, 1964). Common sense here is usually buried under a landslide of optimism and is palpable testimony to humankind's need to yield its emotional miseries at any cost. At the very time that Cassandras are bemoaning the death of psychoanalysis and other traditional therapies, these "new" treatments dip into the pool of mortal credulity to exploit anomalous "cures" for all imaginable ailments. It is almost impossible to chronicle the myriad systems of helping that have appeared on the psychotherapeutic horizon. Many of these are revivals of old and discarded methods; others are more novel and innovative. Still others are products of the counterculture, which spawns a variety of egregious approaches reflecting the anti-intellectualism of the day. All inspire expectations of success, especially when promoted by charismatic leaders who seek to etch a lasting profile on posterity. Most of these approaches, following a spectacular rise in popularity, fizzle out like a Fourth of July pinwheel. Among the surviving systems are some that, blending with the personalities and working styles of certain therapists, actually enhance therapeutic outcomes. They then acquire conventional respectability and become part of an eclectic schema.

Innovative therapies come about largely as a revolt against the semantics and rigidities of the traditional therapies. Some of our present-day theories and methods are coached in language that is confusing not only to patients but also to professionals trying

to make sense out of them. When we examine critically what the "new" therapies introduce, however, we usually find nothing essentially original. Rather they take a small section of the familiar ideas long in use and merely explicate this area in terms that may be more comprehensible and hence acceptable to patients. The great dedication and enthusiasm of the innovators come through to enhance the placebo effect and to enliven other non-specific elements.

Because therapists practicing innovative therapies are so intensely convinced of the validity of what they do, they will score greater triumphs than if they were to use traditional methods about which they feel lukewarm. The results of innovative therapies show that about two-thirds of the patients "improve," irrespective of the models used. This compares favorably with the traditional therapies, which to some observers implies that the theories and even the methods we employ do not account for success in psychotherapy. Rather, the constructive use the patient makes out of the relationship with the therapist toward acquisition of a sense of mastery and more adaptive modes of coping is believed to count most. All therapies are not the same, however, because there are differences in the dimensions and permanence of improvement with different treatment methods. We cannot expect that short-term treatment with supportive educational interventions will influence the personality structure in as great depth as will properly conducted techniques aimed at the intrapsychic structure and dynamic interpersonal operations. But irrespective of the kinds of therapy done, their alignment with the personality and style of the therapist and their coordination with the essential learning capacities of the patient are fundamental ingredients of success (see also Abroms, 1969; Corini, 1981; Dolliver, 1981; Halleck, 1974; Marmor, 1974, 1980.)

Because the faith of the patient in the therapist's techniques is one of the most effective elements of cure, the virtue of the interventions themselves remains open to question. This, however, should not discourage experimentation with a variety of methods. There is no reason why a therapist should not cautiously test those techniques that possess a reasonable scientific propriety to see whether they blend with one's personality and style of operation, provided that the innovations introduced preserve

accepted bounds of patient-therapist decorum. It is only too common to observe therapists so rigidly anchored to standard systems that they stubbornly resist learning innovations even though they have proven merit (Martin & Lief, 1973).

It is beyond the scope of this book to describe all or most of the miscellaneous treatment methods in use today. Corsini (1981) has listed and Herink (1980) has described more than 250 different kinds of psychotherapy. New techniques are evolved yearly. Some come into the therapeutic arena like lions only to depart like lambs when their placebo effect has been expended. Others persevere with ebbs and spurts of popularity. Examples of surviving representative therapies are outlined below.

EMOTIVE RELEASE (BODY THERAPIES)

The paradigm for emotive release was the "cathartic method" developed by Breuer and Freud in the late 1800s, which served as the precursor of psychoanalysis. The theory behind the method was that neurosis developed as a product of psychical traumas that evoked fright, anxiety, shame, or physical pain if there had not been an adequate discharge of affect at the time. Emotion then was so bound up that it could only be discharged subversively in the form of symptoms. It was posited, however, that a cure might be achieved by reviving the memory of the event and putting the buried emotion into words. The task of the therapist was to induce the patient to give utterance to the traumatic event "with an expression of affect." This could be done by eliminating the defense or resistance to permit the proper release or abreaction. Neurosis was thus essentially a "splitting of consciousness" between memory and affect, the cure lying in the healing of this split.

These ideas still form a basic part of the philosophy behind later abreactive, emotionally oriented release methods, including those of scream therapy, active analysis, narcotherapy, primal therapy, expressive hypnotherapy, bioenergetic analysis, orgone therapy, direct analysis (Rosen J, 1947, 1962), and scientology among others. Various rituals are organized around each of these therapies focused on breaking down defenses to the presumably barricaded early psychic traumas. After a period of treatment with the release of a good deal of emotion and the lessening of tension we would expect an impact

on the physiological state of the individual, such as the pulse, temperature, and blood pressure. This effect can be significant (Karle et al, 1973), and indicates a reduction of tension as registered on body organs. In some patients, too, there is at least temporary improvement in their psychological state as a consequence of the total therapeutic experience. Whether this improvement is any greater than in other kinds of treatment is open to question. There are some patients whose learning patterns are singularly susceptible to release techniques, particularly when rendered by an enthusiastic and charismatic therapist. Other patients fail to respond to these techniques and do better with nonrelease modalities to which they are more attuned.

Bioenergetics

Bioenergetic therapy is a modification of orthodox Reichian therapy. Reich (1942, 1949) contended that interruption of the life-energy flow through repression was aided by seven rings of "muscle armoring" and that this was the basis of neurosis. By manipulating these rings progressively from head to pelvis (orgone therapy) conscious awareness of painful vegetative sensations occurred, the energy flow was encouraged, and health brought about. The Lowenian emphasis (Lowen, 1958) in bioenergetics is also on muscular energy blockages, but rather than the therapist manipulating the muscles, as in orgone therapy, reliance is placed on the patient's own muscle activity exercises and verbalizations. The exercises open up an awareness in the patient of malfunctioning of breathing and other muscular operations that are presumably crippled by blockage of the energy flow. The loosening of the muscle armoring is believed to be the first step in personality reorganization.

The actual technique consists, at the start, of assumption of a painful "stress position," such as lying on the floor with the back arched so that support is maintained by the top of the head, the elbows, and the soles of the feet. Other exercises consist of kicking or hitting the couch. The "stress positions" assumed can actually cause the body to vibrate, and the discomfort may lead to yelling or screaming, which the therapist encourages.

A number of adaptations of Lowen's technique have appeared, especially in the

behavior therapy field. One innovation is to fuse bioenergetics with assertive training. An effort is made to elicit in various ways, as through facial, postural, verbal, and other expressive channels, patterns associated with emotion. Assertive behavior, along with expression of appropriate feelings, is in this way gradually shaped. The therapist here participates in the exercises given the patient by modeling an appropriate behavior and by role playing. Emotional release is stimulated by such games as rolling up a towel, with the therapist grasping one end and the patient the other. A tug of war then ensues, the patient being told the towel is his and that he must wrest it from the therapist, demanding "It is mine, give it to me," and maintaining eye contact while the therapist resists and goads the patient on (Palmer, RD, 1971). Other "exercises" given the patient are punching a pillow violently in private, yelling such phrases as "you bitch," "Damn you," and the like. The therapist handles the patient's reactions in the office, reassuring the patient, if necessary, not to be afraid, or forcibly insisting on the patient yelling louder. Some therapists encourage the use of obscenities to cut into the patient's repressions. Some provide the patient with a tennis racket with which to hit the couch, while uttering such statements as "Bastard, I hate you." Some encourage the patient to growl through bared teeth with jaw thrust forward, shaking fists at the therapist while maintaining eye contact. Some ask the patient to repeat angrily, "Yes, I am mean and ugly and nasty, and I will become more so if you don't stop bothering me." Bioenergetic assertive techniques have also been used with proper organization to release affectionate and sexual feelings.

Scream Therapies

Organized to thaw out and to liberate fundamental "survival-based" feelings frozen within the individual by society, scream therapies prescribe a special regime for the patient and subject him or her to maneuvers to melt resistance to "letting go." A typical example are the exercises devised by Daniel Casriel (1972). In a group setting the emphasis is first placed on screaming to *express* feelings rather than to talk about them. Casriel differentiates several types of screaming, each with different sounds and expressing different emotions. "There are basic screams of fear, of pain, of need and entitlement and four screams of anger—the deepest one accompanied by strong feelings

of pleasure." In addition, there are joyous sounds of pleasure. Confrontation, encounter methods, and marathons are utilized to loosen feelings as these come up. The patient is encouraged to scream at the top of his or her lungs. If the patient gets too disturbed, he or she is held or hugged for reassurance and comfort. Once the sounds of repudiated emotions are released and accepted, the patient is encouraged to explore the reasons for them. Role playing may be utilized here to open up pockets of understanding and to reprogram behavioral habits. Progress with feeling emotion and dealing with its source, outside of therapy, is reported to the group at later sessions. The use is made of floor mats for patients to express their "historical feelings" and then to connect these with present-day problems. Character disorders as well as neuroses are said to respond readily to these methods.

Some scream therapy interventions are rationalized by the theory that the release of rage is a precursor to eliminating resistance to emotional growth and development. In one technique to induce rage, the patient is placed on the laps of six or eight people who physically restrain him or her while the therapist, on whose lap the patient's head rests, fires pointed questions at the patient about his or her past. Simultaneously or somewhat later the therapist tickles or prods the rib cage of the patient to induce discomfort or pain. This usually releases cries of helpless protest and violent rage. The "treatment" goes on for as long as 4-6 hours until the patient is literally exhausted. The patient is then released and embraced affectionately by members of the group and the therapist.

EST

Contracted from "Erhard Seminars Training," a brainchild of Werner Erhard, EST was founded in 1971 and essentially is organized around a two-weekend experience designed to transform the participants' ability to "clear up" disabling life situations. Many thousands of people have graduated from EST training courses, which are offered throughout the country. Sessions are conducted in a rigidly disciplinary way to stir up tension. Discomfort and deprivations are deliberately organized, along with a grueling confrontation. Honesty of revelation is stressed, and the emphasis is on assuming

responsibility for one's own actions. "Much of the effectiveness of training is based on surprise, or shock… . You are simply caught off balance… . Our bodies scream for relief" (Kettle, 1976). The leader "harangues us, urges, cajoles, wheedles, roars … one thing that happens in the est training is the attack on the armor with a consequent release of energy." The participants cry, laugh, scream, vomit. Testimonials are ample from participants as to how much they have been helped by EST. The marketing techniques used to publicize the program have made it extremely popular. There is evidence that some persons with good ego strength and strong motivation derive benefits from participation (Simon, 1978), as they might with other experiential groups. On the other hand, psychoses may be precipitated in vulnerable persons as a consequence of the intensive experience (Glass et al, 1977; Kirsch & Glass, 1977).

Primal Therapy

The best known of the scream therapies is primal therapy which had a brief period of popularity. According to Janov (1970), people are born with needs, a part of their "real selves." When these needs are unmet, the neurotic process begins. When the pain of unfulfilled needs is not alleviated, the infant diverts the pain by shutting off the need that is unsatisfied; the child then separates himself or herself from the needs and feelings. Substitute gratifications ensue, usually symbolically, and become the modes of functioning of the "unreal self." Sensations caused by unattended needs are relocated to areas where greater control or relief can be provided. For instance, early weaning can find a symbolic satisfaction later in incessant smoking.

"Neurosis is a symbolic behavior in defense against excessive biological pain." But symbolic satisfactions never really gratify the needs from which they issue, which unfortunately are not available to the person because they have been buried. Tension issues from unsatisfied needs. A constant denial of real needs ("minor Primal Scenes") sensitizes the individual to a precipitating traumatic event (the "major Primal Scene"), usually between the ages of 5 and 7, that produces in the child the realization "There is no hope of being loved for what I am." The child then shields himself from this realization "by

becoming split from his feelings, and slips quietly into neurosis." Neurotic behavior becomes automatic. "Primal Pains" are so intolerable that they, and the memories with which they are associated, become disconnected from consciousness. This resulting tension promotes a life style or "personality" to minimize and dull suffering.

Primal therapy, continues Janov, constitutes a systematic assault on the unreal self "which eventually produces a new quality of being—normality—just as the original assaults on the real self produced a new state of being—neurosis. Pain is both the way in and the way out." There can be no resolution until the "Primal Pains" are reexperienced consciously. This breaks open the memory bank associated with the "Primal Pains."

As with other therapeutic systems, splits have occurred among therapists who practice primal therapy on the basis of dissatisfaction with results.

Criticism of Emotive Release

The concentration on causation in the early years to the exclusion of later etiological factors is a defect from which many therapies, including emotive-release therapies, are blighted. We may rightfully be suspicious of any theory that proposes a unitary cause for all emotional problems. Human behavior is extremely reticular, and unfortunate conditionings may occur anytime between birth and the grave. The traumas of middle age can be no less endurable than those of early childhood. An adult victimized by disastrous contemporary circumstances that are beyond the individual's existing coping capacities may show catastrophic responses that may permanently injure faith in oneself and open the door to emotional illness that plagues the individual for the remainder of life.

This does not minimize the cathartic effect of emotive release. The ability to let go without restraint discharges a good deal of pent-up emotion, for example, fear, indignation, and rage. Relief of tension may then ensue. The ability to express uncurbed emotion without encountering anticipated punitive retaliation or rejection—indeed being encouraged to emote freely in the face of a new, accepting authority—can have an important impact on the superego. The lessening of controls of the conscience and the

freedom in unleashing inner feeling have a strengthening effect on the ego. With the discharge of affect a flood of insights may then be liberated. Surfacing of repressed memories and of repudiated aspects of the self may occur where defenses are broken down catastrophically in the therapeutic process so that the individual has no way of dealing with the stress situation except through regressive parental invocation in screaming. Where dependency needs are extraordinarily pronounced and where one does not encounter a parental agency who comes to one's aid by one's screaming, the individual may in some instances have to develop a more mature way of dealing with needs, such as by greater self-reliance and assertiveness. In other cases the screaming furthers rather than lessens the regressive tendency, and, from a long-term standpoint, this does not help the patient's condition. In borderline cases or schizophrenics, damage may be done to the defensive system so that a break with reality may occur.

The more drastic emotive-release therapies are tailor-made for patients who have a stake in feeling pain as a condition for well-being. If they can accept the premise that suffering of pain is mandatory to overcome problems and that feeling pain fulfills certain needs, such as the propitiation of guilt, the therapy may constitute a tension-releasing experience for them. The charisma of the therapist acts as a catalyst for these patients, but the basic need to accept pain is a primary requirement. Obviously many patients react adversely to paying penance by suffering and will not abide by this premise. Indeed, feeling pain for them will act as a deterrent to getting well. One may call this, if one wishes, a resistance to getting well. In the field of psychotherapy we too often credit an individual's inability to respond to therapeutic stratagems as resistance rather than acknowledge shortcomings in the system itself.

Despite defects in the system, for some individuals, such as severe character disorders, or those unmotivated for traditional therapies, assuming they are not borderline cases or schizophrenics, the dramatic treatment techniques such as emotive release may operate as means of penetrating otherwise unyielding defenses that isolate individuals from themselves or others.

GUIDED IMAGERY

About 1895, Sigmund Freud utilized the "concentration technique." He enjoined his patients to shut their eyes. While he pressed on their foreheads, he instructed his patients to let images come to their minds and, without holding anything back, to verbalize what they imagined. Because Freud felt that touching his patients interfered with the transference, he abandoned this technique in favor of free association and the use of dreams. Since Freud's early use of fantasies, methods of image associations have been periodically introduced that the authors presented as original and unique, even though on scrutiny they were quite similar to Freud's old technique. Some therapists find that imagery plays an important role in their treatment of a number of disorders (Horowitz 1970, 1976; Brett, 1985), and may serve as a vehicle to expedite treatment.

Psychoimagination Therapy

Integrating phenomenology and imagination, Shorr (1972) has introduced what he describes as an existentially based therapy (psychoimagination therapy) organized around how patients view themselves from the inside and how they believe other people view them. Imagery and imagination are used as a means of examining how patients regard themselves and how they see their phenomenological world. Shorr discovered that when a person is asked to say how he or she imagines a thing in two different ways and there is a conflict between the two, a "bipolarization" in the meaning systems will be exposed. A new more unified meaning system must then be organized.

The search for meaning is one of the most powerful strivings in the human being. To survive in a hostile world as a child, the meaning of events may be perverted and this can distort reality. If true facts about oneself and about past personal experiences can be laid bare, new and more adaptive meanings are made available to the patient. The problem lies in how best to achieve true meanings. Shorr believes this can be done through imagery and imagination, which can be used to reach out into the world and differentiate fantasy about oneself from reality. In this way, one can alter one's sense of values. The therapist tries to get from patients their definitions of themselves, how they think other people

define them, and confirmation of these ideas from those they are with. A disparity in definitions about oneself from these various sources makes for conflict. The job of therapy, Shorr alleges, is to change a distorted negative self-definition to a more positive one. Thus, one may ask a patient to look into a mirror and to imagine looking at a different image than one's usual self. Often the person fantasized is one toward whom the patient has a good deal of emotion. A dialogue may be set up between the person and the fantasized object in the mirror. Conflicts are easily elicited in this way. By coming to an awareness of the conflicts within oneself, the individual is more capable of resolving confusion in personal meaning systems.

The patient may be assigned to do "task imagery." For instance, the patient may be asked to climb 1000 steps in his or her imagination. Some will hesitate after a few steps; some will slowly ascent to the top but refuse to traverse the last few steps as if in fear of success; others will rapidly climb to the top. This yields clues as to achievement motives, power motives, and so on. Later the therapist encourages the patient to achieve the task in imagination (i.e., a person who cannot reach the top is enjoined to do so in fantasy). As a way of getting rid of parental representations (the introjects), Shorr utilizes "body focusing." Here patients are queried in what part of their body their mother or father resides. Once the body part is named the patient may be asked whether it can be removed and, if so, how this could best be achieved through imagery.

Imagery can be utilized in a group setting. All members may be asked to close their eyes, imagine throwing a fishing line in the water, and fantasize what they catch. This stirs up interaction between the members and brings out hidden wishes in each patient. Should the patient feel improperly defined by a member in the group, verbal confrontation in the group is encouraged. This may be more easily accomplished through "cathartic imagery," by setting up a psychodramatic scene in which one confronts a group member in the role of a significant personage who harbors a faulty image of the patient. The therapist sides with the patient and with the corrected definition of the self-image to render support in releasing feelings against fancied retaliation. Such expressions emerge as, "1 am not what you say I am. How dare you. Never will you do this to me again," along with expressions of

outraged emotion. These reactions are essential for changing the self-definition. Reaction may vary from verbal outrage to violent screaming.

Shorr claims that his method is faster than analytic methods that depend solely on verbalization since through imagery one can see more clearly what is involved in change.

Psychosynthesis

As described by Assagioli (1965), the patient in psychosynthesis is asked, while relaxed on a couch, to visualize and relive, as realistically as possible, the scene or situation that is stimulating his or her upset and to let the emotion come out as freely as possible. This technique can also be applied to future events that the patient anticipates. Verbal expression, writing, keeping a diary, and muscular exercises are other modes of discharge for the emotions. Eclecticism of method is endorsed. Tien (1972) defines a psychosynthesist as a psychiatrist who fuses "classical psychoanalysis, modern chemotherapy, improved electroconvulsive therapy, family therapy, group therapy and community psychiatry with television as the storage, amplification and feedback system." The electroconvulsive therapy (ELT) is for the purpose of erasing disturbing memories or information. As in any other eclectic system, the practitioners of psychosynthesis design their own unique combination of modalities.

Miscellaneous Guided Imagery Techniques

There are other ways of working with guided imagery and a number of techniques have been evolved, including those taken from behavior therapy, hypnoanalysis, hypnogogic and "affective" imagery, eidetic analysis, and "in-the-body" daydreams.

In the behavioral technique of systematic desensitization a hierarchy of progressively more noxious phobic situations are constructed and the patient is gradually trained to fantasize and tolerate these situations from lowest to highest traumatic significance (Dyckman & Cowan, 1978). Implosive therapy also depends on mobilization of vivid exaggerated fantasies (Wolpin, 1969). In hypnoanalysis the patient is enjoined to

visualize special scenes in order to elicit associations, dreams, and emotions (Wolberg, LR, 1964a; Rochkind & Conn, 1973). In eidetic analysis, a method developed by Ahsen (1968), a series of images involving the patient's parents in various situations are proposed and the patient is asked to tell a story about what he or she feels and sees (Ahsen, 1972). Hypnogogic imagery is a normal phenomenon appearing in some people spontaneously in a drowsy state. It has the same dynamic significance as dreams. Images may be induced in subjects by relaxation exercises, meditation, autogenic training, hypnotic induction, and sensory deprivation during which an alteration of consciousness comes about. A form has been described by Leuner (1969) as "symboldrama-guided affective imagery." Here the patient lies down on a couch or sits comfortably in a reclining chair and is exposed to relaxing suggestions. The patient is told to picture himself or herself on a meadow and to describe what he or she sees and feels. The patient is then asked to take a walk in these surroundings and to describe what he or she sees. Thereafter the patient is enjoined to climb a mountain, to follow a stream, to picture and explore a house, to visualize family members, to see a rose bush and imagine a car coming by and stopping, to see a lion, and a number of other scenes that will bring up a variety of themes and associations. A passive attitude on the part of the therapist is usually adopted unless there is a block when active "symbol-confrontation" is employed. This technique is highly productive in dynamically oriented psychotherapy (Kosbab, 1974). The directive "in-the-body daydream" focuses on bodily tensions and may travel to different zones with many rich fantasies about what is going on (Alexander ED, 1971). The "Flomp Method" consists of daydreaming about a situation or event from one's life where one was disappointed and/or afraid. The patient is taught a relaxation method and asked to see himself or herself acting in the situation with the knowledge, power, and maturity that he or she now possesses "to make the done undone." Other situations are suggested and a variety of techniques of exploration utilized (Hagelin & Lazar, 1973).

Criticism of Guided Imagery

As part of an active psychoanalytically oriented psychotherapy, guided imagery may contribute substantially in the treatment of those patients who are capable of visualizing

and working with fantasies and daydreams. Not all patients are proficient in doing this. Moreover, in borderline or schizophrenic states imagery techniques may liberate explosive emotions and even precipitate acute, though usually temporary, psychotic outbreaks. Reliance on guided imagery as the chief or only technique will bring many disappointments. It must be reinforced by other modes of operation. The data emerging from imagery should never be taken at its face value since distortion, secondary elaboration, and defensive rationalization are common.

ERICKSONIAN PSYCHOTHERAPY (STRATEGIC THERAPY)

"Ericksonian psychotherapy" is the name given to a body of interventions most of which have been taken from the lectures, seminars, workshops, and writings of Milton H. Erickson, perhaps the most outstanding practitioner of hypnosis in the United States. More important than the actual techniques is the philosophy behind the methods, as well as the tactical interpersonal approaches to the patient, which are designed to liberate potentials for self-help in either the hypnotic or waking state (Erickson & Rossi, 1980; Haley, 1973). Discounting the myths and anecdotes, that are so commonly expressed by devotees and detractors of any charismatic figure, Erickson has had a significant influence on thousands of professionals and is registering an imprint on American psychotherapy itself. This is evidenced by the many volumes about Erickson that have been and continue to be published (Hammond, 1984; Rossi & Ryan, 1985; Rossi et al., 1983; Zeig, 1980, 1982, 1985a, b). Some of Erickson's interventions were an outcome of coping techniques that he employed to moderate the pain and disabilities he suffered as a result of having had childhood poliomyelitis. Struggles with his handicaps made for a unique blend of resourcefulness, flexibility, ingenuity, artfulness, and improvisation which, combined with an unorthodox style and a penchant for brinksmanship have created a model of psychotherapy that is exciting to read about but difficult for the traditional therapist to duplicate. There are, nevertheless, lessons to be learned from the dexterous ways Erickson related to his patients and even from the dramatic, histrionic expediences devised by this talented innovator.

Acting variantly with each patient as counselor, analyst, referee, arbiter, advocate, prompter, mentor, accepting authority, or punitive parent, Erickson stressed the uniqueness of each individual, who, motivated by singular needs and idiomatic defenses, required an original mode of approach rather than orthodox, unimaginative, and doctrinal styles. He considered himself and his words, intonations, manner of speaking, and body movements vehicles of influence that could promote change. Interested in action rather then theory, he considered traditional theory a handicap that anchored therapists to a bedrock of hopeless imponderables. Toward this end he suggested, cajoled, and maneuvered with a host of individual, multilevel communicative thrusts, verbal and nonverbal, that were fabricated to influence the patient without the latter's full awareness of being manipulated. Sometimes he failed, but this merely provided him with new incentives to overcome the patient's reluctance to utilize latent resources and potentials for change. Frequently he would join the manifest resistance and seemingly side with the patient's illness and defenses, or he would assign the patient what appeared to be peculiar, irrelevant tasks. He would offer homespun advice and common-sense remedies that made use of the obvious. Conversely, he would use metaphors and obtuse inferences that were not exactly to the point. He would set up situations "where people would spontaneously realize their previously unrecognized abilities to change" (Zeig, 1985). But there was a design in these contrivances if no more than to confuse patients enough to force them to open their minds to a different way of looking at things. Techniques were not selected in advance but were tailored to the exigencies of the immediate situation. Even though Erickson refused to identify himself with any of the well-known schools of psychotherapy, he often used behavioral, cognitive, analytic, and other methodologies within the framework of his unique modes of operation. Hypnosis was employed when it was considered useful in expediting therapy. His immediate objective was symptom relief and problem solving, although personality and value change were considered ideal goals that might sooner or later be achieved.

Some psychotherapists worship Erickson with a reverence that borders on idolatry. Every word, sentiment, opinion, or act are presumed to have an inspired meaning. Such deification, rooted in expectations of timeless power and omnipotence, can ultimately lead

to disillusionment. Equally prejudiced are those who regard Erickson as a maverick whose egregious methods are a passing fancy that will eventually be consigned to the dustbin of outmoded schemes. These attitudes do injustice to a highly creative, imaginative, and original mind who evolved novel approaches to some of the most baffling problems in psychotherapy. Erickson was a marvelous influencing machine, crafted by years of struggle in mastering his painful physical disability. His courage, sensitivity, perceptiveness, and unique modes of coping made him, in the words of Haley (1973), an "uncommon therapist." But his approaches, which blended with his "uncommon" personality and styles of operation, cannot be easily transposed, digested, and used by others.

A poignant criticism of Erickson's strategic therapy is that it is overvalued by those who believe that clever tactics can substitute for disciplined training. Technical modes of operation are only a fragment of what goes into the gestalt of a psychotherapeutic program. For one thing we must know how to deal with a host of variables related to patients' defenses, belief systems, and characterological peculiarities, which can negate and cancel out the effect of all our strategic interventions.

LIFESPRING

An entry into the human potential movement is Lifespring, which, inspired by the work of Carl Rogers, Abraham Maslow, and Fritz Perls, aims to stimulate personal growth through "self-awareness and acceptance." The program is not designed for persons with severe emotional problems; nor is it recommended as adjunctive to an established therapeutic program. Be that as it may, many people attracted to Lifespring seek help for emotional difficulties. Such help may be forthcoming through the relationships that are established with the trainers and other participants, the emotional catharsis that takes place in "sharing" one's difficulties and opening up to others, the group support, persuasive suggestions, operant conditioning, educational awareness, and other bounties inherent in a helping situation. The group leaders, who consider themselves trainers rather than psychotherapists, use a variety of techniques such as meditation, role playing,

guided fantasies, and group discussions. Many of the graduates of the program maintain contact with each other and the organization, gaining the benefits of an extended family.

TRANSNORMAL APPROACHES

The awesome mysteries of existence have inspired some therapists to speculate about the influence of the supernatural on what they do or can do in psychotherapy. Data for these speculations are boundless, having accumulated from such areas as meditation, hypnosis, psychodelic drugs, extrasensory perception, Kirlian photography, plants subjected to prayer, energy fields, biocycles, divination, reincarnation, demoniacal possession, out-of-the-body experiences, and other phenomena and whimsicalities reported by both reliable and dubious sources.

The influence of the occult for good or bad has been especially posited when there has been a shattering of accepted belief systems, as when insecurity and distrust in contemporary stabilizing sanctuaries has occurred. Natural catastrophes and chaotic social order historically have sent people into hopeful excursions into the arcane. At the present time young people particularly have registered suspicion of a society that sponsors violence, pollution, and massive preparations for nuclear war. An upsurge of interest in mysticism, shamanism, astrology, witchcraft, exorcism, and other esoteric subjects has followed. This interest has spilled over into the psychotherapeutic field, motivating some therapists to explore the interfaces of the transnormal and scientific worlds. A new field of metapsychiatry is being promoted that endorses empirical explorations of the occult.

Paranormal (psi) phenomena involving motor and sensory manifestations (telepathy, clairvoyance, precognition, psychokinesis) that transcend normal human capacities have especially been subjected to scientific investigation (Rhine, 1938; Pratt et al, 1940; Soal & Bateman, 1954; Ullman & Krippner, 1970). The reported results have been startling and have left no doubt in the minds of the investigators regarding the authenticity of psi manifestations (Murphy, 1975). Interest in applying the telepathy hypothesis of psychotherapy was stimulated by the possibility that transference and

countertransference could extend themselves through telepathy and thus interfere with the therapeutic relationship (Ehrenwald, 1954; Servadio, 1956; Eisenbud, 1970). The influence of psi events on dreams has also been elaborated (Ullman, 1959; Ullman & Krippner, 1970). What practical use can be made of psi phenomena if they do exist (there is question in the minds of many scientists regarding the validity of the reported experiments on psi) has not yet been demonstrated.

Psychic healing, such as by prayer and the laying-on-of-hands, has also been subjected to experimental investigation (Grad, 1965) as have the aura emanating from living things (Kirlian photography) (Krippner & Rubin, 1973). More scientific evidence will be needed before psychic healing as such can be endorsed as a modality beyond its suggestive and placebo effect.

Pursuit of more bizarre aspects of the occult has caught the fancy of large groups of people who gain stability or heal themselves without the formality of professional help through practices like astrology, witchcraft, and exorcism. Practices here resemble primitive magicoreligious indoctrinations and actually may be a reflection of early teachings or a regression to the pre-logical period of childhood. I recall one patient, a young intern who had come to this country from a Caribbean island to further his medical education. The purpose of the consultation was that he wanted me to hypnotize him to eliminate his impotence. This had developed a week before his departure from home and followed a sexual experience with a young lady, an acquaintance who had decided to pursue prostitution as a profession. Whether out of perversity or mischievousness, the patient had, after she had made clear her fee for services, refused to pay her. In rage, the frustrated entrepreneur shrieked that she would cast a spell over him that would take away his manhood forever. Amused, the patient had ridiculed this nonsense, telling her he had long ago broken away from the voodoo superstitions of his parents. To his consternation and amazement, however, he had from that time on become impotent. Visits to urologists and psychiatrists had achieved no improvement. Discerning that he was not truly motivated for psychotherapy, I advised him that suggestive hypnosis might be of help but that a cure would be much more rapid and sure if he returned home and

paid the disappointed lady the fee that he owed her. My advice worked out as I had predicted, and the patient never followed through on further therapy. The roots of superstition go deep and often are not apparent on the surface.

OTHER ECLECTIC METHODS

It is rare indeed that a therapist will use only one type of intervention and not exploit the rich body of procedures that lend themselves to usage for diverse conditions and situations. Even Freudian psychoanalysts, considered by many the traditional purists in the field, employ or refer patients who require medications, hypnosis, sexual therapy, marital therapy, or other adjunctive procedures in addition to their probings of the unconscious. The application of tactics to coordinate with the needs and specific learning patterns of the patient will promote the most effective results in therapy, and here the sensitivity, experience, and self-awareness of the therapist will be of consequence. Too often, however, therapists employ interventions that are designed to gratify their own needs rather than those of the patients. Under these circumstances the patient is subjected to strategies from which the therapist personally derives greater help than the patient.

Many "systems" of eclectic therapy are presented by their founders as late twentieth-century innovations even though they are derived from identifiable techniques employed for decades and even centuries in the past. Founders of some of these systems give to their schemes an academic primatur, adorning them with elaborate terminologies and neologisms and sometimes organizing a new school around them which if they are charismatic attract enthusiastic audiences.

This is not to deride practical attempts to combine therapies creatively to treat special problems, taking into account the cultural atmosphere of the patient. One such attempt was developed by Morita in 1917 to treat types of neurosis common in Japan. This is known as *Morita therapy* (Reynolds, DK, 1976). The difficulty for which this form of treatment was developed was a morbid preoccupation with bodily odors, inferiority feelings, self-consciousness, problems in working, and other obsessional and

hypochondriacal complaints. Therapy consists of hospitalization, usually in a Moritist hospital, the first week of which consists of complete bed rest and daily visits from the therapist. Patients are not allowed to have visitors or to engage in any reading or conversation. They may at this time worry and preoccupy themselves with their problems. The second week is more active. They are out of bed, engaging in light hospital work, and are assigned simple chores. They are not permitted to have visitors, to read, or to chat with others. They must keep a written diary, which the therapist reads daily and to which the therapist replies in writing. They attend lectures and meetings, being exposed to persuasive arguments toward accepting themselves and their symptoms and toward engaging in constructive activities. In the third week and thereafter they continue to go to lectures and meetings. They are assigned to heavy work and are enjoined to talk to other patients. They may read light literature. Finally they can engage in visits and are delegated to do errands. The Moritist life principles are also utilized on an outpatient basis and in groups.

Another therapy practiced in Japan is *Naikan,* which consists of a concentrated 7-day period of psychological and spiritual restoration during which the therapist as a guide subjects the patient to exercises in self-observation and remembrance of past experiences. The patient is also exposed to persuasive arguments. The sole aim is social readaptation. The technique is active and, as in Morita therapy, avoids focusing on transference and resistance. Where patients in our culture can accept principles of conformity to the teachings of a guiding authority and the fatalistic acceptance of situations that have happened to them, they may respond to Moritist or Naikan therapy.

An example of eclectic therapy in our culture is that introduced by Lazarus (1976) as *multimodal therapy.* It eschews identification with any specific school of psychological thought. Nor is it a separate school in itself. It draws from educational principles of social learning, cognitive processes, and behavioral precepts. First, patients are examined in relation to their salient behaviors, affective behaviors, affective processes, each of the five senses, basic images, cognitions, and interpersonal relations. Symptoms and behaviors in various areas, including thoughts, values, fantasies of past disturbing events, self-images,

interpersonal difficulties, and behavioral lacks and deficits, are explored. The multimodal profile analysis consists of a structural framework to assess the clinical problem, the setting of goals, and the treatment techniques and evaluative procedures to be used. The modalities toward which therapy is directed are, in summary, seven in nature: behavioral, affective, sensate, imagery, cognitive, interpersonal, and "drugs," a symbol for organic or physiological processes. The first letter of each modality spells out the acronym BASIC ID. Problems are treated by a variety of techniques, for example, operant conditioning, classical conditioning, implosion, paradoxical intent, catharsis, sentence completion, "hot seat," hypnosis, awareness exercises (Gestalt), group and individual physical activities, special techniques for sexual dysfunction, deep massage, yoga, meditation, relaxation, rational-emotive therapy techniques (self-talk), thought stopping, fantasy trips, self-suggestion, assertive training, modeling, role playing, role reversal, behavioral rehearsal, psychodrama, and drugs where necessary. These techniques are employed selectively in relation to the special needs and problems of each patient.

Criticism of Eclectic Therapies

Eclectic therapies can easily get out of hand when they are applied unselectively to patients without considering the specific goals of the treatment effort. This necessitates an incisive study of the patient in all areas of his or her living and interpersonal adjustment. While an attempt to blend different theories inevitably results in a hopeless jumble of words and is a fallacy, using different techniques issuing from contributions of workers in the social and behavioral sciences can, if executed correctly, be a constructive and rewarding enterprise. Methodological eclecticism is founded on the premise that no one therapy covers every aspect of the therapeutic process. Each therapy seems to have selected a limited zone of pathology and to have focused on this dimension. In an eclectic approach therapists may employ techniques from different therapies at different phases of the treatment process; for example, they may use some of the methods of the client-centered school during the early stages when they seek to establish a therapeutic alliance; some of the methods of psychoanalysis (dreams, transference, and so on) when probing for conflicts; some of the methods of Gestalt therapy when confrontation is in order; some

of the methods of behavior therapy when trying to convert insight into action; and some of the methods of cognitive therapy when attempting to alter belief systems. Modalities such as drug therapy, marital therapy, sex therapy, family therapy, and group therapy are also used as needed. These methods have to be employed selectively, coordinating them with the patient's needs and the objectives they are trying to achieve. The problem with most psychotherapeutic schools is that they try to approach all phases of the therapeutic process with a limited tool. It would be like building a house with a hammer alone when a variety of tools is needed. Naturally, *how* eclectic methods are used is crucial for success. On the other hand, there is no earthly reason for jumping from one method to another if therapy is proceeding satisfactorily. Most therapists learn a few techniques thoroughly and do well with them. Only when a patient is not responding to one's habitual techniques, and the therapist is assured the failure is not rooted in transference and other resistances, should one change the interventions. The fact that a therapist uses eclectic methods does not mean that he or she cannot be discriminating in using them.

More recently, Frances et al. (1984) have reviewed the eclectic spirit in "differential therapeutics" and have shown the value of employing special modalities for select problems and situations. What we must keep in mind is that no matter how varied our skills may be acceptance by the patient is what crucially matters. In our culture, when we attempt to use psychotherapeutic interventions we find great variations in what patients find meaningful and to which they can respond favorably. The institution of third party payments has broadened the consumer groups seeking mental health services. But any attempt to bring into the mental health care system groups that have been underserved for socioeconomic and other reasons will require a careful study of the techniques that members of these groups find acceptable and those they are not willing to accept. This necessitates an understanding of the varieties of belief systems rampant in our patient population. It necessitates an acquaintance with a broad spectrum of psychological and sociological methods and a willingness to educate patients regarding methods that have a chance of helping them beyond the placebo effect.

13
Similarities and Differences among the Various Psychotherapies

Psychotherapy is a "stew" of a large number of ingredients, most of which are common to its variations. Without minimizing the uniqueness of methodologies among the different psychotherapies, remarkably similar forces are universally manifest. It would seem that the diverse techniques we employ act as forms of communication through which identical influencing processes operate. Except for a few interventions that are best suited for special syndromes most schools of psychotherapy, as heterogeneous as their premises may seem on the surface, display a remarkable unity in the way they register themselves on neurotic problems. In randomized studies of patients selected for treatment, good therapists of even dissident orientations are believed to achieve approximately the same proportion of "cures" and failures (Fiedler, 1950a & 1951). This fact solicits the tempting proposition among the various psychotherapies, that their differences are more in design than effect.

If this proposition is true, the question arises as to what common elements in all psychotherapies serve to bring about therapeutic gains. The windfalls of placebo influence, emotional catharsis, idealized relationship, suggestion, and group dynamics in themselves may restore the individual to homeostasis. These expediencies operate automatically in all relationships, although therapists may credit to their methods the non-specific profits that accrue from nothing more than the patient's faith, hope, trust, and expectancy. Parcels of all therapeutic relationships, transference and resistance display themselves in myriad forms and are tolerated, accepted, bypassed, or resolved depending on the sophistication of the therapist and the goals toward which therapeutic efforts are directed. Psychotherapies are often wrecked on the reefs of resistance and transference, which may have little to do with the specific tactical maneuvers. Crucially influencing results also are a variety of positive "therapeutic" personality qualities in the therapist, which in their presence expedite and in their absence vitiate the applied techniques.

Moreover, negative countertransference will universally prejudice the outcome and will, in each therapist, masquerade itself in diversified forms. Furthermore, in all therapies, explicitly or implicitly, there is an influencing of the patient toward a productive life philosophy. The particular kind of ideology is bound to reflect that which the therapist finds meaningful, and the values of the patient will be molded by this. Even though the therapist may try to avoid revealing them, standards will ultimately become apparent by the therapist's interview focus and interpretative activities.

The confluence of these common elements during any psychotherapeutic endeavor tends to reduce the differences among the psychotherapies even though each applies itself with unique theories and special techniques to singular personality dimensions. A brief description of some of the chief orientations in psychotherapy may illustrate this. In the main, three positions are identifiable:

1. The relationship position (e.g., client-centered and phenomenologically oriented therapies)

2. The reward-punishment position (e.g., behavior therapy)

3. The cognitive restructuring position (e.g., psychoanalytic therapy)

The relationship position rests on the surmise that all persons, including emotionally sick people, possess an inherent drive for self-actualization. In the medium of a congenial, accepting, empathic relationship, positive growth factors can be released. The therapist consequently must communicate to the patient during the therapeutic encounter both understanding and respect for self-worth. Therapeutic methods are designed around these premises. For example, therapy may embrace tactics of "accepting the patient completely," of reflecting and restating the problems expressed, of recognizing and clarifying feelings, and of displaying tolerance toward aberrant impulses that come to light. In an atmosphere devoid of threat, the patient is presumed to be capable of examining and reorganizing a sense of self. This phenomenological viewpoint is bolstered by some research findings that indicate that children who feel accepted achieve greater intellectual maturation than those who feel rejected and hence unwanted. Clinical studies

also show that rejected children tend to respond with coping mechanisms, such as helplessness, defiance, aggression, and withdrawal that can easily interfere with development. In all helping relationships, such as counselor-client, physician-patient, administrator-worker, etc., a warm, respectful, nonpossessive "caring" attitude facilitates security and leads to enhanced self-realization (Rogers, C, 1961b). Theoretical systems do not in themselves cure. What brings results, according to the relationship position, is the dedication of the therapist to a system, the avidity with which the therapist applies it, the sincerity of purpose, and the communication to the patient that the therapist "cares" about what happens to him.

The reward-punishment position contends that behavior, including neurotic behavior, can be altered by exploiting certain consequences of behavior, namely, through the presentation or withholding of rewards or the inflicting of punishment. Neurotic behavior is learned. Anxiety, a secondary drive, fosters neurotic learning by promoting avoidance responses that diminish the intensity and rate of appropriate reactions. It is reasonable consequently to resolve anxiety by the same principles through which it is learned. Environmental stimuli are consequently manipulated to encourage constructive types of behavior. The therapist functions here as a kind of "social reinforcement machine." Various deconditioning techniques, such as "reciprocal inhibition," "operant conditioning," "conditioned reflex therapy," "aversive conditioning," "stimulus satiation," etc., are employed to weaken the conditioned connections between provocative stimuli and anxiety responses. Insight techniques are not considered adequate in breaking up these connections. On the other hand, reconditioning and desensitizing maneuvers are said to be most effective. Illustrative of the behavior therapies is "systematic desensitization" in which the patient is enjoined to fantasy, during hypnotic relaxation, a graded series of progressively intense stressful images, mastering each until all manifestations of anxiety disappear. A generalization of response eventually is said to occur that extends itself to the actual stress situation.

The cognitive position resists any possibility of extensive personality change without a significant alteration of the intrapsychic structure. This may involve a minor shift in

symbolic meanings through educational promptings, or it may embrace a widespread reorganization of value systems and patterns of behavior through the provision within the therapeutic situation of a corrective experience. Illustrative are philosophic and insight approaches.

Philosophic therapies are organized around the doctrine that it is reason's role to organize a happy and harmonious life in the context of the realities of the environment. Modes of facing reality are then offered to the individual in the hopes that one will find new purpose and meaning in one's existence. A change in cognitive organization is thus attempted directly by manipulating personal ideologies.

Considering such a change temporary, the dynamic schools attempt to produce a more permanent reconstructive alteration through various insight maneuvers, including probings of the unconscious. In classical psychoanalysis cognitive alterations are said to be best insured by permitting transference to build up to intense proportions through the therapist's adoption of a passive, neutral, non-interfering manner and through offerings of appropriate interpretations. The hypothesis around which techniques are constituted posits that emotional illness is the product of arrested development fostered by a neurotic disturbance in childhood (infantile neurosis). Cure is possible only when there is a reactivation of this neurosis and a resolution under circumstances that are favorable for its "working through." Appearing and reappearing in the form of the "repetition compulsion," the infantile neurosis is revived in the transference situation ("transference neurosis") as the therapist slowly induces the patient to push aside defenses that act as resistances to an awareness and resolution of childhood conflicts. Submerged in the unconscious to avoid anxiety, these conflicts support neurotic coping mechanisms that sabotage adjustment. An activation of unconscious conflict is fostered by such techniques as free association, dream analysis, a focusing on the past, frequent sessions, and relative passivity and anonymity on the part of the therapist. The patient, however, continuously resists dealing with the infantile conflict. The task of the therapist is to bring the patient to an awareness of any impulses to avoid the anxiety associated with its revival. The relationship with the therapist is of help in the interpretation of resistances. Helpful too is

the more benevolent atmosphere that exists now as compared to that which prevailed at the time that the neurotic conflict was originally developed. Under the auspices of the unique therapeutic relationship, the patient is said to undergo an experience that encourages one to approach life from a perspective shorn of hurtful expectations and neurotic defenses.

Among the interpersonal dynamic schools the focus is on the patient's security operations to neutralize anxiety that derives from the relationships to others. An understanding of the developmental experiences that have led to untoward coping methods and to disturbed behavior is considered vital. Formative tribulations with significant adults in the past are explored. A "corrective emotional experience" issues out of the testing of the patient's assumptions with new authority as vested in the therapist. Activity in the relationship and presentation of the therapist as a "real" person distinguishes the interpersonal from the classical analyst. Through these techniques, dissociated aspects of the self-system hopefully become consolidated.

The "relationship position," the "reward-punishment position," and the "cognitive position" seem worlds apart. However, when we peer beyond their manifest descriptions, we find that they deal with essentially the same processes, in each of which the following are operative—non-specific therapeutic elements, the personality of the therapist, reinforcement of selected responses, and cognitive restructuring.

Non-specific Therapeutic Elements

In themselves the forces of placebo, emotional catharsis, projected idealized relationship, suggestion, and group dynamics (see Chapter 4) can bring the individual to homeostatic equilibrium apart from any specific therapeutic tactics that are being employed. Restoration of a sense of mastery may lead to more appropriate attitudes and even to behavior change. Some reconstructive impact may even be registered in a propitious environment.

Determining Personality Ingredients of the Therapist

The most common elements in the resolution of stress, irrespective of the professional identification or theoretical orientation of the helping agency, or the stratagems employed in the therapeutic process are (1) a *feeling* on the part of the patient of being understood, liked, and respected by the helping agency, in spite of any weaknesses and problems and (2) a *conviction* of trusting, liking, and respecting the agency. Faith in the latter as a person who *wants* to understand and is capable of understanding is crucial. This would seem to point to "acceptance" as a facilitating factor in being helped. The therapist who is capable of communicating empathy, understanding, and "genuineness" will be rewarded with the highest proportion of "improvements" or "cures." So crucial is the issue of the therapist's personality, that consideration of the relative value of the different treatment procedures must presuppose that they are being implemented by therapists with effective personality structures. Since the personality of the therapist has jurisdiction over what happens during psychotherapy, the absence of essential traits, or the presence of negative countertransference that diverts the therapist from professional objectives, will make a shambles out of the therapeutic effort with little regard to the nature and extent of the therapist's training or the special theoretical school espoused. Therapists of the "relationship position" deliberately gear themselves to the expression of therapeutic traits nonverbally, if not verbally. The manipulative techniques of the therapist who supports the "reward-punishment position" and the benevolent paternalism of the psychoanalyst, neutral and seemingly detached as he or she appears to be, cannot conceal essential qualities of humanness, sincerity, acceptance, understanding, and empathy, which will either display themselves or fail to come through during the treatment hour.

Positive Reinforcement of Selected Responses

The relationship situation in all forms of psychotherapy supports selected reinforcement of special aspects of behavior. Widespread and consistent changes in behavior may be influenced by no more than nodding of the head and repetition of the words "uh-huh" or "hmm-hmm" on the part of the therapist (Thorndike, 1935; Greenspoon, 1950;Taffel, 1955; Verplanck, 1955; Wickes, 1956; Salzinger, 1959).

Accepting and approving responses from the therapist thus act as reinforcing stimuli in learning, and experiments in operant conditioning seem to bear this out (Verplanck, 1955; Greenspoon, 1954a & b; Lindsley, 1964).

In the behavior and conditioning therapies the therapist openly and directly presents the reinforcing and extinguishing cues. In the relationship, "client centered," and analytic therapies such cues are constantly being proffered—if not openly, then indirectly. For example, the patient may be rewarded by "approving" vocal and subvocal utterances whenever he or she responds the way the therapist considers appropriate. It is apparent that the therapist galvanizes into alertness and interacts much more readily when the patient deals with certain material. The patient will understandably focus on such rewarding constituents. Repetitive actions of the therapist will tend to circumscribe the patient's focus and to bring forth responses that seem to validate the therapist's theoretical beliefs.

An aspect of constructive relearning that takes place in psychotherapy is identification with the therapist who acts as a model for the reorganization of attitudes and values. In psychoanalytic therapy the working-through process involves a continued extinction of neurotic and reinforcement of positive responses. Motivation to approach life on different terms is provided by the emerging insights, and their translation into action harmonizes with a lessening of the severity of the superego. "Reward punishment" consequently enters into all psychotherapies, even those that disavow learning theory as a significant approach to the understanding of what is effective in treatment.

Cognitive Restructuring

It is doubtful if any significant or permanent personality changes are possible without some substantial shift in cognitive organization. Such shifts *may* occur when the individual gains sufficient understanding of inner needs and problems to challenge the assumptions that he or she cherishes. They *may* develop without awareness of what is happening during systematic desensitization or other conditioning techniques. Occasionally they *may* follow productive interpersonal experiences, inside or outside the

therapeutic situation, that do not repeat traumatic expectations. Unless the intrapsychic structure is altered, neurotic distortions will continue to be sustained, the productive experiences being regarded as happy coincidences to be followed by inevitable disappointments and hurts.

Change in intrapsychic structure is believed to issue most generally out of the working through of transference, which, recognized or not, openly or covertly shadows every therapeutic relationship. In all psychotherapies the patient assigns to the therapist a role of authority, and then tests the old expectations against this new image. As one realizes one is not criticized, condemned, scorned, or excoriated, the captious, accusatory, and fearsome attitudes toward punitive authority may become replaced, on the basis of constructive interactions with a tolerant authority figure, by a more wholesome representation that lessens the severity of the conscience, relieves guilt feelings, modulates expectations of punishment, and permits the avowal of repudiated impulses and needs. In psychoanalysis there is an encouragement, facilitated by techniques that activate the unconscious, of projections into the relationship of pathological needs and conflicts, evolved from past experiences, that continue to distort adjustment in the present. The emergence of these patterns within the treatment setting and the therapist's bringing the patient to an awareness through interpretation of such distortions enable the patient to learn more productive responses to authority. But even where transference is not encouraged, nor recognized, its emergence and working through will constitute one of the most important elements in change. Such resolution may take place on levels below awareness.

Discussion

Thus the three broad groupings of psychotherapy, while addressing themselves to distinctive areas of personality functioning, will evoke essentially similar processes. This does not mean that they will influence to the same degree all symptomatic, behavioral, and characterologic elements. We cannot expect that a few sessions in a benevolent accepting setting in relationship or client-centered therapy or exposure to a gradated

sequence of fearsome images in behavior therapy, however rapidly they melt symptoms, will produce the depth of personality reconstruction possible in well-conducted long-term psychoanalytic therapy. However, alteration of vectors other than symptomatic will have been initiated, and may in a wholesome environment continue to produce more substantial change. On the other hand, long-term analytic therapy may not immediately influence symptoms (which the supportive therapies may accomplish quite effectively and sometimes permanently); indeed, symptoms may even become exaggerated at first. Ultimately, however, where therapy is successful, symptom cure as well as reconstructive personality change may be anticipated.

There is some evidence that psychotherapists who dedicate themselves to special schools possess needs that the theoretical doctrines of the schools appear to satisfy, or they possess personality traits that coordinate with the school's methodological trajectories. Under such circumstances the postulates of a school will provide the therapist with an anchor to stabilize him or her in the uncharted sea of treatment. The abiding faith in the system will enable the therapist to approach with assurance the problems of a patient. It will give the therapist confidence in the patient's capacities to benefit from treatment. At the same time the school's technical maneuvers, appealing to the therapist's logic, permit the therapist to operate spontaneously and "genuinely" to heighten the patient's expectations of cure. These maneuvers are designed to deal with the presenting problem in terms of the assumptions and credos treasured by the particular school.

For example, in psychoanalytic theory a phobia may be regarded as a projected symbolic manifestation of an unconscious conflict or need. The therapeutic intervention then will be to expose, through uncovering techniques, the roots of the phobia as these appear in the unconscious. In behavior theory the phobia will be considered a conditioned response to which the patient is automatically reacting that requires extinction through deconditioning techniques. In relationship, transactional, game, and some forms of communication theory the phobic syndrome may be conceived of as a means of scoring an advantage, of protecting the individual from his or her own problems, and of achieving

control in a relationship with another human being who must share the consequences of the phobia. Strategies will then be evolved to accept the patient unqualifiedly, to prevent the using of the phobia as a manipulative vehicle, while encouraging development of other, more appropriate ways of handling relationships.

In each of these three approaches the pathology has been circumscribed around a limited group of parameters, and operations are structured to deal pointedly with these demarcations. Such attempts, of course, are understandable; but the insistence of most schools to generalize their assumptions to the entire psychological universe has led to much confusion and misunderstanding. It is quite probable that every individual with a phobia is projecting certain unconscious needs and fears on a symbolic level, that there has developed a set of conditioned responses that control one mercilessly, and that additionally leads to employing symptoms to gain certain advantages in one's relationships. Each of the schools considered above merely limits its focus to an aspect of the total problem.

The fact that, in the hands of skilled practitioners, patients get well through the use of any of the three approaches, to emphasize what has been said before, would seem to indicate that the psychotherapeutic experience encompasses factors other than those assigned to it by the different theoretical schools. When we deal with any one set of parameters, we inevitably must influence the others, just as in an equation where the unbalancing of coordinates on one side will require adjustment of the opposing variables. Thus, bringing the patient to an awareness of the unconscious drives that promote phobias may, if one is motivated, enable an effective deconditioning through active exposure to phobic situations. One may then be capable of deriving greater advantages from mature kinds of relationships than by the controlling tactics of the phobia. Or desensitizing oneself to increments of anxiety in behavior therapy may result in better interpersonal relationships as well as the resolution of certain conflicts that have their roots in the unconscious. Finally, dealing with the immediate transactions between therapist and patient during the therapeutic encounter may result in widespread changes in the habitual defensive operations of the individual, including the phobic facade, in

addition to altering the character structure itself.

SPECIFIC DIFFERENCES AMONG PSYCHOTHERAPIES

The similarities of processes among the various psychotherapies does not sanction the idea that there are no differences. Before considering these, it may be wise to recognize that the language forms of the competitive schools emphasize a greater divergence than actually exists. Thus the orthodox Freudian speaks of bringing the patient to "psychosexual maturity"; the disciple of Horney, to "self-realization"; the follower of Fromm, to a "productive personality"; the Rankian, to an "active creative will"; the student of Sullivan, to a "socially integrated adjustment"; the Adlerian, to true "social interest"; the Jungian, to "full self-development"; the adherent of dynamic relationship therapy, to "creative individuality"; the client-centered therapist, to "empathic self-acceptance"; and the existential analyst, to a "being-in-the-world" and understanding of the "meaning of existence." When we examine the connotations of these phrases as well as their implications, we discover that they embody similar abstractions. They say very much the same things in different words.

In attempting to differentiate the sundry psychotherapeutic approaches, two kinds of data are apparent. The first relates to observations of clinical phenomena made by therapists in the course of working experimentally and therapeutically with patients. The second is concerned with the interpretation of this data along theoretic, speculative lines.

Common theoretic constructs deal with the following:

1. The nature of the predisposing factors in emotional illness

2. The manner in which childhood experiences and conditionings produce distortions in personality development

3. The relationship between personality structure and neurosis

4. The constituents of inner conflict

5. The meaning, function, and manifestations of anxiety

6. The structure of the psychic apparatus

7. The mechanisms of defense

Various schools may place an emphasis, duly or unduly, on some of these constructs, or they may accent certain phases of psychodynamics that may or may not be verifiable.

Techniques of psychotherapy, though diversified, are not nearly so disparate as theoretic concepts. Indeed, basic similarities are apparent among all psychotherapeutic schools, which include the following:

1. They are all goal-directed toward specific objectives

2. They are organized around a relationship between therapist and patient

3. They require some kind of interviewing procedure

4. They evoke emotional responses in the patient which must be therapeutically handled

The goals in treatment with supportive, reeducative, and reconstructive therapies have already been described. Briefly, they consist of a relief of symptoms and better adaptation in areas of living in which the patient has failed (supportive therapy), a reorganization of attitudes and values with expansion of personality assets and minimization of liabilities (reeducative therapy), and an alteration of the basic structure of the character with creation of potentialities that were thwarted in the course of the individual's development (reconstructive therapy). The setting of goals may be determined in some psychotherapeutic systems by the patient, in others by the therapist.

The type of relationship between therapist and patient varies among the different psychotherapies. There are some relationships deliberately set up by the therapist in which he or she assumes an authoritarian, domineering, directive, and disciplinary role. There are others that are non-authoritarian, permissive, nondirective, and non-disciplinary, sometimes to a point where the therapist seems detached. There are still others in between these two extremes in which the therapist attempts to relate to the

patient as a cooperative partner. The degree of activity or passivity that the therapist assumes with the patient will vary with the relationship sought; it may remain consistent throughout the course of therapy or may shift at different stages of the treatment process. The kinds of attitudes displayed by the therapist will similarly range from moralistic to tolerant, from judgmental to nonjudgmental. Generally, the degree of authoritarianism of a therapist is dictated by his or her personality structure and may not readily be altered by design.

The kinds of verbalization obtained from the patient may be spontaneous and rambling to the point of "free association," or they may be focused by the therapist on selected topics. Similarly, the responses of the therapist may range from spontaneous comments and conversations to controlled utterances and pointed interpretations.

The interview focus will depend on the approach employed. For example, in supportive approaches it may be existent work, marital, social, and interpersonal difficulties with the object of correcting these as expeditiously as possible; or on faulty attitudes and values with the idea of directing the patient toward more rewarding objectives; or on suppressed and repressed feelings and experiences, with the aim of releasing pent-up emotions; or on irrational fears and attitudes with the idea of mollifying them. In many reeducative therapies the focus is on distortions in interpersonal operations with the object of enhancing character assets and of minimizing liabilities. In semantic approaches it is on language and communication disturbances for the purpose of clarifying concepts, values, and goals. In nondirective client-centered therapy it is on the feelings behind verbalizations in the hope of releasing spontaneous growth forces. In Freudian psychoanalysis it is on past life experiences with an attempt to resolve the Oedipus complex toward development of mature genitality. In Adlerian analysis it is on the present "life style" with attempts to resolve feelings of inferiority and compensatory power mechanisms. In Jungian analysis it is on the exploration of elements in the collective unconscious with the aim of releasing the individual from the crippling influences of "archetypes." In Rankian analysis it is on the union and separation strivings of the patient with the ultimate objective of resolving the ubiquitous birth trauma. In

Horney analysis the focus is on the contradictions of character structure with dissipation of character disturbances and of the unrealistic, idealized self-image. In Sullivanian analysis it is on the individual's relationships with people with the aim of restoring self-esteem and good interpersonal relationships.

It will be seen that the focus of inquiry is on selected aspects of the total functioning. Because the individual projects oneself as a whole into the most minute area of living, exhibiting in this area basic patterns of relatedness and basic defensive operations, the working through of problems in one area may result in a restructuring of the operations in other, apparently unrelated areas. Thus, if the focus chosen is inferiority feelings in relation to an employer, the limited resolution of the patient's attitudes inwardly and toward the employer may result in more harmonious attitudes toward other authorities, in greater self-esteem and feelings of mastery, and in greater self-acceptance including any impulses (i.e., sexual, hostile). If the focus is on sexuality and problems in relating sexually to others, or the resolution of fears of punishment, the capacity to separate the paralyzing archaic prohibitions of childhood from the present will probably eventuate in more constructive attitudes in the patient toward authority, toward colleagues, and inwardly. Consequently, even though our field of inquiry dealt practically exclusively with sexual problems, the total integrative function will have been influenced in successful therapy. These facts perhaps explain why the individual may be helped by many different approaches that selectively consider only a circumscribed aspect of functioning. Readjustment in one area starts a chain reaction that can involve the person as a whole.

The attitudes of the patient toward the therapist show extreme variations in all therapies, the patient reacting to the therapist, first, as a real person and, second, as a symbol of authority. Attitudes will consequently be molded by the actual role that the therapist plays with the patient as well as by habitual attitudes and feelings residual in the patient's previous dealings with authority. The attitudes of the therapist to the patient are also diverse. First, there are feelings toward the patient as a human being who needs help and services that the therapist renders for a fee; second, impulses are mobilized toward the patient that are neurotically nurtured and are parcels of disturbances in the

therapist's own character structure (negative countertransference, or that are manifestations in countertransference of projections by the patient onto the therapist of unconscious needs and impulses.) The methods of handling transference and countertransference, such as by encouragement, avoidance, control, or interpretation, will differ according to the goals in therapy, the specific techniques being followed, and the level of the therapist's understanding of psychodynamic processes in both the patient and personally.

A private survey among a sizable number of psychotherapists practicing supportive, reeducative, and reconstructive therapies yielded some interesting facts that have been detailed in Table 13-1, page 348 Outlined is a comparison of technical procedures in the three main psychotherapeutic groups, according to the duration of therapy, frequency of visits, the taking of detailed histories, routine psychologic examinations, the kinds of communications obtained from the patient, the general activity of the therapist, the frequency of advice giving to the patient, the handling of transference, the general relationship of the patient to the therapist, the physical position of the patient during therapy, the handling of dream material, and adjuncts utilized during treatment.

Duration of Therapy

No exact estimate of the time required to achieve therapeutic goals is possible in supportive, reeducative, and reconstructive psychotherapies. In some instances satisfactory goals are achieved in several sessions; in others treatment requires several hundred sessions. However, the tendency is toward relatively short-term intervals, averaging 10 to 50 sessions in supportive, reeducative, and psychoanalytically oriented psychotherapy. In classical and non-Freudian psychoanalysis the time estimate is from two to five years with an average of three years.

Frequency of Visits

Under most circumstances the frequency of visits, is lowest in the supportive and reeducative therapies, averaging no more than one or two visits weekly. In some

instances, as where anxiety is great, it is as high as three times weekly. In psychoanalytically oriented psychotherapy, visits average twice weekly, with a low of one and a high of three. Most non-Freudian analysts prefer seeing their patients three times each week, occasionally lowering this to twice, or raising it to four times weekly. Some Freudian analysts are insistent on visits no less than five times weekly, but others allege that they can handle patients on a four-times-a-week basis. A minority of analysts contend that, with experience and the proper selection of cases, psychoanalysis can be conducted on the premise of three, two, or even one session a week (Saul, 1958).

Detailed History Taking

In supportive therapy, a routine detailed history is the rule. It is employed in reeducative therapy in the form of a systematic inquiry into areas of adjustment and maladjustment. In reconstructive therapy, analysts, particularly Freudian analysts, prefer a spontaneous unfolding of historical data, some even condemning the practice of history taking as prejudicial to good therapy.

Psychologic Examinations

Intelligence testing and vocational batteries are often used in supportive and reeducative therapies as a means of assaying intellectual capacities, vocational interests, and work potentials. Projective testing, most frequently the Rorschach test, is employed in reeducative and reconstructive therapies, mostly as an aid in diagnosis to determine the presence of organic brain conditions and to ascertain the strength of latent schizophrenic tendencies.

Patient's Communications

The kinds of communication encouraged in the different therapies vary to a considerable degree. Free associations are rarely or never employed in non-reconstructive treatment. Guided interviews are organized in supportive therapy around symptoms, environmental disturbances, and immediate interpersonal problems, and in

reeducative therapy such interviews are organized around daily events and the current life situation. In classical psychoanalysis unguided free associations are considered mandatory in order to circumvent conventional resistances to unconscious content. Content dealing with everyday problems is felt to be of secondary importance, often serving as a diversion from focal areas of conflict. In non-Freudian psychoanalysis, free associations are believed to be useful, but are not felt to be absolutely essential. Interviews are often focused on interpersonal relationships and other apparent areas of conflict. Analysts who employ psychoanalytically oriented psychotherapy tend even more toward focused interviews, especially in short-term approaches.

General Activity of Therapist

As might be expected, activity and directiveness are greatest in those who do supportive therapy and least in practitioners who employ nondirective and Freudian analytic approaches. Irrespective of intent or the kind of therapy practiced, the degree of activity or passivity is determined largely by the personality structure of the therapist. Recordings of treatment sessions prove this point amply, therapists of active temperament finding it difficult to maintain passivity and anonymity even though their brand of therapy calls for these roles. Often therapists whose recordings show them to be very active and directive have no awareness of their activity or directiveness. In supportive therapy an active approach reinforces the authoritarian position of the therapist. This is felt to be helpful to the therapeutic objective. Moderate directiveness in other therapies, except perhaps in Freudian psychoanalysis, is not considered prejudicial to the therapeutic aim, provided it is controlled during phases of therapy where it is essential for patients to think through their own problems and to arrive at their own set of goals and values.

The lines along which the therapist actively works are determined in part by attitudes toward the patient's defensive mechanisms. In supportive and reeducative therapies the defenses are resurrected and strengthened with a rebuilding of those that have enabled the individual to function satisfactorily prior to the present upset. In

reconstructive psychotherapy the defenses are challenged for the purpose of eliminating those that perpetuate the neurosis and as a means toward alteration of the character structure itself.

Advice Giving to Patient

The amount of advice offered to the patient correlates positively with the degree of directiveness and authoritarianism assumed by the therapist in his or her relationship with the patient. In supportive therapy, accordingly, it is often given; in reeducational therapy it is occasionally proffered; while in reconstructive therapy it is, more or less, avoided except in emergencies.

Transference

In supportive and reeducative therapies certain aspects of the positive transference are encouraged, and utilized to facilitate therapeutic change. There is also a constant attack on, and dissipation of, negative transference as soon as this develops. In classical psychoanalysis the spontaneous feelings and attitudes of the patient are encouraged to a point where he or she may actually react to the therapist not as a real person, but as a symbol of authority toward whom archaic emotions and strivings are directed (transference). This enables the patient to live through with the therapist some of the most important traumatic experiences in the past (transference neurosis), gaining insight through actual revivification of events damaging to personality formation. Interpretation is in terms of genetic origins. In non-Freudian psychoanalysis and psychoanalytically oriented psychotherapy transference also is considered an essential part of therapy, but the transference neurosis is reduced by greater therapist activity, by less frequent visits, and by the immediate handling through interpretation of irrational trends and feelings. Transference is analyzed in terms of character structure as well as occasionally of genetic origins.

General Relationship of Patient to Therapist

In supportive and reeducative therapies, and occasionally in psychoanalytically oriented psychotherapy, a positive relationship is fostered and sustained as much as possible by appropriate actions and utterances, the relationship itself being utilized to promote therapeutic change. Transference reactions that interfere with a positive relationship are usually dealt with as expediently as possible. In all reconstructive therapies the relationship of the patient to the therapist is permitted to develop more or less spontaneously. Transference is encouraged in classical psychoanalysis as a vehicle of insight; it is controlled to a varying extent in non-Freudian psychoanalysis and in psychoanalytically oriented psychotherapy.

Physical Position of Patient during Therapy

The sitting-up position is always utilized in supportive and reeducative therapies. In classical psychoanalysis the recumbent couch position is employed as a means of fostering free associations. This requirement is less rigidly followed in non-Freudian psychoanalysis, in which the sitting-up position is alternately or exclusively used with certain patients. In psychoanalytically oriented psychotherapy the sitting-up position is employed, though occasionally, at certain phases of treatment, the recumbent position may be preferred.

Dream Material

Dream material is generally disregarded in supportive and reeducative therapies, although analytically trained therapists, who use such therapies, study dreams without interpreting them to the patient in order to observe the defensive reactions of the patient, including transference and resistance manifestations. In all of the reconstructive therapies dream material is employed as a principal means of access to unconscious conflict. The manner in which dreams are handled will vary according to the theoretic training and orientation of the therapist.

Adjuncts Utilized during Therapy

Somatic therapy, hypnosis, bibliotherapy, physical therapy, occupational therapy, and other adjuncts are often employed by therapists practicing supportive therapy. In reeducative approaches and in psychoanalytically oriented psychotherapy, group therapy, drug therapy, bibliotherapy, play therapy, art therapy, narcotherapy, and hypnotherapy are sometimes coordinated used. Few adjuncts are utilized in non-Freudian psychoanalysis, while in classical psychoanalysis most therapists avoid all adjunctive devices.

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What Is the "Best" Kind of Psychotherapy?

Comparative studies of current psychotherapies have not been able to answer the question of which psychotherapy is best. Among the most interesting are the investigations of Luborsky, Singer, and Luborsky (1975), who in a detailed survey of a large number of reasonably controlled outcome studies discovered insignificant differences in results obtained by the various categories and brands of psychotherapy. This "tie score" applied to individual versus group psychotherapy, time-limited versus time-unlimited therapy, client-centered versus psychoanalytic, neo-Freudian versus Adlerian therapy, and behavior therapy versus traditional psychotherapy. A detailed "meta-analytic" investigation of 400 outcome studies by Smith et al, (1980) has yielded ambiguous results regarding the superiority of one type of treatment over the others. This is not surprising considering the many variables that interfere or enhance the techniques being employed. (See Chapters 3, 4 & 5). All we can do at this point in time is to express some hunches about the relative value of different techniques for specific conditions. Even here *how* the techniques are utilized and the skill of their application will be the determining factor in the results achieved. Considering that psychotherapy is so expensive, it would seem prudent to select that model of treatment best suited to help a patient's particular problem. To a large extent, however, confusion about the value of different forms of psychotherapy is due to the fact that contingencies responsible for therapeutic improvement are still unclear. Psychotherapists are apt to credit their results, not to kindred events common to all psychotherapies, but to casual epiphenomena unique to their own methods of treatment. Accordingly, they have—some with undaunted hubris-made global assumptions about the values of their personal ideologies and techniques.

The thesis that all psychotherapies score similar results is, however, open to a good deal of question. The quality of improvements achieved and permanence of beneficial effects will vary. There is a great deal of difference between an "improved" patient who achieves mere symptom relief and one who in addition to symptom relief and problem

solving is helped to self-under-standing and true personality change. These factors are usually not considered in random outcome studies. Nor is, perhaps, the most important variable emphasized, namely the therapist himself or herself—in terms of training, experience, expertise in working with a special technique, and capacity for empathy, sensitivity and perceptivity—ingredients that are more important than the identifying labels pinned onto treatment interventions. In other words, the value of any psychotherapy is no greater than the competence of the therapist who implements it.

It is probable that the great leveling agency in many of the outcome studies is the sophistication, judgment, experience, and training of the involved psychotherapist—a detail that is glaringly missing in the design descriptions. It may be that the results obtained by the effective versus the ineffective therapists in each of the psychotherapies balance themselves off resulting in the typical bell-shaped improvement curve. This in no way depreciates the importance of research in therapeutic outcome studies; it merely emphasizes the need to include some idea about the therapists who take part in the studies. After all, a scalpel is no better than the surgeon who wields it, and an adequate therapeutic regimen may be blemished by inexpert or undisciplined operations. On the other hand, many worthless procedures in the command of zealous practitioners may yield astonishing bounties as a result of their placebo and other non-specific influences.

Enthusiasm is no substitute for competence. The fact that a therapist is convinced that his or her method is superlative does not make it so. Unfortunately, some of the more undisciplined approaches attract aggressive, charismatic leaders whose bag of tricks lure many followers only too willing to subscribe to their methods, whether these involve nudity, eye balling, touching, screaming or other oddities. Obviously, some of these unconventional interventions while seemingly useful in the hands of one therapist may prove valueless for other therapists. Waging chemical warfare on the neurosis with megavitamins, breaking the sex barrier with "love treatments," massaging the brain with electronic devices, persistently and violently reproducing the regressed conditionings of the infantile period and other specious tactics appear dramatic, even infallible.

It is easy to become oversold on techniques that seem to produce results. Yet caution should remain the keynote in appraising the effectiveness of any method no matter how convincing the outcomes may seem to be. Are positive consequences due to a unique group of patients who constitute the therapist's present caseload? Does a specific therapist possess an affinity for a special technique, applying it with dedicated zeal? In the latter case the patients will respond more to the therapist's conviction and enthusiasm than to the treatment maneuvers themselves.

Statistics reveal that during the early development of each "new" approach there is approximately 90 percent recovery or improvement. This is followed by a period of therapeutic pessimism as the placebo element wanes and failures become apparent. If the improvement rate stabilizes in the 50-60 percent range, the method may foster continued acceptance (Tourney, 1966).

In each of the new approaches there is a narrowing down of the many vectors that enter into interpersonal relationships to a selected group of variables. These are presumed to constitute the essence of the therapeutic process. A common error perpetuated by the average therapist, who is convinced of the validity of his or her theory and virtues of personal method, is that the focus is on obtaining data that will authenticate the individual bias. While unraveling the tangled skeins of a patient's life, the consecrated theoretician may become a prisoner of an unsound model. Having committed themselves to a single point of view, therapists are invariably impaled on the sword of their own postulates. In the midst of present-day Promethean scientific discoveries, we should expect a greater willingness than now exists to introduce more threads of objectivity into the fabric of psychological thinking.

CHOICES OF TECHNIQUES

No psychotherapeutic method exists today that is applicable to all patients or germane to the operations of all therapists. Techniques by which transformations come about accord with the skill of the therapist who applies them and with the facility of the patient to accept and utilize the preferred interventions. Since psychotherapy is a learning

process, the techniques to which a patient is exposed will work best if they coordinate with his or her unique methods of learning. Some persons learn best through cognitive operations, finding out the reasons that underlie their problems and acquiring an understanding of their self-defeating behavior and its origins. Such persons are attracted to insight methods. Others learn by following suggestions of authoritative persons or those they respect. Some learn through action and doing, i.e., achieving positive reinforcements in their environment for adaptive behavior; some through experiencing a corrective emotional experience with their therapist or with another human being who is used as a substitute therapist; others through example (modeling) and philosophical precepts (identification), which provide them with modes of thinking and behavior. Some learn best when subjected to psychological shock, attack, or confrontation that challenges their habitual defenses. These and additional kinds of learning usually act in combination within each individual. What is challenging for a therapist is discerning the form of learning that each patient can best utilize and then working to adopt techniques that are best suited for the patient's learning propensities. An important area of research is a way of detecting a patient's optimal modes of learning. If we can pinpoint these, we may then more precisely determine the best means of therapeutic operation.

SYMPTOMATIC VERSUS INSIGHT APPROACHES

The variant methodologies have implications for the mental health field that go beyond the mere appraisal of what kind of therapy is best. They accent controversial contemporary issues among the different psychological schools, including a reciprocal challenging of the validity of the somatic, conditioning, psychoanalytic, and eclectic psychotherapeutic approaches. In the main, two philosophies of therapy are currently in vogue. The first contends, "Treat the symptom and the person as a whole will benefit." The second avows, "Treat the person as a whole and the symptom, which is only a byproduct of conflict, will abate or vanish." These viewpoints embrace more than a mere matter of emphasis. They encompass contrary hypothetical formulations, discrepant ideological preconceptions, and contrasting values. The first, which, punctuates symptom removal as the prime force in treatment, is founded on the premise that faulty responses to anxiety

are produced by an unfortunate "programming in" of information leading to destructive habits that tend to generalize. The second, which exploits insight as the prime force in treatment, looks upon symptoms as manifestations of unconscious conflicts that are shaped by such mechanisms as condensation, displacement, projection, and symbolization. It considers the relationship of the individual to important persons in life preserved by transferring and discharging dangerous feelings toward symptomatic tokens.

Having identified what each considers the cause, adherents of these two credos deal with it through special procedures, each author proclaiming the virtuosity of a preferential method, which, in description, sounds effective and impressive. Thus a symptomatically oriented therapist, dedicated to somatic treatment, may launch an attack on the complaint factor itself, dissociating the symptom from the psyche as a whole by phenothiazines or tranquilizers, or making available greater amounts of energy by administering energizers, which may help foster the integration of the symptom into the bodily economy. A behavior therapist will attempt to break up the connections between stimulus antecedents and the "habits of anxiety responses" through a desensitization technique. A classical analyst will direct "insightful" efforts toward expanding the strength of the ego, resolving resistances to unconscious conflict, and working through the infantile neurosis in the transference neurosis. A non-Freudian analyst, acknowledging the unconscious origin and defensive intent of symptoms, may work toward their understanding and mastery by a number of psychoanalytically oriented techniques, perhaps blended with directive stratagems, which are often labeled with some original tags. The methods leading to symptom resolution are more or less short term; those geared toward insight, long-term.

When we compare results of the symptom-oriented versus the insight-oriented therapies, we must admit that the former are considerably in the lead insofar as rapid elimination of symptoms themselves are concerned. A leaky roof can expeditiously be repaired with tar paper and asphalt shingles. This will help not only to keep the rain out, but also ultimately to dry out and to eliminate some of the water damage to the entire

house. We have a different set of conditions if we undertake to tear down the structure and to rebuild the dwelling. We will not only have a water-tight roof, but we will have a better house, that is—and this is most important—if the fundamental foundation of the house is strong, if the carpenter is good, and adequate financing is available. Too often we find attempts at reconstruction of both houses and personalities on foundations that are too weak to support new edifices or that are fabricated by builders who are inept. Personality reconstruction is a long-term, tedious, expensive, and risky process. Not all efforts terminate in success; where they do, the results can be most rewarding. The tolerances, however, in terms of therapist competence and patient accessibility are fine. If our object is merely to keep the rain out of the house, we will do better with the short-term repair focused on the roof alone and not bother with the more hazardous, albeit ultimately more substantial, reconstruction.

It is unfair to compare the symptom-directed and insight-oriented therapies. We deal in both with different dimensions and distinctive therapeutic goals. It may be possible to bring about symptomatic relief quite rapidly with various devices as suggestive hypnosis, drug therapy, behavior therapy, and numerous other supportive and reeducative modalities, but to effectuate character change will require a lengthy process that involves a working through of many resistances and defenses. Insight therapy may not produce any immediate symptomatic benefits; if it is effective, these will show up much later.

In appraising comparison studies it is important to remember that no single therapist can apply himself or herself equally well to all techniques. The therapist will have a bias toward and dedication to one or another procedure, and results will then be influenced by the therapist's allegiance to and sophistication with that system. An orientation toward a theory and methodology is far different from intensive training in and experience with these commodities. Above all the personality of the therapist as it displays itself in the treatment relationship is of utmost importance. One's capacity for empathy and understanding, one's sensitivity and one's ability to control and utilize countertransference are crucial in all forms of psychotherapy.

What is it, then, that helps our patients to overcome disorganizing psychological handicaps and to arrive at greater self-fulfillment? Is it the techniques that we use? Is it the *way* the techniques are implemented? Is it the agency who administers the therapeutic stratagems—the healing impact on the patient of subtle empathic qualities and personality traits of the therapist? Is it the insight the patient gains into the antecedents, manifestations, and the consequences of the repetitive-compulsive maneuvers? Is it the corrective resolution of the transference situation? Is it the experience of relating and of communicating in a climate that permits of a reconceptualization and reconsideration of one's basic credendas? Is it the influence of a host of adventitious, intercurrent forces, such as the placebo effect, emotional catharsis, projection of an idealized parental relationship or suggestion that automatically are set loose in any authority-subject relationship?

It is probably all of these things and more. One hypothesis that seems to be clinically substantiated is that in any emotional disorder a continuum of pathology may be observed: from physiological to intrapsychic, to interpersonal, to social, to spiritual. Therapeutic intervention along any link of this continuum will have a feedback effect on the other links of the chain. Thus an assault on the disturbed physiological vectors, i.e., on the biochemical components that make for anxiety, by a phenothiazine, and/or the secondary depression by an energizing drug will dissociate the symptom from its emotional underpinnings and make available psychic energy that promotes a sense of confidence and well-being and a reintegration of the experience into the general psychological economy. The feedback may result in a harmonious realignment of the intrapsychic structure, improved interpersonal relationships, and a more wholesome life outlook. The same results may come about if we properly organize an attack on the conditioning process that sustains a faulty learning experience. Restoration of stability that eventuates from the progressive vanquishing of anxiety will usually have a constructive effect on the total cognitive, affective, and behavioral field. In the insight therapies recognition of the childish underpinnings of characterologic distortions provides the incentive for a working through of these aberrations, resulting, in successful therapy, in a reconditioning of habit patterns. There will obviously be salutory

interpersonal and physiological concomitants in such change.

The philosophical note that we may sound from these observations is that no one school of thought has the monopoly on psychological wisdom. Each deals with *partial* weavings in the total tapestry of truth. We may learn much from our colleagues who happen to indulge a different way of looking at things—provided we face the shortcomings of our theories and methods honestly, accept critical challenge of our ideas, and not allow ourselves to bleed too copiously from narcissistic wounds when people do not happen to agree with us. The heritage of the scientist, in the words of Norbert Wiener, father of cybernetics, is "to entertain heretical and forbidden opinions experimentally." But such apostasy must be imbedded in an atmosphere of tolerance for the ideologies of our peers; otherwise psychotherapy may never be lifted from its present morass of speculation and placed firmly in the family of sciences as a respected member. (See Treatment Planning).

ARE PSYCHOANALYTIC APPROACHES ESSENTIAL FOR RECONSTRUCTIVE CHANGE?

A vital question is whether techniques other than psychoanalysis may have a reconstructive influence on the psychic structure. The answer to this question is the pivot around which rotates much of the current controversy in the psychotherapeutic field. In the main, the answer is "yes." Reconstructive changes are occasionally possible in individuals with flexible personalities in the medium of productive life experiences. They are possible in a therapeutic interpersonal relationship that does not repeat for the patient traumatizing expectations deriving from the past, even though the relationship itself is not the focus for investigation. They are possible in therapeutic relationships that deal with transference, without an actual eruption into transference neurosis, provided that transference is properly interpreted and the resistances handled. The latter contingency is what occurs in psychoanalytically oriented psychotherapy in which transference is encouraged but modulated in its manifestly expressed intensity.

Psychoanalysts, however, recognizing the failure of some patients to give up their neurotic behavior even with years of "depth" therapy, may question the efficacy of

"superficial" therapies that circumvent the unconscious. How, they ask, without free association, dream analysis, exploration of genetic material, and incisive dealings with resistance and transference is it possible for any person to reconstitute the basic personality structure and to get well? Implied is a denigration of psychotherapeutic efforts that deal exclusively with conscious elements. Benefits accruing from a mere rearrangement of defenses, with temporary circumvention of the Oedipal core, are presumed to be cancelable at any time in the future.

This line of thinking may reasonably be questioned. There is no evidence that psychoanalysis is the one agent capable of altering the unconscious. Definitive relearning, influencing personality on a depth level, may occur as the result of fruitful life happenings and wholesome relationships with people. A "superficial" therapeutic experience may thus serve as a means of changing the neurotic constellation on conscious, preconscious, *and* unconscious levels. Kolb and Montgomery (1963) describe an interesting case in which a patient achieved (1) spontaneous insights into his feelings about both his father and men in general, as these were being projected into his relationship with his therapist, and (2) an understanding of his psychosexual development. His therapist, who was an inexperienced person, was completely unaware of what was going on. As a result of "ego modification with change in perceptual capacity" the patient manifested lasting reconstructive effects. The authors conclude, "The borderline between psychoanalysis *per se* and psychotherapy, whether this be administered by a physician, or a member of any other profession, is likely to become less distinct. The various efforts to discriminate the varieties of psychotherapy are unlikely to hold with the expanding capacity" of psychologically minded persons to carry out effectively "procedures that have for long been considered the prerogative of highly trained therapists."

Since the etiology and pathogenesis of most psychiatric ailments are unknown, as are explicit criteria for assignment to special psychotherapies, it behooves us to adopt an empirical approach based on the widest flexibility of method (Guze & Murphy, 1963). The question may be asked, "Is it antithetical to science to adopt theoretical systems in proportion to how useful they prove themselves to be"? Practically speaking, it may be

necessary for the therapist who wishes to benefit the majority of patients to step down from a platform of purism. At the same time, as scientists, therapists may wish to examine the variables that have brought health to their patients in the hope of evolving hypotheses that can be subjected to later testing, toward the goal of replicating good results. Progressive psychotherapists constantly examine their data, developing hypotheses, testing their inferences, scrutinizing their methods, and observing patient responses to these, not hesitating to backtrack and to revise their approach, until the one is found that is best suited for the particular patient and the special problem that is being dealt with at the moment. There are many techniques available for the experimental psychotherapist that will expand the quality and quantity of one's results.

A TRIPARTITE APPROACH TO PSYCHOTHERAPY

In evolving an effective therapy, some therapists must give special consideration to at least three levels of psychological operation present in all individuals and that in the healthy person operate in concert. These levels also act autonomously with a feedback influence on one another. They correspond roughly to, but are not identical with Freud's superego, ego, and id.

The first level is contained in a group of mental operations in the form of values or "meaning systems" through which are filtered perceptions from the outside world, inner sensations, and memories. In large measure values are unconscious, and the individual clings to them tenaciously, since they give one identity and add substance to one's life. Behavior is usually organized around these systems and values, in this way reinforcing their validity. Meaning systems, which in the rank of mental operations are primary, are to some extent modifiable through such agencies as: (1)suggestion, (2) conformity to authoritarian injunctions, (3) group identification, and (4) education and progressive self-understanding.

The second functional level embodies intrapsychic processes that govern interpersonal relationships, modes of managing external stress, mechanisms of coping with inner conflict, and defenses against anxiety. Defects in the machinery through which

the individual attempts to regulate relationships with other people are generally the product of: (1) defective organic equipment, constitutionally determined, that limits the adaptive capacities of the individual and (2) problems produced by destructive and ungratifying childhood experiences with important past personages that have engendered reparative and protective devices that survive in adulthood, even though they no longer serve constructive purposes. Intrapsychic processes are less amenable to change than are the first level meaning systems.

The third level involves the organic continuum, biological residues, which containing alterations in the neural structure are least amenable to psychological influence.

Unless these three functional levels are recognized in the treatment of patients, the therapist may focus attention on one or another without considering that they operate in unity. Thus the therapist may educationally attempt to change values by inculcating in the patient a different philosophy through which it is hoped there will evolve new ways of behaving, feeling, and thinking. Illustrative therapies in this group are persuasion, reeducative existentialist approaches, and meditation. Other psychotherapies—for example, insight therapy or psychoanalysis—may concentrate on intrapsychic processes, hoping to bring the individual to an awareness of their existence, their genetic origins, and the inconsistencies and consequences of their operations. Finally, some therapies may mediate the biochemical milieu (psychopharmacology) or refashion conditioned reflexes through methods derived from learning theory (behavior therapy), attempting to divert the individual from destructive habits by substituting new and constructive ones.

While the correction of one of the functional levels may influence the others through feedback, the chances of this are less than where the therapist specifically directs efforts at all implicated levels. One of the reasons why a fusion of methods is resisted is that in our "scientific" immaculacy we tend to adhere to, and often are frozen in, the conceptual framework of one system. Admittedly, no single theoretical model can embrace all existing levels of behavioral operation. Spiritual, dynamic, behavioral, and neurophysiologic models do not mix. But, irrespective of how disparate their conceptions, *methods* derived

from all of these models may have a pragmatic utility if they are combined with discretion and forethought and if they are focused on the patient's needs, and not determined by the theoretical denomination with which the therapist is identified.

We may find much to criticize in the theories of any of the pioneers in the mental health field. But, however much we disagree with such theories, we cannot ignore them. Nor must we downgrade the richness of their contributions simply because we repudiate certain aspects of their thinking. The original discoveries of the workings of the unconscious by Freud, the role of human relationships in education and child guidance by Adler, the formulations of personality types by Jung, the origins of love and hate in early life described by Melanie Klein, the broad sociological vistas opened by Fromm, the excursions into character structure by Horney, the biological conceptualizations of Rado, the anthropological explorations of Kardiner, the distortions of interpersonal relationship described by Sullivan, the holistic directions of Adolph Meyer, the conditioning experiments of Pavlov—these and other offerings from innovators in the field have fashioned many of our contemporary ideas about how people develop, function, become psychologically ill, and get well again.

Unfortunately, self-appointed guardians of the scientific torch tend to run pragmatic and eclectic approaches into the ground. They warn against their dangers, comparing them to a "shot-gun" prescription that is exploded in the hope that one piece of buckshot will find its mark. Yet it is not the variety of methods that is important—but the intelligence with which they are employed. One does not scatter out techniques in desperation with the frantic prayer that one will work. Rather one selects those suited to a particular occasion and need. Thus an alcoholic may, in addition to psychotherapy, require antabuse and regular contacts with Alcoholics Anonymous. A woman in deep trouble with her adolescent child and her husband may be helped by supplementing her individual treatment with family therapy. A phobic patient, once brought to an awareness of the unconscious roots of the problem, may need to be helped to extinguish any anxiety responses through behavior therapy.

TOWARD A BALANCED ECLECTICISM IN METHOD

Data filtering into the field of mental health from neurophysiology, biochemistry, genetics, behavior genetics, ethology, animal experimentation, conditioning experiments on humans, long-term clinical studies of personality development, learning theory, social theory, role theory, group dynamics, cultural anthropology, communication theory, information theory, cybernetics, philosophy, and field theory are now influencing our traditional ideas about psychotherapy by affirming the conception of function and structure as dynamically interrelated within a field of forces that range from the remotest regions of the environment to the innermost recesses of the organism (Wolberg, L, 1966). In a never ending transactional feedback, the individual develops a personality in all of its cohesiveness and uniqueness. This consolidates a basis for interdisciplinary and eclectic approaches to mental health. An eclectic viewpoint is more than justified by the fact that the various schools of psychiatry, psychology, and other behavioral sciences have made significant contributions to psychotherapy.

Information from fields affiliated with psychotherapy has many practical applications for the psychotherapist.

1. From neurophysiology we may gain an understanding of the mechanisms of emotion, the bodily responses to stress, the nature of the recording of memories, the biology of sleep and dreaming, the functions of selected brain areas, and the dynamic interactions of the neocortex, reticular system, limbic system, and hypothalamus. Such information helps to organize a rationale for the somatic therapies.

2. From biochemistry we gain perception of how the energy resources of the body are governed, the role of enzymes, neurotransmitters and neurohormones, the chemical regulation of brain metabolism, the mechanisms of mood formation and psychoses, and the influence of drugs on specific areas of the brain. This provides a basis for the employment, where essential, of the psychoactive drugs during phases of psychotherapy when depression, excitement, cognitive disorganization, or intense anxiety interfere with the psychotherapeutic process.

3. Genetics supplies leads on how hereditary influences may interfere with proper

metabolic operations within the brain, rendering some individuals more susceptible to psychological disorders. Behavior genetics yields clues regarding the ubiquity and uniqueness of inherited response patterns among different individuals and their potential modifiability through learning.

4. Ethology points out the role of fixed neuromuscular coordinations in man that are operative normally or that are released during neurotic or psychotic adaptations.

5. Conditioning theory forms a structure for knowledge of how: personality organization evolves, higher and lower brain structures interact, and disorganizing and maladaptive behavior is learned. It supports a premise for comprehending the behavioral therapies.

6. Data from animal experimentation, principally the development of experimental neuroses and their removal by various stratagems, introduce avenues for approaching human neurosis. A grasp of the dynamisms of stress and adaptation are vital for discernment of what has happened to the neurotic individual whose coping mechanisms no longer keep one in homeostasis.

7. Developmental and personality theories, which essentially deal with ontogenetic maturation, occupy the psychotherapist's interests, since the therapist will arrange hypotheses around forces in the patient's life that have shattered adaptive potentials.

8. Learning theory grants a foundation for studying the acquisition of disorganizing habit patterns; it introduces principles that, incorporated in the therapist's interviewing procedures, may help facilitate the therapeutic process.

9. Psychoanalytic theory—classical, ego analytic, neo-Freudian, and object relations—presents the therapist with a rich body of formulations that delineate conscious and unconscious intrapsychic operations, subsidizing a systematized methodology. It also opens views to the therapist of his or her own irrational emotional projections toward the patient (countertransference).

10. Social theory and role theory are viable systems for the understanding of social process and interpersonal conflict as a means toward environmental and casework approaches.

11. Group dynamics delineate tactics of altering attitudes and patterns through interaction.

12. Anthropology illuminates the cultural atmosphere that shadows the patient's attitudes and responses. It supports the need to evaluate character structure in terms of family and cultural patterns.

13. Philosophy enables an appreciation of the power of value conflicts and apprises the therapist of the responsibility for altering value systems in a patient that prevent the expression of basic needs and interfere with proper adaptation.

14. Communication and information theories focus the therapist's attention on problems that are expressed through altered symbolic activities.

15. Field theory permits a perspective of neurotic problems in relationship to environmental, interpersonal, intrapsychic, and physiological variables, as well as a gauge of therapeutic goals in terms of the broadest social objectives.

Added to the above are the contributions from psychobiology that have introduced the philosophy of considering the human being an integrate of a variety of functions and have stressed the need for a practical assay of existing assets and liabilities in working out a treatment plan. The casework field has evolved a whole body of supportive approaches, along with carefully formulated interviewing and supervisory processes. The field of psychology, has contributed certain nondirective and directive counseling techniques, along with a number of procedures in play therapy, art therapy, speech therapy, vocational guidance, and rehabilitation. Finally, from the field of medicine there has come the consideration of the reciprocal relationship that exists in physical and psychic illness.

The ultimate effect of these new trends and trajectories from the behavioral sciences is toward a reasoned technical eclecticism (Lazarus, 1967; Halleck, 1971; Woody, 1971; Feather & Rhoads, 1972; As-tor, 1973; Thorne, 1973; Simon, RM, 1974) identified by various titles such as *multimodal therapy* (Lazarus, 1976) and *differential therapeutics* (Frances et al, 1984). Eclecticism does not presuppose a disordered conglomeration of disparate devices thrown together into an expedient potpourri. Rather, it involves the

selection and studied amalgamation of therapeutic interventions from varied sources that are compatible with and reinforce one another. In this way a fusion of concordant methods buttresses up weaknesses in the individual systems. The synthesis, harmonious as it may seem for the moment, is subject to constant reorganization as new ideas and approaches make themselves available. Unfortunately, eclecticism has come to connote unprincipled and even counterfeit opportunities practiced by those who sacrifice integrity of doctrine for temporary rational consistency or utilize it as "a cover-up for lack of scientific commitment" (Maultsby, 1968; Ornstein, 1968; Eysenck, 1970). The uncritical syncretism characteristic of the ancient philosophic sect of eclectics does not apply to the present-day eclectics, although purists and formalists are apt to consider the thinking of modern eclectics too loose and unsystematized. On the whole, the eclectic direction has proven a refreshing diversion from the rigid, oracular, and dogmatic schools and systems —some of whose members refuse to compromise their positions under the mistaken conviction that if they are not God's chosen people, they are at least his principal scientific missionaries.

Eclecticism in method is also justified by the fact that a number of things can be done for a person with an emotional problem that will make one feel better, temporarily or permanently. These include (1) alleviating or removing the symptoms, (2) adjusting the life situation so that it imposes a minimal burden on one, (3) inducing an alteration in disorganizing attitudes and life goals, and (4) investigating what conflicts are at the bottom of the difficulty and dealing with them on various corrective levels.

All psychotherapies approach one or more of these aims, being better adapted to some than to others. Different therapists, by virtue of their unique personalities and specialized training, apply themselves to one or another technical procedure with greater or lesser facility. And patients selectively respond to some therapeutic methods and not to others.

There is, therefore, no "best" kind of therapy except that which happens to suit the patient's needs most at the time of application for treatment. When we consider the

preferred type of psychotherapy—supportive, reeducative, or reconstructive— we must keep in mind exactly what we are trying to accomplish. A patient with even a sound and well-organized personality structure may have gone to pieces in the face of severely traumatizing environmental circumstances. The only help that may be required is a short interval of supportive therapy, which will suffice to bring the patient back to the customary adjustment level. To embark on a long and costly course of psychotherapy would be ill-advised, unless the patient failed to show improvement after the immediate stress source was resolved. A second person may suffer from problems in adjustment that interfere with an ability to get along with people; yet the person may be sufficiently flexible to alter patterns of living once these distorted patterns are brought to light. The preferred treatment here would be some kind of reeducative therapy. Another person may come to treatment with what seems to be a minor work or marital problem. Our examination may reveal that the compliant factor is merely the superficial manifestation of a serious personality disorder and that the complaint cannot be remedied until a drastic reorganization of the person's character structure takes place. This will require perhaps years of reconstructive therapy.

Since psychotherapy is an interpersonal relationship, the personality of the therapist, as reflected in the capacity to relate to patients, is fully as important—if not more important—than the method employed. Indeed, the personality of the therapist influences the choice of method as well as modifications introduced in implementing any set technique. Thus, some therapists, by virtue of their basic characterologic passivity, do better with "passive" techniques, such as nondirective therapy. Other therapists, possessing more active character structures, are unable to play a passive role in therapy and are inspired toward executing supportive approaches, directive reeducative therapies, non-Freudian psychoanalysis, or psychoanalytically oriented psychotherapy. Most patients seem to do well with selected methods of treatment, provided the therapist is skilled in a particular approach and is capable of setting up and maintaining a good working relationship with the patient. This does not mean that goals are interchangeable in supportive, reeducative, and reconstructive therapies because, as has been indicated, there are definite limitations in the extent to which emotional problems may be influenced

by the technical methods employed. Yet, within each of these three large groupings, considerable flexibility in method may be displayed consistent with the therapist's training and personality set.

The beneficial effects wielded by psychotherapy, irrespective of type, are to a large extent due to a restoration of the patient's sense of mastery. This results from a constructive use of the therapeutic relationship in a number of ways. First, patients may gain from therapy sufficient emotional support, sympathy, and understanding to help them to endure and to conquer inner tensions and external demands. The relationship, while supportive, is ideally utilized in such a manner that it does not inhibit, but indeed encourages, impulses for assertiveness and independence. Second, the relationship facilitates the cathartic release of disturbing feelings, with alleviation of guilt and fear. Third, patients are helped to mediate an external or internal stress source or to adjust themselves to it. Fourth, shattered repressions are rebuilt and habitual defenses restored, with alteration of those defenses that are destructive to adjustment. Fifth, a reevaluation of the self develops with modification of certain unrealistic attitudes and strivings and substitution for them of productive patterns that lead to more congenial relationships with people.

Where the therapist's personality and technical skills facilitate the above effects, the results of therapy are usually good. Where the therapist's personality or methods block such effects, results will be poor no matter what school of thought the therapist espouses or how thoroughly conversant he or she is with theory.

In instances where the patient achieves a good therapeutic result, the therapist may assume falsely that what has effectuated the cure or improvement was the focus on a specific theoretic orientation rather than because of important processes evolving out of the patient's constructive use of the relationship in the indicated ways.

THE NEED FOR A UNIFYING CONCEPTUAL FRAMEWORK

In our eclectic effort to expedite psychotherapeutic method, some of us are apt to

extrapolate from the affiliated sciences contours that are applied uncritically to our own field. Particularly prevalent is the practice of applying alien theories to systems with which they have little affinity. A chaotic practice moreover has been the utilization of language pertaining to one system to describe what goes on in other systems. Thus employing the vocabulary and structure of information theory to describe intrapsychic processes, or of neurophysiology to interpret social phenomena, has done little to clarify the intricate exchanges that are taking place within and between these units.

During the past few years a new perspective has evolved in the behavioral field that conceives of the human being as a balanced composite of multiple units functioning in the orbit of a larger group of systems. So intimately bracketed are self and milieu that alteration of constituents in either moiety must inevitably effectuate some change in the total structure. Accordingly, the focus has shifted from operations within single systems to consideration of the commutations and interchanges *between* the systems. Isolated concern with biochemical, neurophysiological, learning, psychodynamic, interpersonal, social, and philosophic models have yielded to the study of transactions of the individual in multiple negotiations within and outside of the self. What has become apparent, since behavior is so reticular, is that we need to develop a better mode of organizing appropriate configurations of models. Unfortunately, we do not yet possess the syntax even to describe these configurations precisely in a meaningful way. Attempts to arrive at a universal language of science have not yet proven successful. Provocative are current efforts that are being made of developing a "general systems theory" that deals with the interface properties of multiple systems, their interactional and transactional patterns, and their hierarchical structuring (Gray, 1966). A reexamination of human behavior has been taking place within the framework of ecological phenomenology that focuses, among other things, on conceptual schemes and communications in the different disciplines (Auerswald, 1966). These concepts have important implications for psychotherapy since theories and methods abound that are related to the different subsystems, each approach being advanced by its proponents as the preferred means of dealing with emotional illness.

The recognition that changes wrought by the varying modalities—somatic, conditioning, psychodynamic, interpersonal, environmental, and philosophic—on selected aspects of behavior can influence all other links in the chain and thus transform the nature of the chain itself, may serve to explain why patients benefit by a wide variety of methodologies. Moreover, the understanding that structure and function are dynamically related to the field of forces operating on the individual in his milieu has tended to shift interest from intrapsychic to extrapsychic, from concern with forces of superego, ego, and id to relationships with extrafamilial groups.

From the convenient dyadic, long-term model of therapy geared toward "insight," we see explorations into various kinds of group approaches, the joint treatment of married couples and entire families, conditioning procedures aimed at specific symptoms, milieu manipulations that may extend to the structuring of an entire therapeutic community, and the combined employment of psychotherapy with somatic treatments, especially psychotropic drugs. Short-term therapy directed at both abbreviated and reconstructive goals is attracting greater interest, being encouraged by insurance coverage for emotional illness that is limited to a set number of sessions. The preoccupation with intrapsychic content is supplemented with consideration of the interpersonal transactions within the therapeutic situation, exploring the varying roles that the patient is playing with the therapist and others. The laboratory of the psychotherapist is being extended into the community, fostering the working in a consultative capacity with various professional persons who deal with problems of people on a broad level, for example, educators, law enforcers, clergymen, physicians, dentists, and lawyers. Community mental health, so vital to the interests of society, has necessitated the acquisition of new knowledge and skills regarding the social and cultural networks that envelop people and institutions. Finally, there is greater recognition of how formulations from certain philosophical systems may be blended with therapeutic techniques. In this context there is increasing awareness of cultural forces as they influence the value orientations of patients as well as therapists, in addition to the need to deal with these forces as part of the therapeutic task.

On the whole, this direction has been promising. However, in some instances the

shift has unfortunately resulted in an aversion toward and neglect of the intrapsychic dimension, abandonment of which has resulted in a void that has left the treatment process denuded and incomplete. The consideration of the transactional links in the chain of behavior complements rather than eliminates other affiliated links. Transactional and intrapsychic are both of vital importance.

What is apparent in studying the existing diverse theoretic systems and methodologic approaches is that no one person nor school of psychologic thinking has all of the answers. It would seem, in fact, as if each variant were dealing with a partial truth, one aspect of a total truth. When we examine critically what successful psychotherapists do, we find that, irrespective of the school to which they belong, and in spite of what they say they do, methods are modified to suit the needs of particular patients and situations. The more experienced the therapists, the more flexible they become in the kinds of techniques utilized. This eclecticism in approach is of the greatest significance if the therapist really wants to help each patient achieve effective relief from symptoms and expanded personality growth.

Obviously, no therapist can be expected to master all approaches. At the most, one's expertise will encompass a few techniques that coordinate with one's professional identification model and personality style. Nevertheless, the therapist will probably have to know, in addition to preferred individual therapeutic measures, as a minimum, something about the indications for the use of psychotropic remedies and group therapy, and, if possible, marital and family therapy. Grounding in dynamic theory should not interfere with the ability of the therapist to employ goal-abbreviated therapies, such as behavior therapy or hypnosis, where indicated. The least we may expect of competent, ethical therapists is that they realize their own limitations and will refer patients to a therapist specialized in an approach that may potentially be more suitable for them.

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The Selective Use of Supportive, Reeducative, and Reconstructive Approaches

Treatment objectives are, more or less, determined by the needs of patients, their motivations, and capacities for change. We converge on these objectives with special psychotherapeutic techniques, always mindful of the fact that patients are the ultimate arbiter of how far they will go toward cure. If they possesses a readiness for change, they may achieve surprising development even with short-term superficial approaches; if there is an inherent resistance to change, the most dedicated depth maneuvers may scarcely move them from their neurotic stalemate.[4] An aspect of all good psychotherapies is facilitation of proclivities for change by rectifying faulty incentives and resolving obstructive resistances. Another requirement is the use of therapeutic measures that potentially can bring about the objectives toward which our treatment effort is being pointed.

First, by supportive stratagems we may focus our sights on a reduction of the patients' suffering and an elimination of their symptoms. Hopefully, through these measures, patients will additionally be restored to a more propitious level of functioning with a healing of their shattered sense of mastery. Second, with reeducative therapy we may aim for a correction of disturbed patterns of behavior with the object being to help patients utilize the resources already possessed to the fullest in quest of a more satisfactory work, interpersonal, and social adjustment. Finally, by employing reconstructive measures we may strive for the development of new resources through resolution of personality blocks, which have strangled maturity, mindful of the many obstructions that lie in our path.

To illustrate how supportive, reeducative, and reconstructive approaches may be employed in practice, we may consider the case of a patient who applies for therapy after the onset of an emotional illness characterized by tension, depression, anxiety, loss of

appetite, insomnia, and gastrointestinal symptoms, especially hyperacidity. The patient in explaining his upset attributes it to challenging work pressures brought about by a shift in his position from a relatively routine one to that involving considerable responsibility.

RESTORATION OF MASTERY THROUGH SUPPORTIVE SYMPTOM RELIEF OR REMOVAL

In reviewing his history, it appears that the patient has, up to the onset of his work problem, made a satisfactory adjustment. He has a good home life; he enjoys his children and loves his wife; he is an excellent provider who conscientiously performs his work duties; he belongs to a number of social organizations; and he fraternizes with the usual quota of friends. According to this record, it would seem reasonable to scale our goals toward bringing him back to where he was prior to his illness. We might calculate that once his symptoms were eliminated or under control, he would have the best chance of recovering his equilibrium. With this in mind, we might attack his symptoms along several different lines. First, we may attempt to subdue them by the administration of medicaments, such as antacids for hyperacidity, tonics for anorexia, hypnotics for insomnia, and Xanax for anxiety and depression. If his depression is intense we might consider a tricyclic antidepressant drug. The patient may also be trained in progressive muscular relaxation in an attempt to relieve his taut muscular state. He may be reassured to the effect that his problem is not irremediable and persuaded to utilize his will power to get well. He may also be removed from his environmental situation. By absenting himself from existing areas of stress, he may experience an assuaging of tension and other symptoms.

Instead of these efforts, attention may be focused on the patient's work difficulty, reasoning as follows: "Here is a man who is involved in a work situation that is too difficult for him to handle. Competitiveness demanded by his present job is not for one with his kind of personality. Prior to the unhappy job change, he was getting along adequately. The treatment objective, then, is for him to obtain another position to which he will be able to adjust satisfactorily."

Assuming that his vocational situation is the primary source of his difficulty, the patient would be helped to appreciate that he cannot and should not adjust to extreme competitive stresses, and he may be encouraged to return to his old position or to seek a type of work that avoids competition. Where the patient is willing to give up his present job and to secure a less burdensome one, he may manage to regain his customary equilibrium.

Environmental difficulties may exist in addition to the work problem that upset the patient, rendering it additionally impossible for him to make an adequate adjustment. For example, were our patient to suffer from a marital or family difficulty in conjunction with his work problem, our focus in therapy would of necessity expand utilizing marital or family therapy.

These measures are obviously all aimed at symptom relief or removal. The philosophy behind such approaches is that symptoms impair the functional efficiency of the psyche like a diseased gall bladder upsets the entire digestive system. Suggestion, persuasion, "thought control," progressive relaxation, purposeful forgetting, the plunging of the self into extroverted activities, and behavioral techniques are among the devices aimed at the symptom, as if it were a foreign body whose presence obstructed an otherwise intact psychic mechanism. In some cases substantial successes may be scored by this type of therapy. Indeed, formal psychotherapy may not even be needed in certain personality types who are able to forestall emotional collapse by practicing such devices as "riding their symptoms," substituting innocuous for painful thoughts, engaging in distracting pursuit of social activities, and observing a punctilious performance of ritual and prayer. In justification of these methods, it must be said that many persons are not motivated to accept more intensive treatment. In these cases the mastery of symptoms helps individuals gain freedom from excruciating distress and sometimes permits them to order their lives in a more fulfilling way.

One must not overestimate what is being accomplished, however. While the manipulation of the patient's environment toward alleviation or removal of stressful

circumstances, or the employment of other supporting measures might be helpful in some cases, in others results would be singularly barren, especially where the individual is victimized by inner conflicts that create these symptoms, or are projected onto the environment sustaining the family and environmental distortions about which he or she complains. Results are poor also when the environmental difficulty has overwhelmed the individual with a substantial shattering of present defenses. Here, infantile defenses may regressively be revived that cripple the patient's adaptive resources to a point where, even though the environmental disturbance has abated, the patient is burdened with continuing problems.

We may compare this situation with that of a man suffering from a minor heart ailment that does not incapacitate him so long as no great strain is imposed on his circulation. Should a severe shock or catastrophic happening occur, or should he engage in physical work that is beyond his endurance, the resources of the heart may fail, producing cardiac damage with symptoms of circulatory failure that remain long after the initiating stress has disappeared. The same applies to a personality disorder around which the individual has managed to organize his or her life. When circumstances remove erected safeguards and the individual is propelled into a situation he or she cannot handle, severe disorganization may result that persists from this point on.

Environmental adjustment may also fail because patients feel tied to their life situation no matter how inimical they may be, considering it an inevitable eventuality they have no right to challenge, let alone change. Any tension and anxiety that accompany this acceptance are usually credited by the individual to sources outside of the self.

MODIFICATION OF DISTURBED ATTITUDES THROUGH REEDUCATIVE THERAPY

An investigation may disclose that our patient's inability to endure competition at his place of work may not be due so much to an environmental peculiarity as it is to the fact that unique ideas and attitudes possessed by the patient make competition an inacceptable or dangerous circumstance.

When we examine the exact nature of his disturbed attitudes, we may find that the patient is being victimized by a tangle of contradictory character trends that inspire personal insecurity, promote devaluated self-esteem, and impair relationships with people. For example, we may observe that a basic character trend is that of dependency, which operates insidiously, causing the patient to ally himself with some other person who is a symbol of strength and omniscience. The patient relates to this person as if the latter were a powerful and providing parental agency. Accordingly, the individual may assume a passive role, exhibiting little spontaneity and initiative, anticipating that these needs and demands will automatically be satisfied. Competition poses a threat to the dependency need, for it puts the responsibility on his own shoulders, which he believes to be too fragile to bear the burden of dutiful pressures. Other character trends may exist that both reinforce and oppose his dependency. While he has managed to keep a tenuous emotional balance up to the time of the present crisis, the alteration of his vocational situation has disrupted his equilibrium, threatening his sense of mastery and precipitating catastrophic fears and anticipations of disaster. He may be aware of how dependent he is, and may even resent this dependency as opposed to his best interests; yet security is so bound to this trend that he may be unable to subdue its operation.

When we inquire further into the circumstances underlying the presumably good adjustment prior to the outbreak of his illness, we find that the patient's security has always been maintained by the satisfaction of his dependency. So long as this has been gratified, he has been able to get along splendidly. Ungratified, he has been riddled with disquieting fears and threatened with an ill-defined sense of restlessness. Investigating the conditions prevailing at the onset of the patient's illness, we discover that for some time prior to the onset, the wife has been withdrawing her attention from the patient and transferring it to her brother and his wife who have, because of financial pressures, moved into the patient's home. As her interest became increasingly diverted from the patient, his feelings of insecurity and resentment expanded. The more importunate his demands, the less she responded, until finally he reacted like an abandoned child in a rejecting world. His helplessness and fears of aggression mounted, until the very act of going to work constituted a challenge that taxed his capacities. Promotion to a more responsible position

was the last straw that precipitated a breakdown in adaptation.

As a consequence of this discovery, we may attempt as a goal to inculcate in the patient some awareness of his dependency as well as of other disorganizing attitudes and strivings. The eventual object here is the retraining of reaction patterns. Thus, we might try to bring our patient to an understanding of the attitudes and designs that he habitually exploits, and we would demonstrate to him which of these facilitate and which obstruct his adjustment. Next we would help him to apply this knowledge toward modifying or changing his behavior.

We would also evaluate his assets and his liabilities to see how much he had minimized the former and exaggerated the latter.

We may attempt to shortcut the therapeutic process by behavioral desensitization slowly exposing the patient to increments of anxiety associated with his job responsibilities, or we may employ assertive training. The mastery of graded tasks, both in fantasy and in reality, abetted by positive reinforcements from the therapist, may enable him to overcome the imagined liabilities of competitiveness and to brace himself to accept hardier burdens.

In the course of strengthening his adaptive reserves, with or without the guidance of the therapist, he may begin to realize the depth of his dependency. He may become cognizant of how compliant he is to authority, overestimating the virtues of others to the minimization of his own abilities and capacities. He may recognize that his fear of competition is actually associated with anticipating hostilities from people or with the belief that in pitting himself against others he would come out second best, thus exposing himself to ridicule. He may discover also that he harbors ambitions that are totally beyond possibilities of fulfillment, contributing to his sense of defeat. Cognitive therapy may help rectify faulty attitudes and self-statements.

The patient would probably be surprised to learn that his character patterns are regarded as problems, since he has accepted them as normal for himself. As soon as he

realizes that his patterns are responsible for much of his turmoil, he may be supplied with a valid motivation to alter his scheme of life. While this motivation in itself would not be enough to produce the desired change, his patterns constituting the only routes that he knows to security and self-esteem, it might help him to approach his problems from a different perspective. Faced with his usual difficulties, the patient would, as a rule, be unable at first to give up his destructive drives. Knowledge that frustration or pain was inevitable to their pursuit would not be enough to get him to relinquish whatever gratifications followed their exploitation. However, even the mere cognizance that his attitudes were responsible for his plight would be healthier from a therapeutic viewpoint than the conviction, existing previously, that sources of misery lay outside of himself. Eventually, when he realized that his suffering did not compensate for the dubious gratifications accruing from indulgence of immature drives and when he understood that his reactions interfered with important life goals, the patient might begin experimenting with more congruous ways of relating.

Once convinced that more creative attitudes were possible, a long period of experiment and training would be necessary before habitual values were abandoned. Generally, habits that have persisted over a long time do not vanish within a few weeks or a few months. In spite of good resolutions, automatic responses operate in line with established routines. Struggle is inevitable until control is won over old patterns, and new ones take their place.

PERSONALITY GROWTH AND MATURITY THROUGH RECONSTRUCTIVE THERAPY

The most ambitious objective we could achieve in therapy, and the most difficult to achieve, would be a replacement of neurotic character strivings with those which will enable the person to develop new potentials toward self-actualization. This objective would be advantageously reached through elimination of anxieties and fears that were rooted in past experiences and conditionings. Important also would be the development of ego strengths to a point where they could cope realistically with inner strivings and environmental pressures.

The individual would evolve into a free agent with the willingness to make independent decisions and to take the consequences of his or her acts. There would be an adaptive choice of ends and means and an ability to act without undue restraint from others. Capacities to plan his or her life and to develop goals and ideals in harmony with the disciplines of society would be vital. A sense of inner freedom, independence, assertiveness, and self-reliance would, furthermore, add to the dimensions of a well-balanced personality.

To achieve these objectives in our patient with the work difficulty, it would be necessary to eliminate the source of his problem rather than only to control its effects. This would necessitate an understanding of the roots of his disorder with resolution of factors that continue to sponsor regressive defenses. We would strive to expand our patient's sense of self so that he might outgrow the need to fasten himself to a parental figure for purposes of emotional support. The focus of our treatment would be the therapeutic relationship into which the patient would project his most intense and unconscious impulses and conflicts.

Were we to treat our patient with the work problem according to these principles we would become involved in a more or less extensive therapeutic procedure that would have to go beyond the mere correction of his work difficulty. Indeed, we would consider the vocational disorder as but one aspect of the problem, and our therapeutic effort would be directed toward mediating disorganizing drives that issued from excessive dependency and a devalued self-image and that were destructive to his total adjustment.

The patient, by becoming aware during therapy of contradictory forces within him would gradually realize that he was harboring attitudes that were a carry-over of early conditionings. The most powerful happening leading to such awareness would be transference to the therapist toward whom he would express and live through vital early formative experiences. Our exploratory process would take the patient back to the genetic origins of his difficulty. For instance, it might reveal the patient's mother as a woman who had prevented him from achieving that type of independent assertiveness that enables a

child to resolve his dependent ties. It would demonstrate how the mother's own neurotic needs sponsored a cloying overprotectiveness that kept the patient infantilized and helpless. It would bring out how his efforts at aggressive defiance were met with uncompromising harshness, until he gave up in his attempts at independence and shielded himself by complying with his mother's demands. It might uncover passive wishes, fears of violence in the assumption of a desired masculine role, and a host of other unconscious conflicts that were engendered by his early experiences. It would finally expose his infantile impulses as living on in his adult life, transferring themselves to those with whom the patient became intimately involved. His wife would be revealed as a figure toward whom the patient reacted as if she were a reincarnation of his mother. Partly because of her own impulses and partly because the patient had maneuvered her into a parental role, the wife might be shown as having responded by mothering him. In this protective atmosphere the patient had made a tolerable adaptation even while he repressed desires for freedom and growth. Interpreting the wife's withdrawal as rejection, the patient had reacted with intense hostility. This he needed to smother for fear of losing every vestige of his wife's affection. His increasing helplessness soon reached an intensity where he could no longer carry on. At this point he was faced with a greater work challenge in the form of added responsibility, and continuing at work meant coping with further stress. The patient reacted to this threat as a child would react—by screaming for help.

Reconstructive psychotherapy would bring the patient to an awareness of these facts challenging him to stand up to the drives sponsored by his past. The taming of irrational impulses, the expansion of the repertory of adaptive defenses toward greater flexibility and balance, and the reduction of the severity of the conscience with a more wholesome adjustment to inner promptings and demands are ambitious objectives. This is the complex task of reconstructive psychotherapy, which, implemented by a trained and skilled therapist, offers the individual the greatest opportunities for constructive personality growth. But whether it can be achieved, or whether we might have to contend with the more partial goals described under supportive and reeducative approaches, will be adjudicated by the patient's readiness and capacities for change, which most advantageously will be influenced toward a constructive end by a knowledgeable and

empathic therapist.

16
Who Can Do Psychotherapy?

With the advent of third-party payments for psychiatric services, the question of who can and should do psychotherapy has become a burning issue. Economic and political factors are influencing opinions about professional competence. The experience of the past decades has convincingly proven that individuals from a number of disciplines who have had adequate postgraduate training and supervision and who possess personalities capable of establishing and maintaining empathic and insightful relationships are capable of doing good psychotherapy.

Unfortunately, there are difficulties in defining what constitutes psychotherapy and no fixed regulations governing qualifications of a therapist. Almost anybody can set himself or herself up as a counselor, or psychotherapist, or guidance expert. What obscures the issues is that any contract between two people is potentially reassuring and comforting, temporary relief being forthcoming on the basis of the placebo effect and other non-specific agencies irrespective of the validity of the treatment maneuvers. The greater the charisma of the "healers" the more dogmatic their allegations, the more rhapsodic are the testimonials of devotees who flock to them for help. Nor are those hopeful devotees always untutored or ignorant. Even the sophisticated and educated possess a covert yearning for magic, hoping that a new entry into the therapeutic arena will bring forth a miracle cure.

Efforts to introduce legislation to control the practice of psychotherapy have not proven too successful, not only because of the lobbying and political efforts on the part of groups potentially threatened, but also because members of the established professions cannot agree among themselves regarding standards of education and practice.

Further complicating the muddle is the fact that an emotionally disturbed person often does not realize the emotional roots of his or her problem and actively seeks out a

professional other than a psychotherapist, like a physician, teacher, minister, lawyer, marital counselor, or social worker, particularly when the complaint is focused on physical, educational, marital, interpersonal, or social difficulties. The urgency of the problems imposed on such professionals has forced many of them to evolve ways of handling people in distress, largely oriented around advice giving and active interference in manifest environmental disorders.

There is little question, no matter how deftly we employ semantics or how we distort words, that some of these techniques are psychotherapeutic in effect, if not process, since they involve the setting up of a relationship with the goal of modifying symptoms or correcting personality blocks. The exigency of community need, coupled with the lack of any other resource to which people in trouble might turn for help, has thus propelled many professionals who have had no training in psychotherapy into a therapeutic role. As Galdston (1950) has commented, "Parent, priest, minister, teacher, faculty advisor, social worker, marriage counselor, vocational adviser: all of them in different ways, indulge in psychotherapeutic gestures. They are in effect lay psychotherapists; have been such for centuries past and are bound to continue as such for a long time to come."

This situation, unfortunately, has proved itself to be not an unmixed blessing, for the great majority of such professionals are not equipped by education, disposition, or experience to do psychotherapy. While they may be able to function in an advisory or friendship role, they do not have the basic knowledge or the skill to handle the patient on a therapeutic footing.

This is not to say that individuals with emotional problems do not improve in the course of professional relationships with people untrained in therapeutic techniques. Offering a sympathetic, reassuring relationship to individuals in trouble may be of great help to them and, if they are not too ill, may suffice to restore their equilibrium. Even sick, schizophrenic patients often do better with a humane and tolerant helping person rather than with a trained therapist who lacks certain interpersonal traits (Castelnuovo-Tedesco

et al, 1971). Helpful as it may prove to be, however, a relationship alone is not sufficient for adequate psychotherapeutic process. Psychotherapeutic skills require much more than supplying a patient with friendship. When an untrained person begins to act as a psychotherapist, and particularly where he or she delves into conflicts, defenses, and resistances, serious difficulties may ensue, the relationship becoming explosive in charges of transference and countertransference. The individual may even find his or her own neurosis interlocking with that of the other person until he or she is unable to extricate himself or herself from the relationship without creating a dangerous crisis in the life of the individual with whom there has become hopeless involvement.

The realization that emotional difficulties are ubiquitous has lent force to an educational movement among professionals whose task it is to handle people in trouble. The aim of such training is enabling the professional to differentiate emotional problems from other problems and to manage the former on some kind of correctional level. The chief professionals involved have been psychiatrists, clinical psychologists, and psychiatric social workers. In addition, increasing numbers of nonpsychiatric physicians, nurses, ministers, educators and an undifferentiated group of nonprofessional mental health aids or paraprofessionals are also being recruited as helpers or adjuncts. While there is general acknowledgment of the need for mental health services and recognition of the shortage of trained psychotherapists in supplying the community needs, a wide spectrum of opinion is reflected regarding who and what to train.

THE PSYCHIATRIST IN PSYCHOTHERAPY

The role of the psychiatrist in psychotherapy is becoming increasingly blurred with entry into the field of a growing number of psychologists, social workers, educators and miscellaneous clinical counselors. Valiantly defending their position as guardians of the medical tradition are societies of medical psychoanalysts and psychotherapists who restrict membership in their organizations and carry on disputations with the unwelcome hordes of intruders desiring entrance into areas they consider their personal domain. The inability to stem the invasion is largely due to lack of legal definition of what constitutes

the difference between verbal interchanges conducted under medical as contrasted with non-medical auspices. The argument that the great need for psychotherapeutic services cannot be supplied by psychiatrists alone is still considered by many medical people as insufficient grounds for sponsoring persons they consider incompetent to diagnose, prescribe, or to treat mentally disturbed patients irrespective of postgraduate training in psychotherapy. Non-medical people believe that the basic source of the quarrel is purely economic, coupled with a need to retain superior status and privilege. It has nothing to do with competence in functioning as providers in mental health. They resent the restrictions the psychiatric profession seeks to impose on their activities especially in regard to third party payments and hospital privileges.

Because "historically, morally, ethically, popularly, and legally, society and patients have always given the ultimate responsibility for patient-care to the licensed medically trained physician" (Dickel, 1966), medicine has assumed the attitude that persons suffering from all forms of emotional difficulties fall within its domain. However, recognition that the medical model is not pertinent for all emotional problems has resulted in greater cooperativeness with other professionals.

New trends in medical education may be forecast that will affect the training of psychiatrists. Both the Association of Medical Colleges and the AMA Council on Medical Education have issued statements to the effect that the undergraduate period of medical education does not prepare a student for independent medical practice without supplementation by a graduate training program. Ideally, undergraduate medical education should foster and encourage the specific interests of each student by tailoring the program to his or her needs. Adoption of these ideas will necessitate a more flexible course curriculum. Moreover, the traditional general internship is being questioned as a requirement. The Mills Report (1971) recommends abandonment of the internship as a separate portion and the combination with the residency into a single period of medical education. Pressures are mounting to reduce undergraduate medical education to a 3-year instead of 4-year span. This plan has already been adopted by a considerable number of medical schools.

The tremendous advances in the behavioral and biological sciences are such that it is not possible to prepare students for specialization in psychiatry within the restricted time of traditional medical education. One of the handicaps of the medical people who wish to pursue a psychiatric career is that they have concentrated on medical subjects during their school years that have relatively little relationship to their functioning in the mental health field. This focus has occurred to the neglect of subjects dealing with social and cultural content, which are highly pertinent to human adaptation. This is not to depreciate the value of a medical background, particularly in areas such as neurophysiology, biochemistry, and other topics that deal with the biological aspects of behavior. On the other hand, the medical information essential for a career of surgery, orthopedics, and other specialties may not be essential for a psychiatrist. Would it then not be better to institute a special program, weighted on the side of the behavioral sciences, during the last half of schooling in medical school? A positive answer to this question has already been put in practice in a new curriculum instituted at Pennsylvania, Einstein, Duke, and Yale medical schools (Lidz, 1970).

A traditional background tends to fixate the psychiatrist on a medical model of mental disorders and to overstress biological development and physiological homeostasis as the core agencies in personality disorders. Interpersonal relationships, group dynamics, and cultural factors become of secondary importance if they are acknowledged at all.

Recommended is a distinctive type of specialization in psychiatry that still has its foundations in medicine. A balance of subjects in the behavioral science field would enable the psychiatrist to cope more adequately with clinical and social aspects of mental health. One plan focuses the 18 months on the basic sciences and the "bridging courses" that prepare for clinical experience, i.e., physical diagnosis, laboratory diagnosis, history taking, pathology, psychopathology, and interviewing. Lecturers are replaced by specially prepared or selected readings, clinical presentations, and seminar discussions; and audiovisual tapes are employed. By the end of the fifth semester the students complete all required clinical clerkships in internal medicine, pediatrics, surgery, obstetrics and gynecology, and psychiatry. The last 18 months of medical school are planned for elective

work involving a special "track" corresponding to goals and interests and involving clinical work and further intensive work in the basic sciences (such as biochemistry and cellular biology). For students preparing for psychiatry the last 3 semesters integrate the course work in the behavioral sciences (including neurobehavioral sciences and work in psychopharmacology) with a variety of supervised clinical experiences in a psychiatric hospital, general hospital, and community mental health agencies. Planned are a personal therapeutic experience, perhaps group therapy, and a research project under a tutor or supervisor.

Lidz (1970) writes:

> On the completion of this program, the student will have reasonable familiarity with (1) psychodynamic and psychoanalytic theory and personality development; (2) the neurobehavioral sciences and psychopharmacology, both at a theoretic and practical level; (3) various psychologies of potential pertinence to the field such as the work of Piaget, operant conditioning, learning theory, dissonance theory, and psycholinguistics; (4) the foundations of sociology, social psychology, and ethnology; (5) techniques and attitudes required for interviewing patients; (6) the various psychiatric syndromes; (7) various types of therapy that will enable him to function as a resident from the start of his residency training.

Another change is the abolishment of the internship in a field or fields other than psychiatry, instituting instead a psychiatric internship. Liberation of the physician who intends to specialize in psychiatry from the medical courses and internship experiences that only remotely relate to future practice will, it is hoped, provide more time to delve into the behavioral sciences and humanities that are more congenial with educational needs. It will permit the student to acquire a firmer grounding in the theories and practices directly related to psychotherapy.

A trend coming into prominence that may affect the psychiatrist in future years, is the demonstration of the maintenance of professional competence through recertification every few years (U.S. DHEW, 1971). The American Boards of Family Practice, Internal Medicine, and Plastic Surgery are already committed to recertification. In psychiatry voluntary self-assessment programs are being sponsored by national organizations, such as the American Psychiatric Association, and continuing education programs have been

required in some states as a prerequisite to relicensing.

What goes into the making of present-day psychiatrists will vary with the opportunities available to them. After medical internship and residency the physician usually becomes associated with a mental institution or with the psychiatric division of a large hospital. To qualify for certification in psychiatry, 3 years of institutional experience are required as well as an additional 2 years of practice in the psychiatric field. Having given evidence of varied experience in adult and child psychiatry, the psychiatric candidate is examined in the areas of psychiatric and neurologic diagnosis, neuroanatomy, neurophysiology, neuropathology, psychodynamics and the various psychiatric therapies. If the examination is successful, the candidate is awarded a certificate of specialization as a Diplomate of the American Board of Psychiatry and Neurology.

During the training period the physician usually learns principles of diagnosis, somatic therapy, community psychiatry, and psychotherapy. Experience in the latter is obtained through supervised work in outpatient departments. The quality of this training will depend upon the teaching and supervisory staff. Hospitals connected with medical schools generally are staffed by therapists skilled in various kinds of psychotherapy, including psychoanalysis, group therapy, behavior therapy, short-term therapy, hypnosis, etc. Obviously, the thoroughness of training will depend on the motivation of the student to learn and the quality of available instruction.

Not as many psychiatrists as in former years seek further formal analytic postgraduate training after completing their residency. Attacks levied on psychoanalysis by both its friends and foes, the long period of training required for analytic specialization, the high cost of personal psychoanalysis, available lucrative positions in community psychiatric clinics, and opportunities for early private practice without further postgraduate work have reduced the percentage of psychiatrists seeking further training in the specialty of psychoanalysis. This involves application to and acceptance by a psychoanalytic school. The content of this instruction consists of several years of didactic lectures and seminars in dynamic psychiatry, clinical conferences, and case discussions, a

personal psychoanalysis, and the handling of several psychoanalytic cases under supervision. Some psychiatrists attempt to learn the technique of psychoanalytic therapy in a less formal way without matriculating, by taking open courses in psychoanalytic theory, by reading the psychoanalytic literature, by entering into personal psychoanalysis or psychoanalytic psychotherapy with a trained psychoanalyst, and by carrying one or more cases under supervision of an analyst. How successful this less disciplined form of training will turn out to be is largely dependent on the caliber of the psychiatrist. Understandably, the psychiatrist who elects such training is under a greater handicap than one who is enrolled in a regular analytic school and is exposed to a formal course of instruction.

Some objection is expressed to the overweighting of the significance of training in psychoanalysis at the expense of other behavioral sciences. There is a feeling that "psychoanalysis while initially a liberating influence in freeing psychiatry from a purely phenomenologic orientation has in turn had stultifying effects on evaluation of psychiatric thinking. Its stimulation of comprehensiveness had led to premature closure in some circuits." (Barton & Malamud, 1964).

The continuing shortage in psychiatric manpower has focused attention on why the proportion of medical students entering psychiatry has diminished. A number of reasons have been given for this (Pardes, 1979). First, psychiatry does not enjoy the prestige of some of the other specialities. Second, the quality of psychiatric teaching in medical schools has not been inspiring, especially where teaching is relegated to younger, less experienced, less prestigious members of the staff who are not considered the best of role models. Third, controversy among the teachers and supervisors as to which form of psychotherapy is most valid, and disagreements about theory do not lend to psychiatry the scientific warrant possessed by other branches of medicine. Fourth, strained relations between psychiatrists and other physicians, and derision heaped upon the personalities and activities of professionals in the mental health field have a bad influence on the student struggling with choices of his future field of practice. Fifth, a most important influence, is probably economic; psychiatrists rank low on the income scale of the

specialities. Moreover postgraduate training in postgraduate institutes of psychoanalysis and psychotherapy require more time and money than the resident can afford, having accumulated a sizeable debt during his graduate training years.

All of these factors contribute to a psychiatric manpower shortage, which for a while was abated by acceptance of foreign medical school graduates in hospitals, clinics, and training centers. For example at one time in the State of New Jersey, 90 percent of the psychiatric residents were foreign graduates. National legislation in the mid 1970s, however, restricted the inflow of foreigners, which left a gap unfilled to this day. The encouragement by the government through funding grants for training of primary care physicians and family practitioners has taken away an important pool of potential psychiatric trainees. The influx into the field of psychotherapy of large numbers of clinical psychologists, social workers, psychiatric nurses, and paraprofessionals has also had an effect through the blurring of roles in the choice of psychiatry as a profession. Many young medical aspirants are sensitive to such jibes as the definition of a psychiatrist as "a social worker who prescribes drugs."

Continuing changes of federal and public priorities as well as altering concepts of psychiatric practice have a deadening effect on the supply of psychiatrists to service public need. Psychiatrists are now in such short supply, according to the President's Commission, that two-thirds of the counties in the United States do not have a single psychiatrist. (Roche Report: Frontiers of Psychiatry, Nov. 1981).

In recent years there have been strong attacks on psychiatry and psychiatrists by the press. Such criticism is eagerly utilized by enemies of psychiatry to discredit the profession as a whole. Some medical groups believe that involvement with social problems has caused psychiatrists to dissociate themselves from medicine. On the other hand there are those who believe that psychiatrists are too biologically oriented and not sufficiently conversant with social pathology, issues of politics, economics, law, and how they affect the mind and emotions. The psychiatrist is, therefore, pulled in two directions: first, toward rapprochement and greater identification with medicine, and second, toward

involvement with psychosocial factors that are important in disease and the maintenance of health. A compromise enabling the psychiatrist to straddle this identity crisis is to practice what is called "behavioral medicine" which is another way of saying that comprehensive, holistic, "compleat" services are provided. A unification with medicine is also being encouraged by liaison consultation work with primary physicians and specialists. Advances in biological psychiatry have encouraged biological research that is better regarded than vague forays into social areas.

Whether these factors will decrease the prevailing shortage of psychiatrists is not at all certain. Economics will undoubtedly play a most important part. At the present time there are few monetary incentives for entering psychiatric specialization. Surveys reveal that compared to all other specialties, psychiatrists are near the bottom end of the earned income scale. Moreover, a smaller number of well paying private patients now exist due to fierce competition by a variety of trained and untrained providers who are willing to work at relatively low hourly rates. Psychologists, social workers, psychiatric nurses, and others are increasingly being employed by Health Maintenance Organizations and insurers at a fee below what is ordinarily paid psychiatrists. These are some of the reasons why the percentage of medical students drawn to psychiatry have fallen from 11 percent to less than half that proportion producing a critical shortage of psychiatrists. The lure of the other high-paying specialties is too tempting to correct the imbalance. As research in the biological aspects of psychiatry has elevated the importance of biochemical and neurophysiological vectors, more and more medical school graduates are applying for psychiatric residencies aiming for careers in biological psychiatry. A sentiment is developing in a number of circles that ultimately psychiatrists will concentrate their activities in helping with biological interventions seriously ill patients while relegating the less seriously ill to non-medical workers for psychotherapeutic care.

THE CLINICAL PSYCHOLOGIST IN PSYCHOTHERAPY

Clinical psychology has come a long way in establishing and legitimizing itself as a primary mental health discipline. To this end, licensing laws for psychology are in effect in

most states. The aim of such licensing laws is to create a measure of accountability on the part of practicing psychologists and to consider consumer protection a worthy responsibility of psychological service. Eligibility for licensing generally includes the Ph.D. degree in psychology, supervised predoctoral internship, postdoctural work, and a state examination. This procedure is currently implemented in most parts of the country. Furthermore, since psychology has been included in some health insurance programs as an independent mental health profession, requirements for licensing have become more uniform on a national scale. In addition to licensing the title of "psychologist," laws are now being drafted that define the function of a psychologist. This recognition of function will ensure that the practice of psychotherapy becomes better regulated so that consumer protection will finally emerge as a major concern of the mental health professions.

The increasing acceptance of the clinical psychologist as an independent mental health professional has in the past decade led to a vast broadening of new responsibilities assumed by the psychologist. For example, clinical psychologists are now being asked to share chief decision-making positions in mental hospitals. It is no longer uncommon to find clinical psychologists in charge of admission and treatment wards in hospitals. Psychologists are beginning to design treatment programs and many clinics have psychologists on their staffs conducting both individual and group psychotherapy. Thus the clinical psychologist has emerged as an independent mental health worker, capable of providing the entire range of mental health services from consultation to psychotherapy, from diagnostic specialist to clinic director. Clinical psychologists serve on a multitude of governmental advisory boards, act as judicial consultants, function on faculties of medical schools and law agencies, and serve on community action boards.

Clinical psychology, therefore, has evolved into an autonomous, self regulating profession with psychotherapy as one of its integral operations. Though the function of psychotherapy itself is not licensed, the practice and title of psychology is now regulated by the 50 States and the District of Columbia. With a current membership of over 50,000, the American Psychological Association (A.P.A.) has supported a National Register of Health Service Providers in Psychology to furnish public and other referral sources with a

listing of those who have (1) State Licenses, (2) a doctoral degree from an accredited university, and (3) two years of supervised experience in a health service in clinical psychology, of which one year is in an organized health service training program and one year at post doctoral. The term "clinical" is in fact gradually being replaced with the title "health service provider" in psychology, defined as a psychologist who is certified/ licensed at the independent practice level in his/her state, who is duly trained and experienced in the delivery of direct, preventive, assessment and therapeutic intervention services to individuals whose growth, adjustment or function is actually impaired or is demonstrably at high risk of impairment. (National Register, 1983) Thus, psychology as a profession has become part of the larger health delivery system in the United States. At this time the majority of members of the American Psychological Association are in some form of clinical practice including counseling, industrial/organizational activity, and psychological services in schools. Current estimates indicate that over 25,000 psychologists are licensed in the various states.

Within the American Psychological Association the movement toward the professionalization of psychology took its major organizational leap in 1948, after World War II, when the Division of Clinical Psychology started. It was not until twenty years later, in 1968, when those clinicians specializing in psychotherapy organized the A.P.A. Division of Psychotherapy. A further specialized organization came in 1980 with the inauguration of the Division of Psychoanalysis, and most recently, in 1982 when pragmatic concerns about issues of private practice led to the formation of the Division of Independent Private Practice. A new Division of Health Psychology is also attracting a large membership. With the self-regulatory evolution of the profession, both standards for practice as well as ethical principles were developed. The A.P.A. Standards for Providers of Psychological Services (1977) promoted the "quality, effectiveness and accessibility of service to all who require them." They also specify the minimum acceptable levels of quality assurance and performance that these providers must reach or exceed. These standards address the issues of public responsibility and accountability. Similarly, the A.P.A. Code of Ethics (revised, 1981) has continued to professionalize psychology, and acceptance of membership in the A.P.A. is considered a commitment to these ethical

principles. These include detailed references to responsibility, competence, moral and legal standards, public communications, confidentiality, patient welfare, and professional relationships, as well as research with human participants.

With the tightening of its internal organization, the field of clinical psychology has been rapidly developing into diversified areas. The direction of this vigorous growth of professional psychology has been largely dictated by social, legislative, as well as economic forces. For example, the current concern with cost containment is the impetus for the expansion of short-term therapy methods. The stretching and broadening of its boundaries indicates that "clinical psychologists are becoming involved in anything and everything that involves human behavior in its normal and abnormal forms." (Edelstein & Brasted, 1983). This has become most evident in the National Register (1983) with its listings of multiple frames of references as well as the variety of both general and specific services offered. According to the Register Guidelines, registrants may identify up to three theoretical orientations in order of performance from among the following: behavioral, eclectic, existential-humanistic. Gestalt, interpersonal relationship, psychoanalytic, rational emotive/cognitive, reality, Rogerian, client-centered, social learning, and systems-oriented. Also, registrants may list up to three service approaches in order of preference from among the following: consultation, couples therapy, diagnosis, family therapy, general practice, group therapy, and individual therapy. Furthermore, five specified services are chosen in order of preference from among the following: biofeedback, child abuse and and spouse abuse therapy, disability determination, forensic services, hypnosis, learning disabilities, marital therapy, neuropsychology, pain management, physical illness/disability, play therapy, psychodrama, rehabilitation, sexual dysfunction therapy, stress management, substance abuse, and women's issues.

As a part of its professionalization, the formal doctoral training programs as well as the internships in clinical psychology are now periodically reviewed and accredited by the A.P. A. These generally consist of a minimum of three academic years of fulltime resident graduate study. Instruction in scientific and professional ethics and standards, research design and methodology, statistics, psychological measurement, history, and systems of

psychology are included in every doctoral program in professional psychology. Each student is required to demonstrate competence in each of the following substantive content areas: (1) biological bases of behavior (e.g., physiological psychology, comparative psychology, neuropsychology, sensation, psychopharmacology; (2) cognitive-affective bases of behavior (e.g., social psychology, cultural, ethnic and group processes, sex roles, organizational and systems theory); and (3) individual behavior (e.g., personality theory, human development, individual differences, and abnormal psychology). Virtually all doctoral programs require students to attend four years of full-time internship. These internships are also subject to accreditation standards by A.P.A. in areas of assessment, research, and therapeutic competence. After attaining a Ph.D. or Psy. D. (about 4 percent of the doctoral programs now offer the Doctor of Psychology degree) many clinical psychology students seek further training in psychotherapy when completing their internship, despite having focused heavily on treatment, personality theory, psychodiagnosis, and field experience during their graduate work. Many students have enrolled in the school of Carl Rogers in Chicago for training in client centered therapy.

Another major development in postdoctoral training has been the appearance of experiential-Gestalt training institutes as well as non-psychodynamic behavior therapy institutes. As a matter of interest, there has been a great upsurge of such schools, and some clinical psychology doctoral programs offer exclusive training in behavior modification psychology. Clinical psychology is becoming so "innovative" and technique-oriented that proponents of different treatment philosophies sometimes appear to be tearing asunder the psychologist-professional-scientist model. Instead of considering the Ph.D. training as a scholarly and scientific study of principles of behavior, there are those psychologists who would consider philosophical differences sufficient to warrant the overthrow of psychodynamic psychology and the creation of new fields of psychology based upon parochial interests.

In late years there has, nevertheless, occurred a keen interest in psychoanalysis. In the past only a few postdoctoral institutes, which offered training in psychodynamic psychology, would accept psychologists. Since the early to mid 1960s, however, a plethora

of training institutes have been started that accept psychologists. Theodore Reik's National Psychological Association for Psychoanalysis in New York City originally had two popular postdoctoral training centers for psychologists. Other postdoctoral interdisciplinary institutes include the Postgraduate Center for Mental Health and the William Alanson White School for Psychiatry, Psychoanalysis, and Psychology, both in New York City. Apart from offering a Certificate in Psychotherapy and Psychoanalysis following the completion of four years of training, the Postgraduate Center provides specialty psychotherapy training opportunities utilizing groups with children and adolescents, with families, and in the supervision of the therapeutic process. In all these programs, psychologists are involved in administration, teaching, and supervision.

Since the mid 1960s other more orthodox psychoanalytic postdoctoral institutes have begun admitting psychologists. In addition, throughout the country new postdoctoral institutes have been created and developed exclusively to deal with the ever increasing demand of psychologists for psychotherapy training. These include the program for postdoctoral study and research in psychology at New York University, the postdoctoral psychotherapy center of the Institute of Advanced Psychological Studies at Adelphi University, and a number of smaller unaffiliated institutes in and around New York. Furthermore, psychologists who have been trained in psychoanalysis and who are identified as both psychologists and psychoanalysts are currently teaching in most psychoanalytic institutes.

Future trends in psychotherapeutic practice suggest both increased diversification and specialization. One of the most popular current areas attracting huge numbers of psychologists is in behavioral medicine or health psychology. With more profound recognition of psychosocial factors in physical problems, psychologists are contributing to resolving emotional conflict as a major source of physical or medical symptoms. Gentry (1981) has defined medical psychology as "the application of the concepts and methods of normal and abnormal psychology to medical problems." It refers to the cooperative effort between behavioral scientists and medical practitioners in the diagnosis, treatment, and prevention of physical illness and reflects an acceptance of the importance of psychosocial

factors in part or in whole to aspects of physical illness." Another area in which the demand for services is enormously greater (almost 80 percent according to Vandenbos, 1979) than supply is in clinical child psychology.

Other specialties include community psychology with its social systems level intervention, clinical gerontology, clinical neuropsychology, and rehabilitation psychology. The field of family and marital therapy is also growing enormously. The deepening involvement of clinical psychologists in mental health and psychotherapy has resulted in the publication of a substantial number of articles and books regarding both theory, process, and outcome of treatment. Earlier publications include those of C. R. Rogers (1947-1951), Thorne (1950), and Glad (1959) and more recent books those of London (1964), Shapiro (1965), Singer (1965), Stieper and Wiener (1965), Beier (1966), Wollman (1967), and Zucker (1967). Other contributions of the psychologist to mental health have been comprehensively reviewed by Rennie and Woodward (1948), Lester (1964), and Howard and Olinsky (1972). In addition, contributions by psychologists such as Erich Fromm, Rollo May, David Rappaport, and Roy Schafer have examined the nature of personality, helping to expand the understanding of the psychotherapeutic process. Some of the more significant books by psychologists that have influenced theoretical and clinical thinking during the past decade include those by G. Klein (1976), Schafer (1976), Wachtel (1977, 1981), Smith, Glass & Miller (1980), Stolorow & Lachmann (1980), Garfield and Bergin (1978), Epstein & Feiner (1979), Strupp & Hadley (1978), Spence (1982), and Atwood and Stolorow (1984). The new A.P.A. Divisions of Psychotherapy and Psychoanalysis both currently print quarterly journals that publish the best contribution of psychologists in this field.

The claim that psychologists have regarding their singular qualifications as psychotherapists lies in their graduate education in psychosocial and research areas that have a bearing on the therapeutic process. Interest in learning theory and development has brought forth many contributions by psychologists in biofeedback, behavior modification, personality development, humanistic approaches, outcome research, and other areas of the field.

In addition to having extensive involvement in the development and practice of new techniques, clinical psychologists have utilized traditional modalities of treatment, including individual and group work, family therapy, systems theory work (Jackson, 1959; Haley, 1968), hypnosis (Gill & Brenman, 1959), and marathon (Mintz, 1971). Also, as a psychotherapist, the clinical psychologist is in a unique position to be involved in clinical investigation on a research level, such as research on motivation for treatment (Krause, 1966, 1967), personal attraction in psychotherapy (Goldstein, AP, 1962, 1971), goals of treatment (Hill, JA, 1969), client variables in treatment (Garfield, 1971), the development of instruments measuring emotionality (Plutchik & Kellerman, 1974), and the motives of therapists (Henry, Sims, & Spray, 1971).

Although this is less than in previous years the increasing differences in clinical practice have contributed to criticism from segments of the psychonomic experimentalists who would rather see clinical psychology excised from scientific psychology. As more candidates have entered the field of clinical psychology, academic psychologists have on occasion reacted unfavorably. Clinicians are regarded, more or less, as renegades from science. Their interest in personality theory, it is claimed, is in defiance of the more precise structure of the experimental approach. Further claims are made that clinicians are geared toward the questionable pragmatism that if a tactic helps a patient, it should be employed irrespective of all its empirical virtuosity and that the use of tests that may be invalid is defended against all logic. Polygraphs and computers should constitute the armamentarium of the scientist, not ink blots. Learning theory is a more suitable companion for the psychologist than psychoanalytic theory. Research, not interviewing, is the psychological matrix. Clinicians, considered inferior mates, find that their marriage to the academicians stands in great jeopardy. Indeed, there are some psychologists who believe that clinical activities should be abandoned by psychology and left entirely to the field of psychiatry. The illicit love affair that clinical psychologists are carrying on with psychiatrists, say these critics, acts against the good name of the profession as a whole. To resolve this situation, a divorce action has been recommended by some, with a splitting of the psychological field into two and the administering of a new degree, Doctor of Psychology, to the clinicians (Henderson, (1966). There are those who object to this move

"to sweep an unwanted progeny under the carpet." On the other hand, there are others who, insisting that sound experimental training does not necessarily produce a competent professional psychologist, believe that a new degree can provide "a broad yet intensive program that emphasizes interdisciplinary training, practical problem-solving in real life settings, and a sophisticated knowledge of how to use research findings without the necessary condition of producing original research" (Wright, MW, 1966). The new degree may help to resolve the antagonism that "has arisen as a result of two different kinds of people, researchers and practitioners, sharing the same degree."

As the identity concerns of the psychologist regarding legitimacy are put to rest, psychologists are evaluating more and more the extent to which they may or may not be maximizing or even properly utilizing their particular contribution.

THE SOCIAL WORKER IN PSYCHOTHERAPY

Social workers, like other professionals, are searching for new roles and values that will bring them into step with the temper of the times. There has been a tremendous increase in social work education at every level. Social work has also achieved increasing governmental recognition as a profession. Some form of licensing, certification, or registration for social workers is required in many states, and professional societies are working toward such laws in states that now do not possess them.

Among the specialties in social work of greatest pertinence to helping people in trouble to cope with external factors that sabotage adaptation, is social casework. Typically, for at least the last 60 years, social casework has been an adjunctive service in a so-called "secondary" setting: an agency such as a school, hospital, or clinic where casework is not the primary function.[5] The range of agencies where casework is utilized is far too wide to be described, but a few typical casework positions could be mentioned: medical settings where the caseworker has the responsibility of helping the family deal with the financial and emotional blows of hospitalization and aid in discharge planning, adoption and fostercare agencies where caseworkers supervise the selection and supervision of foster homes and the emotional adjustment of children to the homes, public

assistance agencies where caseworkers oversee both financial assessment and rehabilitative planning, and child guidance clinics and family service agencies where caseworkers have the primary direct treatment responsibility. The fact that casework is typically practiced in a secondary setting naturally opens up all of the problems common to any professional team, such as issues of professional status and jealousy, divisions of responsibility, and so forth.

In spite of years of theoretical debate and various attempts at systematization, there has never been achieved a generally agreed-on theory of casework, and more than ever, there is disagreement as to what actually constitutes casework. In a real sense a history of casework is a history of debates, of theoretical swings of the pendulum.

The psychoanalytic treatment of "shell-shock" victims of World War I exposed casework, as it did much of the rest of the world, to the work of Freud and his followers. Within a few years the new psychoanalytic principles swept the field of casework, and even relief agencies tried to deal with the emotional aspects of financial assistance. For the first time there was a meaningful explanation of the refusal of clients to follow the treatment plan laid out by the agency—it was "resistance." In an extreme swing of the pendulum, casework became suffused and dominated by psychoanalytic principles. But again, the swing was too extreme and problems arose. Many of the clients had pressing and overwhelming social and financial problems that brought them to the agencies; they were much less concerned about their unresolved Oedipal feelings. Still, the psychoanalytic movement of the 1920s added much to the overall and ongoing body of casework knowledge.

The next great shift in casework practices was brought on by the Great Depression of 1929. The overwhelming social needs of people affected by the Depression made psychoanalytically oriented casework a luxury that few could afford. Skills had to be developed in helping clients, through short-term services, to meet overwhelming economic catastrophe. The Social Security Act of 1935 brought the great expansion of the federal government into the field of social welfare. Many social workers moved to the

newly developing public assistance agencies from the mental hygiene agencies, which were beginning to close down.

The psychoanalytic principles of the 1920s were not being totally rejected; they were being modified by the overwhelming social needs of the 1930s and by a reaction against the mechanistic and deterministic orientation of pre-ego-psychology psychoanalysis. The will therapy of Otto Rank, who was teaching at the University of Pennsylvania School of Social Work, had great influence on the faculty, particularly, Jessie Taft and Virginia Robinson. In 1930 Virginia Robinson published the book that was to usher in the great schism of Functional vs. Diagnostic: *A Changing Psychology in Social Casework.* The appeal of the functional point of view and its difference from the psychoanalytic, which was now called diagnostic casework, was that people were not helpless motes to be buffeted about by wild instincts and unsettled economics. They possessed qualities of responsibility and creativeness that caseworkers could help release. The agency and worker could provide a stable base offering the client specific services within a set time for utilizing relationship in engaging the client to make and act on choices and decisions.

The conflict of ideologies still exists, with modifications, but it has moved on to include a struggle between other viewpoints. There are caseworkers influenced by sociological contributions to small-group development and community forces, drawing particularly from the work of Georg Simmel, Charles Cooley, Kurt Lewin, and Ronald Lippitt. There are those who believe that general systems theory, which conceptualizes interfaces between individuals, families, social groups, and communities, encompasses the impact of stresses on clients and helps make their casework practices more viable. Others are influenced by the existential "humanistic" approach, which accents strife in overcoming obstacles to self-development. Crisis theory and communication theory have their followers, as has learning theory, which has recently been added to the repertoire of interventions used by social workers, and behavior modification methods, particularly in dealing with problems such as juvenile delinquency, drug addiction, and psychotic mental illness. We might say that psychiatric social workers operate with a succession of models

—from the medical-disease model (Richmond, 1917; Hamilton, 1941; Hollis, 1974) to a functional mode (Taft, 1948, to an eclectic problem-solving model (Perlman, 1957) to a behavioral model (Thomas, EJ, 1970; Thomas, DR, et al, 1968).

Between 1972 and 1976 the number of students in graduate schools of social work who concentrated on casework declined from 85 percent to 36 percent. This does not entirely indicate a loss of interest in therapeutic practice. Combined or generic programs of study are attracting the largest group of students and are perhaps bettei designed to equip graduates for the rapidly changing functions of agencies. For example, a sizable number of agencies have shifted from programs focused on casework to those related to community problems and social action, including "advocacy."

Advocacy in social work has a long tradition, social workers being identified as those championing the causes of the neglected population. In recent years it has attracted a more militant group of workers who fight for social benefits of the underprivileged as rights to be provided by government rather than gifts of noblesse oblige. The aim has been not only for improvement of service programs, such as child care, medical care, housing, employment, education, and recreation, but specifically in relation to psychological needs. Because clients have been helpless in claiming their rights, social workers have taken up the cudgel for them in cutting through the bureaucracy and contradictory legal procedures that stymied the beneficiary from getting help. Cooperation between social workers, lawyers, and clients has resulted in legal actions against public agencies not living up to their assigned function. These actions have served to bring about changes in service systems and other social institutions within existing resources and structures. Because public opinion may tend to oppose socialized or welfare state solutions for problems, social worker advocates foster the creation of constituencies that can press for new social reforms (Grosser, 1973).

These directions do not detract from the need for casework since the problems that originally initiated its development still exist and require management. Because interpersonal involvement with the client draws upon processes akin to those of

psychotherapy, caseworkers in practice often find themselves functioning as psychotherapists. This role for greatest effectiveness requires more sophisticated postgraduate training than caseworkers can acquire in their customary work in agencies. More and more social workers interested in the mental health field are accordingly entering into postgraduate psychotherapeutic and psychoanalytic training programs. Facilities for such training are relatively limited, but they will undoubtedly become more extensive as the need arises. For example, at the Postgraduate Center for Mental Health in New York City, postgraduate programs open to qualified social workers include psychoanalysis and psychotherapy, child psychiatry, group therapy, family therapy, and community mental health consultation.

The social worker as a psychoanalyst or psychotherapist is gaining increased acceptance. In 1968 California became the first state to pass a law under which there is a specific category of "clinical social workers" who are licensed to practice psychotherapy. There is a strong movement for a similar law in New York. A small group of social workers started The Society of Clinical Social Workers in New York City in 1968. It is now a national organization with chapters in many states and a sizable national membership of approximately 1500. This represents a movement of some significance since it was only 1955 that social workers united in a national organization after years of being split into such separate work-focused groups. Clinical social workers are attempting to establish their identity distinctive from the general family of social workers, arguing that there is a great dissimilarity in training and services, and they have lobbied for licensing laws that are designed specifically for their functions. As independent workers who have involved themselves more and more in therapeutic areas, some groups have attempted to incorporate the word "psychotherapy" in their title. For example, the Texas Society for Clinical Social Work changed its name to Texas Society for Social Psychotherapy. The chief reason given for the change was that the title helped to define and regulate their own area of competence as differentiated from social workers in community organization and welfare work, from social service technicians, and from social service aids. The question of competence of the members of the clinical social worker group, of course, will be dependent on the quality of their postgraduate training.

While clinical social work has been defined by the NASW Register of Clinical Social Workers as involving "diagnostic, preventive, developmental, supportive, and rehabilitative service to individuals, families and/or groups whose functioning is threatened or affected by social and psychological stress or health impairment" or practiced in a range of settings such as schools, family agencies, mental hospitals, and community mental health centers, the workers entering private practice have grown exponentially as interest in the traditional functions of casework has declined. Golton (1971) points out that for many years private practitioners were unable to get professional recognition and practiced "underground." However, in 1957 the National Association of Social Work acknowledged that private practice was in the "working definition of social work practice," and in 1964 private practice was officially recognized as "a legitimate area of social work practice in meeting human needs." It is difficult to know how many social workers are actually in private practice. In 1967 there was an estimate that 8 to 10 percent of social workers had a private practice; however, most of these had fulltime jobs, and only 5-10 percent of these had full-time private practices. In 1982 the number had grown to 12 percent in full-time practice with an additional 8 percent listing private practice as a secondary employment modality. Whatever the numbers, it is clear that the decrease in clinical job opportunities will greatly increase both the number of social workers interested in private practice and the number of patients that they see who are seeking such treatment. As the lucrative field of direct psychotherapeutic service is being accessed by clinical social workers, there are movements among certain groups of psychiatrists and psychologists to restrict their direct reimbursement by third-party-payers. Such restrictive measures have been protested by many professionals, including psychiatrists and psychologists who believe that it is unfair to treat highly trained and qualified practitioners of clinical social work who possess skills that are important to public health as second-class citizens.

THE NURSE IN PSYCHOTHERAPY

Grounded in medicine, neurology, and psychiatry, tutored in the functional elements of psychology and dynamics, and with their appreciation of legal and personal

responsibilities, nurses constitute an excellent resource in the mental health field. This fact was appreciated many years ago by Lemkau (1947, 1948) who pointed out that public health nurses played a most significant role in early emotional illness, since they saw people in their homes who were interacting with their families manifesting symptoms of emotional illness. The nurses easily established rapport with the family and were readily taken into the confidence of the various members. By careful listening they permitted emotionally distraught individuals to ventilate their feelings; they also reassured, imparted knowledge, and educated. Their contact with mothers at well-baby clinics and with prospective mothers at prenatal clinics enabled them to handle misconceptions, anxieties, and other potential founts of neurosis. Psychiatric nurses were also considered to be equipped to provide psychiatric therapy as a member of the therapeutic team (Committee on Function of Nursing, 1949; Muller, 1950; Committee on Psychiatric Nursing, 1952). In insulin shock therapy (Clawson & Peasley, 1949; Gayle & Neale, 1949), and brain surgery (Behnken & Merrill, 1949; Friedman, E. 1950), their role was regarded as being most constructive to the total treatment effort.

In 1950 Cameron indicated ways that nurses serving in a mental institution could act as psychotherapeutic adjuncts to psychiatrists. Indoctrination in psychiatry and psychotherapy, he avowed, enabled the nurse to assume some therapeutic responsibility. On the wards, for instance, the nurse could organize patients into a group and hold group discussions on a variety of impersonal and personal topics. These discussion groups, in goal and mode of operation, paralleled therapeutic groups. Cameron also described the possibility of employing the nurse in a psychotherapeutic unit of three, consisting of patient, nurse, and psychiatrist. Here the nurse functioned as a counselor, discussing and clarifying with the patient material that had been brought out by the psychiatrist. The nurse could also "role play" with the patient, either acting out a role accorded the nurse by the patient, or gradually shifting this role, so that the patterns of behavior the therapist was seeking to change in the patient would be less and less satisfying to the patient.

Rennie and Woodward (1948) emphasized in an even more emphatic way that the nurse should be able to manage intelligently the more common psychiatric and emotional

problems evidenced by the general medical patient. However, in expanding the nurse's role in therapy a reorientation was needed in concepts of the nurse's function. Required, furthermore, were better psychiatric educational opportunities for nurses. Bennett and Eaton (1951) also contended that basic instruction for nurses in psychotherapy was indicated inasmuch as all nurses who worked on psychiatric wards, whether this was acknowledged or not, did psychotherapy of one kind or another. Participation by the nurse in group psychotherapy was also endorsed by these authors.

With the expansion of the nurse's part in the mental health field revision of undergraduate nursing instruction was necessary—including more concentrated teaching of the dynamics of human behavior, of group relationships and the principles of counseling. Generally through the enlightened leadership of the American Nurses Association, educational programs have been encouraged that are designed for a diploma and qualification for license in practical nursing, for an associate degree and qualification for license as a registered professional nurse, and for a baccalaureate degree in nursing included courses to heighten the nurse's psychological role and function in the interest of the public's needs. Graduate and inservice programs were organized to prepare the nurse for more advanced practice.

The ANA Division of Psychiatric and Mental Health Nursing, over the past years, has attempted to define psychiatric nursing, to place it in proper perspective within the nursing profession and to project goals for nursing in psychiatric services (Conference Group on Psychiatric Nursing Practice, 1966). Qualifications for a psychiatric nurse at present are a Master's degree in psychiatric mental health nursing, license and registration as a professional nurse, and current engagement in direct or indirect psychiatric nursing care functions, as defined by the members of the ANA Division of Psychiatric and Mental Health Nursing and outlined in the 1973 Standards of Psychiatric and Mental Nursing-Practice. A revision of these standards in 1982 stressed the division of nursing practice into two levels; the first involving brief counseling and problem solving which could be done by a "psychiatric nurse generalist" prepared at the pre-master's level and, second, clinical specialists in psychiatric practice who because of more intensive

education on a master's or doctoral level could work more intensively with psychiatric patients in counseling and psychotherapy.

Gradually, the mental health role of the nurse has moved from the narrow confines of the hospital to the community at large. Whether associated with a psychiatric institution, a school, an industrial organization, a public health unit, a clinic, a camp, or a home, the nurse enters into intimate relationships with sick people and thus has unusual opportunities to practice principles of psychological helping. Such practice is determined by the needs of patients and their families and by the structure and policies of the agency under whose auspices the nurse works. While rendering a traditional service to patients with outright mental disorders in collaboration with other disciplines, the psychiatric nurse is also becoming more and more concerned with goals of promoting optimal mental health for individuals and their families in the community. In the concentrated contact with patients and their families the nurse has a unique opportunity to observe emotional interactions and relationships that may have a determining influence on the patient's illness and capacities for recovery and rehabilitation.

Recognition of the significance of emotional factors in both physical and mental illness has continued to foster psychiatric nursing as a most important part of the generic nursing curriculum. For a while there was an increasing number of nurses who pursued a preferred interest in mental health nursing (Sills, 1973) and pursued higher education to meet the challenge of a new role. In 1972 three universities offered doctoral programs in psychiatric nursing. In addition 42 programs offered Master's degrees (Liston, 1973). A new image of the nurse was evolving, one who could provide services to institutions and also direct patient care to clients within the context of family and the community (Rutledge, 1974).

This change in concepts of function has influenced our ideas about how best to provide psychiatric services for certain types of patients. Cumming (1972) stated: "Except for the prescription of drugs, there seems little in a number of modern descriptions of the psychiatric nursing role to distinguish this role from that of the psychiatrist." There are

many who share this opinion to the effect that the group most intimately related with patients over a prolonged period, i.e., nurses, "should be the prime therapists and bear the primary responsibility for treatment," the psychiatrist functioning in a consultative role. Truly the close contact that nurses have with patients under their care sustains a relationship with far greater therapeutic potentials than that afforded by the casual hours the psychiatrist can devote to treatment. As a primary therapist, the psychiatric nurse "assumes total nursing responsibility and accountability for the admission, nursing assessment, planning, therapy, evaluation, discharge and direction of a comprehensive plan of care for individuals diagnosed as psychiatrically ill, on a 24-hour basis" (Rutledge, 1974). The relationship with the psychiatrist is collaborative for medical aspects such as diagnosis and prescription of psychotropic drugs.

Recommended specialized areas of patient care include the nurse's participation in family therapy, behavior therapy, sociotherapy, group therapy, child psychotherapy, and individual psychotherapy. The employment of these techniques will depend upon the level of training, skills, and experience of the nurse, the requirements of specific psychiatric settings, and the availability of competent supervision. With proper training a nurse often makes an excellent family therapist. Since psychiatric nurses usually work with the family as a whole, they are in a strategic position to bring members together for discussions that serve to resolve intrafamilial hostilities. Nurses are also capable of doing expert behavior therapy with training. As a sociotherapist, the nurse contributes to community organization and functioning, working toward the solution of community mental health problems and the implementation of programs to their completion. Knowledge of how to organize a therapeutic environment, providing corrective and remedial experiences for patients, is basic to this function. Nurses often become skilled as sociotherapists and administrators of programs in milieu therapy, remotivation, and resocialization of groups in institutional settings. In group approaches the nurse may function either as a group leader or as a co-therapist. The group process, being more reeducative than reconstructive, will depend on group dynamics rather than on the analysis and working through of transference and resistance. Cooperating with other child therapists, a nurse may contribute to child psychotherapy, or with training, the nurse on a master's level may

function as the primary child therapist.

In so far as individual psychotherapy is concerned, it is obvious that while bachelor's level psychiatric nurses can function as primary therapists with patients who require little more than a comforting counseling relationship, they will require as thorough graduate and postgraduate training as psychologists or psychiatric social workers do if they are to do more intensive psychotherapeutic work. Patients, in their regressive needs stimulated by illness, often perceive the nurse as a symbolic parent. The nurse must be able to gauge the degree of active support that is realistically required, while encouraging independent operations in order to move the patient as rapidly as possible out of what may become a crippling dependency. Nurses must be cognizant of the dynamics of transference in order to control some of its effects. A knowledge of behavioral dynamics, an empathic and nonjudgmental attitude, and the ability to understand and manage personal countertransferential emotional reactions are important assets. At the same time the nurse must know how to provide a therapeutic milieu for the patient, manipulating environmental variables that require correction, assessing the social structure of the treatment unit, evaluating interpersonal relations among patients and staff, initiating and conducting remotivation and activity groups, and planning jointly with other professional workers the means of providing the best service for patients. These generic practices are aspects of the nursing function that can best be realized if the nurse has some self-understanding and is aware of personal motivations.

Functioning in an extended role as primary therapists, thus involves knowledge and experience for which many nurses are now being prepared and others can be prepared. A special committee, at the behest of the Secretary of Health, Education, and Welfare, (U.S. DHEW, 1971) was appointed to examine the field of nursing practice to offer suggestions on how its scope might be enlarged for the benefit of the public. A report published in the journal of the American Medical Association (JAMA 220:1231-1236, 1972) has accented the need for extending the range of services of the nursing profession, but has also stressed the need for further training that this extension would entail. The problem insofar as the psychiatric nurse specifically preparing for psychotherapeutic or

psychoanalytic work is concerned is that opportunities for postgraduate education are still sparse since the nurse has not yet been accorded the acceptance deserved as a candidate for training on the same level as the psychologist and psychiatric social worker. One would hope that this disparity will be corrected in the near future.

Among the recommended readings are the contributions by American Nurses' Association (1973a, b), Crawford and Buchanan (1963), Burgess (1981), Critchey & Maurin (1985), Cumming (1972), Durham & Handin (1986) Ellen (1965), Freedman & Gordon (1973), Garrison (1973), Glover (1966), Haber, et al., (1982), Hofling & Leininger (1960), Johnson, BS (1986), Karnosh & Mereness (1962), Lego (1973, 1980, 1984), Liston (1973) Logsdon (1973) Manaser (1964), Matheney & Topalis (1965), Mereness (1963, 1964), Norris (1963), Noyes, et al. (1964), Orlando (1961), Peterson (1969), Prowse (1957), Robinson (1964), Rutledge (1974), Schwartz, MS (1956), Sills (1973), Stuart & Sundeen (1983), Stueks (1965a & b), U.S. Department of Health, Education, and Welfare (1971), Wilson & Kneisl (1979), and Wolff (1964).

THE MEDICAL-NONMEDICAL CONTROVERSY

Medicine is traditionally defined as "(1) the science and art concerned with the cure, alleviation, and prevention of disease, and with the restoration and preservation of health... (2) the art of restoring and preserving health by means of remediable substances and the regulation of diet, habits, etc." *(Oxford Universal Dictionary,* 3rd ed.). Such a definition conceivably is broad enough to encompass psychotherapy. But whether it is practically justified in classifying verbal interchange, the communicative channel of psychotherapy, as an instrumentality of medicine has been open to challenge from non-medical professionals. For example, the question has legitimately been posed as to what we would call the activities of the minister who consoles a depressed parishioner, of the educator who handles a student's learning blocks, of the lawyer who directs a marital couple in conflict, of the guidance counselor who interrogates a school dropout, of the probation officer who works with a delinquent and the family, of the social worker who functions to rectify the neurotic uses by a client of social services, and of the public health

nurse who persuades the neurotically uncooperative patient to attend to necessary health needs. Are they all practicing medicine?

In an attempt to resolve this dilemma some authorities have advised apportioning emotional ailments into medical and non-medical allotments. Such efforts are bound to end in failure because emotional problems influence every aspect of functioning—intellectual, emotional, and physiological—in an integrated way. As one observer put it,

> When a housewife becomes upset because her husband comes home intoxicated, can we say that she is manifesting a "medical" problem? If she is merely irritated "no," if she vomits or gets a headache "yes." But what if she shows an asymptomatic hypertension that predisposes to arteriosclerosis, or an altered gastric function that eventually may result in an ulcer? The fact that she is unaware of her physiological response, and that it is not diagnosed professionally, does not make her problem non-medical. Are interpersonal tensions associated with marital difficulties to be classified as medical problems? When a non-medical person works with an individual is he "helping" a "client," but when a medical person utilizes the same processes is he "treating" the same "patient"?

These differential points seem petty, but they are aspects around which much controversy brews. Another attempt to delimit the area of the non-medical worker is expressed in this way: "His field of specialization will be social, learning, and emotional problems within the 'normal' range of adjustment. His primary emphasis will be upon the development of optimal functioning rather than treating the emotionally ill" (Wright, MW, 1966). However, the definitions of "normal adjustment," "optimal functioning," and "emotionally ill" have never been clearly made.

The endeavor to bypass issues of operational definition has sponsored a disposition of the problem through classification of who is and who is not a psychotherapist. Lack of uniformity of sentiment was illustrated years ago by the following interchange from "California Dialogue: Defining Psychotherapy Insight" (Roche Report, 1965).

> *Dr. F. Janies Gay* (Neuropsychiatric Institute, Westwood, L.A.): Regarding the definition of psychotherapy, should its connotation be so broad that it includes non-medical people—such as social workers and psychologists? If so, aren't we jeopardizing the responsibility of our role in the medical profession? There are many instances where those outside of our specific medical field do not exercise the same clinical care for people they are working with as we do. I think the term, psychotherapy, perhaps ought to be restricted to working with feelings, fantasies,

resistances, defenses as it is done by psychiatrists.

> *Dr. Alexander S. Rogawski* (Past-President of the Southern California Psychoanalytic Society): I cannot agree. What is important is that a psychotherapist be a professional person educated for this task and that he belong to a self-policing and/or legally licensed group subscribing to a code of operational standards.

These two divergent viewpoints continue to be expressed by psychiatrists, the "oppositionists" maintaining that the medical model could never and should never be replaced by a social environmental model (Kaufman, 1967; Levine, A., 1971), some even insisting that "the end result of the egalitarian principle may be to debase psychiatrists and to promote paramedical team members to superior rank." *(Psychiatric News,* Aug. 2, 1972). The "progressives" on the other hand forsaw closer ties to non-medical professionals *(Psychiatric News,* Jan. 3, 1973). Some recognized the limitations of the medical model, and they foresaw non-medical people handling the bulk of treatment including psychoanalysis (Roche Report, 1974). Romano (1973) states, "I find it difficult to distinguish methods of psychotherapy as used by psychiatrists, psychologists, social workers, or nurses."

As far back as 1961 the Joint Commission on Mental Illness and Health (1961) pointed out the glaring deficiencies in the current care of mental patients, a situation that would, it was estimated, become even more critical

> …if the present population trend continues without a commensurate increase in the recruitment and training of mental health manpower. The only possibilities for changing this negative outlook for hundreds of thousands of mental hospital patients would require a great change in our social attitudes, and a consequent massive national effort in all areas of education, including large increases in the number of mental health personnel.

Among the recommendations were:

> (1) that the management of certain kinds of mental ailments be carried out by or under the direction of psychiatrists, neurologists, or other physicians specially trained for these procedures; (2) that non-medical mental health workers with proper training and experience be permitted to do general, short-term psychotherapy; (3) that psychoanalysis and "depth psychotherapy" must be practiced only by those with special training, experiences, and competence in handling these techniques without harm to the patient, namely, by physicians trained in psychoanalysis or intensive psychotherapy plus those psychologists or

other professional persons who lack a medical education, but have an aptitude for, adequate training in, and demonstrable competence in such techniques of psychotherapy.

These recommendations obtrude themselves into the current smoldering conflict that, as has been indicated, involves two opposing forces. The first recognizes the great need that exists for therapeutic and preventive services that cannot possibly be handled by psychiatrists alone and sponsors programs for training other professionals in techniques of psychotherapy. The second force, activated by the filtering of non-medical people into the field of psychotherapy, seeks by legislation and public sentiment to subdue this trend. In the first group are psychologists, social workers, and other social scientists who resent the fact that psychiatrists have tended to preempt as their special province the entire field of mental health. In the second group are psychiatrists who view with alarm the invasion into the field of vast numbers of workers, particularly psychologists and clinical social workers who often independently offer treatment services to the public.

In the face of the tremendous demand that prevails for additional training, one may expect a continued expansion of non-medical postgraduate training facilities. This possibility has aroused great consternation in conservative medical circles. Alarm has especially been voiced at the development of psychotherapeutic training programs in universities. The arguments expressed are that the absence of proper screening of candidates, the concentration on didactic instruction, and the minimal amount of competent, intensive supervision threaten to turn out unqualified and inadequately trained individuals, not instilled, due to lack of experience, with the judicious caution and conservatism essential in psychotherapeutic work. Such persons, say the oppositionists, constitute a potential public health menace of which they themselves are completely unaware.

Non-medical people reply by stating that it is essential to take a realistic view of the existing serious lack of psychiatric training facilities. This lack accounts largely for the alarming activities of untrained and unqualified therapists in the field of psychotherapy. These individuals not only mulct millions of dollars annually from the emotionally ill, but also inflict irreparable damage upon those who, having no other recourse, turn to

charlatans and to relatively unskilled practitioners in an effort to alleviate suffering. Until sufficient numbers of skilled psychotherapists are available, we will always be plagued by the menace of charlatanry in the area of mental health. It is unrealistic to assume that the medical profession can ever supply from its ranks sufficient numbers of people to satisfy the ever expanding demand for mental health services.

More or less, the sentiment continues among the medical establishment, described almost 40 years ago by Szurek (1949) and Haun (1950), to the effect that the psychiatrist should transfer some functions to ancillary workers only within a supervised medical setting, and that the sharing of responsibilities dispels anxiety in the worker and facilitates better psychotherapy. This is contested on the medical side by a few who absolutely oppose any kind of psychotherapy by non-medical persons irrespective of supervision. It is contested also by the majority of non-medical therapists, who challenge the rights of 'he medical profession to impose on them obligatory controls, supervision, and other restrictions in the therapeutic work including private practice.

With the current scramble for the dwindling health dollar, opposition to independent non-medical psychotherapy has become even more strident. It is organized around one or more of the following arguments:

1. *Psychotherapy is an inherent part of medical practice.* Application of the methods of psychological medicine toward the understanding of the emotional states of patients aiding them to understand themselves *is* psychotherapy. Psychotherapy, hence, is a form of medical treatment and does not form the basis for a separate profession.

2. *A physician must bear medical responsibility for all psychotherapy.* While physicians may employ the services of other disciplines, the medical duties cannot be relinquished to a non-physician. The physician remains responsible—legally and morally— for the diagnosis and treatment of the patient. In doing independent psychotherapy the non-medical person is assuming an unauthorized medical responsibility.

3. *All psychotherapy must be supervised by psychiatrists.* The medical profession endorses the appropriate utilization of the skills of other professions in medically supervised settings, such as hospitals and clinics, their

professional contributions being coordinated under medical responsibility. This means that all psychotherapy must be supervised by psychiatrists. The non-medical person thus may function as an assistant to the psychiatrist in the diagnosis and treatment of patients. If in private practice, the non-medical person will require constant medical supervision.

4. *Only a medical background prepares the professional for an understanding of the human mind, in both its normal and pathologic reactions.* Emotional illness, being an organismic disturbance, requires a thorough grounding in the biologic sciences, which non-medical people do not receive.

5. *Only a medical background enables the professional to make a proper diagnosis.* A non-medical person is incapable of differentiating organic from psychologic disease. Because symptoms of emotional illness may mask organic and especially neurologic conditions, non-medical people may not recognize an early treatable condition until after it has become irremediable. Such instances have been reported in the literature (Kant, 1946; Eliasberg, 1951).

6. *Only medically trained psychiatrists have had sufficient experience with severe mental disorders to be able to deal with psychotic-like reactions and to differentiate these from milder disorders.* Only a psychiatrist has expertise and competency in psychopharmacology, shock treatments, and hospitalization procedures.

7. *The physician, by virtue of the unique position of prestige that he or she traditionally enjoys in the mind of the patient, operates in the most effective medium.* The non-medical person is handicapped in this respect.

8. *A strong sense of therapeutic responsibility for the patient is inculcated in the physician as part of medical training.* It is not so often possessed by the non-medical person.

9. *Society acknowledges that therapy belongs to the medical profession, and it sanctions the licensing of the latter.* In obtaining a license the medical therapist is subjected to a better screening process and measures of control than the non-medical person.

10. *Non-medical persons offer the medical profession unfair competition usually operating on the basis of lower fees.*

Most non-medical therapists resent vehemently these attitudes and allegations of the medical oppositionists. To the arguments presented by psychiatrists, they make counterclaims that their own educational and experimental background equips them better to do psychotherapy than the physician. Having had access to the lush field of therapy, many non-medical practitioners resist continuing in a role of a technician or assistant. They insist that psychotherapy is not a form of medical practice, but rather it is an art in the management of interpersonal relationships. They contend that the orientation required by the medical sciences is totally unsuitable to the problems faced by the psychotherapist (Lindner, 1950). Emotional illness is not a disease that falls in the province of medicine. A medical education, therefore, in no way trains the individual to do psychotherapy better than other types of education.

To buttress their claims to psychotherapy, non-medical therapists point out that some of the most significant contributions to psychotherapy have been made by non-physicians—for instance, Anna Freud in the field of child psychoanalysis, Erik Erikson in "ego analysis," Erich Fromm in character analysis, Ernst Kris and Theodor Reik in formal psychoanalysis, Otto Rank in modified psychoanalytic therapy, S.R. Slavson in group therapy, and Carl Rogers in client centered therapy. They add to this list August Aichorn, Marie Bonaparte, Oskar Pfister, Bruno Bettleheim, Ernst Kris, David Rappaport, Alix and James Strachey, Joan Riviere, Ella Freeman Sharpe, Geza Roheim, Melanie Klein, and Hans Sachs from the field of psychoanalysis alone. Contributions of non-medical people to behavior therapy, cognitive therapy, group therapy, and other forms of psychotherapy are more than abundant. Indeed, some of the best psychotherapists are non-medical people. The latter are possessed of the highest integrity and function with a keen sense of responsibility for their patients.

It is obvious from these negative and positive claims and counterclaims, that opinion is sharply divided. There are responsible medical and non-medical authorities who are unalterably opposed to the practice of psychotherapy by non-medical persons under any condition. Others believe that such practice may be allowed in organized clinics or hospitals under circumstances of adequate psychiatric supervision. Still others do not

object to the private practice of well-trained non-medical persons, provided that they operate in collaboration with physicians and psychiatrists. Finally, there are those who protest that psychotherapy has no identity with medical practice and that a trained non-medical person knows when to bring a physician or psychiatrist into the picture if this is at all needed.

Representative of a prominent psychiatric viewpoint that is still extant is an article written by Norman Q. Brill (1957). Emphasizing the importance of trained clinical psychologists in understaffed state and veterans' hospitals, and admitting that they excel in certain areas of knowledge in the emotional factors of disease, Brill decries their influx into private practice where they assume independent responsibility for diagnosis and treatment and receive direct pay for their services. Brill blames the medical profession for not providing opportunities for supervision of trained clinical psychologists in private practice. Certification of psychologists, he continues, is a well recognized need to protect the public from inadequate and unqualified practitioners. "Any law to certify psychologists should also define psychotherapy and prohibit the treatment of mental or emotional diseases by a psychologist except under the supervision of a physician. If such a provision is omitted, an independent profession which competes with the medical profession is likely to result." Brill sums up quite adequately the opinion of a large segment of the medical profession. His conclusions are worthy of further exploration.

The first point relates to psychotherapy as a process. Definitions of psychotherapy are so diffuse, even in terms of its processes and goals, that there is little chance that lawmakers can do that which the psychiatric profession has been unable to do, namely, to arrive at a designation satisfactory to the majority of concerned parties. The classical example of how difficult this can be was the failure of a committee appointed by the American Psychoanalytic Association to agree to a definition of only one aspect of psychotherapy, namely, psychoanalysis.

Prohibitions as to the treatment of mental or emotional diseases by a non-medical person would call for adequate policing. Who would determine when the latter has

overstepped the bounds? What distinguishes "treatment" from "conversing with," "guiding," "advising," and "counseling"? Obviously, one cannot prevent an individual from talking to another individual and, if agreeable to both, charging a fee for the service. Would it be the subject matter of the communications? The kinds of verbal and nonverbal responses of the therapist? The discussion by the client of dreams, transference, and resistance? Insuperable problems invest attempts to delimit the nature of the communicative flow between any two people.

The matter of identifying a mental and emotional problem and distinguishing it from an "ordinary" problem also needs to be considered. An individual seeking spiritual guidance from a minister may be suffering from a serious mental and emotional disorder, as may a person with a work problem who consults a vocational counselor, or a student failing at school who insists on talking to an educational psychologist. Essential in dealing with the manifest complaint may be the listening to more underlying intrapsychic conflicts. Should the non-psychiatric profession divert the client from talking about these? Would not this professional be shirking helping responsibilities within his or her own field? Apart from the fact that our diagnostic classifications are amorphous and unsatisfactory, we cannot truly distinguish in many instances the pathological from the "normal" since definitions embrace social sanctions and cultural factors that have little to do with health and disease.

The matter of compulsory supervision by a physician brings up some confounding contradictions. How can this be practically arranged? What happens when the non-medical person is (1) the only person trained to do psychotherapy in a certain area and (2) more sophisticated in therapeutic techniques than the physician who is assigned as supervisor? Trained and skilled non-medical therapists now function as psychotherapeutic supervisors to physicians in clinics and hospitals. Should such training therapists, in turn, be supervised by physicians, and, if so, for what purpose? Should compulsory supervision by the medical profession apply only to those in the private practice of psychotherapy and not necessarily to those in clinics, hospitals, or other medical settings? Where can one expect to find the additional psychiatrists who would be

needed to supervise the large numbers of non-medical practitioners?

The last point—regarding the competition between non-medical people and psychiatrists—is perhaps the most crucial issue. Competition (and consequently conflict) exists in the area of mental health as it does in any other field where human beings vie with each other for recognition, status, power, and economic security. Non-medical therapists would seem to pose some economic threat to psychiatrists if it were true that there were limited opportunities for practice. While this may hold for patients who can afford to pay high fees in a few zones within large urban communities, it does not apply to the country as a whole. There is a gross shortage of trained personnel in the mental health field, including those who restrict themselves to the treatment of emotional illness. There is especially a dearth of psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses.

To all of these propositions non-medical professionals have their own answers. Among these is the allegation that psychotherapy is a form of medical practice only where it includes the giving of drugs and the use of the convulsive therapies and psychosurgery. Verbal interchange, the vehicle for psychotherapy, cannot conceivably be graded as a medical procedure. It is manifestly preposterous to insist on medical supervision for all non-medical workers under such circumstances. Even though this could be arranged, it would be quite impossible to administer adequate policing procedures.

Some psychiatrists counter with the statement that while guiding, counseling, reassuring, and supportive tactics are legitimate aspects of the non-medical disciplines, and therefore lie outside the responsibility of the physician, dealing with the intrapsychic processes and employing any kind of probing technique are medically corrective operations. Among the most insistent champions of this viewpoint are the psychoanalysts.

Even here there is no complete agreement, some leaders in the field being not at all convinced that psychoanalysis is a medical procedure. Years ago Freud, himself, defending charges made against Theodore Reik, the noted psychologist, said:

> I have assumed, that is to say, that psychoanalysis is not a specialized branch

of medicine. I cannot see how it is possible to dispute this. Psychoanalysis falls under the head of psychology; not of medical psychology in the old sense, or of the psychology of morbid processes, but simply of psychology. It is certainly not the whole of psychology, but its substructure and perhaps its entire foundation. The possibility of its application to medical purposes must not lead us astray. Electricity and radiology also have their medical application, but the science to which they belong is none the less physics. (Collected Papers, Vol. 5, p. 207)

Freud also wrote:

"I lay stress on the demand that no one should practice analysis who has not acquired the right to do so by a particular training. Whether such a person is a doctor or not seems to me immaterial" *(Standard Edition,* Vol. 20, p. 183). "The practice of psychoanalysis calls much less for medical training than for psychological instruction and a free human outlook" (Introduction to Pfister's *The Psycho-Analytic Method.* Standard Edition, Vol. 12, p. 329).

Maxwell Gitelson (1964), a past president of the International Psychoanalytic Association, questioned almost 25 years ago whether psychoanalysis should loosen its adhesion to medicine:

The prevailing tendency to place exclusive value on antecedent psychiatric training as such may need to be revised in respect to the barrier it erects against scientists with other qualifications who might advance the conceptual horizon of psychoanalysis. While there may have been valid reasons in the late thirties for American psychoanalysis to declare its exclusive adhesion to medicine as its parent discipline, the question must be raised whether these reasons retain their cogency today… .

A Position Statement of the Preparatory Commission on the "Ideal Institute" for the National Conference on Psychoanalytic Education and Research reiterated many of these ideas (American Psychoanalytic Association, 1974).

On the other hand, a large body of psychoanalysts, Freudian and neo-Freudian, protest that Freud was wrong when he identified psychoanalysis as a psychological rather than medical discipline. This is less the case in their personal relationship with lay analysts, and when voicing their private opinions to a select group of intimate friends, than when they are gathered together in a medical body where their sentiments may be

recorded.

Some attempts have been made to classify psychotherapy by including it in the phrasing of certification laws. There is a considerable variation of such laws among the different states. As a rule, certification qualifies a professional to use the title of "certified psychologist" or "psychologist" or "social worker." Some laws include a definition of the practice of psychology or social work; others do not. In the former case certification becomes practically equivalent to licensure. Generally, the certification law excludes the right to engage in the practice of medicine as defined in the laws of the state. In some cases the law includes "psychotherapy" or a form of "clinical counseling" as one of the functions of the psychologist or social worker.

A few medical organizations and groups oppose the concept of certification on the basis that they are against *any* legal recognition of psychologists or non-medical people. In the main, however, there is approval of the concept of certification if it confines itself to the simple protection of a title. In some instances, however, it goes considerably beyond this.

SUPERVISION OR COLLABORATION?

The basic positions of the American Medical Association and the American Psychiatric Association were expressed in 1964 as follows:

> To place the most critical aspect of the problem under specific discussion in its proper perspective, namely the professional need for cooperatively defining and respecting the areas of activity and responsibility for scientists who participate in the care of the patient, it must be fully realized that physicians have the ultimate responsibility for patient care, and that they, and they alone, are trained to assume this responsibility. In the public interest, other scientists, when contributing to this patient care, must recognize and respect this ultimate responsibility. Moreover, not only must there be mutual respect for different abilities and special qualifications, but also concomitant recognition of the interdependence of scientists and physicians in promoting health… .

The viewpoint of the American Psychological Association in 1962 (code of Ethical Standards for Psychologists) was:

The profession of psychology approves the practice of psychotherapy by psychologists only if it meets conditions of genuine collaboration with physicians most qualified to deal with the borderline problems which arise [e.g.] differential diagnosis, intercurrent disease, psychosomatic problems... . The psychologist recognizes the boundaries of his competence and the limitations of his techniques and does not offer services or use techniques that fail to meet professional standards established in particular fields. The psychologist who engages in practice assists his client in obtaining professional help for all important aspects of his problem that fall outside the boundaries of his own competence. This principle requires, for example, that provision be made for diagnosis and treatment of relevant medical problems and for referral to or consultation with other specialists.

The Council of the American Psychiatric Association (1963), reviewing the general views expressed above, concluded:

It must be considered axiomatic that the purposes of "genuine collaboration" is to benefit patients and that it can take place only when there is mutual trust and respect between two professional groups... . The essential problem is how to assure the patient of medical control over his medical care, regardless of the professional background of the psychotherapist. Complete medical control, rigidly interpreted, implies supervision of the psychologist by the psychiatrist. As indicated above, however, in actual practice, the relative rigidity of interpretations of "medical control" will vary according to several factors. For example, the patterns of practice in a university hospital differ from those of a state hospital, and these in turn differ markedly from practice in an urban or suburban upper middle class milieu. From these must be differentiated the small city or rural area where few, and often no, psychiatrists are to be found.

Mere referral of a patient to a psychologist for psychotherapy or testing, without follow-up contact or consultation between psychiatrist and psychologist cannot be considered "genuine collaboration," although it is recognized that in certain cases and circumstances the initiative for further follow-up consultation is properly that of the psychologist. When organic pathology— peptic ulcer, for example—is present, the appropriate consultant for the psychologist, and often the psychiatrist, is the internist, family physician, or other medical specialist. The sustaining principle is that close and frequent contact between the psychiatrist and psychologist is essential, and most especially in borderline cases where there may be a risk of suicide, for example.

While supervision at regular intervals, weekly, for example, might be advisable in some cases, the reality must be faced that it is impracticable in the majority of cases, even when the psychiatrist and psychologist desire it. The manpower and the man-hours are simply not available. Some psychiatrists insist on this as essential to their collaboration, as is their right. It is the Committee's opinion, however, that the rule cannot be universally applied since to do so would make it impossible for psychiatrists generally to meet all of the requests for supervision in all cases together with their other obligations.

It is apparent from these statements that the relationship of medical persons to

psychologists is being regarded as more collaborative than supervisory. The concluding paragraph of the report contains this item:

> Thus, the overwhelming public interest leaves no place for petty squabbles in building more effective interprofessional relations between the two major professions dedicated to the better understanding of human motivation and behavior. What is called for is a sustained, thoughtful seeking of answers to the fundamental questions posed herein—answers which will be in the best interests of the mentally ill. The American Psychiatric Association proposes to work to this end and urges upon its District Branches that they lend support in every feasible way to improving the liaison between psychiatrists and psychologists at the state and local level.

In 1974 John P. Spiegel, President of the American Psychiatric Association, wrote that it was possible for certain mental and emotional disorders to be "treated effectively by mental health professionals other than psychiatrists. Some disorders usually require the special skills of the psychiatrist in both diagnosis and treatment. Still others can be in most circumstances appropriately treated only through a collaborative effort of psychiatrists with other professionals."

Opposed to the idea of collaboration rather than supervision, however, are some dedicated groups of psychiatrists and physicians who support what Levine wrote in 1965:

> We hold that the treatment of the emotionally disturbed and mentally ill patient is a medical responsibility and as such cannot be assumed by any other than a medically trained therapist....

Invasion of medical practice, it is claimed, cannot be countenanced. Ultimate responsibility must not be assumed by the psychologists since they are not trained to diagnose organic disease and to prescribe for them which activities are fundamental to treating the emotionally and mentally ill.

To this, other psychiatrists disagree for reasons similar to those expressed by Edward Gardner (1965), Chairman of the Editorial Board of the *Newsletter of the Psychiatric Society of Westchester:*

> The issues with which we are urged to concern ourselves are "lay therapy," "unsupervised lay psychotherapy," "licensure" and "relations with allied professions." The small print in the Bulletin articles reads with somewhat more heat

than objectivity. We find there references to spreaders of "cancer," "nefarious" practitioners, "flagrant offenders" and even "an assault on the practice of the psychiatry." Hardly the language of a scientific dialogue!

One article raises the question of "ultimate responsibility for the welfare of the patient." This is a thorny problem filled with seductive primrose paths. Basically, the question of "ultimate responsibility" rests with the individual himself. We rightfully delegate responsibility to appropriate experts in a variety of fields from carbuncles to carburetors. This follows the enormous complexity of our lives and increasing wealth and welter of specialized technological data. However, I feel it is more than presumptuous for any single discipline to claim the right to assume "ultimate responsibility" for such an ill-defined segment of the human experience as the one with which we are all struggling. Let us not forget that as physicians we have had certain responsibilities *delegated* to us by society. This does not mean, however, that in any sense we enjoy a variety of divine right.

The time may well have come for cooperative efforts directed toward the welfare of the public. These rather than moves which antagonize and elicit defensive and alienating behavior. Several outcomes are within the realm of possibility: (1) that "unsupervised" psychotherapy becomes the private property of the medical profession to the exclusion of all other disciplines; (2) that ultimately (Perlsh the thought and our humanity along with it) psychotherapy atrophies from disuse in the face of a greatly expanded and refined psychopharmacology; (3) that psychotherapy becomes a separate and collaborative discipline with its own standards of competence and proficiency based on principles sounder than those that currently support it.

The futility of evolving a law, or of enforcing it, that permits "counseling" by non-medical people (caseworkers, psychologists, nurses, ministers, lawyers, etc.) and forbids "psychotherapy" except under medical supervision is accented by the fact that a sharp distinction between counseling and psychotherapy cannot be drawn. *There is no law that can possibly prevent people from doing psychotherapy under the name of guidance or counseling.*

According to the General Counsel of the American Medical Association (J.A.M.A. 247:3-360, 1982) it is not legally required for a non-medical professional in independent practice to call for an examination by a physician before or during treatment of serious behavioral or psychological disorders. Existing licensure laws recognize an independent role for designated non-medical professionals. "Anti-trust laws provide protection against artificial barriers and obstacles that interfere with the legitimate practice of a profession." Citing such a law on March 1, 1985 the group for the Advancement of Psychotherapy and Psychoanalysis in Psychology sponsored the filing of a class action, anti-trust lawsuit against the medically constituted American Psychoanalytic Association as hindering the attempts of American psychologists "to study, teach, and practice psychoanalysis both in

this country and abroad." The lawsuit supports the idea that "psychologists of all theoretical persuasions should be free to teach, train, and practice without medical dominance or exclusion." This action had the endorsement of the American Psychological Association. Moreover psychologists, to the consternation of the medical profession, are aggressively defending their right to unqualified reimbursement for services and are threatening legal suit for restraint of trade. New standards of the Joint Commission for the Accreditation of Hospitals allow individual hospitals to decide what licensed individuals other than physicians may be given clinical privileges subject to what applicable state laws or licensure requirements may stipulate, and in conformity with the policies and bylaws of the medical staff. In this way non-medical professionals, gaining membership to the Medical Staff of Hospitals can admit and treat their own patients. Needless to say, psychiatrists consider this a threat to their own practices. More and more states are defining a role for psychologists in the civil commitment process. In Virginia, psychologists won a battle with Blue Shield over their refusal to pay psychologists unless services were billed through a physician. The ruling in favor of psychologists was upheld by the U.S. Supreme Court. The appeals courts said "we are not inclined to condone anticompetitive conduct upon an incantation of 'good medical practice.'"

As clinical social workers have become more involved in the practice of psychotherapy they too have been demanding rights to reimbursement by third-party-payers for the treatment of patients in private practice. In some states they have been successful, securing licensure and reimbursement privileges in spite of the activity of The American Psychiatric Association, which has launched a campaign against such privileges on the basis that a comprehensive psychiatric assessment is needed prior to initiating therapy, which is crucial for proper diagnosis and treatment planning.

TOWARD AN ECUMENICAL SPIRIT IN THE MENTAL HEALTH FIELD

Continuing shortages of psychiatrists and the growth of community mental health centers have necessitated staffing the centers with trained non-medical personnel who more and more are working on a par with physicians. Recognition that the medical model

is not applicable to all emotional and behavioral problems has resulted in the recruiting of teachers and supervisors from non-medical areas. There are ample evidences of new winds that are blowing to accelerate the acceptance by the psychiatric profession of their colleagues in clinical psychology, psychiatric social work, and psychiatric nursing. We may, however, expect that the fraternal spirit is not consistent nor universal and that the next day may see vitiated what today sounds like a new dawn of tolerance and reconciliation.

We have seen only too vividly how the untidy squabbling among competitive disciplines rises and falls with the economic tides. Indeed, as governmental budgeteers have slashed away at allocations for research, training, and treatment, forecasts of a belt tightening and cadaverous era for mental health funding are supporting a struggle for territorial rights. As national health insurance edges into the picture, the prestigious American Psychiatric Association (1974) issued a *Discussion Guide on National Health Insurance* "for discussion purposes only," acknowledging the need for allied non-medical services, but suggesting that reimbursement presuppose non-medical professionals operating as part of a treatment plan prescribed and supervised by a physician. This statement has been considered by some psychiatrists and most non-medical people as constituting a backward step in relations among mental health professionals. Reimbursement, they insist, should be on the basis of training, functional role, and competence—irrespective of discipline.

The need for greater cooperation among the mental health professions is generally acknowledged. Howard Rome (1966), past president of the American Psychiatric Association, in his address at the opening of the Association's 122nd annual meeting, called for a new coalition of all the social sciences in which no one discipline would be supreme. He urged that psychiatrists abandon the "invidious" conviction that they alone can understand the vagaries of human behavior. In a similar vein the Committee on Psychopathology of the Group for the Advancement of Psychiatry has emphasized the need for collaborative research in the field of mental health and has pointed out that interdisciplinary working together on any single project results in more adequate checks

upon interpretations and hypotheses and also more fruitful conclusions. The highest degree of collaboration is possible where the disciplines are able to communicate with each other. This requires education in allied fields of interest. However, interdisciplinary rivalries and hostilities and the bans levied by some psychiatric groups on the training of non-medical personnel in psychotherapeutic techniques militate against this objective.

A good deal of the misunderstanding between the professions of psychiatry and psychology is due, as Dickel (1966) pointed out, to the fact that "the two groups have never really understood the difference between the medically-oriented and the psychologically-trained doctorate. ..." Recognizing that each discipline is geared toward "the good mental health of each citizen, [they] should be able to comfortably cooperate, and yet should not at any time encroach upon each other's legal, professional, and moral responsibilities, duties, or functions." In his article Dickel describes clinical psychologists as a highly screened, selected, trained, and skilled group of professionals, with many years of academic schooling, who believe themselves capable of policing their own functions. Independently "they have developed intraprofessional, voluntary means to maintain and advance professional competence; they have initiated qualifying boards for recognition of this competence by their peers, and they have established their own scientific societies with suitable credentials for membership." With disciplined postgraduate education, he continues, clinical psychologists are capable of studying and working with the psychologic state of an emotionally disturbed person. Whereas medicine and medical education gear the physician toward an organic view of the human being and support the implication that behavior is not a medical responsibility, psychology and psychological education are largely in the psychosociological-cultural field, concerning themselves with certain aspects of behavior as their principal province.

Certain attempts have been made by some to reconcile the training differences of psychologists and physicians. Thus L. S. Kubie (1947), acknowledging the shortage of existing clinical services and of training facilities for psychiatrists and commenting on the fact that it requires from 10 to 12 years to train one to be a mature psychiatrist and psychotherapist, advocated the setting up of a paramedical discipline of medical

psychology with a condensed, concentrated training program of 5-6 years to be conducted in medical schools and teaching hospitals. Among the courses included would be basic training in anatomy, clinical physiology, and clinical pathology of the normal and abnormal organic processes. Certain aspects of medical education would be omitted, such as most gross and microscopic pathology, clinical pathology, laboratory techniques, and bacteriology. Clinical clerkship would involve history taking, nursing care of patients, and administration of psychologic test batteries. Personal psychoanalysis could begin at any time after work on organic wards is started. Such a program would lead first to an understanding of how organic factors and ailments influence the person psychologically; second, to a special sense of responsibility toward the patient as a sick individual; third, to an objectivity in one's clinical evaluations; and fourth, to self-criticism. With two or three years of supervised psychotherapy, candidates should become fairly seasoned therapists.

J. G. Miller (1947) also foresaw a future blending of medical and psychologic curricula in an extensive kind of training. Undergraduate instruction leading to a Bachelor's degree would consist of 2 years of liberal arts college, 1 year of advanced clinical psychology, sociology, and cultural anthropology, and 1 year of preclinical medical subjects comparable to the first year of medical school. After this, the candidate would enter the second and third years of medical school, and then do medical and psychiatric clinical work for 1 year at a general hospital, mental hygiene clinic, or neuropsychiatric hospital. The granting of an M.D. degree in the psychologic sciences would be followed by 1 year of a rotating psychologic-psychiatric internship, which would include experience in psychologic diagnostic methods and the performance of different psychiatric duties. After this, there would be 1 year of independent research leading to a dissertation. Seminars and a personal psychoanalysis would also be included. Successful completion of these requirements would result in an award of a Ph.D. in clinical psychology. From this time on the candidate would work for boards in psychiatry, clinical psychology, or both.

G. E. Gardner (1952) stressed the need for contact with seriously ill mental patients as part of the training program for psychologists, and he indicated that unless there is a prolonged exposure to the problems of such sick patients, the candidate is handicapped in

developing a proper "clinical attitude." For this reason, at least 1 year of work in a state hospital in close contact with mental patients was recommended as a minimum for all non-medical therapists, including psychologists.

At present similar formulas are propounded with some modifications. Upsetting the professional caste system is the proposition that all psychotherapists, irrespective of discipline, are alike. Supporting this contention are the surveys reported by Henry et al. (1971) who discuss the advisability of setting up a psychotherapeutic "fifth profession." Holt (1971) has included in his book the opinions of leaders in clinical psychology, psychoanalysis, psychiatry, and social work regarding what is necessary for the development of the new profession of "psychotherapist." Criteria for training and accreditation, arguments for establishing a new type of professional school, and the essential curriculum are topics that lead to conflicting views and controversial and unconventional conclusions.

There is generally a feeling that any planning for future educational programs must take cognisance of the fact that ideally what will be required is exposure to a broad range of techniques that include psychoanalysis, behavior therapy, cognitive therapy, hypnosis, strategic therapy, milieu therapy, group therapy, family therapy, couples therapy, and pharmacotherapy. Training should embody when and how to implement these techniques, and their effective integration toward the most extensive objective of personality reconstruction where the patient is able to benefit from this. There are some who forsee education that would lead to a special degree (Doctor of Mental Health) and would encompass all the courses in medicine, psychology, social work, and education that have pertinence to mental health (Watson 1970, Holt 1971, MacDonald 1978). The program described by MacDonald (1978) which is cosponsored by the University of California at Berkeley, Mount Zion Hospital, and Langley-Porter Neuropsychiatric Institute sounds promising. Another design is that after obtaining a bachelor degree a candidate would enter medical school for two years of selected medical courses, eliminating courses that are not essential to psychiatric practice. The next two years would be spent in schools of psychology and social work getting instruction in counseling, psychological testing,

mental health research, community mental health and other related areas. There would be assignments to social and other agencies for practice and experience. During this period or even before candidates could start their personal psychoanalysis and analytic training. They would also participate as patients in a therapeutic group. The last two years would be as residents in a mental institution, at the same time acquiring experience in multimodal therapy and differential therapeutics, learning all the important techniques essential for work as mental health specialists. They would be required to engage in an extensive research project as well as a community project where they would learn community mental health consultation. Finally they would get courses in supervision of psychotherapy. With this comprehensive kind of grooming they would be licensed to practice as a Mental Health Specialist able to do various kinds of treatment, write prescriptions for medication, admit and treat patients in hospitals and do all or more than psychiatrists, psychologists, and social workers are trained to do today in the mental health field.

We may expect a number of roadblocks that inhibit this kind of education. The most likely hindrance will be the power structures of the professions which, having a vested interest in maintaining their identities, are unable to tolerate change. Another impediment is that unfortunately technological advances have progressed much faster than man's capacity to adapt to them. We see examples of this not only in the area of mental health but in many divisions of the biological and social sciences.

It is doubtful that there is any professional who does not recognize differences in the training and function of physicians and non-medical professionals. There are areas where the psychiatrist is at an advantage due to an educational and experiential background. Biochemical, neurophysiological, and physical dimensions of an emotional problem are more easily recognized and treated by a physician. Years spent in residency in a mental institution sharpens diagnostic and therapeutic skills especially in relation to the more serious mental disorders like schizophrenia, borderline conditions, mania, depression, psychosomatic ailments, and organic brain disorders. The prescription of psychotropic drugs is a function assigned for the most part to physicians since it calls for an

understanding of their therapeutic influence and handling of untoward side effects. Specially trained psychiatrists can administer ECT and narcosynthesis when needed. If psychiatrists have not drifted away too much from medicine, they know how to recognize physical conditions that display themselves as psychiatric problems and vice versa. Psychiatrists have the ability to function in liaison consultation with other physicians in general hospitals or private practice. They have experience in dealing with psychiatric emergencies that present themselves at the office, outpatient clinics, emergency rooms, crisis units, and community mental health centers.

The areas in which psychiatrists are at disadvantage because of education relate to psychological and social factors that may confront them in the workplace. Cooperation with psychologists and social workers may serve an educational function toward understanding the crucial part problems of living play in mental illness. But since psychiatrists have been trained to consider themselves as ultimately responsible for the total treatment of patients across the entire biopsychosocial spectrum, construction, and supervision of a treatment plan by non-medical workers in an agency or community mental health center may create conflict within. Psychiatrists usually do accept the fact that psychiologists may in their schooling have had more training in counseling and perhaps in behavior therapy, and are better equipped to work with patients who require counseling or who need a behavioral approach for certain conditions like phobias, obsessive compulsive symptoms, and habit disorders.

It is only at the point where some kind of psychotherapeutic technique is employed that difficulties in defining roles arise. Each group feels entitled to the right to use psychotherapeutic procedures by virtue of its historical development, but each group must also take the responsibility for delineating what it is that their members are equipped to do by training and experience. Those who have had adequate training to do psychotherapy may help persons with emotional problems with reasonable certainty of success. Those who are not so trained should not be entitled to represent themselves as psychotherapists, whether they be psychiatrists, clinical psychologists, psychiatric social workers, or psychiatric nurses. At the moment there is no new profession of

psychotherapy. Questions of licensing and standards automatically raise many issues. Organized social work, nursing, psychology, and organized medicine are actively participating in trying to define their roles in private and agency practice, including psychotherapeutic operations.

While there is no uniformity of sentiment, some general propositions may be tendered. The following are some suggested guidelines:

1. *Competence in the conduct of psychotherapy has little to do with the kind of degree that the psychotherapist possesses.* Professionals with an adequate background in psychiatry, clinical psychology, psychiatric social work, or psychiatric nursing with proper training, supervision, and perhaps personal psychoanalysis, may learn to do good psychotherapy. The need for adequate postgraduate specialized training for all professions, however, cannot be overemphasized.

2. *Morality is not a medical monopoly.* An ethical non-medical therapist has just as much concern and feelings of responsibility for a patient as does an ethical physician. There are, of course, exceptions. However, a few non-ethical practitioners in both medical and non-medical categories do not warrant generalizations that extend to the entire profession.

3. *Training in an interdisciplinary setting is the preferred locus in enriching the understanding of all of the related professionals.* It results in mutual respect for the contributions that the respective professions have to make in the total treatment and preventive programs. It enables the non-medical worker to recognize the need for a relationship with the psychiatrist, and it equips him or her to work collaboratively with the psychiatrist. It apprises the psychiatrist of the special services other workers have to offer in a collaborative work setting with them. Training in an interdisciplinary setting tends to make medical and non-medical trainees highly aware of their community responsibilities; after their training has been completed, they are more prone to devote some of their time to community work.

4. *All patients should coordinately be under the care of a general medical practitioner who diagnoses, treats, and when necessary, refers the patient to other medical specialists for further study of physical ailments.* Because

psychologic disorders may be a reflection of underlying medical and neurologic problems, all patients entering any kind of a treatment program should be thoroughly checked by an internist to ascertain the presence of physical illness and neurologic disease. In the course of therapy a periodic medical checkup is essential. In practice, nearly all patients who seek help from psychotherapists have their own family physicians. Any patient who is in therapy with a psychiatrist, should also be coordinately under the care of a family physician or be referred to one for an initial diagnostic examination and periodic checkups, since the psychiatrist will probably not be managing the physical problems. In view of the increasing lawsuits against psychotherapists for not employing proper medical safeguards in treatment, we may expect greater collaboration and consultations of non-medical therapists with physicians and psychiatrists.

5. *There are certain patients who should preferably be under the care of a psychiatrist* whose background best equips him or her to administer somatic therapy and to handle emergencies that may arise. Included are severely depressed and suicidal patients; violently excited, disturbed, and dangerously assaultive persons; decompensated schizophrenics; acting-out alcoholics and drug addicts; patients whose difficulty is prominently or exclusively expressed in somatic pathology (somatoform disorders); and individuals who require electroconvulsive and constant psychotropic drug administration. Where the non-medical professional is obliged to carry on psychotherapy with such patients, he or she should work collaborately with a psychiatrist who will be available for consultation at all times and who may step in to manage psychiatric emergencies should they precipitate.

6. Assuming that safeguards are maintained in regard to the medical status of the patient, *professionals trained to do psychotherapy and who have had sufficient supervised clinical experience may be able to do psychotherapy under such supervision of the psychotherapeutic process as their level of training demands*, by a medical or non-medical supervisor.

It will be apparent from the diverse arguments and opinions that have been presented that no easy solution of the suspicions and hostilities between medical and non-medical professionals is in sight. The bitterness that has developed between them has not been in the public interest. Charges and countercharges bring discredit to both

professions. The controversies have done little other than to isolate the two groups from one another. In some cases actions have been instituted to extend the medical practices acts to include psychotherapy in order to bar "unqualified and unsupervised persons" from doing psychotherapy. Since improper practice is the product of lack of enforcement of existing medical practice acts, amendment of the present acts are, however, generally not believed to be necessary. Lawsuits solve very little, for basic disagreements between medical and non-medical opponents cannot be settled by legislation or contests for public support. If psychotherapy is ever to develop into a scientific discipline and if we are ever to bring therapeutic facilities within the bounds of community needs, it is mandatory that a solution be found to the differences that exist between physicians and non-physicians in the field of mental health. Reciprocal respect and tolerance are essential before we can even begin to approach the problem constructively.

OTHER HELPERS IN THE MENTAL HEALTH FIELD

As has been previously indicated, a number of workers other than physicians, nurses, clinical psychologists, and psychiatric social workers come into contact with emotionally disturbed persons. Chief among these are non-psychiatric physicians, ministers, teachers, police officers, and mental health aids or "paraprofessionals." Where they possess the proper training and skill, such individuals are in a strategic position to detect incipient neuroses or psychoses, to educate clients in the principles of mental health and the meaning of emotional disturbance, and to refer those in need of psychotherapeutic services to available resources. The kind of therapeutic help that these workers are capable of rendering is generally of a supportive nature contingent on the warm relationship that is established, the opportunities for verbalization and emotional catharsis that are offered, and the employment of casual measures of reassurance and persuasion. In a few instances a gifted helper who has received sufficient postgraduate training may be able to do reeducative therapy. This individual may thus be capable of influencing personality forces at a time when the neurosis is relatively reversible and before obdurate accretions of neurotic defense have accumulated.

The entry of helping persons of varied disciplines into the mental health field is, nevertheless, not without its dangers, for there are always aggressive enthusiasts who do not recognize or accept their limitations of function. Insisting that they are not "helpers" or "counselors" but "psychotherapists," they may plunge recklessly into situations beyond their understanding, in this way potentially harming the patient as well as endangering their own professional stature. This, however, should not discourage the organization of proper educational training programs. Experience demonstrates that with additional education helping persons become more adept, and also more conservative, in what they can do psychologically for their clients.

It is unrealistic to assume that trained psychotherapists can ever supply from their ranks sufficient practitioners to satisfy the ever expanding demands for mental health services. If our concern is with the needs of community, it will be necessary to employ counselors and helpers on whatever levels they may best serve.

Proper training is of utmost importance for new roles in providing service. Well-organized didactic courses combined with small-group discussions and personal group work or personal psychotherapy are helpful in facilitating the most effective execution of duties. Personal psychotherapy provides a discernment of psychodynamic factors that cannot readily be grasped through the traditional didactic courses and case conferences.

The Non-psychiatric Physician in Mental Health

Whether desiring it or not, family physicians are often put into a position where they must function like psychotherapists. A woman with a blinding headache spills out her concerns about her adolescent son whose misbehavior is "driving her insane." A man recovering from a heart attack expresses his anxiety about his future: the support of his family, resumption of sexual relations, the possibility of a cardiac relapse. A teenage girl is insistent upon receiving contraceptive advice and confides that she is having an affair with a married middle-aged man. Liver involvement in a young alcoholic, an intractable gastric ulcer in a tense spinster, insomnia that resists hypnotics, persistent vomiting without cause, suicidal threats in depression, refusal to give up smoking in emphysema, dieting

failures in obesity, and a host of other challenges are examples of what may confront physicians in their daily practice and force them to assume a psychological stance for which they may be little prepared. Actually, the doctor may be the only person a patient will consult for the myriad problems that beset human beings during various age periods. Not only must physicians know what is normal at the different age levels, but they must be able convincingly to communicate facts to the concerned parties and deal with resistances to their absorbing these facts. They must know how to manage the emotional reactions of patients with chronic disabling diseases and terminal illness as well of individuals about to undergo surgery and following surgery, along with the reactions of families whose responses to the patient's illness are bound to influence recovery. Physicians must have knowledge of how to handle the psychiatric emergencies that invade their office, how to deal with the problems of drug abuse and drug addiction, how to diagnose early psychosis, and how to manage the complications of mental retardation. In regard to the world of sexual vexations alone, patients usually turn to their doctor for advice regarding not only genitourinary abnormalities and veneral disease, but also family planning, marital friction, genetic counseling, sex during pregnancy, intercourse techniques and practices, abortion, sterilization, frigidity, dyspareunia, vaginismus, impotence, premature ejaculation, loss of libido, and sundry other troubles that invest their most intimate areas of living. It is the rare physician who knows how to deal with all or most of these difficulties *(Medical World News,* 1973).

This is a most unfortunate situation since it has long been recognized that the non-psychiatric physician is a key figure in the army of mental health professionals. (Draper, 1944; Alvarez, 1947; Overholser, 1948; Rennie, 1949). A sizable number, estimated between 50 to 70 percent, of the patients seeking medical relief suffer from functional instead of, or in combination with, organic ailments. There is scarcely a single bodily organ or tissue that may not be influenced by emotional forces. Due to this, much attention has been centered in recent years on "psychosomatic" factors in physical disease. A virtual plethora of articles on emotionally determined somatic syndromes has appeared in medical journals that have stressed an organismic concept of the human being. The internist or general practitioner probably has an advantage over the psychiatrist in

dealing with the common psychogenic ailments of patients because the internist sees them at an early stage when they are more susceptible to treatment and because he or she is more capable of relating symptoms to the somatic status.Indeed, Groom (1947) stated forty years ago that "only a small percentage of neurotic patients can be or need to be seen by the psychiatrist."

Vital for medical psychological counseling are the following:

1. Ability to diagnose and to manage emotional interferences with physical functioning.

2. Understanding of how to help the patient adjust to critical situations in one's life.

3. Sensitivity to unexpressed communications.

4. Acquaintance with some interviewing, relaxing, and behavioral techniques.

5. Recognition of positive ego resources in the patient.

6. Aptitude in guiding without moralizing.

7. Discernment of an evolving transference and other resistances that will interfere with a working relationship.

8. Sufficient self-knowledge to control negative countertransference—the inevitable contaminant of the physician's personal problems and prejudices.

9. Willingness to spend at least one-half hour with a patient on occasion to encourage and discuss deepest emotional concerns.

10. Possession of adequate information about community resources that may be helpful in the treatment plan.

11. Skill in referring the patient to a psychotherapist for further help when necessary.

The knowledge essential to these competencies is generally acquired in a casual and sometimes haphazard way in the forge of experience. It is rarely taught in medical school.

Some help has been extended to the physician by a few postgraduate courses as well as by consultations with psychiatrists. However, such proceedings have not proven to be altogether beneficial. The usual complaints have been that the information imparted has been "too theoretical" or "too disorganized" to help resolve the everyday problems facing the physician in daily practice. Obviously, it would be helpful if some way were devised of bringing to the physician in an effective form psychological techniques of working with patients within the individual's experiential range and time limitations.

Actually, within the past decades a body of knowledge has accumulated in the behavioral sciences—including psychiatry, psychology, sociology, and anthropology— that has a crucial bearing on problems of physical illness and rehabilitation and that may advantageously be incorporated in the education of physicians. How to develop an efficient means of communication of pertinent principles and techniques is the pivotal question.

In line with this objective, the curriculum of practically every medical school now contains a sizable number of psychiatric courses. The aim of such courses is to prepare the medical student so that the student can deal intelligently and skillfully with patients as persons and to give each student a basic understanding of psychologic and social problems in relation to health and disease. These goals were accented in the *Report of the 1951 Conference on Psychiatric Education* (1952) organized and conducted by the American Psychiatric Association and the Association of American Medical Colleges. At this conference it was generally agreed that instruction in psychiatry be started during the first and second years of medical school. Since then an increasing number of medical schools have stressed behavioral and sociological factors in their curriculum. With improved undergraduate education, the physician's role in mental health may become more structured than it is today. Eventually the non-psychiatric physician may well become a major factor in the management of the bulk of psychiatric patients. Hardin Branch (1965) has remarked, "My own feeling is that the education of medical students in the management of psychiatric problems should be such that within the limits of the kind of practice which the student physician plans, he should be responsible for the specific

psychiatric care of many of his patients."

After medical students graduate as physicians, the roles that they play in the community and the prestige that they enjoy in the eyes of their patients lay a groundwork for psychological helping. How a physician may function therapeutically in a relationship with a patient has been detailed in a number of earlier writings that are still valuable reading—for example, Whitehorn (1944), Rennie (1946), G. Smith (1946), Ebaugh (1948), Bartemeier (1951), and Watts and Wilbur (1952). Useful books for physicians on therapy are those on general psychotherapeutic techniques by M. Levine (1942) and interview psychotherapy by Law (1948). A very good account of the role the physician plays in mental health is included in the early volume by Rennie and Woodward (1948). Recommended books are those by Aldrich (1966), Balint (1957), Beliak (1952), Bennett et al, (1956), Castelnuovo-Tedesco (1965), Hamburg et al, (1982), Missildine (1963), Moench (1952), Nash et al, (1964), Tallman (1961); Thompson and Byyny (1983), Weiss and English (1957), and Zinberg (1964). Recommended also are the articles by Hulse (1950), Balint (1954, 1955, 1961a & b, 1965, 1966a & b, 1969, 1970a & d, 1972), Engel (1982), Orenstein and Goldberg (1972), Borus (1975), Hoeper et al. (1979), Rieger et al. (1978).

Recognizing that readings, while helpful, are not in themselves sufficient to inculcate adequate skills in psychotherapy, a number of postgraduate courses for physicians have been organized that rely on the case method of teaching. Perhaps the most noteworthy study here was that of the Minnesota Experiment set up by the Commonwealth Fund (Witmer, 1947) in which an attempt was made to introduce the most pertinent parts of basic psychiatric thinking into general medicine and included clinical practice under supervision. Ziskind (1951) described a training program introduced at the Cedars of Lebanon Hospital, a general hospital in Los Angeles, in which volunteer practitioners examined and treated patients with psychogenic problems under supervision of a staff psychiatrist. Ziskind felt that the uncovering of psychogenic conflicts was within the sphere of the practioner, although the latter was not qualified to do character reconstruction, which, an objective of long-term therapy, was reserved for the

psychiatrist. In England, around 1950, at the Tavistock Clinic, Balint (1957) organized a full program for physicians that stressed the management of the doctor-patient relationship: "The aim is to make the general practitioners aware of what their patient wants to convey to them, not so much by his words as by his whole behavior, and how their own general behavior and actual responses influence what the patient can actually tell them." Other courses have been organized at the University of Kentucky and at Mount Sinai Hospital in New York City. The National Institute of Mental Health has sponsored a number of programs in which approximately 11,000 physicians have been enrolled. A preceptership model of education, in which a psychiatrist comes to the office of a family physician, has proven of value in selected instances (Grotjohn, 1957; Brook, et al. 1966; Zabarenko et al, 1971). This format enables the psychiatrist to see at first hand with the physician the kinds of cases the latter actually handles. Teaching rather than consultation is the primary goal. Formal courses that have been organized range from simple lectures on drug dosages (a topic most acceptable to non-motivated physicians) to personal supervision of physicians treating patients with psychoanalytically oriented psychotherapy over a period of years (which is most applicable to a few physicians interested in working more in depth with patients). There are courses on psychiatric emergencies, attitudes of the physician toward patients, interpersonal relationships, and specific problems like alcoholism, depression, drug addiction, suicide, geriatric problems, marital discord, and other syndromes.

The Federal government, in the mid 1970s influenced perhaps by studies that have validated the effectiveness of psychological interventions in lowering hospitalization admissions and general medical care (Levitan & Kornfeld, 1981; Mumford, et al, 1982) mandated and supported training programs for residents and postgraduate courses for primary care physicians. Furthermore they provided tuition for those medical students who after internships or residency committed themselves to engage in primary care health services in the community. Federal assistance was also extended for the development of health maintenance organizations and community health centers in different parts of the country. Unfortunately Federal support for these programs has gradually been diminishing.

Models for the psychiatric training of residents in primary care programs have varied depending on the available funding, the sophistication of the administrative agencies, and quality of the training personnel (Pincus, et al, 1983). Some programs have stressed close liaisons with control by psychiatrists. Some have sporadically utilized psychiatrists in consultation and for random supervision. Others have employed in-house staffs of non-medical behavioral scientists as educators. The results have not been consistent, but progress has nevertheless been made in spite of the fact that mutual suspicion and distrust is still obscuring the relationship between a considerable body of physicians and psychiatrists.

Results with postgraduate programs for physicians in practice have not been completely successful. About 90 percent of the physicians say they simply have no time in their busy daily practice to engage in further psychiatric education; some are frozen by hostility toward psychiatric practice and practitioners. Some who do respond favorably are primarily motivated by a need to help themselves with their own emotional problems. But those who sincerely engage in continuing psychiatric education report that they do benefit, thus substantiating the statement made in the Task Force Report of the American Psychiatric Association (Psychiatric Education and the Primary Physician, September, 1970), "because they are conscious of disappointments, failures, and mistakes in their practices and because they recognize the need for more understanding of emotional factors if they are successfully to treat, manage, and reform the patients they see." Most physicians do not desire to practice psychotherapy recognizing their lack of training and the fact that time spent in listening, guiding, consoling, advising, and counseling "is in fact the least highly rewarded activity in fee schedules." They do want information that will help equip them to diagnose, to handle temporarily, and to refer the kinds of patients they see in primary care and other settings. This may abate the fear some psychiatrists have expressed that primary care physicians will encroach on their territory. It can be seen from this that what is urgently needed are innovative training programs that enhance the competency of physician trainees (Borus, 1985).

One of the difficulties that is currently being investigated is why a mental diagnosis

is not being recorded by primary physicians even when mental symptoms are recognized and psychotropic drugs prescribed. This may be due to inadequacies in the current diagnostic system or in physician knowledge and skills (Jencks 1985). It may also be due to reluctance to label a patient with a mental diagnosis in view of the fear the patient's being stigmatized by such a diagnosis.

A problem that seems to defy resolution is a continued prejudice against psychiatry. The 1961 Report of the Joint Commission on Mental Illness and Health brought this out and concludes that general practitioners as a group are not too interested in mental health problems. To cope with this resistance, the American Medical Association, in 1952, created a Committee on Mental Health to formulate policy. Its efforts resulted 9 years later in a planning conference in Chicago, and the next year (1962) the first AMA Congress on Mental Illness and Health focused its attention on 19 specific topics, ranging from undergraduate education to operational research. A second AMA Congress, held shortly after the first, limited its deliberations to the practicing physician's role in developing community mental health services. Helpful toward facilitating action has been the American Academy of General Practice (AAGP), which since 1956 has designed programs aimed at helping general practitioners become better acquainted with psychiatric techniques. With a committee from the American Psychiatric Association, two colloquia were sponsored (in 1961 and 1963) for teachers of postgraduate psychiatric education. The Western Interstate Commission on Mental Illness and Health brought arranged a series of programs for non-psychiatric physicians that covered most western states. These were developed around the idea that it was essential to bring education to the physicians in remote areas rather than to expect them to travel distances in order to obtain schooling. Indiana University also organized "road shows" of traveling teams of teachers, who demonstrated a remarkable flexibility in adapting themselves to the needs of the physician groups being taught. A program of the New York Academy of Medicine also stressed the importance of gearing studies to the requirements and existing sophistication of the students. Beliak's (1963) course at Elmhurst illustrates the wide range of techniques that may be employed in teaching. These include didactic talks, films, tapes, small-group seminars, case presentations, and role playing, with the use of multiple

teachers and special consultative programs.

It is generally agreed that lectures must be practical, structured, crisp, and well prepared. Short formal presentations are best followed by small-group seminars in which cases from the physician's own practice are discussed. The role of the doctor-patient relationship is a central focus.

A valuable contribution as to what to teach was made in the Indiana University questionnaire study, which listed in weighted rank order the following topics: drug therapy, techniques of short-term psychiatric treatment, psychosomatic conditions, interview techniques, adolescent behavior problems, handling psychiatric emergencies, obesity, childhood behavior problems, early signs of schizophrenia, care of the geriatric patient, marital counseling, depression and suicidal risk, emotional concomitants in medical and surgical conditions, premarital counseling, school problems, alcoholism, role of physicians in follow-up of released psychiatric patients, medicolegal problems, emotional problems of the involutional period, and juvenile delinquency.

Bilmes and Civin (1964), who organized a survey to determine the degree of interest in a program of psychiatric education for non-psychiatric physicians, have commented on this study: "That is a fairly comprehensive list. Allowing for regional differences (for instance, one might anticipate that in the New York City area, Juvenile Delinquency and Drug addiction—which ranked 25 in the Indiana study—would rank higher) perhaps the one serious question one might raise is whether what the physicians *want* is exactly the same as what they *need*. Thus the doctor-patient relationship isn't cited even though, as mentioned before, it is one of the key points stressed by everyone planning these programs. Another important point is how much these topics can be gone into without the presentation of some fundamental theory—the theory of defense mechanisms, for instance. Another surprise is the omission of the subject of psychosexual problems. Organic brain diseases are also ignored in the Indiana survey—whereas, by contrast, a separate course in this area has just been started by the Nassau group."

According to Bilmes and Civin, their own survey indicated that physician-students

"almost unanimously spontaneously stressed (the interviews were open ended) that they considered the demonstration of live psychiatric interviews plus ensuing discussion as the most powerful means of teaching psychiatric principles. They strongly cautioned against the dangers of being too abstract, too theoretical, and too analytical at the beginning. Several stressed the need to teach psychiatric nomenclature at the outset to make further discussion fruitful. A number added that if the teacher was good, almost anything was permissible and would be effective." The investigators recommended for a format the following: (1) A series of courses should be offered rather than one course with a fixed series of topics, the courses to be graded not only by subject matter but also in terms of basic versus advanced levels. (2) The most effective format appears to be once weekly meetings of one and a half to two hours, beginning with a short didactic lecture, then followed by small-group seminar discussions with a leader. Stress should be consistently on case material and, wherever possible, live presentation of patients— preferably by the registrants from out of their own practice. Some type of adjunct consultative service is advised as well. Theoretical material and areas of dispute should be shunned and only introduced when essential to the further explanation of the case material under discussion. (3) Announcements of the program and registration is best handled with the collaboration of local, established medical groups. (4) Instruction should primarily be in the hands of medical people with non-medical specialists introduced only gradually and, at first, as an adjunct service. Otherwise too much initial confusion, misunderstanding, and resistance would probably be elicited. (5) The subject matter should be comprehensive and in keeping with the needs various programs throughout the nation have found to exist in their physician population. (6) Though many such programs do not require a registration fee, those that do require it do not seem to have a worse registration because of it. Once the physician is interested in a particular program, he does not get deterred because of a fee. (7) Finally, means should be provided to discuss with the participants their reactions to the program, whether it is meeting their needs, how the program can be improved, both during the actual running of the course and then afterwards as a follow-up study (Bilmes & Civin, 1964).

To evaluate the effectiveness of many of these programs, the American Psychiatric

Association appointed a task force that published a report (American Psychiatric Association, 1970) intended as a guide for those interested in planning continuing education courses for physicians in psychiatry. The report stressed the small number of physicians interested in education: "The apathetic, uninterested, uninvolved physicians who do not enroll in programs continue to be a source of major concern to the Committee, particularly since they seem to comprise as much as 90 percent of the medical community in many areas." Recommendations are made for a small-group case approach in a dynamic setting "that provides an arena for group interaction and better communication, to focus on resistances that hinder physicians work with their patients and to resolve anxieties generated by specific cases."

Many problems superimpose themselves on the teaching of psychiatry to non-psychiatric physicians. Most doctors have neither the time nor motivation to go into any extensive program of study that even modest mastery of the subject would require. Nor is there a satisfactory body of knowledge of what to teach should a willingness to learn exist. What most practitioners wish to know are shortcuts on how to manage emotional factors that interfere with their patients' getting well. In a way the tranquilizers, and particularly the anxiolytics (Valium, Xanax, etc.), have been a dubious boon to many physicians since they immediately subdue complaints without complicated verbal discussions. This has served to lessen the educational fervor of even those physicians who recognize the contribution that psychiatry can make to medical practice. It eventually becomes obvious to the enthusiasts of drug therapy that medicinals are not a complete answer to the psychological problems of their patients and that in some instances they complicate rather than help difficulties.

It is important to emphasize that the training of the non-psychiatric physician in psychiatric principles and interviews does *not* make that physician a psychotherapist. The great majority of physicians are unable, unless they are unusually gifted and intuitive individuals—and have ample time in their practices for lengthy interviewing— to do more than to make a diagnosis, to do supportive counseling, and to motivate the patient to accept referral to a psychotherapist if this is necessary. Yet, even with this limited role,

physicians will find their work immeasurably benefitted through their awareness of psychological factors in illness.

The Teacher in Mental Health

One of the fundamental aims of education is to prepare the individual for the business of life and to equip that person for a proper role as a functioning unit of society. By and large, educational procedures have been successful in broadening intellectual horizons, but they have not been so successful in expanding the individual's capacities for productive human relationships. The concept that a healthy life adaptation is dependent upon a healthy personality evolved through a healthy milieu during early years has given rise to the hope that the school may be able to provide the student with experiences that can reinforce constructive factors and modify destructive factors in the home. According to Rogers and Sanford (1985) "Evidence, based on experience and research, support the opinion that the best of education would produce a person very similar to the one produced by the best of therapy."

Children spend a good part of their life in school, and they are subject, during a relatively plastic period in development, to the disciplines, injunctions, and pressures of the school authorities, particularly their teachers. The latter constitute an enormous untapped reservoir for potential mental health manpower. In addition to helping the child to acquire knowledge, teachers, for better or worse, "continuously are providing a lesson in how adult authority figures behave, providing a model for this child's future behavior, and altering the child's conception for better or worse" (Guerney, 1969). The teachers' personal conditionings with their own parents and resulting conflicts and defenses are crystallized in attitudes toward others and toward themselves, which will decide the standards of conduct expected from their pupils. These will determine the material the teacher selects in teaching, the manner and timing of rewards and punishments, and the willingness and ability to understand and to help children who are manifesting disturbances in learning, interpersonal relationships, and general behavior. Reaching out to the student in trouble when he or she needs the teacher most may register a lifelong

impact. The desired objective is to initiate a feeling that the student is a person of worth. The teacher's incompetence in doing this may reinforce the child's distortions.

Perhaps the most significant aspects of school experience apart from the techniques of instruction and the content of the curriculum are determined by the teacher's personality, skill in managing human relationships, and understanding of children. Where the teacher has severe emotional difficulties or is victimized by current stresses related to status or economic insecurity, these cannot help but influence the stability of the teacher's relationships with pupils. How best to behave and how to maintain equilibrium in the face of present-day school difficulties is a moot question for a teacher. What has been learned in basic training and psychological readings often melts in the firing line of duty. The more unstable the teacher's personality structure, the more anxiety precipitated by difficult and acting-out children in the classroom, the more problems may be expected.

A potent problem is defective motivation particularly in the more disturbed teachers, the press of finances, and disrupting social factors that bleed over into the classroom encouraging violence, delinquency, and involvement with drugs. Many teachers feel that they do well to hold onto their own sanity in the face of the contemporary turmoil. This is scarcely conducive to proper communicating and practicing of mental health principles.

There are few teachers who are adequately prepared as a consequence of their own teacher-training programs to function at top efficiency without further psychological knowledge or self-understanding. Testing the hypothesis that self-knowledge can improve teaching skills, Jersild et al, (1963) set up a research project gathering information from over 200 teachers who had exposed themselves to personal psychotherapy. The results indicated "a sweeping array of gains in self-acceptance and acceptance of others" and an enrichment of their personal lives that had a distinctive bearing on their personal work. Teachers who had undergone psychotherapy were better able to handle untoward personal emotions toward their pupils and "to disentangle their own feelings from the feelings and concerns of others.'' An interesting finding was that, contrary to what might

be expected, the teachers did not consider themselves amateur psychiatrists and appeared to be more aware of their limitations than the control group in dealing with emotionally troubled students.

This does not mean that teachers must undergo psychotherapy to function adequately. Often the proper information about current developments in the field, part of an in-service program, along with some guidance and supervision by professional people may be all that is required. Some maladjustment in the teacher is not necessarily detrimental to functioning. The *kind* of maladjustment is the determining factor. Fear of aggression will inspire undue anger, explosiveness, or retreat in the face of defiant behavior. Excessive competitiveness, such as that issuing from unresolved sibling rivalry, may bring the teacher into conflict with an extraordinarily bright child. Inordinate needs for control may inspire a crushing authoritarianism. Unresolved sexual problems and needs for parenting may encourage a pampering or babying of selected "pets," fostering their dependency. On the other hand, as R. D. Gladstone (1948) pointed out years ago, some maladjustment may make for greater empathy with the needs of students and a dedication to teaching tasks. It is important to realize that teachers will respond with countertransference to select areas of disturbance in their pupils, either overreacting or underreacting to them—for instance, to stealing, cheating, untruthfulness, disobedience, cruelty, destruction of school property, bullying, impertinence, resentfulness, obscene notes, truancy, defiance, masturbation, overcriticalness, unsocialness, suspiciousness, heterosexual activity, depression, sensitiveness, shyness, fearfulness, dreaminess, and puppy love (Thompson, CE, 1940).

That teachers, more or less, ignore problem children, and pay greater attention to and express approval of pupils who have the highest intelligence and academic achievement and the best personality adjustment, was shown in the study by deGroat and Thompson (1949). The children who need help most are consequently most ignored or rejected. Countertransference will also determine the nature of pupil teacher action for the good or bad. How changes in children's responses are determined by the atmosphere established by teachers was illustrated in the interesting experiment by Trager and

Yarrow (1952) and by the studies of H. H. Anderson (1937, 1939; et al, 1945, 1946 a & b; 1954). Mussen and Conger (1956) emphasize the impact on the child of the teacher model and explain it in terms of behavior—social learning theory. The effect of a democratic as compared to an autocratic or laissez-faire atmosphere has been described by K. Lewin, Lippitt, and White (1939).

To some extent personal problems may be assuaged by bettering the conditions under which the teacher functions. This is especially the case where difficulties are contingent on status and economics. Salaries of school teachers are often so low that the best suited teacher will seek employment in other fields. The only applicants willing to take school jobs are in some communities those who are least qualified. Other problems relate to limitations in what is being taught. Some effect may be registered by changing the techniques of teaching and the content of the curriculum in line with mental health needs, by setting tasks and goals that are comprehensible and challenging to children, by helping them to clarify perplexing problems and feelings that are parcels of everyday living, and by inculcating in them some understanding of the complexities of human relationships.

This does not detract from (indeed, it makes more urgent), the need to develop methods in the classroom that will hopefully neutralize the disorganizing forces of contemporary society. The skill of the teacher in the handling of human relationships, as has been mentioned, is a key factor. This may be enhanced where the teacher has a genuine interest in teaching and in children and is not burdened by too severe neurotic and realistic problems. Furthermore, the teacher may be able to acquire a greater understanding of the child and the child's needs through good personal undergraduate or postgraduate mental health instruction. Courses for teachers on human development, psychotherapy and psychodynamics, principles of counseling and interviewing, and group dynamics are important here. In a few instances group discussions, headed by a trained group worker, have been instituted for teachers in order to bring the teacher to an awareness of undercurrent attitudes toward children that may be inimical to the establishing of good relationships with them. Additional training of the teacher is considered important as much now as in the past toward adding mental health goals to

the educational design (Wickman, 1928; Ryan, 1939; Watson, G, 1939; Zachry, 1944; Prescott, 1945; Berger, D, 1947; Baruch, 1948; Mathewson, RH, 1949; Trager, 1949).

Experiments in application of a mental health dimension in education were instituted years ago. In nursery schools (Allen, CM, 1947; Allen, WY, & Campbell, 1949), public schools (Tarumianz & Bullis, 1944; Commission on Teacher Education, 1945; Bullis & O'Malley, 1947, 1948; *Good Education for Young Children,* 1947), and colleges (Anderson, VV, & Kennedy, 1932; Angell, 1933; Anthonisen, 1942; Bernard 1940), programs incorporated in their content and method principles of mental health calculated to meet the emotional needs and to add to social development of the student. A number of conclusions were evolved from these experiments that have been incorporated into school programs (Association for Supervision and Curriculum Development, 1950) and are influencing modern experiments.

The recognition that emotional disturbances may sabotage learning and school adjustment has encouraged some teachers to attempt the diagnosis of emotional illness through observation of the child's behavior, attitudes, and performance. The average teacher is usually able to discern the more gross symptoms of emotional disorder in such manifestations as hyperactivity, underactivity, emotional outbursts, undue restlessness, irritability, temper tantrums, drug involvement, violent rages, tremors, tics, nail biting, apprehensiveness, pervasive phobias, compulsive acts and rituals, speech disorders, reading disabilities, and writing difficulties. With special training the teacher may be able to recognize the less obvious signs of neurosis.

Where the child exhibits patterns of emotional illness and where these patterns have become so structuralized that they cannot be modified through a better school environment, therapy of some kind will be required. In a few instances a conscious effort has been made by the teacher to apply therapy to students who have been blocked in learning or who manifest conduct disorders and other problems in school adjustment. Thus, Zulliger (1941) utilized psychoanalytic formulations in treating conduct disorders. Axline (1947) believed that a teacher trained in nondirective therapy may be able to

reflect back to the child feelings and attitudes that the latter is attempting to express and in this way inculcate insights into the child's behavior. She insisted that nondirective methods may be applied to teacher-administrator relationships. Her work has been substantiated by the reserach of Aspy and Roebuck (1983).

As to other types of interventions that teachers may utilize, these vary and certainly should be eclectic to provide choice according to the needs of the pupils and the level of training, the philosophies, and styles of the teacher. Published studies have detailed the effects of various methods (Torraine & Strom, 1965; Davis, 1966; Redl, 1966; Ringness, 1967; *ATE Yearbook,* 1967; *Journal of School Health,* 1968; Clarizio, 1969; Ekstein & Motto, 1969; Guerney, 1969; Farnsworth & Blaine, 1970; Bernard, 1970; Bower, 1970; Lawrence, 1971; Clark & Kadis, 1971; Tanner & Lindgren, 1971; U.S. Office of Education, 1972; Glasscote & Fishman, 1973; NIMH, 1972, 1973; Holmes, 1974; Kellam, 1974). Applications of learning thoery in the classroom particularly have sponsored research on the effects of social reinforcement on undesirable behavior with the shaping of new, adaptive responses (Zimmerman & Zimmerman, 1962; Horowitz, 1963; Wolf, M, et al, 1964; Becker et al, 1967; Hall, RV, et al, 1968; Thomas, DR, et al, 1968; Harris, FR, et al, 1969). The contributions of learning theory to modern education have also sponsored a more wholesome dimension in discipline, away from punishment for infractions toward control by positive rewards and encouragement.

How far a teacher may go in assuming a therapeutic stance with an emotionally ill student is a matter of dispute. There are those who believe a teacher can function in a psychotherapeutic role. Jersild (1966) for example has stated:

> I am convinced that the view that a teacher's role is incompatible with a therapeutic role (using "therapeutic" in its broadest meaning as a process of healing) has been accepted too readily. I think the compatibility of the roles depends more on the teacher's personality than on his status. It depends also, I think, on the teacher's goals, and on his awareness of what he appropriately can do, and what he definitely should not try to do in an educational setting where self-exposure can be more threatening and anxiety-inducing, at least at the beginning, than within the protected confines of individual analysis or the typical group therapy situation. I also think that in considering the therapeutic role of education in general and of the teacher in particular it is necessary to regard what is therapeutic as falling on a continuum, ranging from a modest degree of ameliorative self-discovery to the more pervasive

and ambitious outcomes sought by a professional therapist.

Most authorities, however, contend that the role the teacher can play in formal therapy is extremely limited. Insurmountable difficulties present themselves to the functioning in a dual teacher-therapist capacity in the average class! While the pupil may establish a relationship with an understanding teacher that is therapeutic for the child, the teacher is usually unable to enter into a systematic therapeutic program. Nor does the teacher, even with special training, possess skills that would make more than a supportive approach possible. Therapy of emotionally disturbed children necessitates the services of specialists more highly skilled than is the teacher in diagnostic and treatment procedures. A number of teachers seek further training in counseling and psychotherapy, those with Doctor of Education degrees sometimes being accepted in certain postgraduate psychoanalytic training programs.

Consequently, it is recommended that a child requiring therapy, be referred to the guidance department of the school, the school psychologist, or a consulting clinic outside of the school setting. Guidance and counseling services at schools are most efficient where a professionally trained counselor or therapist is available in the school and where there exists an organized pupil-personnel program. The latter should ideally offer such services as educational counseling, vocational guidance, and work placement as well as health, social, and psychologic services. The counselor or therapist may supervise the guidance activities of those teachers who are capable of functioning in guidance with students.

As parents, school administrators, and governmental authorities become more enlightened and convinced of the advantages of a mental health approach in education, we may expect expansion of school guidance programs, an increase of diagnostic clinical teams within schools, and more clinics outside of schools that can carry on whatever extensive therapeutic work is required. In the course of this expansion the teacher's preventive and therapeutic roles will undoubtedly become more comprehensive.

Recommended readings for teachers include the books by Abraham (1958), Allinsmith et al. (1962), Bower (1960), Caplan (1961a & b), J. S. Coleman (1961),

Farnsworth (1957), Haring and Philips (1962), Jersild (1955), Kaplan (1959, 1971), L. S. Kubie (1961), Redl and Wattenberg (1959), D. Rogers (1957), B. K. Smith (1964), Torrance (1962), Wallin (1955), V. White (1958), and the U.S. Department of Health, Education and Welfare, Monograph 5, *The Protection and Promotion of Mental Health in Schools.*

The Minister in Mental Health

Frequently the first person consulted in times of emotional stress is a minister who occupies a position of trust in the community. Traditionally, clergymen and clergywomen are called on to advise and consult as well as to act as religious leaders. Their capacity to understand, to evaluate, and to manage the emotional problems presented to them are vital to the impact that they will make on the mental health of their congregation and community. Through community activities of the church (religious, social, recreational), as well as through preaching, clergymen and clergywomen can reach multitudes that have no other contact with a psychological resource. Gurin et al. (1960), quoted in the Final Report of the Joint Commission on Mental Illness and Health, found that 42 percent of the people seeking help with emotional problems turned initially to the clergy. The solace the sufferer receives from such consultation may be great, due in part to the unique prestige that ministers occupy in the mind of the average individual. The ministers' potential mental health role accordingly has become increasingly recognized in recent times (Clinebell, 1965). They have been able to reach large segments of the population who for a variety of reasons (e.g., lack of financial resources, scarcity of trained professionals, language barriers, lack of sophistication in psychological matters, etc.) are unable to avail themselves of professional mental health services.

The problems brought to the attention of ministers are legion. Among those most commonly encountered are (1) marital problems, (2) parent-child problems and behavior difficulties in children, (3) emotional instabilities, especially in young adults, and middle-aged men and women, (4) disturbing love affairs, (5) conflicts in adolescence, and (6) desire for information and help on problems involving education, social welfare, and

mental health.

In recent years, it has been recognized by clergymen and clergywomen of all denominations that while religion often serves as a source of strength for people who are confronted with situations of crisis, it may require supplementation, even in the devout, in the face of anxiety and other manifestations of neurosis. As Martin (1965) states: "Again and again, in interviews with ministers of every major Protestant denomination in every part of the country, came this same sad confession of inadequacy. Whether he preaches from a rural pulpit or in the suburbs or in the inner city, the parish minister is a man assailed by the fear that he cannot effectively cope with the staggering human problems he encounters. And this sense of inadequacy breeds guilt." As a consequence, many ministers have become interested in obtaining a scientific understanding of human beings so as to increase their effectiveness in dealing with people in trouble (Burtness & Kildahl, 1963). It is pointed out that no real disparity need exist between psychiatric knowledge and religious belief (Farnsworth & Brace-land, 1969).

Recognition that many of the problems brought to the minister's attention are nurtured by emotional illness has led to the offering, in the training of divinity students, of psychiatric orientation courses. Clinical training for ministers in hospitals, prisons, and social casework agencies began in 1923 and was carried on two years later by the Council for the Clinical Training of Theological Students in New York and the Institute of Pastoral Care in Boston, and eventually through their training centers across the country. Later these two national groups formed a new organization, based in New York City, called the Association for Clinical Pastoral Education (ACPE). In addition, other national groups were organized such as the American Association of Pastoral Counselors (AAPC), the Mental Hospital Chaplains Association, and the College of Chaplains of the American Protestant Hospital Association. Each of these organizations required its members and training centers to meet at least minimal national standards of competence before certifying members or accrediting centers.

Some of the training programs have offered the student-minister opportunities for

understanding problems in interpersonal relationships, the forces that enter into personality formation, the difficulties people encounter in adjustment, and the manifold reactions to stress. Students are taught methods of working with people in trouble and the ways that they can cooperate with other workers, such as physicians, psychiatrists, nurses, social workers, and psychologists toward helping the emotionally disturbed individual. Awareness of problems in counseling, of the limitations of the minister in counseling, of resources to which persons may be referred, and of ways of handling the more common types of counseling situations are among the objectives in training. Most of the methods taught have been of a supportive nature, although the interviewing process, as described in some of the books and articles on pastoral counseling, have drawn a good deal from Carl Rogers' client-centered approach aiming at personality modification (Rogers & Becker, 1950; Hiltner, 1950).

A review of the training offered in mental health areas at seminaries and theological training centers reveals great variations in the quality and extent of psychological indoctrination. Elaborate lecture and field experience requirements exist in very few instances. Programs in clinical pastoral training have allowed theological students a measure of acquaintance with ministering to the sick and have helped them to gain a degree of awareness of their own reactions within the situation. Yet, most often, training in mental health aspects of pastoral work as related to the working minister's day-to-day counseling problems is either disregarded or limited to 1 or 2 semesters of human relations course on a preprofessional level.

A considerable advance toward the refinement of training in mental health principles was made possible through a 5-year grant that was extended in 1956 by the National Institute for Mental Health to Harvard (Boston), Loyola (Chicago), and Yeshiva (New York) universities for development of mental health material to be included in the basic curricula of seminaries training clergymen of all faiths. Interdisciplinary denominationally based efforts have led to clear definitions of the areas in which the most effective mental health intervention may be instituted by the clergy. They have helped to clarify religion's role in the area of psychological healing and have made

recommendations for better curricula and teaching materials in the seminary training of the three major faiths (Herr, 1962; Hofmann, 1962; Hollander, FI, 1962; Hecht, 1965).

The rapidly growing rapprochement between the ministry of all faiths and the behavioral sciences has led to significant developments in three main areas: (1) organizations and journals have been founded to open up channels for communication and to provide space for discussion; (2) training goals for ministers have been defined, pastoral counseling centers developed, and diverse training programs instituted; (3) lively controversy has developed about the professional identification and qualifications of the minister as counselor (now often called "Pastoral Counselor"). With the increased recognition of the minister's unique role in mental health, a considerable body of literature has come into being. Meissner (1961) quoted 2905 references on religion and psychiatry. There are now many more. A variety of approaches to enhance the mental health training of the minister have been tested experimentally. With increasing frequency the terms "pastoral psychology" or "pastoral counseling" have been used to refer to the minister's mental health functions.

The Academy of Religion and Mental Health, chartered in 1954, "aims to bring together, for exchange of views and full collaboration, those who work professionally in the fields of religion and health." The academy merged with the American Foundation of Religion and Psychiatry, established in 1937, and became known as Institutes of Religion and Health. Among a series of journals established was the *Journal of Religion and Health* and the *Journal of Pastoral Care,* published jointly by ACPE and AAPC.

An area of agreement appears to have been reached early as to the desirable goals of training in pastoral counseling as enumerated, for example, by F. I. Hollander (1959):

> To enable them [the ministers] to recognize signs of mental illness and emotional disturbance among those who seek their aid and guidance and to refer such people to proper sources of help.

> To participate actively in mental health program on a prevention level for the benefit of the community at large.

To gain an understanding of the psychology of the mentally ill, physical sick, and socially maladjusted for the purpose of more effectively helping such people through the media of ministration and pastoral counseling.

To gain a better understanding of the psychology of normal growth and development for the purpose of utilizing this knowledge to convey more effectively those religious resources which can help people in their efforts to maintain a more mature approach to living.

The nature of the training process leading toward the achievement of such goals are still subject to experimentation. Some programs take into account the specific role identification and role definition of ministers and differentiate them, as the enabling persons, explicitly from the psychiatrist, psychologist, and social worker, as the treating persons whom they join on the mental health team. Yet, in other instances the training approach makes such a differentiation difficult, as candidates are subject to a curriculum that only narrowly varies from curricula in psychoanalysis and psychotherapy.

Some programs are administered through theological seminaries. In such settings training is often directed at the student minister rather than at seasoned parish clergy and tends to emphasize varying denominational religious values and their contribution to and integration with mental health concepts. The accent at times is placed on the mental health effectiveness of religion rather than on the interpersonal impact of the religious representative (the minister). Other programs take place in hospitals, prisons, various treatment settings, and parishes, often in collaboration with the local mental health community. They range from short workshops and periodically scheduled conferences to more ambitious long-term efforts.

An adequate training program must consider the clergymen's and clergywomen's special position and identity, the image that they project, their assets and liabilities, and their special problems in professional and community living. It must clearly differentiate the mental health contribution that the clergy can make apart from that of the psychiatrist, psychologist, and social worker. It also must encourage and enhance meaningful team work collaboration with other concerned professions and disciplines. The training process must be geared toward helping the minister with the specific problems encountered daily

among the people of the congregation, and it must consider the full spectrum of their emotional crises. The program must take into account the clergymen's and clergywomen's own emotional responses and must plan to help reduce their own anxiety by a better understanding of themselves and others. Finally, it must emphasize the opportunity to interact closely with colleagues of other faiths and denominations in order to broaden the self-understanding and personal possible prejudices and biases.

As an example, the training program in pastoral counseling at the Postgraduate Center for Mental Health in New York (Hecht, 1965) has evolved a number of training concepts that attempt to meet these requirements. The student body is composed of male and female clergy of various faiths. The entire faculty consists of certified psychoanalysts who are interested in working with religious leaders. Teachers and students form a team and interact closely over a period of 2 years. Cases presented in classes, supervision, and practice are those that the students encounter in their religious work. As part of an ongoing experience, ministers in training meet weekly in small groups with experienced group leaders for the duration of the training program.

Some concepts of pastoral counseling based on psychoanalytic principles have developed from this collaboration. Students practice a goal-directed ego-level approach, maintaining focus on a specific presenting problem. They elicit a matrix of dynamically relevant information (e.g., history, psychosocial development) against which they limit their exploration to the most manifestly bothersome conflict area. Dynamic insights are applied toward an appraisal of the nature, scope, and necessary disposition of the central problem on hand (e.g., suitability for counseling, limitations of goal, nature of referral when indicated). Contacts are geared toward maintaining an atmosphere of reality within a context of here and now. At all times the counselors are encouraged to remain conscious of their religious identity, to consider its impact on the situation, and to use it as fully as possible in the interpersonal encounter.

Inevitably, as more ministers become active in the mental health field and participate at different levels in mental health training, the problem of limitations of

scope, of the establishment of a new specialty within the ministry, and with it the problematic delineation between counseling activities and psychotherapy become questions of considerable controversy. It appears that at this time the large majority of ministers in good standing with their denominations endorse training objectives that permit the minister to recognize and understand signs of emotional disturbance and that allow active participation in mental health programs and to gain a clear grasp of his or her limitations as well as potential participation and intervention in the work role.

The concept of a specialty of practitioners, "pastoral counselors," who may operate in private practice or at treatment centers outside of church settings and control has aroused controversy among prominent psychologically oriented churchmen (Hiltner, 1964; Oates, 1964) and psychiatrists (Pacella, 1966). The identity of ministers as "mental health professionals" in possible conflict with their principal roots and training as religious leaders appears not to have been resolved at this time.

In an attempt to shed light on this grey area, the *Journal of Pastoral Care* devoted its December 1972 issue to the publication of a research study supported by AAPC (Taggert, 1972) and of a symposium of leaders in the field of pastoral counseling, calling it, "Pastoral Counseling at a Crossroad." The contributions to the symposium reflect the prevailing state of controversy.

The Reverend Mitchell, Director of the Division of Religion and Psychiatry at the Menninger Foundation, for instance, states unequivocally, "Pastoral counseling is not in itself a profession at all; it is an activity undertaking within the boundaries of a profession: ministry" (Mitchell, 1972). On the other hand, Cox (1972) writes, "In all honesty, I do not know whether the pastoral counselor has a place in the community as an independent autonomous practitioner." Oates expresses his belief that pastoral counselors could establish a professionally effective role if they were to communicate consistently their special knowledge in the fields of religion and ethics to the mental health professions, but he finds regretfully that they often do not do that (Oates, 1972a). Clinebell (1972) notes the temptations of private practice and possible national health insurance fundings for

"health professionals" and sees them as potentially distracting from the clergy's major commitments.

It is perhaps unavoidable that rapid growth had to bring along its growing pains and that some abuses have occurred in certain fringe areas. The large number of highly responsible people from the religious as well as the mental health field who have committed themselves thoroughly to the measured and well-delineated development of the minister's therapeutic potential, testifies to the social usefulness of this training task.

Conflicts Between Religion and Psychotherapy

Inevitably, in considering the clergy role in mental health, the troublesome relationship between religion and other forms of healing comes to the fore (Pruyser, 1966). More and more it is apparent that a rapprochement between religion and psychotherapy is possible if each discipline respects the other's services and standards (Appel, 1959; Banks, 1965; Braceland, 1955; Doniger, 1954; Einstein, 1954; Hiltner, 1950; Liebman, 1948; Long, 1951; Loomis, 1963; Stace, 1965; Whitehead, 1925). There should be little need on the part of the pastor to undermine the goals of the psychotherapist, and of the psychotherapist to depreciate the effectiveness of the pastor.

A general consensus is that good psychotherapy will not alter the individual's faith, unless faith has been employed not as a genuine means of searching for meaning but as a neurotic defense, in which case faith will loosen itself from destructive anchors toward a more wholesome mooring. Psychotherapy does not depreciate religion or promote atheism. On the contrary, it deals with dimensions that can release the individual's spiritual promptings toward values that reflect or are identical with the virtues of religion. Psychotherapy neither attempts to indoctrinate patients with the religion of the therapist nor to attack the religious beliefs of patients in whom religion acts as a constructive moral force. Patients accordingly, by being helped to tame impulses that are beyond their control, may emerge from psychotherapy with firmer and more illuminating religious sentiments. However, if their uses of religion are neurotic, they may in the course of psychotherapy evince skepticism toward the value for them of religion. Psychotherapy,

thus, by exploring the neurotic employment that the patient makes of religion and probing his or her attitudes toward religion releases the patient to approach religion from a more mature perspective toward the expression of humanitarian impulses, not to appease an avenging deity but out of love and esteem for mankind.

It is said that no conflict should exist between psychotherapy and religion about in whose domain sin and guilt reside. The concept of sin and the emotion of guilt are both geared toward a properly restrained social functioning. The conscience—the repository of guilt—is a constituent of a person's psyche. Moral codes are vital for society's survival; it cannot exist without ethical and legislative canons. Guilt is an instrumentality that helps inhibit antisocial drives; it can however become excessively harsh punishing even normal behavior. Sin is a concept that designates certain actions as transgressions and sponsors the withdrawal of religious or social sanction for these acts. Ministers have sometimes accused psychiatry of forgiving sin and minimizing free will and moral responsibility. Psychotherapy does not seek to mollify essential guilt. But both guilt and the branding of actions as sinful can become pathological manifestations of a disturbed psychic and social organization. It seems that sound religion as well as sound psychotherapy can most often agree fully on definitions of destructive-sinful behavior and the importance of *rational* guilt feelings; similarly, they can agree on the underdesirability of *irrational* guilt and scrupulosity. Psychotherapy then recognizes the vital role of religion in helping to foster appropriate guilt and to designate antisocial drives as sinful. Nevertheless, it also considers that certain religious directives may sponsor abnormal guilt feelings and too easily label certain human desires as sinful. It is in these instances that psychotherapy must be concerned with the impact of such directives on the functioning and balance of the individual searching for help. It aids in the individual's freedom of choice between good and evil. It seeks to release the person from irrational guilt toward normal maturity.

The acts of turning to religion (conversion) and seeking salvation also point up areas of conflict between psychotherapy and religion. Personal consciousness of the need for salvation will enjoin many persons to seek institutional outlets, such as those provided by religion, for its realization. A search for a sense of peace and unity may lead the individual

toward moral restitution as a means of making the best use of one's life. The release of affective energy on the object of faith, the joyful ecstasy, lightheartedness, disappearance of perplexity, feeling of a new life, and sense of operating under divine control certainly have psychological components. Interest on the part of the psychotherapist in the act of converting to religion as a predictable phenomenon stemming from natural causes has led ministers to assume that psychotherapists bring their patients to doubt the entire conception of the nature of divine activity and to consider conversion an abnormal phenomenon rather than the bestowal of grace. However, irrespective of psychological and deterministic factors, psychotherapists recognize that conversion to religion and reaching for salvation are powerful resources toward which a burdened soul may turn for solace and peace of mind. Giving themselves up to a stronger power may be the only way through which certain patients arrive at a satisfactory adjustment. Though interested in neurotic reasons why a patient may seek the solace of conversion and salvation, and while he or she may consider it a responsibility to explore and work through neurotic defenses, the psychotherapist will not interfere with a patient's arriving at the decision that conversion to a faith is for him or her an appropriate objective.

Psychotherapy does not willfully set itself up as the arbiter of whether or not there is life after death, nor does it qualify to interpret the Scripture. These are matters for the theologian. The psychotherapist, however, does consider it important to determine the neurotic uses the patient is making of preoccupation with an afterlife and with various religious concepts that the patient presses into service for the exploitation of neurotic drives.

Recommended books for clergymen interested in mental health and pastoral counseling are those by M. K. Bowers et al. (1964), Braceland and Stock (1963), Brister (1964), Bruder (1963), C. A. Curran (1952), Hall and Gassert (1964), Hiltner (1952), Johnson (1957), Linn and Schwartz (1958), McCann (1962), Maves and Cedarliaf (1949), and Oates (1955, 1962), Zilboorg (1953).

Mental Health Aids and Paraprofessionals

The search for mental health services has been far above what present professional providers alone can supply. Filling the wide crevices of need has poured a river of human resources from the ranks of volunteers and low paid workers. "They have many names: indigenous worker, incentive specialist, enabler, clinical assistant, expediter, advocate, ombudsman, semiprofessional, paraprofessional, mental health assistant, and new professional." (Greenblatt, 1985). The diverse array of roles has been staggering: storefront managers, home visitors, tutorial and remedial assistants, homemakers, counselors, translators, activity and recreational program assistants, mental health advocates, community organizers, aftercare service planners, and purveyors of supportive psychotherapy. The employment of allied professionals and nonprofessionals in the mental health area has been justified by society's effort to satisfy unmet mental health needs. Attempts to supply large segments of the population with guidance, rehabilitation, and therapeutic services must, of necessity, recruit workers who traditionally have been considered on the periphery of the psychiatric profession (Gerty, 1965; Rieff, 1964; Lief, 1966; Sobey, 1970; Castelnuovo-Tedesco, 1971). An obstacle to accomplishing this end was the idea sponsored by psychoanalytic theory that insight into one's inner conflicts was essential before definitive help for emotional difficulties could be expected. As long as this concept prevailed, it was assumed that training in depth psychotherapy was essential and that this had to be restricted to those with an appropriate background in medicine, psychology, and psychiatric social work. The successes achieved by group therapy, nonanalytic approaches, behavior therapy, and milieu therapy, which rendered important help to victims of emotional illness without intensive historical and intrapsychic probings, have encouraged the evolvement of innovative methods that could be taught to an array of workers with adequate intelligence, motivation, and interpersonal sensitivities toward the goal of social rehabilitation for their clients rather than the reconstructive overhauling of personality. These workers are often indigenous to the community in which potential clients exist, and, knowing the prevailing environmental conditions and subcultural codes, they are often able to make better contacts with individuals requiring help than more highly trained professionals (Bloomberg, 1967). On a maximal level they operate as primary providers of service especially where they have been trained in behavioral

approaches as in the treatment of substance abusing adolescents. On a minimal level they are able to act as a bridge between the client and the professional should more specialized services be required.

The focus on cost factors has also served as incentive toward encouraging entry into the field of less highly skilled individuals. Finally, realization that the medical "illness" model is not applicable to a bulk of community problems has sponsored experimentation with techniques oriented around educational, behavioral, and social prototypes that better permit the use of helping agents with a wide variety of backgrounds.

Experimental programs have been set up to use stable but untrained volunteers with adequate motivation to render direct help to the client (Berlin & Wycoff, 1964; Nichtern et al, 1964; Rieff & Riessman, 1964; Riessman, 1964, 1965; Christmas, 1966; Felsenfeld et al, 1966; Klein W, et al, 1966; MacLennan, 1966; Guerney, 1969). Included are citizens such as those interested in the Big Brother movement (Lichtenberg, 1969), high school students (Fellows & Wolpin, 1969), college students (Umbarger et al, 1962; Cowen et al, 1963; Reinherz, 1964; Brennan, 1967; Goodman, 1969), offenders (Hawkinshire, 1969), police (Bard & Berkowitz, 1967), and peers (Perlmutter & Durham, 1965; Buehler, 1966).

Parents have been trained to do "filial therapy" on their emotionally disturbed children under the control and supervision of a psychotherapist (Guerney, 1964, 1969; Hawkins et al, 1966; Andronico & Guerney, 1967; Johnston, 1967; O'Leary et al, 1967). Interestingly, a mutual change is brought about as a result of the guided interaction between parent and child. After a short period of training the parent or parents are usually capable of having play sessions with their children while observing their own and their children's reactions to what they are doing. Empathic understanding is thus facilitated. The therapist's emphasis is, as in family therapy, on the interactional difficulties of the family members rather than on the individual pathology of the child.

The rationale of training police to help manage family quarrels and other difficulties among people in the community resides in the fact that fully 80 percent of their time is spent on "social services" rather than catching criminals. Unfortunately trainers are often

unable to project themselves into the position of an officer who is plunged amidst a violent and hysterical scene where immediate decisions are necessary. Information about psychodynamics and psychopathology are of little help in the firing line of duty. Knowledge of how to listen to family members, encouraging them to verbalize ("talking it out is better than acting it out"), how to reassure and calm frightened and aggressive people ("when you are sympathetic and concerned, people reach out to you for help"); when, how, and where to refer people for further aid and services are of utmost importance. To function like social workers and psychological counselors, a police officer requires considerable instruction. Small-group discussions focused on simulating situations commonly encountered, with role playing, led by a mental health professional experienced in working with the police and who is cognisant of their problems and responsibilities, as well as by an officer who has been trained in techniques and has observed the results of interventions, are extremely valuable. During family quarrels, for example, the simple expedient of separating the combatants and interviewing each separately while seated helps to quiet the situation. The officer is taught to avoid taking sides and to shy away from participating in the brawl, at all times observing his or her own emotional reactions and desires to impose personal values on the combatants. Of vital importance is knowledge of the referral resources in the community. Bard and Berkowitz (1967) have demonstrated how effective a training program with the police can be.

Experience with Synanon for drug addicts, Alcoholics Anonymous for drinkers, and Recovery, Inc., for emotionally disturbed individuals has lent credence to the idea that people with certain types of problems can help other people with more severe forms of the same problems and that this effort is mutually beneficial. Some of the self-help programs act as informal training facilities so that the recipients of help eventually learn to become the dispensers of help. Whether they function as homemakers, recreation aids, youth workers, delinquency workers, or in other capacities, indigenous personnel usually are able to relate better to their clients than professionals from a different social and cultural setting. Young pupils have also been utilized as homework or reading helpers for younger pupils who are manifesting certain problems, with both parties sharing the

benefit (Riessman, 1965). This principle of learning through teaching has many potentials. It goes without saying that adequate supervision is an essential requirement, particularly where a comprehensive training program has not been in effect.

Obviously, a great range of personalities, levels of education, experience, skills, and inspiration will be encountered whenever a therapist attempts to enlist the help of a nonprofessional person. The therapist has to adapt to the educational level and idiosyncrasies of the trainees, and, assuming that he or she is sufficiently skilled in community educational and consultative procedures, the therapist must act as a teacher and overseer. This supervisory role is not so easily accepted, particularly by professionals who are wedded to the exclusive medical model and resent the influx of workers from non-medical areas. Special training will be required for the therapists who seek to be a supervisor above and beyond their psychiatric, psychoanalytic, and psychologic education that will enable them to fuse mental health concepts with sociological principles. In this way therapists can best contribute to nonprofessionals who work with people in various settings.

An important question relates to the kinds of patients and problems that are most effectively helped by the endeavors of the nonprofessional. No less important are the methods and techniques that nonprofessionals can learn and utilize with proficiency. Of great help is the fact that many of the complaints and afflictions encountered in the community are often expediently managed under the auspices of a sociological, reeducative, or rehabilitative model rather than a medical model. Learning irregularities, habit disorders, vocational difficulties, delinquency, perturbations related to extraordinary environmental stress, recidivism, and drug addiction are among the conditions that often respond better to counseling, educational, rehabilitative, and behavioral approaches than to traditional psychotherapies. The advantage of such auxiliary measures is that the objective of adjustment may often be rapidly achieved through the ministrations of personnel who may be trained without spending the years of graduate and postgraduate instruction that go into the making of a psychotherapist.

While gifted nonprofessional people, possessed of a natural empathy and capacity to inspire confidence, often function well in supportive and educative roles as helping agencies, how much further they can progress in doing depth therapy, even with further training, has been open to question. In 1960 Margaret Rioch (1963, 1965), a clinical psychologist, and Charmian Elkes, a psychiatrist, started a pilot project at the clinical center of the National Institute of Health to see whether "middle-aged, married women whose children are just about leaving home" could be trained to render therapeutic services. "By using them the need for more low-cost therapy can be alleviated and the mature woman's need to be useful can be filled… . Here is a gold mine of psychological talent."

Married women, all college graduates, were selected for the experiment of seeing whether they could within two years be trained to do psychotherapy, with certain limitations. Cases assigned ranged from mild ("adjustment reactions") to very serious emotional problems ("psychosis in remission"). The objectives in training were not simply milieu therapy. It soon became clear "that we were training our students for the practice of a profession… . The training was narrow but intensive and practical, and sharply focused on psychotherapy… . Participating in the program were psychoanalysts, psychiatrists, psychologists, and social workers, who all held quite broad, undogmatic points of view…. No one was an evangelical disciple for a particular school of psychology. No one had the need to have a precious identity confirmed as a physician or psychologist."

In evaluating (Rioch et al, 1963, 1965) the results, a number of methods were employed including a group of examiners (two psychiatrists and one psychologist). The consensus of a group of examiners was enthusiastic. "I could think of an awful lot of patients that I would like to be able to refer to them [the trainees] and I wouldn't feel badly that they weren't going to see a psychiatrist." Following completion of training, all of the graduates were hired by community clinics, hospitals, and schools. "All of them intend to continue working indefinitely, possibly to add to the work force available in the mental health field by tapping a hitherto unused reservoir of capable people." Lawrence S. Kubie, summarizing the experiment, wrote:

It has been my privilege to observe these trainees on three well-spaced occasions, starting a few months after they had begun their training in psychotherapeutic counseling. It has been a heartening and exciting experience to see how a group of mature women, who have gone through the stresses and turmoils of bringing up their own families, with diverse college backgrounds but no prior technical training in psychological disciplines, could, in so short a time, become thoughtful, astute, perceptive, sensitive, and patient psychotherapeutic counselors. If anyone needed it, there would be no better proof that this opens up an important new way to attack the bottleneck caused by the shortage of trained workers in this field.

Ten years after the project with the first group had ended the majority of the mental health counselors were engaged in full-time work at different institutions though chafing at the difficulty of achieving rewards concomitant with professional function. "We were paid less than traditionally trained workers; we were excluded from professional organizations; patients' insurance did not pay for our services; there were no civil service slots for us" (Showalter, 1971).

The reactions of this group are not extraordinary since creation of a new profession of psychotherapist has been brewing a storm of controversy. The eye of this hurricane is the lay person with no background in medicine, psychology, nursing, or psychiatric social work who seeks an identification as a "therapist." There is no argument with both the need for expanding therapeutic services for the multitudes in need of help by training more personnel nor the competence of adequately qualified nonprofessional participants who undergo proper instruction and supervision. In public clinics comprehensive regulations by State laws help prevent abuses. The problem lies in the less than properly qualified individuals who expose themselves to threadbare courses and seminars that lead them to overvalue their abilities and to venture into risky zones of private practice far beyond the limits of their training and experience. Undaunted by the conservatism that is a hallmark of careful training, these eager neophytes, with exuberant faith in themselves, easily gather a coterie of impressionable clients and, exploiting the bounties of spontaneous improvement (Brill & Beebe, 1955; Saslow & Peters, 1956; Goldstein, AP, 1960; Endicott & Endicott, 1963) and the non-specific forces of a helping relationship, may deceive themselves into believing that they possess God-given talents as therapists. Testimonials from satisfied customers are not necessarily a proof of competence. What is

forgotten, or perhaps not even noticed, are the dropouts from treatment and the relapses into illness after leaving treatment of those who were "successfully cured."

These unhappy contingencies do not detract from the potentially useful and socially constructive aspects of the training of nonprofessionals. The implications of such training for both the teaching of psychotherapy and for the staffing of clinics and hospitals are interesting. Can we revise our standards for training in psychotherapy in terms of (1) lowering pretraining requirements, (2) abbreviating the course curriculum, and (3) shortening the length of training? What will be the effect of training of mental health counselors in psychotherapy on the professionals now practicing in the field? What will happen when the number of counselors gets great enough to encourage the organization of a special society dedicated to the protecting of their interests in the field? What about the independent private practice of such counselors of psychotherapy as they realize that the rewards of private practice are greater than those afforded by working in institutions? The problems now being experienced between the medical and non-medical groups will undoubtedly be compounded unless attitudes change or new laws are formulated— contingencies that in themselves pose many dilemmas and quandaries.

It may be expedient to mention that nonprofessionals may make valuable contributions to the training and the functions of professional mental health workers since they are often in closer and more prolonged contact with special patient populations, such as those engaging in substance abuse and other addictions, and come from many of the same kinds of backgrounds and environment. Intelligent par&professionals are thus better able to translate patients' cultural and subcultural group values, behaviors, linguistic metaphors, nonverbal cues, and conceptual frameworks into their own language. They also know more practical ways of solving problems, which are often peculiar to their community and which can be utilized in executing the treatment plan (Talbott et al, 1973).

THE CONCEPT OF TEAM FUNCTIONING

In many psychiatric clinics the traditional mental hygiene team, consisting of

psychiatrist, clinical psychologist, and psychiatric caseworker, is no longer considered the preferred therapeutic framework. Changing conditions of practice have altered this conception to that of a constantly changing team membership and shifting leadership. The professional responsibility of each team member is defined, and a base is provided for mutual interaction and the pooling of skills. The team is regarded as a group of specialists or consultants, each playing a specialized role as well as having some sort of therapeutic function. In addition to the three professionals mentioned, other professionals are sometimes employed, on staff or consultatively used in the clinic varying with the cases that are being treated. Thus, teachers may be utilized for reading and writing disabilities, speech therapists for stuttering, physical therapists for special losses of function, nurses for organic ailments and disabilities, and rehabilitation workers for chronic mental illnesses. The traditional specialized operations of the conventional team members in a community psychiatric clinic are delineated in Table 16-1. In recent years psychiatric nurses have been constructively added to the regular team, especially in agencies where day care facilities are available. Because of the shortage of psychiatrists, as well as the high costs of psychiatric consultation that the clinic cannot afford, there has been a breakup of the usual lines of command, non-medical professionals assuming some of the roles that in the past have been an accepted and exclusive part of the psychiatrist's functioning. A non-psychiatric physician in consultation for such things as the prescription of medications has been used with variable results when a psychiatrist has not been available.

In clinics headed by psychiatrists and dedicated to the medical model, the background training of the psychiatrist, and the affiliation with the discipline of medicine, is presumed to place the psychiatrist in the best position for the assumption of responsibility for the total treatment of the patient. The medical model dictates that the psychiatrist may utilize ancillary workers, usually clinical psychologists, psychiatric caseworkers, and psychiatric nurses while retaining medical responsibility. These precepts, however, as has been mentioned, are not always followed, particularly in agencies that do not have a psychiatrist as a full time staff member and merely call in a psychiatrist for consultation.

Modification of the team model is, in summary, the order of the day, but occasionally one may come across vestiges of its survival.

In some psychiatric clinics a routine history is still taken by the social worker who has had no training in therapy. The social worker, during this process, observes the motivations of the patient for therapy, not in a deep dynamic sense, but in terms of what the patient says on a surface level. This enables the worker to evaluate why the patient comes for help and what is expected from the clinic. The very process of giving information in the social history helps the patient to be relieved of certain immediate anxieties. In discerning the motivations of the patient and the misconceptions that he or she may have, the worker has a good opportunity to explain to the patient how treatment can help a specific problem.

The particular aspect of the case history stressed by the social worker is the patient's social situation, especially the interpersonal relationships within the family, and disturbing aspects in the home. In the event that the patient decides to accept treatment, the social worker will be able to utilize this information in helping to relieve environmental pressures, provided the therapist decides that the adjunctive services of a social worker are required.

Another function of the social worker in such clinic setups is to help prepare the patient for psychotherapy, where, for various reasons, the patient is not yet ready to enter into a treatment process. In instances where the patient has already started therapy but does not have adequate motivation, the therapist sometimes sends the patient back to the social worker for further preparation. The attitude the social worker assumes is friendly and supportive, in the hope of clarifying the situation and perhaps helping the patient to see what it is he or she actually wants from the clinic. Another basis for referral to the social worker is for counseling and casework. Here there is a differentiation of psychotherapeutic functioning, the social worker doing supportive therapy where needed, and the psychotherapeutically trained personnel doing deeper educational and reconstructive therapy.

In carrying out supportive therapy, the social worker may not insist on regular appointments but rather will see the patient at any time. If personal visits are not made, a relationship may be attempted either by telephone or by letter. Contacts of this type may eventually develop in the patient a desire for more intensive treatment. If the social worker is not equipped to carry the patient in deeper therapy and the latter requires further help, the social worker may send the patient back to the psychotherapist in the clinic or to resources elsewhere for help. In clinics where no intensive supervision is provided for the psychotherapists, patients who exhibit severe resistances may be referred to a social worker. The worker here attempts to evaluate with the patient what has been going on, with the object of making a reassignment of the case to another therapist should this be necessary. If the patient stops treatments with the therapist, the social worker may attempt to work out the problems that have developed between the patient and the therapist. The psychotherapist may employ the social worker as a co-therapist for patients who require some kind of environmental manipulation in addition to psychotherapy.

The social worker, furthermore, helps in any necessary referral of the patient to other agencies. Where members of the patient's family require clarification about the patient's problems or where they need help themselves, the social worker enters into the situation, sometimes taking over the management of the disturbed relative.

The clinical psychologist, who is untrained in psychotherapy, is employed in a clinic of this type to administer diagnostic batteries like intelligence, educational achievement, vocational, and projective personality tests. He or she is used as a consultant for difficulties in school adjustment and placement, for corrective work in educational disabilities, for vocational guidance and rehabilitation, and for research designing, execution, and administration. Clinical psychologists who have had special training in behavioral techniques or biofeedback, may be called on to utilize these.

Sometimes, following those patterns of the old-time clinic, the psychologist and the social worker have conferences related to the problems of a single patient. The

psychiatrist contributes information about medications and differential diagnosis; the psychologist brings up an evaluation of the patient from a psychologic point of view, including projective testing; and the social worker helps round out the picture with an account of social problems in the environment and the family structure. Occasionally, the three team members operate jointly, as, for instance, where the patient requires vocational placement and rehabilitation. The psychiatrist here attempts to identify the sources of the patient's difficulty as related to the work area. The clinical psychologist administers a battery of tests, including vocational interest and aptitude tests. The social worker helps with social problems that are linked to the work area. In work placement the psychologist continues to do vocational guidance, while the psychiatrist treats the patient as a whole. Where group therapy, family therapy, and milieu therapy are parcels of the clinic's operation, all team members may work jointly on a patient or family, assuming the team members have been appropriately trained.

This type of teamwork was, and occasionally now is, especially employed in child guidance clinics where the treatment involves not only dealing with the child's personality, but a manipulation of the environment. Interviews with the child's parents and other members of the family are held individually, jointly, and with the child. These are often beneficial especially where the child's disturbance is provoked by interaction with those around the child. The child may be treated by one of the team members, for example, the psychiatrist, while the the parent is handled by a non-medical therapist, for instance, the caseworker. Consultations between the two therapists, and with the psychologist who does the necessary testing, result in a coordination of the therapeutic program. In most clinics there is no hesitation to call non-medical interventions "psychotherapy," justifying this by saying that the therapist is operating under medical supervision. In some clinics trained and untrained non-medical therapists carry the bulk of the therapy with both parents and children.

Teamwork, such as has been described, is not employed in psychiatric clinics where the function is primarily psychotherapy with adults. This is because the interference of another team member in the treatment program may adversely influence the therapeutic

relationship. If psychologic testing is required, nevertheless, the patient is referred to a clinical psychologist. Should environmental difficulties arise, the therapist may attempt to work out with the patient adequate ways of dealing with the problem. The therapist may perhaps consult with a social worker in order to learn of available resources in relation to a specific social need. Having this information at hand, the therapist may then attempt to help the patient utilize essential resources, by working out resistances to a particular plan of action.

In some clinics following a general screening by the intake social worker, the psychiatrist does the initial interview and provides answers to the following questions:

1. Are there any medical problems that should be referred to a medical practitioner or specialist?

2. Are there any neurologic problems that should be treated by the psychiatrist or referred to a neurologist?

3. Are there any existing psychiatric problems, such as suicidal tendencies, severe depression, excitement, antisocial proclivities, alcoholism, drug addiction, psychoses, or emergencies that require immediate attention, sedation, hospitalization, or electroconvulsive therapy?

4. Are there potential psychiatric problems that will need constant observation?

5. What is the diagnosis?

Thereafter the case may be assigned to the team member best qualified to treat the patient. The psychiatrist is selected where severe psychiatric problems prevail. Non-medical therapists are chosen where there are disturbances in vocational, educational, social, marital, and personal adjustment. Sometimes an attempt is made in case assignment to differentiate between "social" and "medical" psychologic problems. Non-medical therapists are assigned to simple situational maladjustments, personality disorders, and behavior disorders. Medical therapists are assigned to syndromes characterized by a breakdown in defenses and adaptation with severe symptom formation. The syndromes here are acute alcoholism, drug addiction, psychosomatic

ailments, active psychoses, neurotic and psychotic disorders in organic and neurologic conditions, and traumatic neurosis. This differentiation of social and medical psychologic disorders is, however, artificial inasmuch as the individual is involved as a totality, and every one of the functions—somatic, psychic, and behavioral—are influenced in any emotional illness. Consequently, except for dangerous psychiatric problems, all types of emotional ailments are assigned in some clinics to non-medical therapists, provided they are sufficiently experienced and operate under competent supervision.

The subject of supervision in psychotherapy is complex and often befogged in competitive professional rivalries and semantic confusion. Actually, several forms of supervision are employed. There is, first, the general supervision of medical problems *(medical supervision).* Second, there is supervision for detection of medical and psychiatric emergencies and for problems in diagnosis (psychiatric supervision). Third, there is supervision of the psychotherapeutic process itself, the relationship between patient and therapist *(psychotherapeutic supervision).* The first type of supervision may be rendered by a good internist. A psychiatrist, while qualified for the second type of supervision, may have neither the inclination nor the skill to look after the medical problems of the patient. Nor may the psychiatrist be qualified to supervise the psychotherapeutic process. A physician who has had exclusive analytic training and has drifted away from medical practice may not be the best person for medical and psychiatric supervision. In some clinics a highly skilled non-medical therapist may be used for psychotherapeutic supervision. In certain cases a non-medical therapist may, due to training lacks, be able to do no more than counseling or supportive therapy. More likely the therapist may be qualified to do reeducational psychotherapy, and, if trained to do reconstructive therapy, to do intensive psychotherapy, under whatever supervision that may be required. These rules also apply to the psychiatrist whose training may qualify him or her merely to do supportive therapy. Where there has been further training, the psychiatrist may be able to do reeducational and reconstructive therapy under whatever psychotherapeutic supervision is indicated by his or her experience.

Once a case has been assigned, psychiatric supervision of the non-medical therapist

may be provided. The psychiatrist may designate the intensity of supervision, its frequency, and the mode of checking on existing or potential medical, neurologic, or psychiatric emergencies. No satisfactory system of reporting has yet been devised that can result in constant and complete psychiatric supervision of all patients in psychotherapy. In many clinics psychiatric supervision is spotty for many reasons, e.g., shortage of available psychiatric help, inability to afford such services, resentment of non-medical people at what they consider being put into unnecessary overseeing by the medical profession. With the continuing shortages in psychiatric personnel, and expanded training of psychologists, social workers, and nurses in psychotherapy, the quantity and quality of psychiatric supervision has declined.

When one examines the practices of representative clinics in relation to the matter of psychiatric supervision, one finds great variation. In some instances the non-medical therapist spends at least one hour weekly with the psychiatrist, bringing up problems that occur in the total case load. This presupposes that there has been sufficient training to make the therapist aware of cases that show signs of impending somatic, neurologic, or psychiatric difficulties. In many clinics the lack of psychiatrists has resulted in a spotty kind of psychiatric supervision, in that the psychiatrist is called in for consultations whenever, in the opinion of the non-medical worker, a psychiatric consultation or medication is required.

Inevitably, staff working with individuals under emotional stress are drawn into some kind of a psychotherapeutic relationship. Because of this, many clinics have set up in-service training programs calculated to help develop the skills of their clinic personnel. One of the problems here is that the specialized training in psychotherapy of the various team members tends to divorce them from the roles usually identified with their profession. Thus, the physician doing psychotherapy may give up interest in general medicine, may lose diagnostic medical skills, and eventually may feel unqualified to do a good physical and neurological examination. Most psychiatrists for this reason refer patients who require medical attention to internists. The clinical psychologist tends to become removed from testing, often on the basis that a psychotherapist functions more on

a sophisticated level. The clinical psychologist, too, may lose testing skills and will refer patients requiring testing to another clinical psychologist. The psychiatric social worker doing psychotherapy often resents doing casework and may want to give up identification with the profession. In some instances the psychologist and caseworker may even drop their professional titles and insist on being called "psychotherapists." Many therapists, as soon as they have become sufficiently skilled, are lured by motives of economic betterment into private practice. This creates a difficult situation for the clinic and makes it more of a training than service resource.

17
The Equipment of the Psychotherapist

Competence in practicing psychotherapy is developed only after a disciplined exposure to a variety of learning experiences. Integrated didactic instruction, participation in clinical conferences, and supervision of one's work with patients constitute the essence of pedagogical grounding.

EDUCATIONAL EQUIPMENT

Unfortunately, there are no shortcuts to the achievement of therapeutic proficiency. Estimates of the length of time it takes to turn out a fairly seasoned therapist vary. In most instances it requires 5 or 6 years of intensive postgraduate work. A balanced curriculum includes the behavioral sciences, basic neuropsychiatry, the history of psychiatry, the development of dynamic psychological thinking, techniques of psychotherapy, group therapy, marital therapy, family therapy, principles of pharmacology, behavioral approaches, child therapy, preventive and community consultative techniques, research techniques in mental health, and clinical conferences and continuous case seminars. Recommended texts on the courses that follow will be found in a special section at the end of Volume 2. In this section each of the subject fields just listed is presented with a brief outline description of what may be included in the respective courses.

Behavioral Science Contributions to Psychotherapy

Contributions of the biological, social, psychological, and philosophic fields to modern psychotherapeutic theory and practice include the ways in which data from neurophysiology, biochemistry, genetics, behavior genetics, ethology, conditioning theory, learning theory, developmental theory, personality theory, psychoanalytic theory, cultural anthropology, social theory, role theory, group dynamics, communications theory, information theory, cybernetics, field theory, Gestalt theory, ecology, philosophy, and

religion influence contemporary theoretical and methodological approaches to psychotherapy.

Basic Neuropsychiatry; The Practice of Psychiatry

Review of neuroanatomy, neurophysiology, neuropathology, descriptive psychiatry of schizophrenia, manic-depressive psychosis, involutional psychosis, psychosis with cerebral arteriosclerosis, senile psychosis, other organic psychoses, paranoia and paranoid conditions, mental deficiency, and epilepsy. Recent statistical surveys of mental illness. Classification of mental and emotional illness. Causes of mental disease. History taking (anamnesis) and the conduct of the psychiatric examination. Contemporary psychiatric practice.

History of Psychiatry

History of psychiatry up to the period of Sigmund Freud, including contributions of Mesmer, Braid, Bernheim, Charcot, Watson, Pavlov, Cannon, Janet, Baudouin, DuBois, Kretschmer, Kraepelin, and Bleuler. History of the mental hygiene movement. The psychobiology of Adolf Meyer.

The Development of Dynamic Psychology

Readings in psychoanalysis and allied fields. Selected writings of Sigmund Freud. Writings of contemporaries of Freud, including Abraham, Ferenczi, Adler, Jung, Stekel, Rank, Reich, Reik, Fromm, Sullivan, and Horney. Contributions of the ego psychological and object relation schools.

Psychosocial development. The various forces that enter into the molding of human personality. The roles of heredity, constitution, and environment in character formation. Experiences and conditionings in infancy, childhood, adolescence, and adult life that enter into conflict formation. The various methods of conflict solution.

Psychopathology and psychodynamics. Anxiety and its manifestations. Mechanisms of

defense. Symptomatology, psychopathology, and psychodynamics of the principal neurotic and psychotic syndromes.

Techniques in Psychotherapy

Introduction to psychotherapy. Scientific foundations of a psychotherapeutic program. Prognosis and goals in psychotherapy. General outline of psychotherapy.

The various psychotherapeutic approaches. Similarities and differences in theory and technique of the various psychotherapeutic approaches:

1. *Supportive therapy*—environmental therapy, reassurance, guidance, persuasion, emotional catharsis, desensitization and somatic therapy, inspirational group therapy.

2. *Reeducative therapy*—behavior therapy, casework approaches, client-centered therapy, directive therapy, distributive analysis and synthesis, confrontation methods, reeducative group therapy, family therapy, and marital therapy.

3. *Reconstructive therapy*—Freudian psychoanalysis, Kleinian analysis, non-Freudian psychoanalysis with modifications of Adler, Jung, Rank, Stekel, Fromm, Horney, Reich, and Sullivan, object relations theory. Psychoanalytically oriented psychotherapy, Gestalt therapy, transactional analysis, and existential analysis. Analytic group therapy.

4. *Eclectic Therapies*—differential therapeutics.

Dream interpretation. Understanding, utilizing, and interpreting dreams in reconstructive psychotherapy.

Interviewing. Basic interview approaches—with methods of opening the session, maintaining the flow of verbalizations, directing the flow of verbalizations, selective focusing, and terminating the interview.

The initial interview. Problems involved in the initial interview. Motivating the patient for psychotherapy. Correcting misconceptions. Structuring the therapeutic

situation.

Technical procedures in psychotherapy. The conduct of psychotherapy, including such aspects as the establishment of a working relationship with the patient, determining of the causes of the neurosis, the promotion of activity toward therapeutic change, and the termination of therapy.

Handling of special problems in therapy. Coping with severe reactions of panic, suicidal ideas, threats of violence, "acting-out," and other acute reactions of the patient. Somatic complications during psychotherapy and their management.

Short-term psychotherapy. Statistical studies on brief psychotherapy. Selection of cases and goals. Methodological differences between long-term and short-term methods. Treating target symptoms. Conjunctive use of somatic and other methods. Psychoanalytic, behavioral, casework, and counseling approaches. Short-term group therapy.

Hypnosis as a therapeutic adjunct. Historical aspects. The phenomena of hypnosis. The nature of hypnosis. Hypnotic induction methods. Hypnosis in supportive, reeducative, and reconstructive psychotherapy. Limitations and dangers. Self-hypnosis. Group hypnosis.

Psychotropic drugs in psychiatric and psychotherapeutic practices. Biochemical interactions. Drug influences on neocortex, thalamus, reticular formation, limbic system, hypothalamus, synapses, interneuronal circuits, and neurohormonal depots. Biochemistry of depression. Biochemical postulates in schizophrenia. Action, uses, and misuses of neuroleptics, minor tranquilizers, and psychotomimetics.

Behavior (conditioning) therapy. Applications of learning theory to emotional problems. Classical and operant conditioning. Positive counterconditioning and aversive counterconditioning—extinction and reinforcement procedures. Implosive therapy. Values and limitations of behavior therapy.

Miscellaneous adjuncts. Uses of occupational therapy, recreational activities, dance

therapy, music therapy, art therapy, play therapy, and bibliotherapy.

The Technique of Group Psychotherapy

Group therapy with parents of children who are in treatment. Inspirational, educational, activity, and analytic group therapy. Psychodrama. Group therapy in private practice. Group therapy with unselected groups as in institutions. The organizing and working with groups. The practical significance of group constellations, group dynamics, reexperiencing of historic nuclear conflicts, the use of dreams, imagery, and modes of self-expression in a group setting. The use of interpretation and countertransference. Multiple transference, resistance, and working through. The use of co-therapists.

Child Psychiatry and Psychotherapy

The organization and function of a child guidance and therapy clinic based on theoretical and pragmatic child and adolescent practices. The intake process, evaluation of treatability, and initial stages of therapy with children and parents. The team approach. History of child psychiatry. The child in the process of growth; the interaction between the child and the environment. Diagnosis of childhood disorders. Organic, psychoneurotic, and psychosomatic disorders of childhood and adolescence. Behavior disorders and delinquency. Play therapy techniques. Use of creative media. The nonverbal and non-communicative child. Transference and countertransference problems in initial, middle, and terminal phases of child psychotherapy. Conjunctive treatment of child and parent. Family therapy in the treatment of the child.

Preventive and Community Consultative Techniques

Community mental health and the mental health consultant. The psychotherapist as a mental health consultant to community agencies. Theoretical and technical implications of the process of consultation. Orientation to types of problems and settings in which the consultant will work. Philosophy and structure of community coalitions and their relation to the larger community constellation—network of private and public service agencies in

the community: concept of consultation and the nature of the relationship of consultant to agency, to community, to individuals; multilevel concept of social organization in institutions and its relation to consultation; supervisory and administrative processes; multidisciplinary interaction as a process in consultation; methods of determining need in response to request for mental health consultation; multisystem trend study as a survey method in assessing needs and providing a base for a blueprint of action.

Group methods and process in mental health consultation. Basic concepts and methods of group process utilized in mental health consultation. The achievement of educational, therapeutic, problem-solving and decision-making goals in group situations. The role and techniques of the consultant in helping leaders and group members to develop the responsibilities and skills required for group productivity. Dynamics of group process and group structure and the dynamics of the individual personality. Methods for analyzing and resolving group interaction problems.

Educational techniques. The use of educational media in preventive mental health. Methods of conducting discussion groups;—the use of films, recordings, and sociodramatic technqiues, An evaluation of current books and pamphlets on mental health written for the public. The mental health lecture. Writing on mental health topics for the public and for ancillary professions.

The comprehensive community mental health center. The comprehensive mental health center, its philosophy, function, organization, financing, and operation. Inservice training programs. Inpatient services. Outpatient services. Partial hospitalization, including day, night, and weekend care. Community services, including consultation to community agencies and professional personnel. Diagnostic services. Rehabilitative services, including vocational and educational programs. Precare and aftercare community services, including foster home placement, home visiting, and halfway houses. Research and evaluation. Planning grants and hospital improvement programs. Outpatient clinical routines—the processes of reception, intake, history taking, initial interviewing, cooperation with outside agencies, the keeping of case records, the taking of progress

notes, and methods of case presentation. Needs for consultative services in agencies such as social agencies, hospitals, outpatient clinics, schools, public health services, industry, unions, courts, civic organizations, etc. Methods of maximizing cooperative working relations with community organizations.

Function of clinical team members The professional responsibility of the psychiatrist, caseworker, nurse, and clinical psychologist in terms of specialized role and psychotherapeutic function. The uses and misuses of teamwork. The psychiatric consultant and the psychiatric supervisor. Survey of testing procedures used for diagnosis and treatment planning. The place of casework and counseling in a psychotherapeutic program.

Industrial mental health. Problems in industry of a normal and psychopathologic nature as they affect employers and employees. Application of psychologic and psychiatric techniques to situations of hiring, job placement, training, problems of staying on the job (including transferring), and discharge. Occupational neuroses, and placement of the handicapped, alcoholic and psychotic individual; accident proneness, absenteeism, problems of aging workers, role of the industrial nurse, problems of compensation. Techniques of interviewing, testing, and psychodramatic training.

Forensic aspects of emotional illness. Application of mental health information and knowledge to legal procedures in relation to such problems as criminal responsibility, determination of guilt, mental fitness for trial, disposition of prisoners after conviction, torts, wills, contracts, deeds, guardianship, annulment, divorce, compensation as well as other medicolegal problems and tactical approaches to these.

Culture and Personality

Influence of culture on character structure. Effect of cultural background on response to therapeutic technique. Cultural anthropology.

Psychological Tests in the Field of Mental Health

The uses, values, and limitations of psychological tests in diagnosis and in appraising personality assets and liabilities. Mental ability, concept formation, special aptitude, attitude, interest, objective personality, and projective personality tests. Integration of test findings with clinical findings.

Research Techniques in Mental Health

Research design, methodology, and execution of projects in mental health; Evaluation of the results of research and their application. Process and outcome research in validating, sharpening, and testing techniques in individual and group psychotherapy and in investigating factors in epidemiology as a basis for organizing services and developing programs to meet community mental health needs.

The Treatment of Special Conditions

Treatment of the alcoholic. Hereditary, constitutional, and experiential factors associated with alcoholism. Treatment of the acute and chronic alcoholic patient from various viewpoints, including drug treatment (antabuse, LSD), institutionalization, individual and group psychotherapy.

Treatment of the drug addict. Background material and techniques for the treatment of narcotic, barbiturate, amphetamine, and tranquilizer addictions.

Management of delinquency. Major theories of the etiology and characteristics of juvenile delinquency; considering sociological, psychological and biological factors. Diagnostic formulations with respect to their implications for the prevention, treatment, and control of juvenile delinquency. Somatic, casework, counseling and psychotherapeutic approaches. Techniques and methods as they relate to the entry into, relationship with, and withdrawal from client systems in the area of delinquency.

Treatment of the criminal. The role of psychiatry, casework, counseling, and psychotherapy in the prevention, control, and treatment of criminals.

Management of mental retardation. Etiology, diagnostic evaluation, prognosis, and management of the mentally retarded child and adult. Somatic, educational, vocational, casework, psychotherapeutic, and institutional placement approaches.

Treatment of anxiety, phobic, hysterical, somatoform, and obsessive-compulsive disorders. Etiology, diagnostic evaluation, prognosis, and therapy with drugs, and behavioral and psychotherapeutic methods.

Treatment of depressive reactions. Etiology, diagnosis, prognosis, and treatment of neurotic and psychotic depressions. Drug, electroconvulsive, and psychotherapeutic management.

Treatment of sexual problems. Psychopathology, psychodynamics, and treatment problems in sexual disorders—particularly impotence, priapism, frigidity, vaginospasm, fetishism, sadism, and masochism. Homosexuality as a problem.

Treatment of speech and voice disorders. Physiology of speech and the symptomatology of the most frequent disturbances in this area—including disturbances of articulation, motor function, phonation, symbolization, and rhythm in relation to organic and psychogenic varibles. Diagnostic, prognostic, and treatment aspects with special emphasis on stuttering.

Management of family problems. Premarital, postmarital, and parent-child problems and their handling. Problems of aging and aged parents in the transactions of the family in its beginning, expanding, and declining phases.

Treatment of psycho-physiologic disorders. Etiology, symptomatology, diagnosis, prognosis, and therapy of psychogenic autonomic and visceral reactions—including the skin, musculoskeletal, respiratory, cardiovascular, hemic, gastrointestinal, genitourinary, endocrine, and special sensory systems.

Treatment of habit disorders. Etiology, diagnosis, prognosis and treatment of obesity, bulimia, anoroxia nervosa, alcoholism, substance abuse, and insomnia with hypnosis,

drugs, behavior therapy, and psychotherapy.

Treatment of personality disorders. Etiology, manifestations, diagnosis, prognosis and therapy of personality pattern and trait disturbances. The management of "acting-out."

Treatment of schizophrenic and borderline patients. Special techniques and modifications of methods in dealing with schizophrenic and borderline schizophrenic patients.

Management of organic brain disorders. The etiology, symptomatology, diagnosis, prognosis, and treatment of organic brain syndromes. Thinking, memory, speech, learning, emotional, and behavioral disturbances. The treatment of convulsive phenomena and episodic psychotic outbreaks.

Hospital treatment of mental disorders. General hospital management; institutional management and aftercare of mental disorders. Rehabilitative, somatic, and psychotherapeutic procedures.

Management of the paranoid patient. Special problems involved in working with the projective mechanisms and acting-out behavior of the paranoid patient. Dealing with transference and countertransference phenomena.

Management of emergencies.

Clinical Seminars

Diagnostic conferences. Presentation of cases for purposes of discussing the diagnosis, psychopathology, and psychodynamics of different syndromes.

Clinical conferences. Problems in the conduct of therapy through presentation of a variety of cases.

Continuous case seminars. Presentation of one case throughout the course period, preferably by video, audio, or process recording. Discussions concerning the handling of

the therapeutic situation as it develops over an extended period of time.

PERSONALITY EQUIPMENT

The most important variable in psychotherapy is not its techniques, but the human instrumentalities through which the techniques are implemented—i.e., the psychotherapist. This is because "the therapist sets an example of caring, reasonableness, predictability, maturity—in short is capable." (Strupp and Binder, 1984). The proficiency of the therapist, and the dexterity with which technical knowledge is employed are vital. Fundamental also, even crucial, is the presence in the therapist of certain kinds of personality characteristics without which the most highly trained therapist will be unsuccessful. As Strupp (1960) has pointed out, "The greatest technical skill can offer no substitute for nor will it obviate the preeminent need for integrity, honesty, and dedication on the part of the therapist."

The practice of psychotherapy requires that therapists possess special qualities that will enable them to establish and to maintain the proper kind of relationship with their patients. These characteristics may be roughly classified into five categories: namely, sensitivity, flexibility, objectivity, empathy, and relative freedom from serious emotional or characterologic disturbance. The personality ingredients of the therapist have a crucial influence on the direction and outcome of treatment.

Sensitivity

Essential is the capacity to perceive what is happening in the treatment process from the verbal and nonverbal behavior of the patient. Therapists must be attuned not only to the content of their patients' communications but also to the moods and conflicts that underlie the content. They must be aware also of their own feelings and attitudes, particularly those nurtured by their personal neuroses that are activated by contact with the patient. These qualities presuppose good judgment with the ability to utilize one's intelligence in managing practical life problems.

Objectivity

Awareness of one's own feelings and neurotic projections helps the therapist to remain tolerant and objective in the face of irrational, controversial, and provocative attitudes and behavior manifested by the patient. No matter what the patient thinks or says, it is urgent that the therapist have sufficient control over personal feelings so as not to become judgmental and, in this way, inspire guilt in the patient. Objectivity tends to neutralize untoward emotions in the therapist, particularly overidentification, which may stifle the therapeutic process, and hostility, which can destroy it. Objectivity enables the therapist to endure attitudes, impulses, and actions at variance with accepted norms. It permits the therapist to respect the patient and to realize essential integrity, no matter how disturbed or how serious the illness may be.

Among the most common projections and attitudes toward which objectivity is mandatory are infantile demands by the patient for protection, love, gifts, and favors; insistence that the therapist be omniscient at all times; desires to be preferred by the therapist above all other persons; demands for sexual responsiveness; expressions of resentment, hostility, and aggression; and complaints of being exploited, deceived, and victimized. In the face of such projections, it is essential that the therapist be able to recognize and handle personal fears, prejudices, intolerance, and other neurotic attitudes as they develop and be able to deal with such feelings as impatience, disgust, resentment, boredom, and disinterest, whenever these appear. This will necessitate self-understanding and awareness on the part of the therapist of self-possessed conflicts and problems in interpersonal relationships.

Flexibility

Rigidity in the therapist is a destructive force in psychotherapy. Unfortunately, it is a common occurrence whenever there is tenacious adherence to any one "system" of psychotherapy. Rigidity prevents coordinating one's approach with the exigencies of the therapeutic situation. Too zealous regard for the sanctity of any system must of necessity reduce therapeutic effectiveness, for the requirements of the therapeutic interpersonal

relationship call forth promptings that defy methodologic bounds. Flexibility is not only essential in the execution of technical procedures but is also essential in other aspects of therapy, such as the defining of goals and the setting of standards. Flexibility is also necessary in interpreting the value system of the culture in order to permit the relaxation of certain austere demands in the face of which a change in the patient's severity of conscience may be thwarted.

Empathy

Perhaps the most important characteristic of a good therapist is the capacity for empathy. This quality enables the therapist to appreciate the turmoil that the patient experiences during illness and the inevitable resistances that will become manifest toward change. It presupposes that the therapist is not characterologically detached, a trait most destructive to a proper relationship with the patient. Lack of empathy interferes with the respect the therapist needs to display toward the patient, with the interest to be shown in the patient's welfare, with the ability to give warmth and support when needed, with the capacity to concentrate on productions and to respond appropriately to these. Empathy must not be confused with maudlin sympathy or tendencies to overprotect the patient. Empathy means tolerance of the patient's making mistakes, of using his or her own judgments, and of developing an individual sense of values. This means that the therapist must harbor no preconceived notions as to the kind of person that the therapist wants the patient to be.

The importance of empathic understanding in psychoanalysis is stressed by Fleming and Benedek (1966): "The message from the patient, whose latent as well as manifest meanings are 'heard' with the analytic ear, is often responded to without any cognitive mediating step. The 'experiential fit' facilitated by empathy enables the analyst to identify the communication behind the patient's words and translate it into words not yet available to the patient."

RELATIVE ABSENCE OF SERIOUS EMOTIONAL PROBLEMS

Certain traits in the therapist have been shown by experience to be damaging to good psychotherapy. Among these are the following:

Tendencies to be Domineering, Pompous, and Authoritarian

While tolerable in supportive therapy, the tendency to be domineering, pompous, or authoritarian is not too helpful in reeducative therapy and is definitely harmful in reconstructive therapy. These attitudes prevent patients from working things out for themselves in order to evolve their own growth patterns. They reinforce fears of authority and cause overevaluation of the powers of people in high positions. They inhibit self-growth and the development of assertiveness while reinforcing traits of dependency, submissiveness, ingratiation, and detachment. Sometimes they release rebellious and hostile tendencies that interfere with therapeutic gains. Domineering tendencies in the therapist may mask strong fears of people, and in the therapeutic situation they may constitute a way of maintaining control by putting the patient in a subordinate or inferior role. They may also be a means of expressing not fully conscious feelings of omniscience, grandiosity, and a need to play God. This does not imply that the therapist must shy away from assuming the role of an authority; it indicates that the therapist must have the capacity of acting as an authority without being authoritarian.

Tendencies Toward Passivity and Submissiveness

These traits may inspire insecurity and hopelessness in the patient. They stimulate latent hostile and sadistic traits as well as reactive defenses against such traits. Passivity may manifest itself in a fear of offending the patient or in an inability to be firm, on occasion, and to take a positive stand when it is essential that the therapist do so.

Detachment

Whereas the patient may manage to establish some kind of a relationship with a domineering or passive therapist, making essential contact is totally blocked because of detachment in the therapist. This trait may be rationalized by the therapist as a designed

attempt to act neutral or to assume a scientific and structured attitude toward the patient. Detachment interferes with the capacity to empathize with the patient and to feel sympathetic with his or her problems. It thwarts the giving of the therapeutic doses of reassurance and support whenever these are required.

Need to Utilize the Patient for the Gratification of Repressed or Suppressed Impulses

The therapist may attempt to gain vicarious gratification of impulses by living them through in the experiences of the patient and by encouraging open or covert acting out. Where this is done, the therapist will tend to lose objectivity and fail in the effort to help the patient. It is vitally important that the therapist be sufficiently well-adjusted and possessed of basic satisfactions in living or else compensating adequately for any lack in vital satisfactions so that he or she avoids using the patient to gratify any frustrated needs. Among the most common frustrated impulses are those related to sexuality, the expression of hostility, and the gaining of prestige. Unpropitiated sexual needs of a normal or perverse nature may be stimulated in the therapist by the patient's recital of past erotic behavior. The patient's present sexuality may also receive an unwarranted concentration and emphasis. The acting-out of sexuality with the patient poses destructive and other unfortunate risks for both, no matter how rationalized it may be. A therapist who harbors an excess amount of hostility may unduly encourage its expression in the patient, directing it toward those agencies with whom the therapist is neurotically concerned. Thus, the therapist may sanction a hostile defiance of authority or aggressive acts toward parental figures, with a resultant involvement of the patient in activities that are not in his or her best interests. Finally, overambitious therapists may, under press of this impulse, goad patients into working for success, power and fame, much as parents dissatisfied with their own mediocrity will try to fulfill themselves through their offspring. Such efforts tend to arouse defiance in the patient and interfere with the proper patient-therapist relationship. Ambitiousness may additionally cause the therapist to react with resentment to the patient's resistances and to the absence of what the therapist considers to be appropriate progress; the feeling here is that the therapist's own reputation is at stake.

Inability to Tolerate the Expression of Certain Impulses

Reaction formations and other defenses in the therapist against important inner drives may mobilize antitherapeutic tendencies. Thus, anxieties investing the therapist's sexuality, hostility, and assertiveness may result in minimization of the importance of such impulses in the patient.

The therapist may divert the patient from talking about these topics whenever they are brought up or adopt subtle punitive tactics that cause the patient to repress such impulses or their derivatives—driving them deeper away from awareness and preventing a coming to grips with them. In the same way the therapist, sensitive to anxiety within, may be unable to tolerate it in others. Therefore, when even minimal quantities of this emotion arise during treatment, the therapist may tend to dissipate anxiety with reassurance and other supportive measures, in this way obstructing an examination of its source. A therapist with this kind of problem may do excellent supportive therapy but will fail in the more extensive reeducative and reconstructive approaches.

Neurotic Attitudes Toward Money

The therapist's insecurity may reflect itself in anxiety about fees and payments. Such concerns will stimulate in many patients feelings of being exploited and hostile attitudes toward the therapist on the basis that there is more interest in the patient's money than in the patient.

Sundry Destructive Traits

Many neurotic character traits in the therapist are detrimental to good functioning. Included are these:

1. The therapist may be unable to tolerate blows to his or her self-esteem by the patient's acting-out tendencies, by manifestations of resistance and transference, and by the inevitable failures and frustrations in treatment.

2. A neurotic need to be liked and desires for admiration and homage may prevent

the therapist from making interpretations that are offensive to the patient or otherwise challenging of the patient's defenses.

3. Compulsive tendencies toward perfectionism may make less ambitious goals than the patient's complete character reconstruction unacceptable and may cause the therapist to drive the patient obstinately toward such goals even when there is little chance of achieving them. Perfectionism may also produce a fear in the therapist of making mistakes.

4. Perhaps the most destructive traits present in the therapist are those that create a relationship that specifically duplicates and perpetuates the early defeating, frustrating, and traumatizing experiences in the patient's childhood. The patient will, of course, always try to maneuver the therapist into such a relationship, but an observant and objective therapist will tend to block this design. However, where the therapist's personal needs play into the patient's demands, the therapist may lose perspective and enthusiastically enact the kind of role that must inevitably end in defeat.

5. Any character traits that interfere with the therapist's ability to understand, to accept, and to deal constructively with the verbal and nonverbal behavior of the patient without feelings of threat or counterhostility are damaging to the treatment relationship.

6. Hostility toward the patient, open or disguised, justified by reality or inspired by prejudices and countertransference, brings about rejection, lack of empathy, loss of objectivity, and other manifestations destructive to therapeutic objectives.

7. Lack of faith in what he or she is doing can sabotage and destroy a therapist's effectiveness. Trust in techniques can have a most pronounced influence on therapeutic results, even when the methods employed are unscientific. Indeed, it has been said that an important possession of the psychotherapist is an undaunted belief in the virtue of one's system.

8. Militating against good therapy are a number of other characteristics—inhibited creativity, a poor sense of humor, an inability to take criticism, low personal integrity, diminished respect for people, failure to acknowledge self-limitations, low energy level, and poor physical health.

Influence of Therapists' Attitudes

The proper therapists' attitudes, as has been explained, are crucial for effective psychotherapy as they are probably important for all kinds of learning. They constitute powerful reinforcers that may effectively influence the patient's behavior. Not only do such attitudes as empathy, warmth, and understanding tend to promote positive feelings in the patient, but they also relieve tension and lower the anxiety level. In such an atmosphere learning is enhanced. Interviewing, focused by the therapist on anxiety-laden content, may then be rewarding. Thus the dynamically oriented therapist will probe for and encourage the patient to talk about areas with an anxiety potential that are usually resisted or repressed. The patient is rewarded by approving responses from the therapist when dealing with repudiated material. Apart from the temporary benefits of emotional catharsis, the patient learns to tolerate this material, thus placing it in the context of the historical past. An opportunity of revaluing it is then possible.

Schedules of selected reinforcement, in the course of probing for anxiety material and exploring its origins and meaning, tend to extinguish responses previously affiliated with the anxiety content. These aspects of operant conditioning are an integral part of cure in dynamically oriented psychotherapy. In behavior therapy, while the dynamic anxiety sources are not delineated or examined, the patient is also exposed in the medium of a rewarding emotional climate to reinforcers that tend to extinguish self-defeating responses and to accentuate others that have adaptive promise. Symptom relief and the acquisition of constructive behavior patterns occur without the formality of insight. In both dynamic psychotherapy and behavior therapy operant conditioning thus plays an important role. In both it encourages the regurgitation of material that affirms the therapist's personal theoretical biases.

Apart from the specific reinforcing maneuvers executed in dynamic and behavioral approaches, the therapist-patient relationship itself serves as a relearning experience from which the patient may generalize responses toward other relationships. Dynamic approaches have the advantage of working with transferential contaminants that can effectively block therapy. Where transference is not bypassed but dealt with firmly in terms of its genetic roots, and the patterns and defenses that it embraces are skillfully

analyzed, they will tend to undergo negative reinforcement and extinction. The therapist relationship will then become a corrective experience for the patient. This does not mean that cure is automatically guaranteed, since in some cases psychic damage is so profound, the secondary gain benefits so intense, the masochistic needs so great, that the inner rewards for the perpetuation of transference exceed those the therapist can supply by approving-disapproving tactics. Nevertheless, in a considerable number of patients the development and unravelment of transference can be most recompensing toward fostering personality alterations. Behavior therapies, while remarkably effective in promoting symptomatic improvement and behavior change in some cases, cannot approach the depth of reconstructive personality alteration possible in selected patients exposed to dynamic therapy with trained psychotherapists whose personality structures contain the proper ingredients of warmth and understanding.

A question immediately poses itself. Is not the proper climate of classical psychoanalysis a neutral, detached one, and if so, would not the patient then respond in an antitherapeutic way to the unconcerned, non-sympathetic manner of the therapist? The answer to this question lies in the simple fact that effective psychoanalysts are not really neutral and unconcerned. They communicate, in spite of practiced noninterference and passivity, an understanding of and empathy toward their patients. The patient quickly discerns from nonverbal cues the true emotional feeling of the analyst. The non-effective psychoanalyst is personality-wise truly detached, cold, and uninvolved, and this lack of empathy will reflect itself in negative therapeutic results.

IS PERSONAL PSYCHOTHERAPY OR PSYCHOANALYSIS NECESSARY FOR THE THERAPIST?

It is obviously impossible for any one person to possess a totality of positive personality features or to be devoid of every negative characteristic that makes for an ideal psychotherapist. These deficiencies do not obstruct good psychotherapy, provided the therapist is not too seriously handicapped by personality disturbances. The therapist, like any other person, will undoubtedly be possessed of a certain amount of neurotic illness. This may manifest itself in difficulties in personal adjustment outside of the

therapeutic situation. The fact that the therapist exhibits evidences of personal problems in everyday life does not always mean that it is impossible to manage therapy in the unique setting of the patient-therapist relationship, for in this relationship the therapist plays a different role than in usual associations with people. The position occupied with the patient generally makes the therapist feel more secure and permits divestiture of self from many personal customary neurotic defense mechanisms. A mild neurosis need not necessarily interfere with the effective conduct of therapy if the therapist is aware of interpersonal problems and is capable of inhibiting their operation in the encounter with patients. The therapist will, of course, exhibit greater insecurity with some patients than with others. Varying defenses will be mobilized to ensure handling better certain kinds of problems and with selected patients. Yet mandatory in all individuals doing any kind of psychotherapy is some awareness of and control over their stereotyped interpersonal reactions. There are some individuals who are sufficiently healthy by virtue of a sound upbringing and a spontaneously mature development so as to be able to avoid untoward reactions in therapy. Additionally, they possess values and attitudes that are consonant with mental health objectives. Admittedly, such persons are in the minority since most of us are not so bountifully blessed by a fortunate upbringing and wholesome childhood experiences to make us completely integrated human beings.

The burdens imposed on the average therapist, particularly in doing reconstructive therapy, the fact that personal unconscious conflicts may be mobilized, and the need for him or her to function simultaneously in multiple roles require greater freedom from neurosis than the average person. Categorically, it may be stated that all therapists may benefit from personal psychotherapy if they plan to do reconstructive therapeutic work. Such personal therapy provides the individual with an opportunity to study psychodynamics through self-observation, in watching minutely one's own emotional conflicts, their genetic origin, and their projection in present-day functioning. It also helps to liberate the therapist from those problems and character disturbances that interfere with the establishing and maintaining of a therapeutic interpersonal relationship.

Where the therapist contemplates specializing in psychoanalysis, a "didactic"

personal analysis is one of the training requirements. According to Freud, a personal psychoanalysis is vital in bringing the analyst to a standard of psychical normality that one sets for one's patient. Only in this way can the therapist serve as an appropriate model. The end of a training analysis is reached, said Freud, when the learner has arrived at a sincere conviction about the existence of the unconscious and of the repressed conflicts and pathological processes that otherwise would have been considered incredible. This acts as a basis for further ego transformation after the analysis has ended, enabling the analyst to apply new insight to all subsequent experiences. In the face of the tensions and anxieties that the analyst is forced to handle in patients, it is not remarkable that instinctual demands that had hitherto been restrained may be violently awakened. For this reason Freud enjoined every analyst periodically, say every 5 years, to enter analysis once more "without any feeling of shame in so doing" (Freud, 1952). Few analysts have heeded this injunction.

In delving into unconscious processes, the basic understanding of dynamics derived from personal experience is far more meaningful than knowledge from traditional forms of instruction. A personal psychoanalytic adventure, particularly one in which a transference neurosis is instituted, permits the analysand to observe conflictual aspects of oneself and to objectify this learning. This contributes to the empathic understanding, intuitive perceiving, cognitive discernment, and conceptual generalizing that are essential for psychoanalytic work.

Personal therapy is not always necessary where the psychotherapist confines work to supportive, reeducative, and the less intensive reconstructive approaches, provided, of course, that he or she does not possess too many therapeutically destructive personality handicaps. However, a period of personal treatment may eventually prove itself to be one of the soundest investments the therapist can make. In addition to helping with the therapist's own problems, personal reconstructive therapy or analysis contributes to one's sophistication in understanding what is happening, even in supportive treatment. For instance, by observing (without interpreting) the patient's dreams, fantasies, and acting out, one may follow more effectively resistance to change, the development and

vicissitudes of transference, the building of more adaptive defenses, and the general trend of progress.

There are many variables in assaying how much more effective the therapist will be with and without personal therapy. Some therapists, never having received personal analysis, are remarkably flexible, sensitive, empathic, and intuitive. They recognize and are capable of dealing with their own and their patient's unconscious mental processes, and they are able to do better psychotherapy than many therapists who have undergone treatment. It does not, however, follow from this that they could not have developed themselves even further with personal therapy.

Entering into therapy does not necessarily guarantee the success of the effort. Over and over again we observe well-qualified individuals who, exposed to prolonged personal analyses, characterologically seem to be little influenced by the process. There are many reasons for this failure. Perhaps of greatest import is the tendency for the student therapist to consider personal therapy a "didactic" requirement rather than a therapeutic necessity. Unlike the average patient who is driven to treatment by anxiety and the discomfort of disabling symptoms, the student therapist enters therapy because it is something that one is "supposed to go through" as a requirement in his or her training. The latter motivation is not strong enough to induce one to tolerate the anxieties necessary for the yielding of the protective and pleasure values of his or her neurosis. One's resistance to deep change is consequently greater than that of the patient, since the student therapist is not enjoined by suffering to revise personality patterns. Sometimes a training analysis may have bad effects on a trainee, where flexibility becomes impaled on the sword of the trainer's theoretical dogma, resulting in a handicapping rigidity.

Currently, there is a tendency to shy away from a labeling of personal therapy or analysis as "didactic" and to accept the principle that every student therapist possesses a neurosis that requires treatment. Accepted, also, is the premise that even where symptoms are lacking, the alteration of character patterns, with removal of therapeutically destructive traits and the expansion of therapeutically constructive

tendencies, will be a long-term proposition. It is recognized that failure in personal therapy to achieve goals of character change, does not cast a slur on the therapist's integrity or the ability to engage in successful supportive and reeducative approaches. These are to be regarded not as methods substitutive for, or inferior to, reconstructive therapy, but rather as processes that have a preferred validity in the specific instances where they are employed.

EXPERIENTIAL EQUIPMENT

The basic knowledge a good psychotherapist must possess is substantial. Especially where one wishes to deal with dynamic vectors in the personality, a consideration of the following is in order:

1. How people evolve their personality structures in the matrix of hereditary constitutional, experiential, and cultural variables.

2. The psychodynamics of healthy and pathological adaptation.

3. The mechanisms of defense and the psychological constellations that accrue from insoluble stress and anxiety.

4. The interviewing tactics through which rapport is established, communication facilitated, essential content explicated, and obstructive emotional projections resolved.

5. The principles of eliciting and understanding unconscious material—including fantasies, undirected associations, dreams, and transference phenomena.

6. The stratagems of dealing with resistances that strangle therapeutic progress.

7. The understanding and management of one's own irrational drives and conflicts that interfere with sensitivity, spontaneity, and self-discipline.

8. The specific problems of and suitable tactics for dealing with children, adults, the aged, the infirm, the families of patients, and persons from varying socioeconomic and cultural backgrounds.

Without extensive experience in the therapeutic handling of a variety of cases, no

therapist can be considered well trained. Preferably the therapist should have treated the common clinical syndromes, including anxiety disorders, phobic disorders, conversion hysteria, obsessive-compulsive neurosis, psychosomatic problems, personality disorders, behavior problems, alcoholism, drug addiction, personality disorders including borderline patients, schizophrenia, manic-depressive psychosis, involutional psychosis, and paranoid states. Experience should have included varied emotional problems in children. It should have given the therapist an opportunity to observe and to do group therapy, marital therapy, and family therapy. The therapist should know the basics of psychopharmacology, the drugs in common usage, and other forms of somatic therapy. Therapists should be acquainted with the common emergencies in therapy and how to deal with them. Therapists working in hospitals and clinics also ideally should learn how to operate in the kind of teamwork with psychiatrists, nurses, caseworkers, and clinical psychologists in which the professional responsibility of each team member is defined, providing a basis for mutual interaction and the pooling of skills. They should be capable of playing a specialized role within the team and of functioning ably as psychotherapists. Understanding the principles of preventive mental health and how to utilize educational media in a skilled way is also important. They should finally be able to act as a consultant to those community agencies and auxiliary professions that are in contact with people suffering from emotional ailments.

Such training will obviously take a long time. Indeed, as has been previously mentioned, it is rare for any student to become a seasoned therapist without a backlog of at least 5 or 6 years experience under competent guidance. Each therapist must be "custom-tailored," serving an apprenticeship under careful supervision that is specifically designed to take into account the therapist's various personality problems and characteristics. Sharing experiences in the actual practice of psychotherapy with a highly trained supervisor is the greatest catalyst to the learning of psychotherapy. By bringing students to an awareness of their blind spots and their personality and learning blocks, one can most effectively help them toward matureness as psychotherapists. Supervision of the psychotherapeutic process is so important and essential an experience that an entire chapter in this book will later be devoted to it.

18
General Principles of Psychotherapy

No single mechanism or theory can explain what happens in successful therapy. A variety of factors, specific and non-specific, are coordinately operative. Some theorists believe that therapy essentially is a relearning process where old destructive patterns become extinguished and new constructive behavior learned through conditioning tactics and sustained by reinforcement. There are others who avow that psychotherapy is effective because it supplies the patient with a second chance for personality development, but this time with an empathetic surrogate parent who makes up for the deficits of the original developmental period. To some, psychotherapy provides a corrective emotional experience within the matrix of a good therapeutic interpersonal relationship, which is more or less actively manipulated to avoid the mistakes of the past. To some, the seeds of change are latent within each individual requiring a mere accepting, warm, nonjudgmental relationship to sprout into blossoms of maturity. There are many other theories of why psychotherapy works, probably because so many different factors account for change in different patients. Actually theorists, espousing a special point of view, appear to select a single item out of a field of multiple responsible agencies, all of which are undoubtedly operative at one time or another.

When we try to examine the processes of change in therapy, we find that they contain many hypothetical assumptions that are difficult to subject to experimental validation. This is largely because the therapeutic interpersonal relationship on which psychotherapy is based embraces sundry variables that do not readily lend themselves to measurement. It is consequently difficult to apply to an evaluative study of psychotherapy the precise principles on which scientific method is based—namely, an unprejudiced compilation of facts and information, the formulation of reasonable hypotheses, the retention of objectivity in observation, and the retesting of findings with an attempt to reduplicate results. For the most part, descriptions of psychotherapeutic technique reflect the personal values and convictions of the observer. The clinical attitudes expressed are

more pragmatic and empiric than they are scientific.

It is perhaps for these reasons that psychotherapy has been regarded by many as an art rather than a science. One may justifiably consider the ability to establish and maintain a relationship with a patient a form of artistry, since it is dependent on certain personality factors with which some therapists are more highly endowed than others. Yet conceding that psychotherapy, at our present state of knowledge, is less a science than an art, certain basic principles must apply as in any other art of which an understanding is crucial to its effective practice. Without a disciplined application of these principles no amount of artistic endowment can inspire good psychotherapy.

Another factor that makes a study of any psychotherapeutic method baffling is the confusion of broad basic techniques with the unique personal ways in which they are implemented. In psychotherapy, as in any other art or partial art, we are confronted with the phenomenon of a highly personalized style that is employed in the medium of a particular method.

An analogy may illustrate this point. Students learning to paint will be aided greatly by studying fundamental techniques of painting and general principles of composition. They will also derive much in observing the methods of painters who have achieved proficiency in their work. Their art instructors will help them to master blocks and ineptitudes in putting fundamental techniques into practice. As they gain confidence in themselves, their training will blend with individual personality assets, such as creativity, sensitivity, and originality, and, out of this amalgam, they will develop their own styles of painting—a preferential mode of symbolic representation and a unique use of color and texture. They will still operate within the broad framework of the fundamental techniques, but their finished products will be their own, different from those of their teachers and colleagues who have been exposed to the same kind of instruction.

In psychotherapy, students will be helped also by studying general principles and techniques—such as the conduct of an initial interview, the establishment of a working relationship with the patient, the determination of the dynamics of a neurosis, the

promotion of activity toward therapeutic change, and the termination of therapy. They will be benefited by observing how trained psychotherapists execute these procedures. Like the artist, they will need to function under supervision, in this way becoming aware of their deficiencies that interfere with the putting into practice of what they have learned. As their experience grows, they will fuse the supervisor's method with their own working mode, introducing new elements and modifying others, until they develop their own style of therapy. They will still follow the broad principles of technique, but in a manner that is uniquely their own.

A broad structure of therapy must take into account this factor of spontaneity of style in the psychotherapist. For without spontaneity, therapists are truly handicapped in relating to their patients and in allowing their intuition to help them grasp the dynamic forces that are operative during the treatment process.

DYNAMICS OF THERAPEUTIC CHANGE

Before describing a structure of psychotherapy that provides for this kind of flexible framework, it may be helpful to consider the dynamics of psychotherapy in terms of an example of what happens to the typical individual who is exposed to a reconstructive psychotherapeutic approach. Modifications consonant with reeducative and supportive therapies will be considered later.

When average patients enter into therapy, they are usually bewildered, confused, and upset by what is happening to them. Their symptoms seem more or less dissociated from the matrix of their life. Consequently, they are confounded by attempts to investigate in detail aspects of their experience that they consider irrelevant to their complaint factor. Not realizing that their symptoms stem from deep problems of long standing that are presently being reflected in disturbances in relationships with people, patients expect rapid results. In this respect they are rather like the obese patients who want the physician to remove, in 2 weeks, the excess weight that has taken 10 years to accumulate, while at the same time refusing to exercise or diet. Patients seek to retain fixed ways of dealing with people and situations, which provoke and exaggerate their symptoms, while

demanding that the products of their disturbed way of living be quickly extirpated.

With this in mind, patients desire to relate to the therapist in the traditional way that patients utilize physicians. Patients demand some kind of immediate dramatic help or, in their helplessness, the performance of a miracle by means of a mysterious nostrum or formula. Patients hopefully conceive of the therapist as an omniscient authority who will palliate their suffering and expeditiously lead them to health and personal success. The sicker the patients the more likely they are to consider therapy a conjuring trick. Operative almost from the start are intercurrent forces of the placebo element, emotional catharsis, and suggestion that may serve to bring the patients to temporary homeostasis. These subsidies, however, are generally short-lived, and more substantial therapeutic interventions will be needed to control the continuing symptoms.

It may require a great deal of perseverance on the part of the therapist to demonstrate to patients that their symptoms do not occur at random but are exacerbated by definite life situations that involve their attitudes toward people and their estimate of themselves. Before progress can be made, however, it will be necessary to achieve the realization that symptoms are not independent manifestations; rather they are representations of problems of which there is only partially awareness. Once patients accept the idea of continuity between their symptoms and certain other problems within themselves, they are more capable of abandoning hopes for immediate symptom relief by some spectacular performance on the part of the therapist. Motivated by the discomfort of their symptoms and the desire for more fulfilling lives, they will enter into deeper inquiries into themselves and the multiple forces impinging on them from the outside.

Soon the patients will comprehend that symptoms fluctuate, often depending on some happenings of daily life and on certain difficulties encountered in interpersonal relations. Awareness of these facts will tend to divert the emphasis from their immediate complaints. As soon as this occurs, the first basic step in therapy will have been taken.

To bring patients to such an understanding, however, may prove to be more than an ambitious undertaking. The patients are habituated to themselves, their character traits

and attitudes. These are so "ego-syntonic" that the patients can only perceive them as an incontrovertible everyday component of life. The possibility that their behaviors are abnormal may not only be unacceptable but also unbelievable. Nearly all neurotic people assume that their own particular pattern for living is average, if not universal. If they do recognize themselves as variant, then that in itself is regarded as a special attribute, contingent upon the possession of a unique constitution and the existence of external conditions that offer them no other course than the one they are pursuing.

It is this attitude that makes for obstinate resistance to change. The patient cannot readily be persuaded to see that he or she projects attitudes and fears without actual basis. In the course of therapy, however, the patients may gain an understanding that what they once assumed to be normal may actually be unusual. Clues to their fundamental difficulties will be pieced together for them by the therapist. The unique relationship that has developed between the patients and the therapist will help them to accept interpretations of their behavior and their symbolic life as revealed in their verbalizations, dreams, and fantasies.

No better way exists of bringing patients to an awareness of their problems than by actually living them through in the therapeutic situation. Sometimes patients will develop and show the same kinds of unreasonable impulses toward the psychotherapist that they have displayed in important previous relationships. The long period of conditioning that makes the individual's patternings a part of the self inspires continuing repetitive and compulsive responses. The patient is usually unaware of reasons for his or her irrational responses, such as development of attitudes of an unusual or destructive nature toward the therapist that cannot be suppressed. The therapist here becomes the target of the patient's neurotic projections. Patients may, for instance, submit themselves, render themselves defenseless, or become martyrs. They may struggle with a need to be victimized so that they can criticize the therapist. They may identify with the therapist, or tear the latter down in fantasy, verbally, or by aggressive acts. They may strive to cash in on submissiveness by toadying to the therapist while at the same time burning inwardly with indignation. They may be paralyzed in relationships and take a thousand precautions

before expressing themselves, so as not to offend. They may compete with the therapist and try to outshine him or her. They may strive to crush whatever atom of individuality persists, if they believe the therapist will be good to them and protect them. They may resent intrusion into their private fantasies and express disguised or open hostility. These and countless other attitudes may unfold as the therapeutic process proceeds.

Such behaviors are important clues to underlying impulses and strivings, which when provisionally interpreted provide a good chance to examine pivotal problems while reexperiencing them. This potentially enables the working through of the dynamics of one's reaction patterns in the relationship with the therapist. Under these circumstances the various defense reactions and resistances, which are directed against inner fears and strivings, become apparent to patients, not as theories but as real experiences, and they are gradually enabled to gain insight into their inner impulses and motivations—the source of some disturbing symptoms.

Identifying significant patterns may greatly surprise the patient and may be countered with resistance, for basic adaptational patterns are being challenged which, though unsatisfying and productive of anxiety, constitute for the patient the only known way of life. Moreover, there are many hidden spurious gains and benefits that patients derive from their neuroses that they will refuse to forfeit. Debilitating as some symptoms may be, many of them serve a protective purpose in the psychic economy. To give them up threatens exposure to inconveniences far greater than anything that the patients already suffer. They will, therefore, in an exasperating way, tend to obstruct their own progress.

The exact form of resistances will depend to a large degree on the kinds of defenses that patients customarily employ to avert danger. They may feel helpless, or hopeless, or hostile or they may get discouraged, inhibited, fatigued, or listless. They may succumb to irritability or to contempt for the therapist, or they may develop feelings of being misunderstood. Some patients may become forgetful and fail to show up for appointments, or they may manifest depression and complain incessantly about their health, presenting a vast assortment of physical symptoms. They may express suspicions

regarding the therapist's intentions or training or political convictions as a possible justification for halting therapy, or they may try to disarm the therapist with strong professions of praise or devotion. They may even evince a forced and artificial "flight into health."

Thus it seems that patients do not entirely want to get well. What they want is a magic recipe from the therapist whereby they may retain their neurosis but be stripped of any suffering. They want to be dependent, yet secure and strong within themselves, or they wish to detach themselves, to keep their freedom, yet at the same time to form successful and gratifying relationships with people. They will resent the attempt to change their way of life significantly, and, in order to hinder the therapist, they will continue to erect impediments to the treatment process.

Counterbalancing resistance, however, are the values that patients inject into the therapeutic relationship and the respect that they have for the therapist's opinions and judgments. A powerful ally is also operative in the spontaneous urge that exists in all persons for health, development, and creative self-fulfillment. Utilizing whatever opportunities that present themselves, the therapist attempts to dissipate resistances by constantly interpreting them to patients in relation to their content, their manifestations, and their function. The exposure of the therapist's defensive operations leads patients to a gradual understanding of their conflicts and character drives and of the vicarious satisfactions derived from them. In this way patients learn to comprehend many perverse gratifications, to countenance unconscious fears, and to master the anxieties that prompt neurotic coping mechanisms.

Realization that a bulk of their responses are not justified by present-day reality, but are residual in past conditionings, is an important step in getting well. Nurtured is a desire to explore more thoroughly the meaning and origin of various drives and attitudes. Most patients have a long past history that goes back to crucial formative experiences in early life in relation to important intimate figures, particularly parents and siblings. Traumatic conditions centered around feeding, toilet training, sexual curiosities, desires for approval

and status, and other important biologic and social needs are often discovered as the sponsoring agencies of current defenses. In properly conducted psychotherapy awareness dawns that attitudes toward the world are built up from early experiences with the world. Such needs as sexuality and assertiveness have become, as a consequence, inhibited or distorted in expression. Impulses such as anger cannot gain an acceptable adaptive outlet. Patients learn that they carry within themselves expectations of the same kind of frustration and injury that they experienced in early years. Some present-day patterns are understandable in the light of anachronistic expectations. The patients may be able to remember or to reconstruct the situations in early childhood that are at the basis of their expectations.

Sometimes patients will repeat, in their relationship with the therapist, their most traumatic early experiences and perhaps revivify archaic attitudes and feelings that were originally engendered in their dealings with parental or sibling figures. Such transference manifestations usually reflect circumstances that patients failed to master as children, which were responsible for deep anxieties and deviations in character formation. Because the relationship with the therapist is unique in its protectiveness, fearsome past happenings, once too great for immature adaptive capacities, may now be reanimated and faced again with not too shattering anxiety.

Each successful effort, though minor, will both punctuate the handicapping influence of neurotic defenses and inspire a wish to meet life on new terms. The crippling anxieties that conditioned former reaction patterns are in this way progressively mastered. When at last patients are able to liberate themselves from ghosts of the past, the world becomes a bastion of hope: feelings of security expand; interpersonal relationships become freer, unhampered by dependency, aggression, or detachment. Basic needs and demands are emancipated from anxieties that impede their materialization.

Roughly, reconstructive therapy may be divided into two phases. The first aspect involves an *uncovering process,* during which patients become aware of impulses, fears, attitudes, and memories that have interfered with wholesome relationships with the

world and people. The second aspect is *reeducative* and consists of an elaboration of new and adaptive interpersonal patterns. Social reintegration does not occur automatically. It is a slow reconditioning process, necessitating the establishing of fresh habit and reaction patterns to displace outmoded destructive ones.

The uncovering period of treatment proceeds as rapidly as the individual is capable of tolerating anxiety. This makes possible the gradual yielding of repressions. During therapy ego strength increases as the positive relationship with the therapist consolidates. But the patient constantly strives to ward off a close relationship out of fear of arousal of strivings hitherto kept in suspension and out of awareness. The patient displays resistances to the therapist as a defense against what he or she believes will lead to liberation of intolerable anarchial impulses. These impediments must be dealt with firmly and constantly before the patient begins to appreciate that he or she can handle conflicting feelings and attitudes.

The reeducative phase of therapy is usually even more prolonged than the uncovering phase. Established patterns of behavior are changed with great reluctance— the revelation of the unconscious conflicts that initiated them is only the first step in this change. Patients fight desperately to hang on to habitual values. They continue to show resistance even when they have become aware of the extent to which they are at the mercy of disabling inner fears and strivings. They continue to reject insight as an alien force, although it finally comes into its own as they gain glimmers of understanding of their repudiated drives. Intellectual insight alone, however, does not divert them from their customary reactions. It does permit them to gain a foothold on new interpersonal pathways. This support is, however, tenuous, and they retreat constantly before the onslaught of their neurotic demands, which, though known to them, continue to persist with dauntless vigor.

Slowly, against great resistance, alterations occur in patients' behavior. It becomes less and less motivated by irrational needs and increasingly relegated to fulfillment in mere fantasy. Yet, though blatant neurotic patterns vanish, shadows of them persist and

come to life sporadically. It is as if the balance of power keeps shifting from old established ways to the as yet rudimentary new.

A further development in the maturative process is inherent in the recognition of the incongruity of customary defenses and drives. Patients slowly come to regard them as irrational elements that they would like to eliminate from their lives. A battle then ensues between their desire for change and the urgent forces that compel them to resume their old neurotic actions. After a period of strife, more or less prolonged, a remarkable change occurs in the inner dynamics of the personality. Habitual impulses, which have functioned compulsively or which have been accepted as an inevitable part of life, are alienated from the ego. Even though these continue to emerge, the individual responds to them with more and more reluctance, refusing them their original hold. Coordinately there is a reorganization of interpersonal relationships and a more realistic reintegration between the self and its past experiences. Signs of abandonment of compulsive patterns are registered in a sense of inner peace, happiness, security, and absence of neurotic suffering. These positive gains serve as resistance barriers to old neurotic attitudes when the latter try to force individuals into their previous modes.

With expanding emancipation from their past, patients become more self-confident, assertive, and expressive. They accept as their right the making of salutary choices and decisions and the establishment of new values. As the ego of patients expands, the superego loses its force and tyranny. Patients appreciate joy in living and the experiencing of fruitful productivity. Finally, they no longer require help from the therapist, and the world itself becomes an arena for gratification of fundamental needs, which, prior to therapy, they felt to be utterly beyond their reach.

MECHANICS OF THERAPEUTIC CHANGE

Therapeutic change is brought about in the medium of the patient-therapist relationship. Through verbalization patients become aware of the forces within themselves that produce their symptoms and interfere with a successful adaptation. On the basis of this understanding they then proceed to 7. challenge those designs that

interfere with their adjustment and to substitute for them mature patterns that will gratify basic biologic and social needs. As they abandon archaic fears and liberate themselves from paralyzing past forces, they achieve a progressive mastery of their environment, the ability to relate better with people, and the capacity to express their impulses in a culturally accepted manner. The function of the therapist during this evolution is as an agent who catalyzes change, helping patients to resolve resistances to maturity.

Breaking a successful treatment process down into component parts, the following sequences are usually encountered:

1. The patients, concerned with their symptoms and complaints, elaborate on these.

2. The patients discuss upsetting feelings that are usually associated with their symptoms.

3. Patients believe that their feelings are related to certain dissatisfactions with their environment and that they are inescapably controlled by a mysterious turmoil that ranges within them.

4. Along with their feelings, they recognize patterns of behavior that frustrate them, are repetitive, and compulsive. Soon they appreciate that some of these patterns are responsible for their tension. This causes them to doubt their value.

5. As they become aware of how dissatisfied they are with their behavior, they begin to try to stop it; yet they find that it persists in spite of themselves.

6. Patients slowly perceive, then, that their behavior serves a function of some sort and that they cannot give it up easily. Indeed, they find that their patterns repeat themselves in various settings, perhaps even with the therapist.

7. If they have the incentive to explore their operations, they discover that some have a long history, going as far back as their early relationships with their parents, siblings, and other significant personages.

8. Gradually they discern that they are influenced by occasional impulses and feelings akin to those present in them as children. They fathom that by carrying over certain attitudes into their present life they are reacting to

people as facsimiles of past authorities.

9. With great trepidation patients begin to challenge their early attitudes; progressively they inhibit automatic and repetitive behavior patterns, slowly mastering their anxieties as they realize that fantasied dangers and expectations of injury do not come to pass. In the therapeutic relationship, particularly, they show change, especially in their attitudes toward the therapist.

10. Patients begin to entertain hopes that they are not the weak and contemptible people who have constituted their inner self-image, that they actually have stature and integrity, that they need not be frustrated in the expression of important needs, and that they can relate themselves productively to people.

11. This causes them to resent all the more the devices that they customarily employ, which are products of devaluated feelings toward themselves and their devastating fears of their environment.

12. Slowly patients experiment with new forms of behavior that are motivated by a different conception of themselves as people.

13. Finding fulfillment in these improvisations, patients become more and more capable of liberating themselves from old goals and styles of action.

14. Growing strength within themselves contributes to a sense of mastery and produces healthy changes in their feelings of security, self-esteem, and their attitudes toward others.

15. Patients liberate themselves more and more from anxieties related to past experiences and misconceptions. They approach life as a biologic being, capable of gaining satisfactions for their inner impulses and demands, and as a social being, participating in community living and contributing to the group welfare.

19
The Conduct of the Psychotherapeutic Interview

Mandatory for psychotherapy is a thorough understanding of the process of interviewing. This is because communication is the channel that vitalizes the therapist-patient relationship. Its structured manipulation through interviewing is a studied attempt to influence the mental processes of the patient toward therapeutic gain.

The very act of verbalizing has certain releasing values for the person. It provides a kind of emotional catharsis in which the individual discharges quantities of pent-up tensions and feelings. The benefits of "talking things over" with a sympathetic person and of "getting off one's chest" burdensome thoughts and painful feelings are well known. Irrespective of any advice received, the mere ventilation of attitudes and emotions helps the individual to evaluate the situation better and to approach problems in a more constructive manner.

These beneficial effects, unfortunately, are short-lived. While the person may quiet down for a while and perhaps approach life with renewed vigor, any vexations provocative of tensions usually continue in force. When sufficient tension accumulates, one will find oneself in precisely the same position as before, requiring further cathartic release to appease unrest.

Instead of permitting a discursive rambling productive of emotional catharsis, the organized interview promotes a selective scrutiny of verbalizations. Focusing the patient's attention on certain aspects of personal experience and the deft choice of the therapist's comments facilitate an understanding of underlying feelings.

Each interview in therapy that emphasizes cognitive awareness of and insight into one's problems necessitates a number of activities on the part of the therapist. These are summarized in Table 19-1. An elaboration of these and other items will constitute the subject matter of this chapter. In supportive and reeducative therapy where there are

more directive activities than in reconstructive therapy, interviewing to determine the status of the patient's thinking and feeling, and particularly resistance, are still of great importance.

THE RATIONALE OF INTERVIEWING

Ontogenetically, feelings antedate symbolic or verbal operations. Present at birth, they condition many of the automatic reactions of the child. With the development of the symbolic functions of the ego, feeling experiences become affiliated with verbal responses. The child then becomes better capable of identifying feelings. Coordinately, there develops an ability to exercise some voluntary control over emotions, as if the very linkage of thoughts with feelings encourages the capacity for such inhibition.

In neurosis a confusion in coding interferes with this acquired ability. The significance of many emotionally determined symptoms and behavioral patterns is baffling to most patients, the meanings having been subjected to repression. As a result, the patients are bewildered by their symptoms and compulsive behavior. They find it difficult or impossible to find words that lend meaning to their feelings or actions.

One of the aims of psychotherapy is to restore to patients control over their emotions. Before this can be done, they must be able to make the proper symbolic connections with their emotions. Therapeutic interviewing helps to accomplish this, and enables patients to scrutinize, identify, and elaborate on their feelings and the sources of those feelings. Patients then no longer feel helpless; they become capable of gaining some mastery over their emotions, which have hitherto operated autonomously.

This process was described by one patient in a note to the writer following a session during which she tried to verbalize her feelings of tension:

> As I talked, I just didn't know what was happening to me. I felt, at first, as if I was groping in mist, and then I started feeling better. I felt that I was not helpless, that there might be something behind the tension. When I left, I realized what some of my difficulties were, and that realization brings releases from a great many tensions. I noticed I had greater physical energy (still far from its peak), improved memory for small details of organization of work and of every-day living, and

Saturday night I approached the vitality which I had three years ago. I must go further into my sympathies for the underdog and into my feelings that I am a second class citizen because I am a woman.

THE LANGUAGE OF THE INTERVIEW

Verbal Communications

A common language is essential for the conduct of the interview. Problems arise where the therapist and the patient do not understand or speak the same language.

Problems may also develop where there is a marked disparity in education, cultural background, and socioeconomic level or where the patient comes from an area of the country in which a local dialect contains unusual colloquialisms. Here the flexibility of the therapist will be put to test, for it is the therapist who will have to make the adjustment, not the patient. This will necessitate an inquiry, from time to time, into the meanings of the words and concepts used by the patient, with adoption of these in the vocabulary of the therapist.

The use of vocabulary similar to that employed by the patient helps interviewing. Many patients lack the sophistication necessary for the understanding of complex psychologic ideas. It is essential to recast these into simple words and phrases that are readily comprehensible to patients. Even well-educated persons may not grasp the meaning of certain interpretations and comments of the therapist, although these apparently have been clearly stated. A definition of terms may be essential. Additionally, after the therapist has offered clarifications and interpretations, it may be necessary to check the patients' understanding by asking them to formulate what has been said, in their own words. In the event there is a lack of understanding, a reformulation may be made by the therapist, and another check then executed of the patient's comprehension.

The therapist should judiciously watch the personal need to impress the patient with complex words and high-sounding phrases. The use of language that is as unadorned and straightforward as possible will guarantee best results in interviewing.

Nonverbal Communications

Nonverbal communications during interviewing reveal aspects of the self that evade verbal expression. The patient is as much aware of the therapist's moods through the latter's nonverbal behavior as the therapist is of the patient's emotions. Thus, the patient often picks up attitudes of disinterest and annoyance expressed by the therapist through facial expressions, mannerisms, and behavior that belie verbal pronouncements of interest and concern.

Since individuals project themselves into every situation with their total personality, one may gain important clues to some of their underlying turmoil and their less conscious attitudes by observing their behavior in the therapeutic setting. Their gait, posture, facial expression, gestures, and mannerisms all reveal patterns, defenses, and facades that are either part of their habitual character structure or specifically reflect the role that they are playing with the therapist. One must make these observations casually so as not to give patients the impression that they are being watched like a specimen under a microscope.

It is usually easy to discern tension and anxiety in the patient by noting muscular spasms, which communicate themselves in gait peculiarities, fidgetiness while sitting in the chair, wringing of the hands, picking of the skin and lips, flushing, and lapses of attention conveyed by facial blankness. Anger is apparent in a stiffening of posture, clenching of the fists, tapping of the toes and grimness in facial expression. Enthusiasm and excitement are similarly evidenced by appropriate behavioral attitudes.

A check of one's own nonverbal manifestations may be necessary periodically to ascertain that one is not conveying disapproval, boredom, and irritation to the patient. Ideally, the therapist's facial expression should be pleasant, relaxed, and noncritical. Inappropriate scowling, frowning, and angry expressions are destructive to good therapy, as are continued acts of yawning, skin picking, wriggling in one's chair, and tapping of the extremities.

Head nodding is advantageously employed as a sign that the therapist is paying rapt

attention and is following the associations of the patient. This is often accompanied by such vocalizations as "uh huh," "mm hmm," "yes," and "I see." Head shaking is used only occasionally as a sign of sympathetic understanding when the patient discusses personal suffering, or when the therapist wishes to communicate disapproval over what is going on. In the latter case it may be accompanied by a slight frown and the expostulations "mm mm"! or "hmm"! sharply expressed. A smiling facial expression is often employed to indicate acceptance and approval.

Subvocal utterances are also tremendously important during interviewing. How the patient says things may be as important as what he or she says. Inflections, intonations, accents, emphases, pauses, gaps in statements, slurring of speech, and varied sound expostulations may reveal to the therapist emotionally charged areas that the patient cannot put into words. By the same token, subvocal expressions and intonations influence the patient significantly. Frank (1961) cites a number of studies that illustrate this fact dramatically. For instance, during nondirective therapy it was possible to show that approbatory sounds and gestures at selected statements increased these categories from 1 percent in the second hour to 45 percent in the eighth hour. On the other hand, disapprobatory expressions reduced other categories from the 45 percent present in the second hour to 5 percent during the eighth hour. The therapist must, therefore, judiciously observe the *manner* in which remarks are presented to the patient to avoid an untoward effect. Voice training for therapists, where there are problems in articulation, may be invaluable.

Silence may also be an important nonverbal tactic, applied when the patient is pondering or groping for solutions (Strean, 1969). It may also be employed as a way of stimulating tension to activate thinking and problem solving in the patient. It can, however, be overdone, and particularly in short-term therapy it should be used with discretion.

OPENING THE INTERVIEW

The First Interview

During the first interview it is highly desirable that the patient be put at ease and that the purpose of the interview be made clear. Consequently, the therapist is more active than at later interviews when the patient will have been subjected to more responsibility.

As the patient enters the therapist's office, the latter may greet the patient with a smile, gesture to the chair, invite the patient to be seated, and briefly introduce the general objectives of the interview. For instance, a man referred by his family physician for treatment walks through the door:

> *Therapist,* (smiling) My name is Dr._. Won't you sit down in that chair over there so that we can talk things over.
>
> *Patient.* (*smiles, walks to chair, and seats himself)* Thank you, doctor. As you know, Dr. T. sent me here. He thought I needed psychiatric help. I've been going to him with a stomach condition for several years.
>
> *Th.* Yes, he told me a little about your condition. I thought it might be helpful to talk things over in order to see whether you do need psychiatric help, and, if so, the kind of help that would be best for you. Would you like to tell me about your condition?
>
> *Pt.* Yes, I have had this stomach trouble for some time. (*Patient continues to elaborate on his complaint factor.)*

The conduct of the first interview will be described in great detail in a later chapter, in which variations of approach will be considered, conditioned by special problems.

Subsequent Interviews

Later interviews are managed by briefly but pleasantly greeting the patient and waiting for an opening remark. The reason for this is that one must avoid diverting from material that is disturbing or otherwise significant to the patient. In the event the therapist starts talking at the beginning, the patient may avoid discussing things that concern him or her most urgently. The patient may then either try to please the therapist by pursuing topics he or she imagines that the therapist wants to explore or the patient may welcome and take advantage of the opportunity to evade anxiety-provoking material. The therapist should avoid conventional pleasantries when greeting the patient and should refrain from the temptation to make "small talk."

Sometimes it is impossible for the therapist to avoid bringing up a reality problem at the beginning of the session. This naturally tends to divert the patient. In such a situation the therapist may attempt to retrieve the situation by saying, "Now, would you like to talk about yourself?" and then remain silent until a trend is defined.

Where the patient starts a session by sitting quietly without comment, he or she may merely be gathering fleeting thoughts. If silence continues, this may indicate resistance. In the former case the patient will soon start verbalizing; in the latter silence may be maintained. If, after a moment or so, the pause remains unbroken, the therapist may say pleasantly, "Well, what's on your mind?" An example of this illustrated in the following excerpt of an interview.

Because of an unavoidably prolonged telephone call, the therapist had to keep the patient waiting for several minutes. When the patient entered the room, he showed no sign of annoyance or anger. He sat in the chair, slowly removed a cigarette from a pack, lit it, and kept staring at the window. After a short interval he was interrupted.

> *Th.* I wonder what's on your mind?
>
> *Pt. (pause)* Oh, nothing. I just don't seem to have anything to say.
>
> *Th.* Any reason for that?
>
> *Pt.* I do ...I don't know. I guess I was a little upset and irritated at having to wait.
>
> *Th.* I'd be mad myself if I were kept waiting without reason. *[This comment is an attempt to support the patient, alleviate his guilt, and show him that he is not dealing with an arbitrary authority.]*
>
> *Pt.* I suppose I'm too sensitive.
>
> *Th.* After all, this time *is* yours. Whenever I do encroach on your time because of emergencies like this phone call, I try to make the time up by extending the session, or at a later one.
>
> *Pt.* Thank you. (*smiling)* What I really wanted to talk about today was my reactions to being criticized. (*Patient continues exploring this trend.)*

In the event silence continues after the therapist's initial attempt to break it, the therapist may employ the techniques dealing with silence described in the following

section of this chapter.

MAINTAINING THE FLOW OF VERBALIZATIONS

The encouragement of verbalizations is a prime task during interviewing. This is done by listening attentively to the patient, signaling that the therapist is following what is being said by nodding of the head, by controlled facial expressions, by such utterances, as "yes," "I see," and "mm hmm," and by carefully selected questions that indicate interest and understanding. As long as a patient continues on an important trend, fulfilling the specific goal toward which therapy is directed at the time, one does not interrupt. However, when there are too prolonged pauses, where the patient shifts concentration from the pertinent focus, or where one wishes to reflect feeling or to make interpretations, the therapist makes added verbal comments. There are some patients who need little encouragement apart from a few nonverbal interpolations. There are other patients with whom the therapist will have to manifest much more activity, perhaps even after every sentence.

Managing Pauses

Pauses in the verbal stream are to be expected and, in themselves, do not merit interruption. They are advantageously used by the patient to think through some ideas. When pauses continue for more than a moment or so, however, the therapist may do one of the following:

1. Repeat the last word or the last few words that the patient has used, with the same intonation as that of the patient, with a rising inflection, or with rephrasing as a question. The following part of an interview illustrates these:

> *Pt.* I would say that there is a certain amount of tranquility now, but a lack of direction. A lack in the sense of what I expect. *(pause)*

> *Th.* Expect? *[repetition of the last word] Pt.* Yes, what I expect out of life. I did use to enjoy some of the activities I indulged in— drawing, painting, music—but I think those activities were enjoyed for their effect on other people.

Th. I see. *(nodding) [encouraging the patient to continued]*

Pt. I'm not interested in impressing people any more. Before this, if we went out, we saw people, and I was very particular about the way I dressed and shaved. Every little thing had to be just right. But now I don't care.

Th. Mm hmm. *(nodding) [encouraging his expression]*

Pt. I can come home late and rush and shave quickly. I don't particularly care how I look as much as before. Things are looking up. What I did before, something seemed to be lacking. *(pause)*

Th. Something seemed to be lacking, *[repetition of the last few words]*

Pt. I feel somehow that there was lack of pleasure. I'm not clear about it, but it has to do with sexuality, *(pause)*

2. Rephrase what the patient has said, either as a plain statement of fact or as a question. Continuing with the above interview:

Th. What do you mean that this lack has something to do with sexuality?

Pt. I feel that if such a thing is psychologically possible, that I was getting substitute satisfaction for sexuality. Careful how I looked, if there were attractive women around. By showing people how smart I was, or how cultured I was, or how rounded I was would show me as a great person, as though to cover up various lacks that I had, one of which was sexuality, my sexual performance, sexual craving, and that sort of thing. Now that I can find sexual pleasures, it's different, *(pause)*

Th. Now that you can find sexual pleasures all the substitute pleasure outlets have lost their driving force, *(pause) [rephrasing what the patient has said]*

Pt. That's exactly it. I would put all my energies into these things, and now that I can find sexual pleasure, I don't have to keep going in those other directions to find pleasure. But I miss it. *(pause)*

3. Ask a question related to the material under discussion to stimulate associations. Continuing the above interview:

Th. You miss something that still has value for you. I wonder if there were any other benefits you got out of some of the things you did? *[asking a question related to material under discussion]*

Pt. I miss the feeling that I'm not doing something constructive, something that adds to my stature.

Th. Mm hmm.

Pt. I would like to develop myself in as many directions as I can, feasibly. I don't know if it's completely neurotic. If it's partially neurotic, life to be lived and enjoyed for the moment it

affords is not enough for me. As though I have to be building toward something, building something up, building myself up, growing, increasing in stature and accomplishment.

Managing Silence

The significance of silence, when it occurs, must be appraised. Is it a defense? Is it an attack? Is it a pause in which creative cogitation is being executed? A common response to interpretation is silence, which may indicate that the interpretation is correct and startles the patient while he or she attempts to integrate it, or is incorrect, the patient responding with varied resistances or attempting to test its validity. Silence may reflect a fear of revealing oneself or of releasing anxiety as one approaches repressed conflictual foci. It may be a self defeating masochistic maneuver or a hostile act against the therapist.

If silence is perceived as a hindrance to the interview, it is dealt with in the same way as any other resistance. If it appears to be a transient phenomenon, it may be purposefully ignored. It is then handled by confrontation, by countersilence or other tactics. Fortunately, long periods of silence are rare in good therapy. Should it continue, the therapist may try the following in order.

1. Say "mm hmm" or "I see" and then wait for a moment.

2. Repeat and emphasize the last word or the last few words that the patient said.

3. Repeat and emphasize the entire last sentence or recast it as a question.

4. If this is unsuccessful, summarize or rephrase the last thoughts of the patient.

5. Say, "and" or "but" with a questioning emphasis as if something else is to follow.

6. If the patient still remains silent, the therapist may say, "You find it difficult to talk" or "It's hard to talk." This focuses the patient's attention on his or her block.

7. In the event of no reply, the following remark may be made: "I wonder why you are silent?"

8. This may be succeeded by, "There are reasons why you are silent."

9. Thereafter the therapist may remark, "Perhaps you do not know what to say?"

10. Then, "Maybe you're trying to figure out what to say next?"

11. This may be followed by, "Perhaps you are upset?"

12. If still no response is forthcoming, a direct attack on the resistance may be made with, "Perhaps you are afraid to say what is on your mind?"

13. The next comment might be, "Perhaps you are afraid of my reaction, if you say what is on your mind?"

14. Finally, if silence continues, the therapist may remark, "I wonder if you are thinking about me?"

15. In the extremely rare instances where the patient continues to remain mute, the therapist should respect the patient's silence and sit it out with him. Under no circumstances should one evidence anger with the patient by scolding or rejecting him.

A patient who had been manifesting greater and greater difficulty in talking finally became completely silent. The therapist tried to break the silence by employing some of the tactics just noted:

> *Th.* I see ... (*silence*) ... when he went away? *[repeating last few words]* (*silence*) ... You were talking about how little you miss your husband when he is away. [*repeating last sentence*] (*Patient remains silent*). Perhaps you don't know what to say? (*silence*) Maybe you're trying to figure out what to say next. (*silence*) Perhaps you're upset. (*silence*) You find it difficult to talk. (*Patient is still silent.*) I wonder why you are silent? (*more silence*) There are reasons why you are silent. (*Silence continues.*) Perhaps you are afraid to say what is on your mind? *(no interruption of silence)* I wonder if you are thinking about me?

> *Pt.* I know this is ... sounds silly. But you *are* on my mind. I mean I keep thinking about you, sex, and all. Isn't that terrible?

> *Th.* You feel ashamed of some of the things you think about me?

> *Pt. (obviously agitated)* Yes, it is so frustrating and it makes me mad. I imagine how you would be as a husband or a lover. I know one is supposed to react to their doctor, but this is so difficult. I've never really felt this way about any man.

DIRECTING THE FLOW OF VERBALIZATIONS

In formal psychoanalysis the verbal stream is undirected. The patient is enjoined to say whatever comes to mind without concentrating on any specific topic. Complete spontaneity is the keynote, and the absolute license in verbalization enables the patient to evade repressive barriers and to liberate derivatives of the unconscious, not ordinarily available to awareness. This process of *free association* is helpful toward mobilization of the transference neurosis, which becomes the fount of insight into the most significant unconscious conflicts.

Free association is not employed in supportive and reeducative therapies. This is because one is not too much concerned with the content of the unconscious in these treatment methods. Free association may be used in non-Freudian analysis but rarely in analytically oriented psychotherapy because of the infrequent weekly visits and because the setting up of a transference neurosis is not ordinarily an objective in treatment. When free association is employed in the latter therapies, it often is used by the patient as resistance, for instance, as a means of diverting attention, of concealing the content of disturbing everyday problems, of seducing the therapist with words, of flaying oneself masochistically with recriminations, or of parading personal virtues in a narcissistic recital. If left to his or her own devices, the patient will frequently ramble along in verbalizations, veering away from anxiety-provoking material when crucial subjects are touched on. To allow the patient to follow such a circuitous thought channel may result in endless circumstantiality, which serves as a defense against important verbalizations.

Instead of free association, the kinds of communication generally used in psychotherapy center around the focused interview.

THE PRINCIPLE OF SELECTIVE FOCUSING

In general, the process of selective focusing consists of initially identifying an important theme in the patient's verbalizations, of guiding this theme into a goal-directed channel, and of circumscribing the area of subject coverage.

Identifying an Important Theme

If one has followed the suggestions outlined in opening the interview—namely, not interfering with the thought content of the patient—the therapist will become aware of certain immediate preoccupations. Irrespective of how unimportant the therapist considers these to be, it is urgent to heed them carefully. They may be far removed from the material that the therapist wants to discuss, but to neglect or circumvent them, or to substitute other topics, constitutes a fatal error in interviewing.

Studies of the learning process show that the most effective learning occurs when the individual is concerned with things of strong emotional significance. Discussing material of no immediate interest to the patient interferes with learning; dealing with important moods and attitudes facilitates learning. This is why the therapist must be sensitized to current emotions and trends and not throw the patient off by introducing irrelevant topics or asking unrelated questions.

Sometimes it is difficult to select a dominant theme from the content of what the patient says. One may have to reach for feelings that lie behind verbalizations. Sometimes a great number of trends coexist, and the therapist may have trouble selecting one as more significant than the others. Focusing on certain themes by asking pointed questions may be helpful here.

For instance, a male patient talks about how hard things are for him because of the high cost of living. He is unable to afford luxuries any more. He needs new clothes; his wife wants a Florida vacation; his children are insistent on a new television set. Demands are being made on him to contribute a sum to a necessary charitable cause with which he is identified. He senses pressure from all sides, and this makes him feel disheartened and depressed. As he talks, the patient elaborates on each of the above items, justifying the reasonableness of the demands made on him.

It may be hard at first to discern what it is that preoccupies the patient most. Is it that he is complaining about the unjust demands made by his family or by the world? Is he expressing a hidden wish to receive rather than to give? Does he consider his inability to supply luxuries a sign of his failure to live up to responsibilities or to an idealized image of

himself? Is he criticizing the therapist subtly for depleting his funds? Is he projecting dissatisfactions from some other source onto immediate tangible foci?

Indicated in these questions are a number of themes that we might pursue, some of which would be productive and others not. One might easily go off on a tangent by focusing on the virtues of new clothes, vacations, or television sets or by talking about the high cost of living. Expressing anger toward his family would be presumptive on the part of the therapist and perhaps too reassuring. Interpreting a hidden wish to receive on the basis of the material presented would be making a judgment without adequate evidence. At least some pre-conscious awareness by the patient of this wish would be necessary. There is, similarly, insufficient evidence to warrant the interpretation that the patient is subtly criticizing the therapist for exploiting him. Focusing on his feeling that he is a failure in not being able to supply luxuries or make charitable contributions, however, may be one way of starting a more intensive inquiry into his feelings. The comment, "Do you think that there is something wrong with you for not being able to do these things?" may then be expedient.

On the other hand, the therapist may not desire yet to explore the area of the patient's self-depreciation and may want to obtain more associations from the patient before focusing. Accordingly, the therapist might remark, "You seem to be dissatisfied with things as they are." The latter statement may center the patient's attentions around his most provocative problems. This was the remark actually utilized during the session with the patient. A recorded fragment of the interview follows:

> *Th.* You seem to be dissatisfied with things as they are.
>
> *Pt.* Yes, I am. *(pause)* I sometimes wonder if I would do what I did if I lived my life through again. You see I really didn't want to quit school so early. But I had to get married. Sometimes I think it's a mistake to marry so young. You really don't have any idea about things.
>
> *Th.* Do you feel *you* made a mistake in getting married so early?
>
> *Pt.* Well, I do, in ways I really do. I could have waited, but she, my wife, insisted that we go ahead. And you know, doctor, when you have a family to support, well you pass up opportunities you could snap up.

Th. For instance? *[The patient then elaborates on his frustrated ambition and verbalizes resentment at his wife for exploiting him. This provides a basis for examining his dependency needs and his inability to stand up for his own rights.]*

It is seen in this interview that the actual content of what the patient brings into the session may be merely a reflection of deeper feelings. These may be elicited through careful interviewing.

While the comment made to the patient elicited satisfactory associations, it might not have done so at some other time. Thus, the patient might have responded with an outburst, elaborating on what he already had said in a frantic attempt to justify his feeling. He might have reacted also by commiserating with himself more intensely.

Other statements by the therapist may have been made rather than the one utilized. For example, "A lot of demands are being made on you these days. How do you feel about this?" or "Things do seem to be different. In what ways are they different?" Actually there is no right or wrong about the comments made, and the therapist must be guided by his or her own feelings as to which are the most important aspects to accent. The more experience one has had in interviewing, and the more skill one develops in doing therapy, the more satisfactory will be the selection.

The choosing of themes is complicated by the fact that the individual's verbalizations deal simultaneously with a number of different psychic levels. Most importantly the patient is concerned with three aspects:

1. Current environmental distortions

2. Manifestations of characterologic strivings and facades

3. Derivatives of unconscious impulses and strivings

Existing environmental difficulties constitute a bulk of the individual's preoccupations. This is natural since the person is influenced by the environment in both positive and negative ways. During therapy the patient may discuss factors in his or her environment that facilitate gratification of needs, that produce satisfactory repression of

destructive impulses, and that permit of a reasonably good relationship with others. More likely the patient will be prompted to talk about inadequacies in the environment that provoke inharmonious strivings, inspire conflict, create disturbances in interpersonal relations, and vitiate the satisfaction of basic needs.

The patient's characterologic manifestations will always reveal themselves in accounts of current happenings. Involved in the patient's daily life are the specific ways that he or she relates to people, the distortions that contaminate habitual adjustments. These display themselves in attitudes and behavior tendencies toward authority figures and subordinates as well as personally. Such patterns as dependency, aggression, detachment, perfectionism, masochism, sadism, and compulsive ambition may be interwoven into the fabric of personal adjustment. The patient may be unaware of some of these destructive character traits or of their compulsive nature, assume that they are quite normal, or accept them as an unusual though constitutional part of the self. The patient may verbalize circumstances that have thrown one's character strivings out of adaptive balance.

The third and most repressed level involves the deepest conflicts that have survived the passage of time. These were initiated in the formative experiences of early childhood, and consist chiefly of unresolved fears, guilt feelings, and manifestations of shattered security and undermined self-esteem. Such conflicts reflect stages of development, from early infancy to puberty, in which important traumata occurred. They exhibit themselves in such symbolic ways as incorporative tendencies: fears of starvation, oral injury, anal damage, contamination, hostility, murderous impulses, fears of castration; incestuous desires, and penis envy. Many repressive defenses shield unresolved infantile impulses and additionally contribute to the crippling of personality maturity. Because of repression, only distorted and highly symbolized derivatives of unconscious conflicts are available to awareness. These are sufficiently disguised to evade repressive barriers.

The following account of a session illustrates the simultaneous operation of the three main psychic levels described above.

A patient started the session by reciting an incident that had happened two days previously during which he had experienced a brief attack of anxiety. While listening to a friend talk about golf, the patient began to feel uncomfortable and tense. He was filled with a sense of helplessness and with an expectation of impending but indefinable disaster. The attack passed, but he was left shaken. He could not understand why he had had such an attack, since there was nothing to account for it. As the patient continued talking, he revealed having been perturbed at receiving a letter from his employer in Boston inviting him to a house party at the employer's home to be given in a fortnight. His employer, a tycoon whom he admired, seemed to have an overwhelming amount of confidence in him, constantly commending him as the best man in the firm. He even had hinted at making the patient a director of his organization. Flattered, the patient developed misgivings at having duped his employer into thinking he was better than he was. While conceding that he had done a good job, he was aware of how frightened he was inside, how inferior and weak he felt most of the time—characteristics that contradicted the strength and masculinity his employer had assigned to him. The patient sought to avoid too intimate contact with his employer, lest the latter discover his weaknesses. On a business basis he was able to assume a sufficiently detached attitude to maintain what he considered to be a facade. His self-confident pose, however, was severely challenged whenever he socialized with his employer. Particularly upsetting were contacts with the employer's friends. He felt vastly inferior in their company, especially when they paraded before him their wealth and other material signs of success. The last social visit that he had paid to his employer had been like a nightmare. During the party, attended by important men in the business field, he had felt dizzy and upset. By sheer will power he had forced himself to stay. The next morning he had concocted a false emergency at home, and with vociferous regrets, had cut his visit short. He resolved never to return if he could possible help it.

When the patient was asked, in the session, to talk about his employer, it was apparent that he both admired and envied the latter's great success and forcefulness but resented his employer's curt, abrupt manner. He never had dared challenge the authority of his employer, since this would not have been discreet. Moreover, he had no desire to vent his resentment, since, in his opinion, his employer was a great man who had climbed to the top of his profession with little or no help. In his employer's presence he experienced a feeling like that of a small boy who was on his "good" behavior. That his employer reminded him of his father had become more and more apparent to him since he had started therapy. His feelings toward his father paralleled those toward his employer in an astonishing way. He had loved, admired, and respected his father; he had feared and resented him too.

Questioned regarding his last bout of anxiety, the patient related having received a surprising invitation from his employer to spend several weeks in the country. As an inducement, the employer promised to take the patient golfing daily. No novice at golf, the patient played a game far inferior to that of his employer. He realized now that he had tried to put out of his mind the invitation of his employer in the ardent hope that something would eventually come up to prevent him from making the trip. He could see that the mention of golf, at the time immediately preceding his anxiety attack, had reminded him then of the visit from which there seemed no escape.

The patient then recalled a dream that he had had the evening of his attack.

He was in a large barnlike structure that resembled the house of his grandfather. A large man walked into the room balancing an egg on a bloody stick. Then he saw himself drowning in a body of water. He awoke with a feeling of strangulation. Associating to the dream, the patient recalled the talks that his father had with him during childhood on the subject of sex. His parent had warned of the dangers of masturbation and of sex play before marriage. He recollected how he had, in spite of these warnings, experimented with masturbation and with sex play, constantly anticipating an indefinable punishment. Even as an adult, sex had seemed wrong.

Reviewing the content of this material one may detect (1) an assortment of provocative environmental circumstances (invitation to the home of the employer and the golf incident), (2) characterologic distortions (attitudes toward authority in general and toward his employer in particular), and (3) deep inner conflicts historically rooted in the past (fear of punishment for sexual desires).

The selection of the material to be discussed will depend on what we are trying to achieve in the interview. Because flexibility is the keynote, the focus of concern may have to shift from one level to another—as from problems residual in unconscious conflict to those of an immediate situational nature. We may have to deal with certain levels to the exclusion of others. Thus, in some patients, or in doing supportive therapy, it may be necessary to avoid stirring up inner conflict by keeping the interview on everyday situational problems. In other patients we may purposefully avoid reality discussions, maintaining silences and encouraging the exploration of deeper emotional problems. The kind of content selected must at all times be that which would be most helpful to our immediate therapeutic objective.

In working with unconscious content the therapist must function as a decoder who unravels the symbolic messages from the unconscious. To act in this capacity special training in the language of the unconscious will be necessary. Interpretation of this language varies in the different schools, as does the emphasis on what is considered the basic core of the neurosis. Thus, a therapist trained in Freudian theory will focus on manifestations of the Oedipus complex; in Kleinian theory, on infantile aggression, envy, and projective identification; in Sullivanian theory, on the devalued self-image and paradoxic distortions; in Adlerian theory, on inferiority compensations as they affect the life style; in Rankian theory, on separation anxiety; and in Jungian theory, on residues of

archetypes as they invade and distort the present existence. The patient will soon learn to communicate in the therapist's dialect and to utilize the latter's concepts and formulations in dealing with fundamental aspects of one's experience; however, the therapist will have to spend time educating the patient to think in these terms.

"Reading between the Lines"

There are many times that patients will say with conviction things that they do not entirely believe. Early defenses to avoid hurt and censure continue to operate in adult life toward masking true meanings. This unconscious duplicity is reinforced in the here-and-now by many aspects of contemporary society that endorse deceit in social communication. We become so concerned with the consequences of our behavior (e.g., the effect of what we say on persons whose esteem we seek to sustain) that we exploit counterfeit tactics to please rather than to voice our genuine convictions. While such unauthenticity sometimes has certain immediate practical advantages, we pay a penalty for this indulgence in the currency of fear, hopelessness, guilt feelings, and a diffuse sense of outrage. The shaping of our behavior according to such a spurious design often causes us to live a good deal of the time outside of ourselves.

Taking at face value everything the patient says adds to the patient's hopelessness. Secretly the patients may wish that therapists will see through their verbal camouflage and will then help them endure the consequences. It is toward this effort that "reading between the lines" becomes so vital a tactic in interviewing. I remember one patient, a refined, driving, intellectual individual who spent a good portion of the second interview with me talking about the wonderful woman whom he had married. She was kind, charitable, meticulous, interesting, artistic, in addition to having numerous other virtues including sound judgment and keen perception. I smilingly nodded and said, "Then she must be kind of tough to live with." The patient was startled for a moment, then broke out into gales of laughter. As he wiped the tears from his eyes, he commented, "I find myself constantly trying to please her, to live up to her standards." Our focus in interviewing then centered on why he felt he had to be a "good boy" and why he could not allow himself the

indulgence of making mistakes. It was to be expected that my seeing through the facade that he had erected would release a good deal of anger at authority in general and his wife in particular.

By a simple maneuver of challenging *in a soft or humorous way* statements that seem out of place or exaggerated, patients may sometimes rapidly be forced to face up to their self-deception. Moreover, they will usually regard the therapist as a trusted ally who can help them stand up to the truth. Unless a therapist can enter the inner world of the patient, empathizing with the patient's needs and struggles, the therapist will be handicapped in rendering truly significant help.

Guiding the Theme into a Goal-directed Channel

While the dominant theme may be the vehicle of the interview, it is essential to direct the theme toward a fruitful goal. Of their own accord patients may not be interested in moving toward this goal. They may even resist violently attempts to shift the topic of discussion away from the goal that is dominant in their mind. It will be necessary, therefore, to accept the patient's choice of topic and then try, in as subtle a way as possible, to influence the content of thought toward an important objective.

We may illustrate this, perhaps, by the example of a mule who is hopefully surveying a barn loaded with oats that is in a direction other than that toward which the driver of the mule is taking him. This clash of motives results in an obstinate stalemate, the mule refusing to heed the injunctions of the driver. However, once allowed his freedom, the mule will start for the barn, and it may then be possible to take advantage of his momentum to steer him into a different direction. Our patients often act very much like mules when we try to push them toward an area of discussion in which they are not interested. Instead, if they are allowed full liberty of verbalization, it may be possible to swing them, by careful focusing, toward goals that we consider of vital importance. This is done by establishing a relationship between the subject of the patient's preoccupations and the area the therapist considers to be important.

For instance, a patient who has recently started therapy comes to a session perturbed at the indifference of her husband. She has wanted a coat for some months and, after dropping several subtle unrewarded hints, has made an open demand. A vague promise has resulted in no action. Moreover, her husband has been acting bored with family life and has taken advantage of every opportunity to remain away from home, giving such reasons as union meetings and American Legion "get-togethers." The evening before the present session she felt emotionally excited and wanted to make love, but her husband informed her he was fatigued. He then retired early, and she felt frustrated.

At the previous therapeutic session the patient had professed curiosity about how mere talking could help her complaints of backaches and migraine. She seemed to show some suspicion of the therapist. Since her distrust would interfere with a working relationship, we would be tempted to continue exploring it during the present session. To do this, however, would mean cutting her off from her desire to talk about her trouble with her husband.

Following the principles outlined above, she is encouraged to verbalize her feelings about her husband and an attempt is made to communicate empathy. At the same time her thinking is directed toward her feelings about the therapist. An excerpt of the interview follows:

> *Th.* Was your husband always as indifferent as he seems to be now?
>
> *Pt.* No, at the beginning of our marriage things were different, more exciting I mean. But it didn't last more than a short time.
>
> *Th.* Mm hmm.
>
> *Pt.* He found more interest in other things than he did me. *(pause)*
>
> *Th.* What about your relationships with other men besides your husband? Have you ever noticed how they react to you? *[The attempt here is to delineate a larger problem with men into which the pattern of her relationship with her husband fits.]*
>
> *Pt. (pause)* Well, I never thought of it. I never got along too well, that is got too close. That is before my husband, I mean.
>
> *Th.* What about *our* relationship? How do you feel *we* are getting along? *[Here an attempt is made to*

focus on the therapeutic relationship.]

Pt. (flustered) Why I just didn't, don't know. I keep wondering if this is what will help me.

Th. Whether it's the sort of thing that will make you well?

Pt. Yes, I just don't know what you expect me to do.

Th. What do you think I expect you to do?

Pt. That's it, I just don't know if I will do what is right, that you will think I'm doing well.

Th. I see. I wonder if you don't have ideas about how I must feel about you.

Pt. Why, *should* I?

Th. It would be rather strange if you didn't have *some* ideas about me and perhaps have wondered about how I feel about you.

Pt. Yes, as a matter of fact, I did wonder. But why should you feel anything about me?

Th. Perhaps you feel I am indifferent to you?

Pt. Why should you feel any other way?

Th. In what way have I acted indifferently? *[From this point on there is an exploration of her expectations of rejection in the therapeutic relationship.]*

Were the patient in the middle phases of therapy, and were the relationship with the therapist a good one, the focus of therapy would be on exploring the broader dynamics of her feelings that men reject her, on the role that she plays in bringing on rejection, and on the genetic origins of this trend. The interview would be directed into channels that would point toward these areas.

The goals pursued are also related to the kinds of therapy done. In supportive therapy the ultimate goal may be the correction of a situational disturbance. The therapist here organizes the interviewing around the following aims:

1. The establishing of a working relationship with the patient.

2. The understanding of all factors in the environment that provoke stress.

3. The evolution of a plan for coping with the stress situation and the execution of

this plan once the individual is brought to a realization of his or her potentialities and aptitudes.

4. The termination of therapy.

In reeducative therapy the general goal is a reorganization of the individual's destructive attitudes and behavior patterns. Interviewing is pursued along these lines:

1. The establishing of a working relationship with the patient.

2. The understanding of the more conscious irrational attitudes and patterns that interfere with a good adjustment.

3. After evaluating positive assets and liabilities, the mobilization of activity toward a reintegration of attitudes with reinforcement of positive factors and unreinforcement or extinction of behavioral deficits.

4. The termination of therapy.

In reconstructive psychotherapy the successive goals are these:

1. The establishing of a working relationship with the patient.

2. The understanding of unconscious conflicts through exploration of verbal associations, dreams, fantasies, slips of speech, and behavioral irrationalities, both inside and outside of therapy.

3. The utilization of the gained insight toward the freeing of oneself from the effects of unconscious conflict, with resolution of blocks in self-development and maturity.

4. The termination of therapy.

All activity during a session, including the selection of content for focusing, is organized around the goals that dominate an existing phase of therapy.

The general area of inquiry around which the interview is focused will, furthermore, vary with the kind of therapy performed. Thus, the prime focus may be on the environmental distortions that surround the person and on the symptomatic disturbances

that immobilize him or her. This is the case in supportive therapy where the aims are, first, to reduce environmental pressures to a point where the patient can deal with them with his or her existing personality resources and, second, to restore homeostasis within the person that was unbalanced by illness. No concentrated attempt is made here to modify character strivings or to deal with deep inner conflicts except where they act as immovable resistances to rectifying the existing situational or symptomatic disturbance. The focus in reeducative therapy may involve examining how the individual relates to people and the contradictions of one's disturbed drives. An inquiry into the more conscious character drives may have to be made, with the hopes of enabling the patient to suppress those drives that disorganize adjustment and of encouraging others that expedite adjustment. A search for the more unconscious drives is the object of reconstructive therapy. Here the understanding of the more repressed strivings is facilitated by the examination and analysis of dreams, fantasies, and transference manifestations. There may be an exploration of infantile and childhood experiences and fears as well as the immature strivings they embrace.

Circumscribing the Area of Subject Coverage

Studies of the learning process show that only a relatively limited number of things can be mentally absorbed and integrated at the same time. For this reason, once a dominant theme has been guided into a goal-directed channel, it is essential to focus on as concentrated an area as possible during any one session. Taking up one subject at a time and exploring as many facets of it as possible will result in the most effective use of the interview.

A patient, in the middle phases of reconstructive therapy, for example, presents in one session the dominant theme of how, since her marriage, she has tended to give up her own creative activities for family responsibilities. The exploration of her attitudes toward married life, and the sacrifices entailed therein, are believed by the therapist to be in line with the goal of understanding the dynamics of her psychosomatic complaints. By verbal and nonverbal means the therapist, therefore, encourages the flow of verbalizations along

these lines. The patient responds by recounting the events of the past day. Her child dawdled at breakfast. This irritated her so much that she felt like pushing his face into the cereal. Things at home have continued to be "in a mess." Her part-time maid is on a rampage and may have to be discharged. She fears getting another maid with problems as serious or more serious than those of her present maid. Because her maid had come to work late yesterday, she was delayed in attending a meeting of the parent-teacher association. She anticipates getting out of the house, but she does not derive too much pleasure from parent-teacher meetings. Indeed, she has been having some difficulty with an aggressive, argumentative member of one of the important committees who is opposing a resolution for a new school building. She is considering giving up her post as secretary of the organization in order to spend her time studying Spanish. Some day she would like to visit South America because she has been told it is a romantic country. This reminds her of a book she has been reading about Brazil. The book is about the Amazon River. It was sent to her by the Book-of-the-Month Club. She wonders if she would really be happy in South America because of all the insects and diseases that must infest this continent. The United States is the healthiest of all places to live. If only she could be happier. She had hoped that therapy would be able to do this for her. Perhaps she should explore the possibilities of getting an outside part-time job. She might in this way make herself more useful.

This type of rambling achieves very little unless we can confine it to a limited, but significant area. Possibilities are:

1. Exploration of her feelings about her child and his dawdling. A question such as "Your child, does he dawdle much at meals?" may open up the subject of her attitudes toward her child and his rebellious behavior. This may lead us into the field of her relationships to other members of the family and her feelings about herself as a wife and mother.

2. Exploration of her activities away from home, for instance, the teacher-parent association and the possibilities of her getting an outside job. We may ask, "You put in a good deal of work there. What do you get out of it?" This may encourage an elaboration of her ambitions.

3. Exploration of her feelings about the recalcitrant member of the association. The comment, "This woman must stir things up in you," may help her verbalize her feelings of competitiveness and her attitudes toward this woman as well as toward the other members.

4. Exploration of the general subject that things are not entirely satisfactory at home. One may remark, "There are things that go on in your life right now that bother you. What bothers you most right now?" This may center the patient's attention around her current unhappiness.

5. Exploration of her feelings about therapy. A comment may thus be phrased, "You seem to be disappointed that therapy has not done for you what you had anticipated it would do for you." This would open up an inquiry into her resistances to therapy and the therapist.

Which of the above aspects to stress would be difficult to say, for this would be determined by the needs of the immediate situation. However, there are certain general rules of priority in content selection. Sensitizing oneself to the trends in the patient's verbalizations, one may select topics in the following order:

1. Negative feelings toward the therapist.

2. Negative feelings toward therapy.

3. Unwarranted or unrealistic attitudes toward the therapist, such as distrust, sexual demands or fantasies, aggressive impulses, overwhelming dependency, and serious detachment.

4. Resistances to exploring attitudes or feelings that could give the patient insight into the problem.

5. Resistances to translating insight into action where the patient has gained an understanding of the problem.

6. Feelings of any sort that are verbalized.

7. Feelings that are not openly expressed but seem to underlie the content of thought.

8. Dreams, fantasies, and slips of speech (except in supportive therapy).

9. Observations of the relationship of symptoms to certain environmental happenings.

10. Pressing environmental concerns and interpersonal relationships with attempts to differentiate realistic problems from projections.

11. Important past experiences and relationships.

Returning to our patient, it will be seen that on the basis of priority items, the second possibility listed (negative feelings toward therapy) would be the best. The interview would be focused as much as possible on her feelings about therapy and why she seems to be discouraged at her progress. This does not imply that the other possibilities are unimportant. However, in order for the patient to benefit most from the interview, dealing with her resistances to therapy would be strategically more important than exploring a character trait at a time when she is in an emotionally discouraged mood. Later the other possibilities might be considered appropriate items for discussion.

In order to help circumscribe the areas explored, the therapist may apply the principles already outlined for maintenance of the flow of verbalizations, that is, as long as the patient is talking about a selected trend. If the patient veers off into an irrelevant area, the therapist may focus on pertinent material by quickly summarizing what the patient has said and then asking a question related to the selected area. Resistance to exploring this area, in the form of blocking, evasions, fatigue, and other reactions, will have to be dealt with by further questions or by interpretations. If the patient persists in dealing with an unimportant subject as a defensive manifestation against handling important material —for instance, if one insists on talking about one's car or a current television program at a time when important relationships with people should be explored—the therapist may employ certain discouraging tactics. Thus, an attempt may be made to divert the patient with certain comments, such as "Now that's very interesting, but I'd like to get back to what we were just talking about." A question dealing with this material may then be asked. If the patient again resists, the therapist may have to handle the patient's resistance directly.

A patient who had been discussing his feelings of discouragement because of his impotence mentioned an impending date with a young woman who was a musician. He then veered off into a prolonged account of the virtues of Dixieland jazz over Bebop. A fragment of the recorded interview follows:

> *Th.* That's very interesting, but I'd like to go back to this young woman and the date with her. How do you feel about it?
>
> *Pt. (pause)* Well, all right, she's a very interesting sort and we have a lot in common. I expect that she doesn't approve too much of my views about music because she has some ideas of her own. She likes jazz all right, but not the way I do. Now we happened to be together at Eddie Condon's place one night, and his orchestra played a whole series of old numbers, reorchestrated for his band. He ...
>
> *Th. (interrupting)* Yes, there may be a number of differences of opinion that you have with this girl, but what do you expect will happen when you have your next date with her? *[bringing patient back to the subject]*
>
> *Pt.* Well, I don't know exactly. I suppose we'll end up in bed.
>
> *Th.* How do you feel about that?
>
> *Pt.* I don't know. It sort of scares me in a way. If I could only have an erection and get started.
>
> *Th.* Perhaps what concerns you is that you may have a repeat failure on your record, that is, that you won't be able to perform. That must upset you.
>
> *Pt.* It sure does, I hardly feel like talking about it. In fact I wanted to call the whole thing off.
>
> *Th.* Maybe that's why you find it so hard to talk on this subject. It upsets you.
>
> *Pt.* Yes, yes, it does, and then I feel like chucking the whole thing up. *[The remainder of the session is concerned with dealing with the patient's resistances to exploring his impotency problem.]*

INCULCATING INSIGHT

It is important to realize that insight is not always essential. Behavioral changes can come about purely as a consequence of conditioning and reinforcement. Interestingly, insight regarding what has been responsible for faulty coping patterns may follow such behavioral change. On the other hand, we always strive for some cognitive improvement or change, and often the therapeutic focus is on bringing the individual to an insightful awareness of what is behind his or her difficulties. This awareness (insight) then can act

as a motivating force to inspire the person to take steps to change offensive patterns. Peculiarly, the "insight" may not always be valid. The patient may arrive at false conclusions through his or her own resources, or by incorporating incorrect assumptions offered by a therapist dedicated to an anomalous psychological system. Sometimes spurious insights, alleviating tension and bringing about freedom from fear, may enable the person to give up pathological defenses. The individual is then free to pursue behaviors which are constructive and which through reinforcement may lead to a healthy adaptation. On the other hand, if the false insight is a blatantly deceptive canard, the individual will eventually see through it, and he or she may experience a relapse.

In the cognitive and reconstructive therapies an important objective is the deliberate inculcation of insight. The act of verbalization often enables the individual to convert vague feelings and undeveloped convictions into concrete explicit formulations. The therapist helps catalyze the process by getting the patient to focus on significant areas of his or her life. Before this can be done, however, the therapist must know which aspects are important enough to stress at any given time.

By observing the patients' verbal and nonverbal behavior within the session, by listening to their account of what has happened in their relations with people outside of therapy, by scrutinizing their dreams and fantasies, the therapist will gain an understanding of driving motivational forces. Everything patients say or do during the treatment session must be carefully noted. This includes how they walk into the room; their posture as they sit in the chair, their bodily movements, gestures, and facial expressions; random muscle spasms and tensions; how they get out of the chair; and how they leave the room. In the patient's verbal behavior the therapist must note not only the content of what is said, but also the inflections, intonations, evasions, silences, blocks, and other evidences of emotion. Listening intently to *what* the patient says, the therapist concentrates on *why* certain verbalizations occur—the underlying feelings and conflicts that evade the awareness of the patient. The therapist must become alerted to the meaning behind the content by observing the patient's associational processes, shifts in emphasis, omissions, denials, inconsistencies, undue underscorings, inappropriate

attitudes or emotions, and slips of speech. The therapist must be constantly sensitive to the existence of trends in the content of thought and to underlying emotions. The more experience one has had, the more "intuitive" one will be in perceiving significant areas.

At the therapist's disposal are a number of maneuvers to use that help the patient achieve insight. Among these are accenting, summarizing, restating, reflecting, establishing connections, maintaining tension, extending support, and making interpretations.

Accenting

Where an important trend in the patient's verbalizations is observed, the therapist may ask a number of questions related to this trend or repeat again and again what the patient has said. By bringing it to the patient's attention constantly, forcing thinking about it in a concentrated way, the trend is highlighted in the awareness of the patient. This encourages the patient to explore its purpose and origin. Accenting is also useful in getting patients to accept certain facts about themselves and their situation. These may have escaped verbalization for the following reasons: (1) a lack of incentive to reveal facts, (2) a conscious fear of such revelations, (3) unconscious fear of the factual implications, (4) a confusion as to which facts are important, and (5) complete ignorance of what the facts are, due to repression. Pointed questions help their patients break through resistances. Repetition serves the added purposes of questioning the validity of the patient's comments and of obtaining more information about specific topics.

Summarizing

Patients often ramble in their verbal accounts. They may become so engrossed in details that they lose sight of the interrelationship of the various topics discussed. They may fail to connect casual happenings with basic themes. A rapid summarization from time to time, therefore, is helpful in pulling together material that seems to be uncoordinated. It is useful also as a measure preliminary to a pertinent question intended for purposes of focusing.

Restating

Recasting certain statements of the patient into different words brings out related aspects of the material that may have escaped attention. It also explicates what may be difficult for the patient to verbalize. Repetitive reformulations emphasize important trends in the patient's mind and help to rephrase his or her problems in more cogent terms.

Reflecting

Reading between the lines of what the patient says, the therapist becomes attuned to feelings affiliated with verbalizations and to emotional undercurrents of the content of thought, as well as to attitudes that have not been expressed. The therapist reflects these back to the patient, putting them into terms that the patient will be able to accept without stirring up too much anxiety. For instance, a patient launches into great praise of her employer and the possessions of the employer: Cadillac car, country estate, and important friends. The therapist senses jealousy and restrained contempt in the patient's tone and reflects these feelings by saying, "Yet some of the things your employer does may irritate you." The patient responds by cautiously criticizing, then openly attacking her employer. The exposure of the patient's feelings and acceptance of these by the therapist relieve guilt and encourage a deeper exploration of emotions and conflicts.

Establishing Connections

Due to the factor of repression even obvious connections between symptoms, feelings, and inner conflicts may not be seen by the patient. The relationship of daily happenings in the patient's life with tension and anxiety states that are constantly being mobilized also continues to remain vague. The patient will, therefore, require help from the therapist who establishes the associations for him or her. A woman suffering from bouts of migraine, for instance, manifests such attacks following contact with strong, aggressive females. Confoundingly, the patient has no idea that there is any association between her attitudes toward aggressive women and her headaches. In recounting her

experiences she presents these two situations as isolated and unrelated events. Whenever this happens, the therapist attempts to fuse the two by saying, "Now here is a situation where you get in a tangle with an aggressive woman and following this you get a headache." The patient may not respond with insight to this consociation at first, but repeated comments along the same line, whenever the facts justify them, bring the patient around to seeing a casual relationship of one to the other.

Maintaining Tension in the Interview

The maintenance of a certain amount of tension in the interview is essential in getting patients to think things through for themselves. Tension acts as a driving force by creating in the patient an incentive for change through active participation in the therapeutic process. On the other hand, a relaxed, tensionless state tends to diminish activity. Tension may be created in a number of ways, particularly by focusing on provocative topics, by asking challenging questions related to painful or avoided subjects, by giving patients interpretations of their disturbed attitudes or behavior, and by the strategic use of silence.

By maintaining silence the therapist initiates a state of discomfort in the patient. Discomfort deepens into tension that may promote a spontaneous exploration of feeling. Unfortunately, the patient may react adversely to silence, interpreting it as evidence of the therapist's rejection or hostility. For this reason silence, in therapies other than classical psychoanalysis, must be employed discreetly and not too frequently, the other indicated measures being more often utilized to promote tension.

Where tension is created in the interview, it must never be permitted to grow to a point where it overwhelms the coping resources of the individual, producing destructive or infantile reactions, such as acting-out tendencies and other strong resistances to the therapeutic process. In the event such contingencies occur, the therapist will have to step in with supportive measures to alleviate the tension state.

Extending Measured Support

Measured support is given the patient whenever the ego resources crumble and the patient shows symptoms of collapse. This temporary prop may help the patient retain the insights he or she has developed, since it prevents the ego from employing repressive and regressive defenses elaborated to preserve its integrity. An ego threatened by too great anxiety may protect itself by repudiating the insights it should integrate. Among the measures practiced to give the patient support are reassurance, avoidance of conflictual topics, and direct advice and guidance. Reassuring comments, for example, may involve statements such as, "In spite of all your difficulties, you have achieved a good deal in life." Following this, one may enumerate positive achievements of the patient or the patient may be told, "All people make mistakes and go through periods of misery." Such techniques must be employed sparingly and only where absolutely necessary, in reconstructive therapy.

Confrontation

Patients may be confronted with certain contradictions in their behavior, queries being made as to why they react the way they do. This will impose pressure on them, to which they will respond variantly: defensively with rationalizations, angrily with rage, indifferently with detachment, tremulously with anxiety, or with a host of other responses fashioned by their feelings toward the therapist, how they imagine the therapist regards them and their foibles, and what the exposure does to their self-image. The way confrontations are communicated—the wording, tone, and facial expression of the therapist—will influence the quality and intensity of the patient's responses. Some highly challenging confrontations may be made, and they will be accepted if presented in a kindly, non-condemning, firm, but understanding manner that conveys a nonjudgmental and non-punitive intent. On the other hand, confrontations posed accusingly or demeaningly, or before a good working relationship has been established, may be resisted violently.

Making Interpretations

The making of interpretations, especially in reconstructive therapy, is an important

step in promoting insight since it constitutes a frontal attack on existing blocks in patients and enables them to come to grips with anxiety. Anxiety is at the root of practically all psychopathologic problems. Defenses against anxiety cripple the adjustment capacities of the person, causing one to react in an inappropriate way to casual happenings. Interpretations directed at bringing patients to an awareness of their anxiety show them how they are responding to this emotion and the defenses that they utilize in warding it off. Interpretations also help to dissolve resistances that constantly interfere with patients' capacities to think for themselves. Interpreting blocks that prevent patients from becoming aware of their problems is a prime task in interviewing.

While interpretation is one of the chief tools of the psychotherapist, it is not without its dangers. Confronting the patient with repudiated aspects of his or her psyche may promote greater anxiety and stimulate more obdurate resistances toward the warded-off content. Consequently, it is important to interpret to patients only material of which they have at least preconscious awareness. For instance, a patient came late for a session. By observing his behavior and verbalizations, the writer got the impression that the patient felt hostile toward him. This seemed to be substantiated by a dream in which the patient fled from a monster who turned into a doctor. There was a temptation to confront the patient with his hostility. Therapeutic conservatism however, necessitated biding one's time until the patient came out with a statement of how he felt. The following is a recorded fragment of the interview:

> *Th.* I wonder how you have been feeling?
>
> *Pt.* All right, I guess, *(pause*)
>
> *Th.* All right? *(pause)*
>
> *Pt.* Well, yes and no. I felt a little upset when I found I was late.
>
> *Th.* Mm hmm.
>
> *Pt.* I just can't seem to remember the exact time of my appointment.
>
> *Th.* I wonder why? [*focusing on the causes of the patient's lateness*]
>
> *Pt.* I guess so many things are going on that I just don't think of it. *(pause)*

Th. I wonder if there might be other reasons? *[again focusing on causes]*

Pt. Are there, I mean do you think there are?

Th. I don't know, but often when a person comes late, he does so because of certain feelings about therapy or the therapist, *(long pause)*

Pt. Well, to tell you the truth coming here does upset me, that is, lately.

Th. I wonder why?

Pt. I keep getting feelings as if you've done something, or haven't done something, like as if you want to spite me.

Th. Mm hmm.

Pt. Yes, that's what it is. You know this is silly because I can't figure out why I feel this way.

Th. Is there anything I have done that has upset you? *[attempting to differentiate reality from projection]*

Pt. Honestly, doctor, you haven't.

Th. Then you must be resentful toward me for some other reason.

Pt. I feel flashes of resentment, but I don't know why. That's probably why I've had trouble coming here, on time I mean.

It will seem from the above that the patient has been led to make his own interpretations. Dangers are minimal where this is done. The therapist helps the patient by giving cues, by arranging material in a sequence, and by asking pointed questions. The patient is then in a position to figure things out for him or herself, which will facilitate therapeutic progress immeasurably.

From time to time, however, it will be necessary to give the patient direct interpretations, especially when resistances prevents making them on his own. The kind of relationship that the therapist has with the patient and the manner in which explanations are presented are important here. If the relationship is a good one and if disclosures are made in a nonjudgmental way, they can have a beneficial effect. Interpretations must always be given in such a manner that the patients feel free to reject them if they wish. To insist that the patient accept proclamations is a poor tactic.

Instead of presenting an interpretation as an authoritative dictum, one may precede it with such phrases as "perhaps" or "it would seem as if." This gives the patient a feeling that the therapist is not being arbitrary. Where there is good reason for feeling an interpretation to be true and where it has been offered to the patient and roundly rejected, the therapist may say, "Well, maybe it doesn't appear plausible right now. Suppose you think about it, and observe yourself, and see if later it makes more sense." If the patient tries to force the therapist into being absolute in his or her declaration, the therapist may reply, "I get the *impression* that the situation as I have indicated it *may* be true. But it's important for *you* to test it out for yourself and see if you feel it really applies to you." Eventually the patient may come around to accepting the validity of the therapist's impression.

Interpretations may be made in relation to any unconscious or partly conscious aspect of behavior. Of particular importance is its use in dealing with resistance and in uncovering repressed material. Interpretation of resistance often helps the patient make progress in therapy. A patient with the problem of impotence, for instance, comes into a session in a distraught state. He rambles along on inconsequential topics and keeps looking at his watch every few minutes as if he is anxious for the session to end. The recorded fragment follows:

> Th. I wonder why you have been checking the time so often, *[bringing the patient to an awareness of an unusual aspect of behavior]*
>
> Pt. Oh, I've been wondering what time it is.
>
> Th. I see. (gazing at his own watch) It's 10:24 (pause)
>
> Pt. Time seems to go so slow today.
>
> Th. I wonder why?
>
> Pt. I just don't seem to have anything to talk about.
>
> Th. Nothing?
>
> Pt. I can't think of anything.
>
> Th. I wonder if there is anything that bothers you, that you don't like to talk about? *[focusing on*

possible resistance]

Pt. Like what?

Th. Well, what would be unpleasant to talk about? (pause)

Pt. (smiles) You know what flashed through my mind?

Th. What?

Pt. I almost forgot the date I made with Helen tonight.

Th. Mm hmm.

Pt. It's something I feel I've got to do, but I don't feel up to it. Maybe I'll call it off.

Th. Any reason for calling it off?

Pt. It's nothing too important, I thought I might go to the opera tonight.

Th. I wonder if you just don't want to avoid seeing Helen because of the fear of the sex business. [interpreting]

Pt. I suppose I should go through with it, but I'm afraid of disappointing her again.

Th. Mm hmm. And suppose she was disappointed?

Pt. I'd be disappointed and upset.

Th. You feel you want to be successful and don't want to face any disappointments, [further interpretation]

Pt. (laughs) I guess that's why I didn't want to talk, to tell you I was going to break the date. I guess I shouldn't really break the date because it's silly to feel I'll be rejected. I must be really scared of failure.

Interpretation of the content of the repressed is less frequently practiced and is utilized only in reconstructive therapy where the therapist has a very good relationship with the patient. A woman dating a man for the first time experienced faintness, heart palpitations, and overwhelming fear in his presence. She talks of this experience during the session. The recorded fragment follows:

Th. What do you think this is all about?

Pt. I don't know.

Th. Here you meet this man, and then you get this attack.

Pt. Yes, it sounds funny.

Th. Do you think there is any connection between seeing this man and your attack?

Pt. There must be, but what?

Th. Well, what? *(pause)* What do *you* think?

Pt. I ... I don't know, doctor, I really don't.

Th. Well, perhaps the man stirred up feelings in you, upset you, scared you? [*interpreting deep fear of men*]

Pt. (blushes, stammers, pauses) Yes, I feel upset. This kind of man makes me feel funny.

Th. What kind of man is he?

Pt. Well, his eyes and build. He reminds me of my father when he was drinking, which was most of the time.

It is important to remember in interpreting the content that material from dreams, slips of speech, and transference manifestations should not be directly interpreted until the patient gives evidence of having some conscious or preconscious awareness of the material. The tone of voice, the pauses, and the emphasis are as important as the content of the therapist's interpretations. Creation of word pictures can convey meanings more readily than abstract intellectual statements. Hendrick (1958) contends that the therapist functions best in interpretation not by paraphrasing what the patient reported but by indicating at appropriate moments what the patient was not reporting.

Too broad interpretations, covering the wide range of the patient's reactions, are not as effective as specific, pointed, limited interpretations directed at a target area. Patients are better able to generalize from these concentrated thrusts into their defensive structure, particularly if they are repeated whenever they indulge themselves in neurotic activities that have for them aversive consequence.

Interpretations must be made repeatedly to be effective. The first interpretation may be resisted violently. If the patient has an untoward reaction, the therapist must respect

the patient's resistance, and perhaps make allowance for the fact that the interpretation may be wrong. The therapist may say, "Perhaps we can explore this resistance further to see what the real situation may be." As the core of the resistance is resolved, patients may themselves later acknowledge the accuracy of the therapists' observation, or present it as their own discovery.

Interpretation is so vital a technique in interviewing that a special chapter is devoted to it in a later section of the book (see Chapter 45).

TERMINATING THE INTERVIEW

The proper termination of the interview is extremely important. There are some therapists who mismanage this phase of the interview due to a fear that they may offend the patient. Thus they are unable to interrupt a patient at the end of a session for many minutes after the interview time has terminated. The invasion of the next patient's hour complicates the schedule of the therapist and often creates resentment in the succeeding patients.

No matter how lenient the therapist may be in other respects, strict adherence to a time schedule is important. If at least 5 minutes' interval between patients is allowed, the therapist will be able to extend several minutes' time to a patient who is upset or to one who is dealing with highly charged material. The only exceptions to a rigid time schedule are treatment sessions with very sick patients. Here, at least 15 minutes of leeway between sessions should be arranged in advance to allow for an extension of the interview if necessary.

In terminating a session, one may take the opportunity in a pause in the patient's conversation to say, "all right" (mentioning the patient's name) or "all right, we meet again on_____" (mentioning the next appointment date). This interruption becomes a signal to which the patient will respond automatically after it has been used several times. In the event the patient is discoursing on an important topic, the therapist may add, "We'll continue with this next time." If the patient, on occasion, continues to talk for too long

after interruption, the therapist may simply say, "I'm afraid we'll have to stop. We'll talk about that next session." By his or her manner, the therapist should convey an interest right to the moment that the patient leaves the room. It is important not to dismiss the patient arbitrarily nor to engage in other tasks, like reading one's mail, before the patient goes.

Some patients linger at the door talking on and on. The therapist here may remark, "That's very interesting. Suppose you think about it, and we'll discuss it next time." If the patient asks a question that requires time to answer, the therapist may say, "That's a good question. Suppose you think about it, and we'll talk it over next time you come."

SPECIAL PROBLEMS IN INTERVIEWING

Occasions will arise when patients will bring up names and events that they have mentioned in the past that the therapist does not remember. Here the therapist may remark, "I don't distinctly remember. I wonder if you would mind repeating what you had said about (mentioning the person or the event) to refresh my memory."

If the patient asks the therapist a personal question, it is important to find out why the question is asked. Thus if the patient asks, "Doctor, are you married?" the therapist may reply, "You're curious about me." After the patient has responded, the therapist may ask, "Do you think I'm married?" As a general rule, it is best to be truthful with a patient, and, once the reasons behind the patient's questions are discerned, they should be answered as directly as possible.

If the patient indulges in self-devaluation by making such statements as "I'm a queer, peculiar person," or "I really am terrible," or "I'm a hopeless mess," the therapist must never agree. One may ask, "What makes you think you are?"

If the patient continues to engage in intellectual discussions or talks about topics like the weather, sports, and current events, one may interrupt in a manner illustrated by the following excerpt:

Pt. What do you think about the President and the steel industry? Isn't it something terrific? When I heard about it, it made me feel we were in for exciting times. The *Times* editorial says …

Th. Yes, now what about you? *[The focus may also be brought back to the patient with such questions as "How does that affect you?"]*

There will be times when the therapist feels restless and may manifest discomfort by shifting around in the chair or moving his or her hands and feet. These movements may be interpreted by patients as evidence of the therapist's disinterest or even maladjustment. If the patient comments on the therapist's fidgetiness, the therapist may ask the patient what he or she believes this signifies. If an answer is not easily forthcoming, the therapist may ask the patient if he or she believes that the therapist's movements indicate disinterest. The therapist may, if the facts warrant it, give the patient a plausible explanation for the restlessness, such as that sitting all day in a chair makes one want to stretch one's muscles a little. This does not indicate disinterest in the patient.

One should resist the urge, tempting as it may be, to "command" the patient to execute certain tasks; to engage in talk about oneself, one's accomplishments, and one's problems; or to chastise the patient irrespective of the provocation.

THE INTERPERSONAL CLIMATE OF THE INTERVIEW

Without a congenial working relationship with the patient, there will be little progress even with the most expert interviewing techniques. A proper atmosphere will be present where the therapist possesses personality qualities of sensitivity, objectivity, flexibility, and empathy; where the therapist accepts the patient uncritically, refraining from arbitrary, moralistic, and punitive responses; and where the therapist shows sincere respect for the patient's growth potentials. The maintenance of a tolerant, accepting, permissive attitude will eventually convince the patient that the therapist's role is to help the patient to understand himself or herself, and not to pass judgment. This unqualified, sympathetic acceptance enables the patient to explore further within the self and the environment, the sources of trouble, helping the individual to bring up material difficult to verbalize even to oneself. The calm scrutiny of his or her productions, with absence of praise, surprise, blame, or shock cuts deeply into the defenses of the patient, helping to

expose the most disturbing and painful conflicts.

Were rules for maintaining the proper interpersonal climate during interviewing to be enumerated, the following might be listed:

1. One should try to put oneself in the patient's position in order to see things from that point of view. It is obviously impossible to feel exactly what the patient feels because his or her reactions are habitually different from the therapist's reactions. Nevertheless by approximating the patient's situation as closely as possible and considering the latter's background and experience, the therapist may be able to communicate an empathic warmth.

2. One should appreciate the impossibility of understanding the patient's reaction patterns from the standpoint of common sense. Realistically viewed, the patient's symptoms and behavior seem futile and destructive. Yet they are compelling and persist in the face of the most intense exercise of will power. It is necessary to realize that the years of conditioning responsible for symptoms will not yield themselves to a few months of therapy.

3. The therapist ought to recognize that he or she inevitably will be prejudiced in relation to some aspect of the patient's problem. One cannot escape being disturbed and perhaps even shocked by certain past experiences or by present perverse and antisocial impulses of some patients. The fact that the patient's values conflict with one's sense of "right" and "good" does not necessarily make them "wrong" and "bad." Cognizance of this will encourage greater tolerance of standards and attitudes that do not coincide with those of the therapist.

4. The reactions of the patient toward the therapist—such as awe, reverence, or hostility—often have little to do with the therapist as a real person. They may be carryovers of attitudes toward past authorities, or they may be dramatized feelings toward idealized authorities. It is, consequently, important not to react to unpleasant, seductive, insulting or provocative responses as if they were personal assaults or favors.

5. The therapist's reactions to the patient may also be determined by projections from the therapist's own past. It is essential to examine responses toward the patient such as anger, boredom, sexual feeling, and overconcern. Not

only must the expression of such responses be controlled, but an attempt should be made to analyze them as to source and meaning. While personal biases and blind spots may be recognized, they may still be hard to control. But recognition of them will be of great help in preventing a too harsh judging of the patient and a blocking of his or her rights to self-determination.

6. Flexible and tolerant leadership is the ideal matrix of the therapist-patient relationship. No matter how passive or nondirective the therapist may wish to be, he or she remains the leader in the therapeutic relationship. The manner in which leadership is applied will help determine treatment results. If the leadership is arbitrary, intolerant, and punitive, this will merely repeat the reactions of past traumatizing authorities. The patient may respond with compliance or defiance, and there will be an absence of constructive participation. If the leadership is minimally arbitrary, the patient will have an opportunity to work through feelings toward authority, perhaps gaining a new self-concept in the direction of personality maturity. The therapist accordingly must refrain from dominating the interview and allow the patient to talk freely despite rambling. The therapist must never cross-examine, ridicule, laugh at, or belittle the patient, nor pointedly argue with the patient or engage in extensive polemics. Contraindicated are open disagreements with the patient over religion and politics. The therapist must respect the patient's rights to his or her own ideas and convictions, even though these are senseless or neurotic. There will be times when the tolerance of Job will be required, even while the patient is making what seem to be unnecessary mistakes.

7. There is a need for faith in the basic goodness of human beings, in the potentialities that all people possess for personality growth and maturity. The therapist must view disturbed reactions as responses of illness and must respect the essential integrity of the patient in the face of any abnormalities displayed.

20
The Physical Surroundings of Psychotherapy

The physical surroundings are the least important factors that enter into psychotherapy. With the proper didactic, personality, and experiential equipment, the therapist will be able to do good psychotherapy in almost any kind of setting. Once psychotherapy is under way and the working relationship has developed, the surroundings do not seem to make much difference, provided they are not too uncomfortable.

A poor kind of physical set-up nevertheless, may create certain complications. Due to the inevitable projections that occur in psychotherapy, the physical surroundings should be made as minimally provocative of frustration and hostility as is possible.

PHYSICAL PLAN

It goes without saying that the therapist's office should be reasonably warm, properly ventilated without drafts, and free from disturbing extraneous noises. Obvious comforts need to be provided. These include a conveniently accessible bathroom and a mirror so that patients may groom before leaving the therapist's office. The lights should be as soft as possible, while making provision for accessory illumination, for note taking on the part of the therapist, and for reading written memoranda by the patient.

Because the material discussed with the therapist is highly confidential, the patient should be assured that others will not listen in on the conversations. Precautions will have to be taken to prevent what is being said in the therapist's office from being overheard by people in the waiting room. This may mean hanging draperies on the walls adjoining the the waiting room, or it may necessitate an extensive alteration job employing sound-proofing materials. Where sound-proofing or sound-deadening arrangements cannot be practically made, a good layout is a separation of the waiting room from the office by at

least one intermediate room. Where this is not possible, some therapists have found it convenient to operate a small fan or an air-conditioning unit in the office or waiting room, the distracting adventitious sounds of the motors serving to make indistinguishable the conversations going on in the therapist's office.

A system of separate exits and entrances is sometimes advised so that patients will not meet each other. In the opinion of most therapists this precaution is not necessary and merely contributes to the patients' idea that is is shameful to possess an emotional problem. There is no reason why patients should not accept as part of the reality situation the fact that therapists treat people other than themselves. Any anxieties, hostilities, or jealousies that are engendered by meeting fellow patients who may be regarded as rivals may be handled in a therapeutic way.

Practical circumstances sometimes require that a therapist's home and office be together. This fact need not be harmful to good treatment objectives, provided that no distracting influences obtrude themselves into the therapeutic situation. Interruptions by tradespeople, the presence of children playing in the waiting room, engaging in such activities as would be normal in any home, and other influences related to problems of maintaining a household understandably may impose hardships on both the patient and the therapist. Where such interferences cannot be controlled, a separation of home and office is mandatory.

Decorative Scheme

The decorative schemes of the office and waiting room are not too important. Disturbing pictures, gaudy draperies, and embellishments should be avoided. In the early phases of therapy patients may extract cues from the surroundings to help them in their estimate of the kind of human being they are dealing with in the therapist. At the same time they may project into the surroundings their own emotional attitudes, and they may try to find evidences for their prejudices in the decorative tastes and furniture preferences of the therapist. The decorative plan, hence, is not of great consequence, as long as it is not too outlandish.

Furnishings

The furnishings of the waiting room should be simple, consisting of a few chairs, coffee table, ash trays, and selected magazines. It is to be expected that the patient will tend to judge the therapist by the kinds of reading material in the waiting room. A clothes rack and umbrella stand are important conveniences.

The furnishings of the office should be simple. Absolute requirements are two comfortable chairs facing each other. These should neither be too hard nor too soft. Massive, lounge-like chairs are orthopedically bad for the therapist since they do not give the proper back support in the long periods of sitting to which one will be exposed. They also tend to frighten some patients who feel trapped within the confines of their embrace. There is some advantage in having the chairs as closely similar to each other as possible, in terms of size and height of seat. Since one of the goals in therapy is to bring the patient to a point where he or she feels on an equal plane with other human beings, some therapists believe that the seating arrangement should not emphasize the difference between therapist and patient. A huge chair in which the therapist towers above the patient imposes an artificial barrier to the cooperative, give-and-take atmosphere that should prevail in treatment.

In addition to the chairs that are employed in interviewing, one may have an additional side chair or two for use in conferences with members of the patient's family on the rare occasions when these are necessary. One may also have a desk for writing up reports and records. A comfortable couch in the room is also necessary if the therapist wishes to employ the technique of free association, enabling patients to deal with painful material without diluting it through observation of the therapist's facial expressions. Accessories such as conveniently placed end tables, ash trays, and matches for patients who smoke are necessities. This is a moot point since some therapists will not permit smoking in their offices. Folding chairs may be stored in a closet and used for conferences or for group therapy.

Pets

Some therapists enjoy having a pet, such as a dog or cat, in their offices on the basis that this creates a homey atmosphere. However, the presence of a pet in the room creates turmoil in some patients, who may regard the pet as a rival, and then realizing that their resentment is unreasonable, suppress or repress feelings of hostility. The behavior of the pet, whether it is quiet, noisy, or seeking attention, may influence the character of the patient's responses. In general, then, a pet ranging through the office is distracting although the patient may manage to adjust to this complication.

Telephone

The matter of the telephone is important in any description of the physical surroundings of therapy. Arrangements are best made so that the phone bell may be disconnected during sessions, since telephone calls constitute a serious interruption in the continuity of the therapeutic hour. They are naturally resented by the patient and, if they occur frequently enough, may disturb the therapeutic relationship. Except for extreme emergencies, then, telephone conversations should be restricted to times between sessions. This is no problem in clinics where a switchboard is used. There may, however, be a problem in private practice except where the therapist has a secretary in an adjacent room. In most communities telephone answering services are available, so that important messages may be communicated to the therapist without cutting into the patient's time. A telephone-message recorder is equally convenient.

21
A Practical Outline of Psychotherapy

In psychotherapy we are navigating a sea of imponderables. So many variables exist that we may find ourselves adrift with few bearings to chart our course, or we may become marooned on seemingly endless reefs of resistance. A general plan of action, however, can help many therapists stabilize their journey and guide their efforts in a meaningful direction.

As a catalyst to personality growth, the therapist may operate within the framework of a disciplined therapeutic plan that is geared toward resolution of the patient's resistances to change. Such a plan ideally should be sufficiently pliant to allow for the functioning within its structure of therapists of varied orientations and different kinds of training.

The design of psychotherapy in Table 21-1, founded on psychoanalytic doctrines and learning theory, is pointed in this direction. It strives to correlate the positive factors of the various systems of psychotherapy into a flexible framework in which therapeutic skills may be developed. The framework is intended to be sufficiently broad so as not to interfere with a spontaneous utilization of the self in the dynamic interpersonal relationship that is the essence of psychotherapy.

The framework may rightfully be termed eclectic since it utilizes concepts derived from various schools of psychiatry, psychology, and social sciences. The objectives of this framework are aimed at a reconstruction of personality, although there is recognition of, and allowance for, the fact that this goal may for practical reasons have to be scaled down.

The delineated principles of therapy are fashioned for the therapists whose training enables them to do psychoanalytically oriented psychotherapy; they will also be helpful, however, to therapists who have not been analytically trained and who confine themselves to supportive and reeducative methods. The principles are equally applicable

to short-term and long-term approaches.

The four phases of treatment described in the present outline have been schematized for purposes of convenience. In actual practice, considerable overlapping occurs among the various phases. Nevertheless, a definite sequence will be observed in successful therapy that generally follows the outline.

Part II
The Beginning Phase of Treatment

The beginning stage of therapy has for its principal objective the establishing of a working relationship with the patient. This is the crucible in which problem solving is forged and personality change cast. Without such a mutuality, maximum therapeutic progress will not be made. Because the working relationship is so vital to success in therapy, all tasks must be subordinated to the objective of its achievement. Too frequently the therapist plunges into an exploration of provocative stresses prematurely, or challenges the patient through strong confrontations, before the working relationship has become solidified. Attitudes of respect, trust, and confidence in the therapist, inherent in a good working relationship, enable the patient to endure anxiety and to cope with resistance inevitable in the challenging of basic adaptational patterns. If a working relationship does not exist to absorb the impact of suffering and resistance, the therapeutic process will be hampered. This, unfortunately, is often the outcome of therapy that is not carefully planned.

To ensure an adequate working relationship, a number of therapeutic tasks are in order. First, the patient must be motivated, if not already, to accept treatment. Persons who are inadequately motivated— who come to therapy at the insistence of their physician, or of a concerned relative or friend, or to forestall punishment when they have been involved in some legal infraction—or who, for any other reason, are not convinced that they need psychological aid—start treatment with a handicap. The fact that an individual is unmotivated does not mean that he or she will not respond to therapy. The therapist here will have to concentrate efforts on creating in the patient the proper incentives for the acceptance of help. No matter how tempting it may be to work on provocative stress stimuli or the operative dynamisms, the therapist will have to inhibit this impulse until cooperation is secured from the patient.

Equally important is the second task of clarifying and removing misconceptions

about therapy. Many persons coming for treatment have stereotypes about psychiatrists and other mental-health workers. They expect the therapist to be a miracle worker who reads minds and who can infallibly produce a rapid cure once guilt and problems have been aired. Popular periodicals and books may have depreciated the value of psychotherapy or warned of its potentially harmful effects. Attacks by uninformed speakers or professional people on psychiatry, psychoanalysis, and psychotherapy may have created a pessimistic attitude that will prove inhibiting to the fruitful utilization of treatment services. Countless other misconceptions may burden the therapeutic effort and will require careful handling to bring about a proper working relationship.

The third therapeutic task of the first treatment phase is to convince the patient that the therapist understands the patient's suffering and is capable of helping. Heretofore the patient will probably have felt condemned or rejected for his or her impulses and complaints and anticipates the same kind of judgmental and punitive attitudes from the therapist. Guilt ridden and resentful, the patient dares not open up completely to anyone who will repeat the hurts previously experienced at the hands of authority. Obviously it would be futile to tell the patient that the therapist is a different kind of authority since the patient would not understand how this was possible and would regard such a statement as a dangerous lure. Respectful listening, sympathetic reflections, and accepting, non-condemning verbal and nonverbal responses eventually convince the patient that this is a new kind of interpersonal relationship that warrants full cooperation. The therapist must keep keenly attuned to new frequencies in the patient's attitudes that signal progress in the evolution of the working relationship.

The fourth therapeutic task, which follows upon the successful execution of the former three, is the tentative defining with the patient of objectives in therapy. This charge is one the patient may not readily accept since he or she is not sure how far to go in treatment or exactly what is involved. A brief account of possibilities in a factual unprejudiced way is indicated. An explanation that a complete rehabilitation of the personality is the most desirable goal (but that it is indicated in some instances and not necessary in others) and that it will require a greater period of treatment than less

ambitious goals. The latter may achieve a reasonable equilibrium, even though a few problems may still remain that the patient feels can be lived with. It is hardly to be expected that the patient will grasp the full meaning of this exposition.

If the patient is unable to comprehend what therapy is and how interviewing helps, time may have to be spent in structuring the therapeutic situation, expounding on the process in very simple language, illustrating with examples of how other persons have been helped by psychotherapy. This will usually lead to greater acceptance of technical procedures, and more sympathetic acknowledgement of the need for a relationship based on mutual interaction and responsibility.

Resistance to a working relationship and to the therapeutic tasks during the first phase are to be expected. Thus the patient may refuse to become motivated for therapy, boycotting attempts by the therapist to demonstrate that the problem is treatable. The investment in remaining ill and the need to perpetuate any secondary gains will interfere with reasoning powers. Similarly the therapist's explanation of the treatment situation may not be accepted, the patient instead insisting on a personal definition and on setting the conditions for cooperation. These may not be congenial with the requirements of good therapy. The patient may, for instance, resent the professional nature of the relationship and wish to be handled in a special, more personalized manner, even to hobnobbing socially with the therapist. To yield to the patient's wishes may risk therapeutic failure.

Of greatest interference in the development of a working relationship are characterological resistances that crop up as manifestations of the patient's habitual interpersonal activities. The threatened intimacy of close contact with the therapist will kindle customary and conflagrate latent character distortions that prevent from evolving in treatment the kind of relationship that will be most conducive to therapeutic gain. Some of the distortions are unique in that they are inspired by the special kind of encounter that takes place in therapy. Thus, transference feelings and attitudes may flare up almost from the start in the form of irrational expectations, sexual desires, protective demands, guilt feelings, fears of injury, distrust, and intense hostility. The triad of dependency,

aggression, and detachment may become operative alternately or in combination.

Dealing with these manifold resistances to a harmonious working relationship constitutes the primary pursuit in the opening phase of treatment. It is obviously difficult to attempt supportive palliations, reeducational tactics, reconditioning procedures, or active analysis of deep conflict while such resistances are operative. Irrespective of how impatient the therapist may be to deal with symptoms or emerging conflicts, it may be necessary to devote the initial treatment sessions largely to the resolution of resistance, while observing rules that make for a positive consolidation of the working relationship. Resistances, however, may not yield themselves readily. Character resistances, especially, may persist for months, and in certain patients for years. Interpretation of these may meet with constant repudiation. Perseverance, nevertheless, coupled with continued demonstrations of understanding and empathy, may eventually lead to their successful un-ravelment.

Certain problems in the therapist— some of a countertransferential nature— also obstruct the achievement of a working relationship. The patient may arouse hostilities in the therapist that the latter neither fully recognizes nor can control. The therapist may not be able to show the quality of warmth or sympathy essential to enable the patient to feel accepted and understood. Where the patient is prominent socially, economically, or politically, the therapist may be in fear of the patient or even in too great awe. In addition the therapist may show irritability with the stubborn fight that the patient makes against accepting therapy and the therapist. Discouragement or any outbursts of vexation displayed by the therapist may have a disastrous effect on the creation of proper rapport.

These sketchy precepts will be elaborated in the forthcoming chapters.

23
The Initial Interview: The First Contact with the Patient

The initial interview is probably the most crucial therapeutic session of all. Vital hours appear later during treatment when resistance and transference manifestations become rife. Errors in the handling of a session after the therapeutic process is well under way, however, are not nearly so fatal as mismanagement during the initial interview.

The primary goals of the initial interview are

1. *To establish rapport with the patient*

   a. by supplying the proper emotional climate for the interview

   b. by structuring the purpose of the interview

   c. by clarifying misconceptions about psychotherapy

   d. by dealing with inadequate motivation

   e. by handling other resistances and preparing the patient for psychotherapy

2. *To get pertinent information from the patient*

   a. by listening to the patient's spontaneous account

   b. by focusing on selective data

3. *To establish a tentative clinical diagnosis*

4. *To estimate the tentative dynamics* (in terms of inner conflicts, characterological distortions, mechanisms of defense and their genetic origins)

5. *To determine the tentative etiology*

6. *To assay tentatively the assets, strengths, and weaknesses of the patient, actually*

and latently

    a. by estimating the areas of living in which the patient is succeeding and failing

    b. by determining the motivations for therapy

    c. by exploring the level of insight

    d. by estimating the tentative prognosis

7. *To make practical arrangements for therapy*

    a. by tentatively assessing optimal goals

    b. by tentatively selecting a therapeutic method

    c. by accepting the patient for treatment or arranging for another therapist

    d. by making appropriate time arrangements

    e. by making financial arrangements

8. *To arrange for essential consultations and psychologic testing*

HANDLING THE FIRST INQUIRY

The first patient-therapist contact is very important since it provides the patient with notions of the personality qualities and traits possessed by the therapist. Generally, the patient will have been referred to the interviewer by a physician, minister, teacher, friend, acquaintance, or relative of the patient. Sometimes the patient, learning of the work or reputation of the therapist, will apply for help without an intermediary.

If the therapist is working in a clinic, the intake worker will probably handle the initial contact. Under other conditions the referral source may communicate directly with the therapist. When the source is someone other than the patient, it is usually best, once it is ascertained that the therapist has time to see the patient, to advise the referral source

that it is important to have the patient get in touch with the therapist or the therapist's secretary directly to arrange for a consultation. This puts the initiative in the hands of the patient and constitutes one more positive step that the patient has taken spontaneously in working out his or her problem. Under some circumstances, however, this will not be feasible, as when the patient is a child or when the patient is too ill or is intractably unmotivated for treatment. Where a telephone call has been made for an appointment, this, if at all possible, should be given the same day especially where the patient is very upset. People generally hold off making the final plunge into therapy. Should a patient be rebuffed by the cold statement that an appointment cannot be made until some date in the future, motivation may be dulled. Even though the appointment is kept, resistance and resentment may persist on the assumption that the therapist is an unsympathetic person no matter how impelling the situation that necessitated the delay.

Should the therapist have absolutely no time for an interview on the same day, he or she should try to talk to the patient on the telephone, even for a few minutes, and attempt to extend some reassurance. By the tone of the conversation the therapist should try to convey an interest in the patient. An excerpt of a telephone conversation follows:

> *Pt.* Doctor, I've got to see you today, I feel upset, like I'm going to pieces. Doctor___ told me to call you.

> *Th.* This must be very upsetting to you. How long has this been going on? *[attempting to communicate sympathy]*

> *Pt.* For a long time now, but it's never been so bad.

> *Th.* Well, naturally, I want to help you, but we'll have to arrange for an interview. I'd like to see you today, but I could give you only a minute or two. This might be upsetting to you, and I'd rather see you when we can spend some time together to talk things over, *[conveying interest in the patient and attributing the delay in appointment time to a desire to help him more fully]*

> *Pt.* Can't you see me today?

> *Th.* Much as I'd like to, the amount of time I could give you wouldn't be helpful to you. Now what about Tuesday at 3:40 P.M.?

> *Pt.* Yes, I can make that, but what shall I do in the meantime?

Th. I'd very much like to help you, but it is hard to do this without spending a little time with you. What have you been doing for this trouble up to this time? *[Instead of rejecting the patient's demand, a polite statement suggests that help will follow a short wait.]*

Pt. I've been taking some sedatives, some red capsules the doctor gave me. They don't help much.

Th. Why don't you continue doing what you have been doing that gave you a little relief, and then, when we meet on Tuesday, we'll talk the whole thing over? I'll be of more help to you when we go over all the facts.

Pt. (slight cough, as if in relief) All right, doctor, I'll be there.

Th. Fine, see you then. Goodbye.

Pt. Goodbye.

If there is no time on the schedule and it is apparent that the patient needs help immediately, the patient may be given the names of several other therapists. Better still, the therapist may offer to see if these therapists have available time and then communicate this information to the patient.

PRELIMINARIES TO THE INTERVIEW

When appearing for an appointment, the patient should be greeted by name by the receptionist, if there is one, and made as comfortable as possible. If the therapist uses forms that the patient is to fill out for essential statistical data, these may be given to the patient (see "Personal Data Sheet," Appendix D). Brief statistical entries may be made by the receptionist in the case record (statistical data sheet forms under Appendices A, B, or C may be used here). The case folder may be either a plain manila folder or a special folder such as Appendix J. Sometimes simple printed informational material on psychotherapy proves helpful (see Appendix M) and is handed to the patient by the receptionist. If a personal history form is to be filled out (see Appendix N) the patient should be asked to come in at least twenty minutes before the interview. If no forms are employed by the therapist, the receptionist may get the patient's name, address, and telephone number and make up a case folder, which may include an Initial Interview Form (such as Appendix C) or blank sheets of paper on which to enter the initial interview data.

It goes without saying that the therapist should see the patient promptly at the appointed time. This sets the pattern of precision in appointment times, one of the necessary disciplines in treatment.

INSURING THE PROPER EMOTIONAL ATMOSPHERE

The average patient at the initial interview is burdened with great anxiety, harboring many conflicting emotions at the prospect of opening up pockets of guilt, of discovering fearsome secrets, of being exposed to the scrutiny and judgment of a strange individual, and of becoming the victim of unscrupulous practices. The degradation of consulting a "mind doctor" who may detect personal weaknesses, anticipating hurt in some mysterious way through probings of an unpredictable authority, yet hopeful that this new healer will achieve what others have failed to do, may release fantasies and expectations that know no bounds. This tangle of contradictory attitudes and feelings may mortify the patient until their reality is tested in the relationship with the therapist.

No better rule can be followed in the therapist's first contact with the patient than to heed the injunction to "be thyself." Artificial dignity, practiced pompousness, and professional poise will easily be penetrated by most patients. A studied, "deadpan," coldly analytic attitude and manner, advocated by some schools of psychotherapy, are particularly poisonous to a therapeutic atmosphere, which relies on honest communication. The patient must sense, from the behavior of the interviewer, that his or her turmoil is appreciated and that adequate steps will be taken to help with the problem. At all times the interviewer must manifest as kindly and sympathetic an attitude as possible. Exhibitions of irritation, disgust, or disinterest or intimations that the patient's difficulties are hopeless or irremediable may prove to be irreparably destructive.

In the enthusiasm to get information the initial interviewer is apt to lose sight of the fact that it may be more important to establish rapport with the patient than to make a diagnosis. Many patients are lost during the first session because their emotional resistance to the acceptance of help has not been considered by the interviewer.

A good way of handling the initial contact is to greet the patient with a smile and introduce oneself. The patient is then invited to sit down. This casual way of approaching the patient is generally most reassuring.

> Th. (*smiling*) Are you Mr. Jones? I am Dr. Smith. *[If the patient extends his hand, the therapist shakes hands.]* Won't you sit over there in that chair so we can talk things over.

> Pt. *[The usual reaction is a smile and a polite comment of some kind.]*

STRUCTURING THE PURPOSE OF THE INTERVIEW

In structuring the purpose of the interview, the role that the therapist will play with the patient in the future must be kept in mind. If the therapist is merely seeing the patient in consultation in order to make a diagnosis and to refer the patient to another professional, this must somehow be conveyed to the patient. At the end of a well-conducted initial interview the patient will have established a feeling of confidence in the interviewer and will want to continue in therapy with that particular person. If not clear about the purpose of the interview, the patient, assuming that the interviewer will continue as therapist, will be frustrated, upset, and resentful at being referred to another professional who may bring to pass a realization of the fears somehow avoided with the present interrogator. The patient may be told, "Now the purpose of this interview is to get an idea about your problem so that I can find the best therapist to help you. It is important that you get treated by the very best available person, and I'll help you find such a person."

If there is available time and it is possible to accept the patient, the therapist may simply state, "Now the purpose of this interview is to get an idea about your problem so that we can decide the best thing to do for it." This leaves the door open in the event that the therapist decides to work with the patient.

If a resentful or unmotivated patient is being interviewed, the therapist must not convey an eagerness to get the patient into therapy. A statement such as this may be appropriate, "Now you've been sent here to talk things over with me. I don't know what I can do to help you, but if you give me an idea of the trouble you've been having, I'll see

what I can do for you."

Most patients proceed to relate their problems to the interviewer without too great difficulty, following the structuring of the interview situation. As long as talk continues readily and spontaneously, the patient is not interrupted, being encouraged by the therapist's sympathetic facial expressions, noddings and subvocal utterances. After the patient's spontaneous account, specific information is obtained by pointed questions.

Some patients, however, may be too upset to proceed with an account of their problems. They may feel helpless and insecure and believe themselves to be at the mercy of forces that they can neither understand nor control. Often they resent the circumstances that forced them to apply for psychotherapeutic help, the efficacy of which they unreservedly doubt. Ashamed at being unable to handle their problems personally, they consider themselves to be weak and stupid. Unsure of the therapist's designs, uncertain of whether they will be exploited, humiliated, subjected to hospitalization or to other forceful measures, they may respond with resentment. They are apt to express their anger in the form of open defiance. Sometimes, they may handle themselves by acting apathetic or by displaying a kind of braggadocio that conceals their underlying turmoil. They may resort to a clinging dependency, plaintively appealing for succor and support. These reactions have to be handled carefully. One way of doing this is by calmly and sympathetically verbalizing how the patient must feel, indications being gathered from verbal and nonverbal clues. Putting feelings into words does much to help the patient accept the fact of the interviewer's understanding and non-punitive role.

The interviewer will have to display relatively great activity at the start of the interview under the following conditions:

1. If the patient is manifestly upset emotionally.

2. If the patient talks about attitudes toward therapy and toward the interviewer, rather than about the problem.

3. If the patient cannot seem to get started talking or does not know what to say.

4. If the patient pauses or is silent too long.

5. If the patient shifts the trend of talk from relevant to irrelevant material.

The handling of a patient who is upset emotionally will depend on the kind of affect involved and on the intensity of response. If the patient is depressed, agitated, and tearful, a display of warmth and understanding may stabilize the patient sufficiently so that he or she can verbalize freely. For example, one patient, following a structuring of the interview, broke down into tears after uttering a few words:

> *Pt.* Oh, oh ... I don't know what to say. ... I feel lost ... completely lost ... *(cries)*
>
> *Th.* I know how difficult this must be for you. *[communicating sympathy]*
>
> *Pt.* Oh, oh, oh ... *(continues crying)*
>
> *Th.* You have suffered a great deal and understandably are upset. But I am going to do everything I can to help you.
>
> *Pt.* Thank you, doctor.
>
> *Th.* Now if you will tell me about your trouble, I will see how I can best help you.
>
> *Pt. (relates problem)*

If a patient is tense and fearful, he or she may be approached as in this excerpt.

> *Pt.* I just can't think of anything to say. I'm so scared to death.
>
> *Th.* What do you think is going to happen?
>
> *Pt.* I don't know. I've read so much about psychology. I'm afraid I'll find out something about myself that will be terrible.
>
> *Th.* Most people feel this way when they start treatment.
>
> *Pt.* Yes, but, I'm afraid I'm different than other people are.
>
> *Th.* I see, in what way?
>
> *Pt.* I get so keyed up about nothing. (*Patient gets into the problem from this point on.)*

In the event that the patient is excessively hostile, one must refrain from responding with counterhostility. A man referred by a physician arrived for his appointment 10 minutes late. While the interview was being structured, he angrily stared at the interviewer. The following conversation took place:

> *Pt.* Dr. B_ sent me here for these headaches. He thinks it might be mental. I really don't think it was necessary for me to come.
>
> *Th.* Do you believe it's mental?
>
> *Pt.* Good Lord, no! I think I need something that will ease this pain. I've been told a million different things of what's wrong.
>
> *Th.* Perhaps you are right. It may be entirely physical. What examinations have you had?
>
> *Pt. (Patient details the many consultations that he has had.)*
>
> *Th.* Then it perhaps made you angry to come here?
>
> *Pt.* I was angry. Not now though. Do you think you can help this headache?
>
> *Th.* I'm not sure; but if you tell me about your trouble from the beginning, I might be able to help you with any emotional factors that can stir up a headache.
>
> *Pt.* How can that do it? I know I have been emotional about it. *(The patient proceeds now with an account of his difficulty.)*

In the event that the patient is preoccupied with feelings about the interviewer and does not wish to discuss any problem, it is important to explore such feelings as thoroughly as possible before proceeding with the interview. How the patient was referred to the interviewer is important. The patient may have been forced into treatment by an actual or implied threat, may have been told that he or she is a nuisance and deserves to see a psychiatrist, or may have been promised a cure in a few sessions in view of the presumably rapid strides psychiatry has made in recent years. Under these circumstances the person will possess a certain mental set that will have to be rectified before the proper therapeutic situation prevails. Misconceptions about psychotherapy are rampant and will require clarification. Examples and methods of handling these are detailed in Chapter 34.

The management of difficulties in verbalization, and of pauses, silences, and shifts from pertinent material may be along the lines indicated in this Chapter.

A source of great initial resistance is the patient's disappointment in the therapist. Patients usually come to treatment with a stereotype in mind of the kind of individual whom they want as a therapist. This is generally a kindly and wise middle-aged male psychiatrist. Such an image is partially the product of the universal need for an idealized father figure and partially the popular movie and magazine conception of the "mental healer." Other notions of an ideal therapist are nurtured by desires to fulfill, through special qualities in the therapist, impelling neurotic needs. For example, masochistic patients may yearn for a powerful and cruel individual, who will deal with them firmly, and they will try to seek out a therapist who possesses punitive potentialities. A frustrated middle-aged woman may have a longing for a virile, handsome, male figure through whom she may sublimate her unpropitiated longings. A passive, dependent male may desire a strong female therapist who can dominate him and mother him. If the patient is aware of and verbalizes disappointment, this will have to be handled in a therapeutic way. Examples of managing such situations follow:

1. *Questions about the age of the therapist*

> *Pt.* I expected to see an older person.
>
> *Th.* You are disappointed that I'm too young?
>
> *Pt.* I really wanted an older man than yourself to treat me.
>
> *Th.* I see. Perhaps you feel you could have more confidence in an older man. *[Reflecting possible attitudes behind the desire for an older person]*
>
> *Pt.* It isn't personal, doctor, it's just that I've had this so long, I wanted a person with lots of experience. Dr. J told me you had a great deal of... well, but I thought you'd be at least 55 or 60 years old.
>
> *Th.* Yes, it's natural for you to want to get the best kind of help for your problem, and you might feel that an older person has had more experience. If you'd like to tell me what your difficulty is, perhaps I could help you locate such a person *(accepting the patient's desire)*
>
> *Pt.* Well, it goes back a long way. *(Patient discusses the problem.)*

2. Questions about the experience and training of the therapist

a. The extent of experience

    Pt. I'd like to ask you about your training.

    Th. Mm hm. (smiling) what would you like to know?

    Pt. Well, how long have you been doing psychiatry?

    Th. You must have some question about my qualifications. What kind of a therapist do you believe you would be able to work with best? *[reflecting possible attitudes behind the question]*

    Pt. Well I wanted someone, someone who had a lot of experience.

    Th. I don't blame you for that. Certainly you would want someone who would really know how to handle your problem, *[again accepting the patient's wish]*

    Pt. Yes.

    Th. Suppose I tell you that I have had enough training and experience to have helped many people. Now whether I am the best person to help you, I don't know. But why don't you tell me about your problem, and then we'll decide on the best kind of a psychotherapist for you. If I'm not the best person, then I'll help you find someone.

b. The kind of experience—sometimes the patient seeks a specific kind of psychotherapy and questions the orientation of the therapist

    Pt. Do you do hypnosis and hypnoanalysis?

    Th. Do you feel you need hypnosis?

    Pt. Well everyone tells me I should get that. I read about it.

    Th. Certainly if you need hypnosis, you should get it. But I'd like to go into your problem and then we can decide whether hypnosis is the best treatment for you. If you need hypnosis, then we can decide on the best person for you.

c. The kind of training

    Pt. Could I ask you a question? Where did you get your training?

    Th. You must be wondering whether I'm adequately trained enough to help you. *[reflecting possible attitudes behind question]*

    Pt. I'm wondering what kind of therapy you do.

    Th. I see. Do you have an idea of the kind of therapy you feel you need?

Pt. Well, no, but I know training is important.

Th. I think you have a right to know that the person treating you is adequately trained. [At this point the therapist may outline his or her training, and, if the patient is not satisfied, the patient may be told that after going over the problems, referral will be discussed.]

3. *Questions about the sex of the therapist*

Pt. Somehow I pictured being treated by a woman.

Th. Do you have any feelings about working with a man?

Pt. No, but I think a woman would be better for me. I could talk easier.

Th. I see, well perhaps what we might do is talk about your problem, and then we can decide on the best person to treat you.

4. *Questions about the religion of the therapist*

Pt. Are you Catholic?

Th. No. Do you feel that makes a difference?

Pt. I think a Catholic doctor might understand my problem better. You see, I'm Catholic.

Th. Yes, it's possible that a therapist with a background similar to yours might do better with certain kinds of problems. But suppose you describe your problem, and then we'll decide on the best person who can treat you.

5. *Questions about the professional identification of the therapist*

Pt. I was told to see a psychologist because I'm failing in my studies.

Th. Does it make a difference to you if I'm not a psychologist?

Pt. Well I don't know. You see, my sister called you about me when I told her I should see a psychologist because of how I was doing in college.

Th. It's true that psychologists do deal with educational problems, but other trained persons can do that too. Now, I'm a psychiatrist and I think I can help you, but suppose we talk about your problem, and then we will discuss whether a psychologist would be better for you. I'll then find the best one who can help you.

The principle outlined in these interviews is to *join the initial resistance* rather than fight it. The object is to get the patient to verbalize and ask more questions if desired.

Once these questions are answered, the patient will, as a rule, talk freely about the problem. It is rare, in a properly conducted interview, to encounter a desire to change therapists. The patient will usually have found the interviewer sufficiently discerning and empathic to want to continue in therapy with that therapist.

24
The Initial Interview: Collating Essential Data

Essential data will be needed to enable the therapist to fulfill the purpose of the initial interview. These must be obtained in an atmosphere of empathy in order to get a cogent understanding of the existing problem, to pierce resistances the patient has to treatment, and to assess existing and latent coping strengths. In collating data one must remember that the patient may withhold significant information for a number of reasons, such as (1) the patient may not know which facts are most meaningful and thus may stress the less important details; (2) may accept certain neurotic aspects as "normal" and environmental stress situations as inevitable and not consider them worthy of mention; (3) may have emotional blocks to revealing some incidents (anxiety here invokes suppressive and repressive mechanisms); (4) may have no respect for, mistrust, or fear the interviewer.

Because of these facts, it may be necessary to piece together tentatively whatever information can be obtained at the start and await resolution of the patient's resistances during therapy before one can gather sufficient material for a correct evaluation of the problem.

Some interviewers believe a formal case history to be of advantage in getting pertinent data: others challenge the value of history taking for patients who are to receive psychotherapy. Those in favor of the practice insist that great gaps in information are present where reliance is placed solely on the spontaneous unfolding of historic material. Only a careful inquiry into the various areas of somatic, psychologic, interpersonal, and community functioning is said to reveal a complete picture of what has been happening to the patient. If adequate historic data is lacking, it may be months before the patient gets around to talking about an aspect of the personal problem that never was revealed at the beginning, and this may give the therapist an entirely different perspective of the situation.

On the other hand, there are many reasons why interviewers hesitate to take complete case histories. First, exhaustive histories are not considered absolutely necessary from a diagnostic point of view. Second, they are not believed to be therapeutically valuable. Therapy is regarded as a process not of collecting information but of helping the patient to develop a new outlook on life. Background material is felt to be not too important in promoting this goal. Third, it is argued that when the patient is asked to reveal personal data, resistance may be mobilized and significant facts concealed. Fourth, the patient may assume that a report of personal history entitles a sitting back to await an automatic solution of existing troubles.

Some therapists have attempted to get around the arguments against taking a case history by having the patient fill out a questionnaire or by having some other person, such as a social worker, do the history taking. There is an advantage to be gained in this if the therapist needs as much information as possible in outlining a treatment plan. Even here, however, the presentation to the therapist of historical data at this stage may not be as helpful as one may imagine; the eliciting of these data during the ongoing therapeutic process tends to bring the patient and therapist more closely together, helping to establish a working relationship.

In clinics, the tendency is toward history taking, particularly where teamwork is employed. In private practice the tendency is away from formal history taking. Among psychoanalysts there is an inclination to follow Freud's (1913) injunction to avoid the structuring of the initial interview, to abstain from "lengthy preliminary discussions," and, in E. Glover's words (1955), not to "repeat the emotionally strenuous experience of a prolonged anamnesis." Gill et al. (1954) have recommended a spontaneous unfolding of the patient's problems in the initial interview. V. Rosen (1958), on the other hand, while admitting that this is suitable for the experienced professional, believed it advisable to encourage a traditional diagnostic interview for the inexperienced therapist.

Whether or not a case history is taken, the desirable data to be obtained from the patient are given in Table 24-1.

Kanfer and Saslow (1965) have prepared an outline for the gathering of information for use in approaches that are related to behavior therapy. The job of psychotherapy, they contend, is not the removal of intrapsychic conflicts but the utilization of a variety of methods that control the patient's environment, behavior, and the consequences of the behavior. Control of reinforcing stimuli "require that the clinician, at the invitation of the patient or his family, participate more fully in planning the total life pattern of the patient outside the clinician's office." Data collecting is concerned with identifying major variables that can be modified or controlled as well as with pertinent controlling stimuli in the environment. Toward this end the authors present a working model for a behavioral analysis: (1) problem analysis (categorization of behavioral excesses and deficits that are targets of the therapeutic intervention, along with the patient's behavioral assets); (2) clarification of the problem situation (which people and what circumstances maintain the patient's problem behavior and the consequences of such behavior); (3) motivational analysis (arrangement of a hierarchy of events, objects, and people that reinforce approach as well as avoidance responses); (4) developmental analysis (biological equipment, sociocultural experiences, behavioral development); (5) analysis of self-control (deficits and excesses of self-controlled behaviors and persons and situations that reinforce these); (6) analysis of social relationships (which people influence problematic behaviors or are being influenced by the patient); and (7) social-cultural-physical environment (norms in patient's environment and relationship to patient's idiosyncratic life patterns).

The above information permits manipulation of motivational controls for modification of the patient's behavior. Since, according to learning theory, behavior disorders are learned response patterns reinforced by definable environmental and internal stimuli, a delineation of the circumstances that control the patient's behavior output is at least as important as describing the pathology. Test findings, interview protocols, and referral histories must be supplemented by an account of the patient's behavior "*in relationship* to varying environmental conditions." Past history is important only in defining independent variables that control the current behavior. A verbal self-report is not equivalent to actual events or experiences; these represent current behaviors

in terms of verbal chains and repertoires that the patient has built up. The traditional interview techniques that are used are reinforced by role playing, free association, observation of the patient's interactions with other individuals, confrontations of the patient with tape recordings, material about the patient supplied by the patient's family and other informants, study of the patient's daily work behavior, responses to psychological tests, and other procedures for gathering pertinent information.

Obviously it will be impossible, due to the limited available time, to obtain all of the essential data related to the patient and the patient's problem during the first interview. Nor will information be in the order outlined. Therefore, material will have to be pieced together from various fragments of the interview. Some order in the eliciting of facts, however, will be helpful in obtaining as complete a picture as possible.

THE CHIEF COMPLAINT

Immediately after structuring the purpose of the initial interview and handling initial resistances, the therapist may attempt to get into the presenting problem with such a remark as "Suppose you tell me about your problem" or "Would you like to tell me about your problem?" Responses to such remarks are many.

1. The patient may proceed to detail the complaint factor.

Th. Suppose you tell me about your problem.

Pt. Yes, it's that I can't eat. My stomach gets upset, and I have to watch my diet. And then I get jittery all over for the slightest reasons.

2. The patient may hesitate on the basis of an inability to gather his or her thoughts or because of unclarity as to the nature of the difficulty. Here, a rephrasing of the question may help.

Th. Would you like to tell me about your problem?

Pt. (pause) I just don't know where to begin.

Th. Well, what bothers you most? *[rephrasing the question]*

Pt. Well, my worst trouble is how I get along with my wife. We've been married now going on 10

years, and we've never gotten along well.

3. The patient may be completely blocked in voicing the chief complaint. Asking repeated questions may be necessary.

Th. Suppose you tell me about your problem.

Pt. (pause) I just don't know what it is.

Th. Would you rather that I asked you questions?

Pt. Yes, I'd rather you did.

Th. What bothers you most?

Pt. I don't know.

Th. Do you have any special trouble with anything?

Pt. Nothing seems to stand out. I feel upset all over.

Th. Physically upset?

Pt. Yes, I get the shakes and my bowels are upset when I get tense.

Th. Anything else?

Pt. You mean physically?

Th. Yes, or otherwise.

Pt. Well, I can't think clear. My mind is in a fog. I can't remember things.

Th. Mm hmm. *(pause)*

Pt. And I can't work because I just feel so weak I can hardly sit. *(Patient continues to elaborate on his problem.)*

The chief complaint may not be the most important problem for which help is needed. As a general rule, the patient voices the complaint in terms of manifest disturbing symptoms. Here one symptom may be focused on to the exclusion of others. Thus, the patient above may present as a chief complaint the fact that he is depressed. As he describes his problem, it is evident that he is also detaching himself from people, that he has a gastric ulcer, and that his inability to work has jeopardized his economic security.

Statements by the patient of the most important difficulties as the patient sees them should be recorded verbatim if possible. The initial interview form in Appendix C in Part II is excellent for this purpose and for the recording of other data during the interview. The use of a form to tabulate highlights of the interview relieves the therapist of much writing and frees the therapist to interact with the patient.

HISTORY AND DEVELOPMENT OF THE COMPLAINT

The patient, immediately upon mentioning the complaints, may spontaneously begin discussing how and when they originated. If this does not occur, pointed questions may be asked, such as:

1. *Onset:* "How long ago did your troubles begin?"

2. *Circumstances under which the complaints developed:* "At the time your trouble began, what were you doing?" "Were there any changes in your life situation?" "Were you happy or unhappy at the time?"

3. *Progression from onset to the beginning of the initial interview:* "Once this trouble started, what happened?" "Did your difficulty get worse as time went on?"

In revealing the history and development of his or her complaint, the patient may elaborate on the current environment, daily habits, and routines. The description of the patient's present life situation involves judgments by the patient that must be carefully scrutinized. Depending on emotional needs, some persons will react catastrophically to even average vicissitudes, while others seem capable of tolerating very severe environmental stress. The patient may consequently exaggerate, distort, or minimize life difficulty. There may be a need to blame inner turmoil on environmental factors that were self-created. On the other hand, the patient may be unaware of how disturbed the situation actually is, accepting it as an inevitable consequence of living, yet reacting to it with untoward emotion. The interviewer must, therefore, never accept the patient's statements at face value and must later validate the account given.

The unfolding of the historical development of the complaint may be accompanied by the introduction of many tangential and perhaps irrelevant elements. It will be necessary constantly to focus on pertinent aspects of the patient's problem since many points will have to be covered to fulfill the purpose of the interview. Generally, if more than 15 minutes or so are consumed in discussing the history and development of the complaint, the patient may be interrupted.

STATISTICAL DATA

If the patient has not filled out a Personal Data Sheet (see Appendix D) or if a statistical form has not been made out in advance by a social worker, it is incumbent on the therapist to get essential statistical information (see Appendices A or C). Assuming that the patient has discussed sufficiently the development of the complaint, the therapist may interrupt this and proceed, as in the following excerpt:

> *Th.* Well now, I'd like to ask you a few questions about yourself, and then we'll go ahead discussing your problem.
>
> *Pt.* Fine.
>
> *Th.* Your full name is?
>
> *Pt.* George Dickens. *[The patient's name and other identifying details have been changed to conceal his identity.]*
>
> *Th.* Your address is?
>
> *Pt.* 211 Thorton Street.
>
> *Th.* Home telephone?
>
> *Pt.* 677-4228.
>
> *Th.* Business telephone?
>
> *Pt.* Well, I'd rather you didn't call me there.
>
> *Th.* Yes, of course. If I do call to change an appointment or the like, when can I call you?
>
> *Pt.* After six o'clock.

Th. Would you rather that I wouldn't mention my name if I do call? *[This is to reassure a patient who is fearful that others will find out he or she is consulting a therapist.]*

Pt. It really doesn't matter. It'll be all right.

Th. What people are living with you at present?

Pt. My wife and child.

Th. How old are you?

Pt. Thirty-two.

Th. You are married you say?

Pt. Yes.

Th. How long have you been married?

Pt. Three years.

Th. I see. Any previous marriages?

Pt. No.

Th. How old is your wife?

Pt. Thirty.

Th. Does she work other than doing housework?

Pt. Yes, she writes copy for an advertising company part time.

Th. Mm hmm. About what is her salary?

Pt. Well, I don't know. I'd say about $5000 yearly.

Th. What about children; how many do you have?

Pt. Just one; she's two years old.

Th. How far through school did you go?

Pt. Two years of college.

Th. And your occupation?

Pt. I'm a linotype operator.

Th. What do you earn?

Pt. About $15,000 a year, take-home pay.

Th. Were you in the armed forces?

Pt. Yes, for three years.

Under some circumstances, this statistical data may be obtained at the beginning of the interview before the patient talks about the complaints and symptoms. It is recommended, however, that the procedure outlined be followed, since the average patient is under considerable tension and considers the giving of statistical information about oneself a diversion. If the patient has filled out a Personal Data Sheet (Appendix D), it is unnecessary to burden him or her with the above questions, unless there are points that have been omitted or that need clarification.

OTHER SYMPTOMS AND CLINICAL FINDINGS

It is helpful to get a general idea of other symptoms besides those discussed by elaboration of the complaint. Due to the limited time available in the initial interview—45 minutes to 1 hour is the usual time allotted to a session—pointed questions are necessary. Suggested areas of questioning are indicated in item 3 of the Initial Interview Form (Appendix C). Continuing with the interrupted interview above:

Th. Now, I'd rapidly like to ask you about other symptoms you may have. What about tension; do you feel tense?

Pt. Oh yes, all the time.

Th. Mm hmm. What about depressions; do you get depressed?

Pt. Yes, now and then.

Th. You snap out of it, though?

Pt. Yes, I do.

Th. How about anxiety?

Pt. I don't know what you mean.

Th. Well, spells when your heart palpitates and you get panicky.

Pt. Yes, when I am in the company of people.

Th. Any other time?

Pt. When I'm asked to do something, like make a speech.

Th. I see. What about physical symptoms; do you have those? [*It will be noted that questions are not asked in reference to suicidal tendencies, hallucinations, delusions, and dangerous and excited tendencies. The therapist should ask these questions only where the clinical condition of the patient warrants it. To ask them when they are not indicated may be upsetting to the patient or may be productive of resentment.*]

Pt. (pause) I don't know.

Th. Well, for example, what about fatigue and exhaustion?

Pt. Oh, yes, all the time.

Th. How about headaches?

Pt. No.

Th. Dizziness?

Pt. No.

Th. Stomach or bowel trouble?

Pt. Yes, when I get nervous, upset, they come. Butterflies in my stomach.

Th. Diarrhea?

Pt. Sometimes.

Th. Do you have any sexual problems?

Pt. I wouldn't say so.

Th. Your sex life is satisfactory then?

Pt. Yes. [The patient's evaluation of this and other aspects of his functioning should not be accepted at face value. As he explores his problem, he may find that what he considers "normal" may not be good functioning. In this patient, for example, sexual frequency was once every 3 weeks with no true enjoyment.]

Th. Any phobias or fears?

Pt. Of talking in front of groups, of meeting strange people.

Th. Mm hmm. Any other fears?

Pt. I don't think so.

Th. Any thoughts or obsessions that crowd into your mind and frighten you?

Pt. No.

Th. Any compulsions—the need to do things over and over?

Pt. No.

Th. What about sedatives; do you take sedatives?

Pt. No.

Th. Do you drink alcohol excessively?

Pt. Well, I have an occasional drink.

Th. Get drunk?

Pt. Oh no.

Th. What about insomnia; how do you sleep?

Pt. I sleep fine.

Th. Any nightmares?

Pt. No.

DREAMS

The recording of a nightmare, of a typical dream, and of repetitive dreams are helpful to the analytically trained therapist in gaining clues as to unconscious foci of conflict. Continuing the interview:

Th. Do you dream a lot or a little? *[This question is phrased this way because patients are apt to think, if they are asked merely whether they dream, that dreaming is abnormal.]*

Pt. Oh, a little.

Th. Remember your dreams?

Pt. Sometimes.

Th. Suppose you tell me a dream that you had recently.

Pt. I can't seem to remember any right now.

FAMILY DATA

Briefly recorded family data are valuable to the initial interviewer in appraising the quality of the patient's relationships and in anticipating responses to male or female therapists. The interview continues:

Th. Now, I'd like to ask you a few brief questions about your parents. You mother, is she living?

Pt. Yes, very much so.

Th. What kind of a person is she?

Pt. Well, a nice person; she did what she thought was best. She was a nervous person, self-centered, always fighting with my father.

Th. How did that make you feel?

Pt. Well, I don't know. My mother and father were divorced when I was eight years old. He left. I saw him rarely.

Th. How did you feel about that?

Pt. I don't know; all right, I guess. My mother thought he was a heel.

Th. Did you?

Pt. No, he was all right. I guess he took quite a beating from my mother. She was the smarter of the two.

Th. What sort of a person was your father?

Pt. A quiet fellow. I didn't know him well.

Th. How did you feel about him?

Pt. I liked him.

Th. Any brothers or sisters?

Pt. Only one older brother. He's 36 years old.

Th. What about him; how did you get along with him?

Pt. Well, when we were small we'd fight a lot. He didn't like me. But we see each other now. (*laughs*) I guess we learned to tolerate each other.

Th. How do you feel about him now?

Pt. (*laughs*) O.K., I guess. We like each other.

Th. Now how about your wife; what sort of a person is she?

Pt. Nice, patient with me. She's got her troubles. Her mother hounds her.

Th. How do you feel about her?

Pt. Fine. We get along better than we ever did.

Th. Like her?

Pt. Oh, sure.

Th. What about your daughter; what sort of a youngster is she?

Pt. Oh, she's a devil, all right. Gets into everything.

Th. How do you feel about her?

Pt. Oh, fine; I like her.

The patient's evaluation of his family and his expressed attitudes toward them do not always indicate his true feelings. Guilt may cause him to conceal or to repress important attitudes that may come up later in therapy when he has developed the strength to tolerate the implications of his suppressed or repressed emotions.

PREVIOUS EMOTIONAL UPSETS

The patient should be asked questions about any previous emotional disturbances that were experienced. This will give the interviewer clues as to the severity of the patient's disorder and how far back in one's life it goes. The interview continues:

Th. No.w, what about nervous problems previously; any previous attacks of the same kind before?

Pt. No, not exactly like this.

Th. Well, any other kind of nervous upsets?

Pt. I've always been nervous.

Th. How far back would you say your nervousness goes?

Pt. As a kid, I was afraid of other kids. I didn't like to fight.

Th. Did you have any nervous troubles for which you needed help?

Pt. My mother was always concerned. I was a sickly kid, always had one thing wrong with me or another. I had ear trouble a good deal.

PREVIOUS TREATMENT (INCLUDING HOSPITALIZATION)

Any previous therapeutic efforts should be recorded to discern the problem for which help was sought, the progress achieved, and the patient's response to all former therapists. Unless indicated by the severity of the problem, questions need not be asked about hospitalization. Continuing the interview:

Th. Have you ever had treatments for your condition from a psychiatrist or any other person who gave you psychotherapy?

Pt. No. I've read some books but never gotten treatments.

25
The Initial Interview: Making a Diagnosis

Although diagnosis is, more or less, an arbitrary matter and should not prejudice the therapeutic approach or the goals, it is convenient to attempt classification as soon as possible.

All emotional problems spread themselves over a wide pathologic area and include a combination of intellectual, emotional, behavioral, and somatic symptoms. A disturbed character structure will be found in practically every patient, reflecting itself in difficulties in interpersonal and social relationships. One may discern, in most instances, at least mild manifestations of tension, anxiety, depression, and psychosomatic symptoms. If adaptation is being interfered with, there will appear psychological defenses singly or in combination, such as phobic, compulsive, conversion, and dissociative mechanisms. In some instances certain symptoms and defenses are so outstanding as to constitute definite syndromes. For example, the patient may complain of an inability to walk outdoors due to intense anxiety. Emphasis on this symptom tempts the therapist to diagnose the condition as a phobic disorder. Yet a search will probably reveal a concomitant personality problem, psychosomatic manifestations, depression, and symptoms characteristic of other syndromes.

What obscures diagnosis are a number of cultural determinants. Unlike organic pathology, psychological pathology is often a matter of values and standards. Whereas psychotic and severe psychoneurotic syndromes are sufficiently deviant from "normal" to be distinctive, the milder psychoneuroses and character disorders are afflictions that may pass unrecognized. Indeed, they are so common that they may not be considered in the category of disease, particularly when they are accepted in the culture or subculture in which the individual functions (Opler, 1957, 1963). Thus, within certain groups, alcoholic over-indulgence, compulsive-obsessive manifestations, and perverse sexual drives may not be considered unusual.

A diagnosis is frequently made on the basis of the most important complaint factor. This can be misleading. For example, a patient complaining of intractable insomnia may be classified as suffering from a habit disorder. Yet on examination there may be found underlying the insomnia a masked depression concealed by spurious conviviality. It is most advantageous to make a diagnosis on the basis of the total picture, irrespective of the emphasis placed on symptoms by the patient.

RULING OUT ORGANIC SOURCES OF SYMPTOMS

It is important also, before making a psychologic diagnosis, to rule out the presence of a somatic disorder that may be inspiring emotional symptoms. In the event the patient has not had a recent physical examination, this should be recommended.

Most organic diseases are accompanied by various psychological symptoms, the latter sometimes severe enough to block the therapist from perceiving the existence or type of somatic problem. Some of these psychological manifestations result from tension aroused by a diminished sense of self-mastery because of the underlying disorder. Feelings of insecurity, helplessness, inability to function at an optimal level, fears of prolonged disability, dependency, or death will tax the coping capacities of the patient and mobilize varying degrees of anxiety. The symptom picture will depend on the individual's personality, strength of defenses, and characteristic mode of dealing with anxiety.

In addition, some emotional symptoms are inherent to certain physical illnesses. In view of the potential medicolegal problems involved in a missed diagnosis, and in service to the patient's best interests, it is important that the psychotherapist have sufficient knowledge of somatic symptoms so that any necessary referral for diagnostic studies can be made. Unfortunately, there are few pathognomanic signs so characteristic of each disease syndrome as to make possible an immediate diagnosis. The most that the therapist can do is to err on the side of caution and to secure consultative help at the least suspicion that a physical or neurological condition exists.

Epilepsy can be accompanied by alterations in emotional and behavioral expression

that may be admixtures of psychologically determined personality problems and physiologically based disruptions in the pathways of the emotional centers of the brain. Periodic and inappropriate outbursts of rage, anxiety, and depression are common. Bizarre behavioral manifestations are also apt to occur and are characterized by compulsive sexual activities, inordinate food proclivities, and violence and aggression. These behavioral disorders may be anticipated and diagnosed if the patient has a history of epileptic seizures. They are not so easily diagnosed when there are no outright grand or petit mal attacks. The only sign of organic disturbance are abnormal brain waves as recorded by electroencephalography over the temporal lobes. The test abnormalities are most pronounced when the behavioral disturbances are at a maximum. Another clinical type involves cases in which there are symptoms akin to an acute schizophrenic outbreak, with delusions, hallucinations, and disturbed cognitive functions. During symptom-free periods these manifestations are not apparent. The therapist should, consequently, be alerted to the possibility of epilepsy when the patient's history reveals fluctuating acute schizophrenic symptoms. If abnormal brain waves are discovered through electroencephalography, responsibility for therapy should be shared with a neurologist.

Brain tumors should be suspected if patients complain of headaches and display distinctive neurological signs. Such cases are relatively rare compared to the truly functional "tension" headaches, but when after long-term therapy a brain tumor is discovered, the consequences can be severe for the patient and present a potential legal problem for the therapist. The frequency of brain tumors in patients with neurotic symptoms is not known, but at autopsy in patients hospitalized for psychotic illness, the rate ranges from 1 to 2 percent. How many of these would have been operable if detected is difficult to say. Problems occur in diagnosis when brain tumors are "silent," that is, when they do not cause intracranial pressure and do not impinge on sensory and motor pathways, the effects of which may be undetectable during physical examination. Not even a neurologist, let alone a psychotherapist, can discover some early tumors. But the latter should be aware that brain tumors can mimic neurotic and psychotic syndromes, and, when it is impossible to explain confusing symptoms on the basis of dynamic formulations, a good physical and neurological examination—including

electroencephalogram, skull x-ray, and diagnostic brain scan— should be obtained.

Head injuries may bring forth a host of neurotic and psychotic symptoms, including exhaustion, depression, memory impairment, confusional episodes, and vague psychosomatic symptoms. Psychological compensation for disability exaggerates and prolongs the physical symptomatology. The therapist obviously should have in the patient's records a report of a recent examination from a neurologist, and if neurological signs are discovered, work jointly with the neurologist. Other neurological conditions may be associated with neurotic or psychotic symptoms. In *multiple sclerosis,* for example, in a certain number of cases there are found emotional instability (such as silliness and giddiness) and various behavioral changes. The therapist is apt, if unaware of the patient's condition, to credit these manifestations as well as the shifting physical signs to conversion hysteria.

General paresis, though rare because syphilis can be treated with penicillin when caught early, still occurs and may produce a variety of psychiatric syndromes, most commonly a manic type of euphoria with delusions of grandeur.

A number of endocrine conditions can be responsible for symptoms that the therapist may mistakenly credit to a functional neurotic etiology. *Pituitary disorders* may sometimes produce symptoms similar to depression and anorexia nervosa (Simmond's disease). *Thyroid disorders* are much more common, and the therapist should be alerted to *hyperthyroidism* when the patient is losing weight, sweating, and is tense, tremulous, and extremely irritable. Both overactivity and depression are possible, and in more severe cases a maniacal type of behavior with delusions may be seen. *Hypothyroidism* may be accompanied by mental apathy, sluggish speech, and dulled behavior as well as by dementia and even delirium. The physical signs of hypothyroidism—obesity, dry skin, myxedematous facies, puffiness of the hands and face, and alopecia of the scalp and eyebrows—should make the diagnosis of this condition possible. *Hypoparathyroidism,* associated with thyroid surgery can cause neuromuscular excitability, paresthesia, tonic contractions of the muscles, and impaired breathing. Neurotic symptoms such as anxiety,

depression, and emotional instability are common. *Hypoglycemia* can be organic (as in tumors of the pancreas) and functional. Symptoms resemble those seen in anxiety states. Attacks often occur several hours after meals and include sweating, chilliness, trembling, headache, weakness, dizziness, apprehensiveness, restlessness, and emotional instability. Diagnosis is made by establishing, during an attack, a low glucose level (i.e., less than 40 mg/100 ml venous blood). A rapid relief of symptoms occurs with the administration of dextrose. In *hypoadrenocorticism* (Addison's disease) there is, as a consequence of atrophy or destruction of the adrenal cortex, increasing weakness, fatigue, anorexia, apathy, depression, intolerance to cold, negativism, dizziness, and syncope. If a patient displays such symptoms along with increased pigmentation over the exposed and nonexposed parts of the body, this condition should be considered and ruled out. *Hyperadrenalism* (Cushing's syndrome) is often accompanied by psychiatric symptoms (depression, delusions, hallucinations) and is due to hyperfunction of the adrenal cortex. A round "moon" face, truncal obesity, and slenderness of the distal extremities and fingers are the usual physical charcteristics in this disease. *Pheochromocytoma* (a chromaffin cell tumor of the adrenal medulla) is associated with increased release of catecholamine hormones, norepinephrine and epinephrine. This produces persistent or paroxysmal hypertension along with symptoms that resemble an anxiety reaction: headache, nausea, sweating, pallor, and palpitation. Proper medical treatment for such endocrine disorders is generally followed by an abatement or loss of neurotic or psychotic-like manifestations.

Among common medical conditions seen are many nutritional deficiencies resulting from inadequate intake of nutrients—usually the product of poor diet, allergy, or gastrointestinal disease—resulting in vitamin, protein, or mineral deficiencies. For example, in *thiamine (vitamin B,)* deficiency, there is often a neurasthenialike syndrome that will clear up rapidly with the administration of thiamine. In severe thiamine deficiency, a condition of cerebral beriberi (Wernicke-Korsakoff syndrome) may occur in which mental confusion and aphonia are early symptoms. *Nicotinic acid (niacin) deficiency* may produce neurasthenic-like aberrations and even an organic psychosis, with confusion, disorientation, memory impairment, and confabulation in addition to the glossitis, stomatitis, and gastrointestinal symptoms characteristic of pellagra. *Vitamin C*

deficiency over a long period may be accompanied by irritability, lassitude, weakness, and poorly defined muscular and arthritic pains. *Protein deficiency* may occur when the individual habitually (often as a result of a fad diet) fails to take in at least 30 grams of protein daily, Anorexia, lethargy, and weakness are common symptoms of this condition. *Hypervitaminosis,* caused by excessive intake of vitamins A and/or D may manifest itself in weakness, headaches, and tension. Vitamin B12 deficiency may produce pernicious anemia, sometimes manifested in psychotic-like symptoms such as fleeting paranoia, irritability, and depression.

In chronic alcoholics who have undergone *alcoholic withdrawal* we may observe tremor, sweating, weakness, and gastrointestinal symptoms. Severe withdrawal syndromes are characterized by delirium tremens with anxiety, confusion, insomnia, sweating, and depression. Hallucinations and convulsions may occur. Chronic excessive alcohol intake may result in *alcoholic hallucinosis,* with paranoidal delusions and hallucinations, or *Korsakoff's psychosis,* with lapses in recent memory, confabulation, euphoria, and lack of spontaneity.

A variety of rarer diseases may also be accompanied by neurotic or psychotic symptoms. In *hepatic porphyria* (acute intermittent porphyria), manifestations range from irritability, anxiety, confusion, and restlessness to delirium and hallucinations. The systemic form of *lupus erythematosis* may produce psychotic symptoms, a complication shared also by *acute infectious endocarditis,* and *temporal arteritis* (an inflammation of the temporal arteries).

The fact that an individual has an organic disease does not mean that the person cannot benefit from psychotherapy in addition to medical treatment. Indeed, the disease may have so ruptured the individual's security mechanisms and adaptive capacities that he or she will require psychotherapy to avoid being plagued for months or years by a neurosis. If an organic cause of psychological symptoms is ruled out, the psychotherapist may proceed in the attempt at diagnosis.

A COMPREHENSIVE APPROACH TO DIAGNOSIS

If there is one great empty space in psychiatry it is in the area of nosology. Classifications are more or less inherited from late nineteenth-century pioneers, such as Kraepelin, who compartmentalized syndromes into neat, descriptive symptom clusters. Such systems have proven themselves to be surprisingly sterile in either providing an understanding of the disease process or supplying appropriate directions for therapeutic intervention. Even in so identifiable a syndrome as schizophrenia, symptomatic criteria for diagnosis are unsatisfactory, varying from doctor to doctor and hospital to hospital (Brill & Glass, 1965). D. A. Freedman (1958) appropriately deplores the lack of value of the term "schizophrenia" for purposes of understanding the etiology or approach to this illness. Moreover, emphasis on symptoms, as Kanfer and Saslow (1965) have pointed out, has resulted in efforts to change feelings, anxieties, and moods "rather than to investigate the environmental factors which produce and maintain these habitual response patterns." Questioned are the ultimate utility of current quantitative procedures for classification of psychiatric patients through objective symptom ratings programmed for computer applications (Overall & Hollister, 1964), although the validity of diagnoses by computer compares with that of interviewing clinicians.

Attempts to assort emotional problems by etiology are also unsatisfactory since the causes of disturbed behavior cannot be identified with any kind of assurance or precision (Zigler & Phillips, 1961). Collocation according to prognosis, furthermore, falls short of its mark since there are no reliable means of correlating measures of illness and responses to specific treatments (Fulkerson & Barry, 1961).

In criticisms of the medical model, suggestions have been made that it be abandoned or substantially supplemented (Scheflen, 1958; Szasz, 1960). A solution offered by Noyes and Kolb (1963) is that each diagnostic formulation be tripartite: (1) a genetic diagnosis of existing constitutional, physical, and historical-traumatic vectors; (2) a dynamic diagnosis that deals with the coping mechanisms and defenses of the individual; and (3) a clinical diagnosis that outlines the reaction syndrome, the probable course of the illness, and applicable treatment methods.

A learning-model avenue to diagnosis, presented by Kanfer and Saslow (1965), strives to assign preferred therapeutic procedures from an assessment of the patient's current behaviors and their controlling stimuli. This lends itself to pragmatic use since, as Ferster (1965) has stated, "a functional analysis of behavior has the advantage that it specifies the causes of behavior in the form of explicit environmental events which can be objectively identified and which are potentially manipulable." This way of viewing behavior—i.e., the continued evaluation of the patient's life pattern and factors that control it, with manipulation of discernible variables through such means as reinforcement and direct intervention—may, in the opinion of some therapists, lead to a more effective restoration of emotional health than efforts aimed at personally change through nonverbal therapeutic interactions (transference, self-actualization, and so on). Other proposals have been made to solidify the nosology used in psychiatry (Panzetta, 1974; Spitzer, 1975; Strauss, 1975), the current DSM-IIIR multi-axial approach being the most sophisticated.

It cannot be minimized that the present systems of nomenclature are still somewhat in a state of disarray and that proposed new groupings merely compound the confusion. Alternative proposals to scrap all systems of diagnosis have not been too helpful, although the arguments justifying this are many. Diagnostic labels do give incomplete data about etiology, prognosis, and response to therapy. They do not always help in the understanding or treatment of the presenting problem. In exceptional instances, diagnoses have been used as a means of social control to justify the apprehension, detention, and coercive involuntary treatment of patients. Diagnosis do not always designate the quantitative dimensions that differentiate average "normal" aberrations from disease. To classify all personality problems, educational distortions, and social malfunctioning as illnesses also leads to befuddlement. Moreover, it is difficult to establish in most patients a diagnosis to which even the most experienced psychotherapists would universally agree. A symptom picture may change drastically, sometimes from day to day (as from an anxiety to a depressive reaction). Accordingly, the diagnosis revolves around a time axis, which is rarely kept in mind.

Computers, as has been mentioned, do process data that can be used for diagnosis and, on the whole, the results have been encouraging. How valuable computer programs (Smith, 1966; Sletten et al., 1971) will prove to be in solving current dilemmas about diagnosis is still problematic, but some of the computerized systems have been shown to provide diagnoses that are at least as accurate as those made by clinicians using the same protocols (Spitzer & Endicott, 1974). As the technology improves, a combination of clinician and computer diagnoses promises to provide the best results. (See Chapter 64.)

Although current systems of diagnosis are still deficient, we would be worse off without them. In a sizable number of cases, diagnosis provides facts that help assessment and offers leads toward treatment tactics. The words "feeblemindedness," "depression," "mania," "phobia," "obsession," "schizophrenia," and "psychopathic personality" bring to mind a generally valid, though perhaps incomplete, picture of the patient's behavior and suggest prognosis and suitable treatment interventions. Finally, some type of classification is insited on by insurance companies and other third-party fee dispensers. With the enactment by Congress of the Tax and Fiscal Responsibility Act (TFRA), the use of Diagnostic Related Groups (DRGs) has been mandated to determine the cost of hospital, and probably in the future psychological, medical care. From the standpoint of pragmatics the therapist must make a decision about what is being treated, and this, as may be seen from the foregoing, can be confusing: in every emotional problem all systems are implicated in major or minor degree—biochemical, neurophysiological, developmental-conditioning, intrapsychic, interpersonal, philosophical-spiritual. It may be difficult to select among these constituents the primary culprit. Here priorities in diagnosis are often determined by social and economic pressures. For example, to satisfy third-party insistence on a diagnostic label, therapists often are obliged to enter the term "anxiety disorder." This means very little in terms of identifying the real problem. But it does accomplish one thing: it gets the bill paid, which may not happen with a more descriptive and perhaps more accurate diagnosis not recognized by the reimbursement agencies.

A DYNAMIC INTERPRETATION OF DIAGNOSIS

Threats to adaptation, whether inspired by external stress or inner conflict, produce tension, anxiety, and physiological reactions associated with a disruption of homeostasis. This may result in a nascent *anxiety disorder* (anxiety state, anxiety neurosis) and/or *somatoform disorder* (anxiety equivalent, psychosomatic disorder, psycho-physiological disorder).

In general, four levels of defense are employed against anxiety: (1) conscious efforts at maintaining control, (2) characterological (personality) defenses, (3) repressive defenses, and (4) regressive defenses. The individual may stabilize at any of these levels with a disappearance of tension, anxiety, and physiologic reactions. Or the elaborated defenses may only partially control symptoms. Finally, the defenses themselves may involve the person in difficulties and may act as further foci of conflict, stirring up additional anxiety and necessitating other defenses. For instance, claustrophobia may interfere with the economic and social adjustment of the individual, and the ensuing anxiety may provoke characterological defenses, such as detachment, aggression, and dependency.

First-Line Defenses: Conscious Efforts at Maintaining Control through Manipulating the Environment

All persons employ defenses on the conscious level to lessen tension and to neutralize anxiety. Such defenses may be considered "normal." Among them are the following:

1. *Removing oneself from sources of stress:* A man irritated with work conditions may quit his job and find a less strenuous work situation.

2. *Escaping into bodily satisfactions:* Overeating, smoking, and excessive sexual indulgence may be employed as tension-relieving mechanisms.

3. *Extroversion:* Plunging into hobbies and recreational and social activities may divert the individual's attention from inner problems.

4. *Wish-fulfilling fantasies:* Indulging in daydreaming may act as a substitute gratification for unfulfilled impulses.

5. *Suppression:* Willfully keeping painful ideas or impulses from awareness.

6. *Rationalization:* Providing reality and social justifications for behavior motivated by inner needs.

7. *Use of philosophical credos:* Adoption of codes of behavior and ethics to reinforce one's conscience or to justify one's impulse indulgence.

8. *Exercising "self-control":* Forceful conscious inhibition of tension-producing impulses.

9. *Emotional outbursts and impulsive behavior:* Gaining release of tension through emotional catharsis and by acting-out.

10. *"Thinking things through":* Arriving at a rational solution of one's problems by carefully weighing alternative courses of action.

11. *Alcoholic indulgence:* Alcohol often serves as a means of reducing tension and of allowing emotional release; excessive alcoholic intake may occur.

12. *Use of drugs:* Minor tranquilizers (benzodiazepines) and sedatives (barbiturates) may be employed to alleviate anxiety and tension, while stimulants (amphetamines) help to promote energy in situations where the person feels listless and inert. Narcotics (marijuana, cocaine, and other opiates) and psychotomimetics (LSD) are abnormally employed. Excess drug indulgence leads to many complications.

Second-Line Defenses: Characterological Defenses

In the event that the first-line defenses allay anxiety, adjustment is possible. If anxiety is not relieved or if the device used to control anxiety creates more anxiety, second-line defenses may be exaggerated, which involve a disturbed manipulation of one's relationships with other people and with oneself.

1. *Strivings of an interpersonal nature*

   a. *Exaggerated dependency* (immaturity)

   b. *Submissive techniques* (passivity)

c. *Expiatory techniques* (masochism, asceticism)

d. *Dominating techniques*

e. *Techniques of aggression* (sadism)

f. *Techniques of withdrawal* (detachment)

2. *Strivings directed at the self-image*

a. *Narcissistic strivings* (grandiosity, perfectionism)

b. *Power impulses* (compulsive ambition)

The characterological defenses, if too exaggerated, inflexible, and maladaptive, may make for *personality disorders* that reflect themselves in educational, habit, work, marital, interpersonal, and social problems and in delinquency, criminality, sexual perversions, alcoholism, and drug addiction. The individual may manage to regain some stability and periodic freedom from anxiety but at the expense of disturbed personality manifestations. The person may still retain those first-line defenses that he or she finds helpful in subduing anxiety. The person may be stabilized temporarily while continuing to experience, from time to time, bouts of anxiety.

Third-Line Defenses: Repressive Defenses

If anxiety cannot be controlled with characterological defenses or if the defenses, and the conflicts they create, produce more anxiety, third-line defenses may come into play. These consist of mobilization of repressive defenses and other manipulations of the intrapsychic processes.

1. *General efforts directed at reinforcing repression*

a. *Reaction formations:* Characterologic drives to oppose and repudiate inner drives; for example, ingratiation and passivity to oppose hostile, murderous impulses.

b. *Accentuation of intellectual controls* (with compensations and sublimations).

2. *Inhibition of function*

      a. *Blunted apperception, attention, concentration, and thinking*

      b. *Disturbed consciousness* (episodes of fainting, increased sleep, stupor)

      c. *Disturbed memory* (antegrade and retrograde amnesia)

      d. *Emotional indifference or apathy* (emotional inhibitions)

      e. *Sensory disorders* (hysterical hypoesthesia, anesthesia, amaurosis, ageusia, and so on)

      f. *Motor paralysis* (hysterical paresis, aphonia)

      g. *Visceral inhibitions* (e.g., impotence, frigidity): Inhibition of the various cognitive, affective, autonomic, and visceral functions reinforces repression of inner impulses to the point of keeping symbolic derivatives from awareness and preventing the expression of forbidden impulses. Behavioral syndromes that are characterized by repressive inhibition of function are *post-traumatic stress disorders* (traumatic or combat neuroses), *dissociative disorders,* and *conversion disorder.*

3. *Displacement and phobic avoidance:* The impulse here is displaced to an external object and then an attempt is made to repudiate the impulse by avoiding the object. The syndrome resulting from an extension of this mechanism is a *phobic disorder* (anxiety hysteria, phobic neurosis).

4. *Undoing and isolation:* The mechanism here consists of a kind of magical neutralization of the offending impulse or its obsessive derivates through compulsive acts and rituals. The resulting syndrome is an *obsessive-compulsive disorder.*

These efforts directed at reinforcing repression are usually interrupted by failing of repressive barriers with breakthrough and release of repressed impulses. This is usually in obsessional form, that, if accentuated, may produce an *obsessive-compulsive disorder* (obsessional state, obsessional neurosis, compulsion neurosis, psychasthenia). Intense revery and dreamlike states may also result. Among the other defenses are an autonomous expression of the repressed impulses by *dissociative disorders* (conversion

disorder) in the form of somnambulism, fugues, dissociated (multiple) personality, and depersonalization. The repressed impulses may also gain expression by being converted into physical symptoms involving the sensory organs (e.g. anesthesia, blindness, deafness), motor organs (tics, tremors, posturing, spasms, convulsions, paresis, aphonia), and visceral organs (including globus hystericus and vomiting.) If sufficiently extensive, these may constitute a *conversion disorder* (conversion hysteria). An internalization of hostility and its concentration on the self may produce a *dysthymic disorder* (reactive depression, neurotic depression). A projection of hostility toward outer objects or individuals may assume the proportions of a *paranoidal reaction.* Finally, there may be an impulsive breakthrough of the repressed material, with "acting-out" in the form of an excited episode.

Characteristic, then, of the third-line defenses are manifestations of failing repression with release of repressed material and desperate pathological attempts at the reinforcing of repressive barriers. First-and second-line defenses that are useful may be coordinately retained. Anxiety may be episodically present whenever defenses fail to preserve the equilibrium.

Fourth-Line Defenses: Regressive Defenses

Stabilization at the level of third-line defenses is possible, but if anxiety cannot be held in check, fourth-line defenses may eventuate.

1. *Return to helpless dependency:* Failing to adjust at an adult level, the individual may attempt to invoke the protective parenting ministered to him or her in childhood by assuming the attitudes and behavior of a child. This regressive appeal is associated with a renunciation of adult responsibility and the throwing of oneself at the mercy of a parental substitute.

2. *Repudiation of, and withdrawal from, reality:* Characteristic of withdrawal from reality are dereistic thinking; disorders of perception (illusions, hallucinations); disorders of mental content (ideas of reference, delusions); disorders of apperception and comprehension; disorders of the stream of mental activity (increased or diminished speech productivity, irrelevance, incoherence, scattering, verbigeration,

neologisms); disturbances in affect (apathy, inappropriate affect, depression, excitement); and defects in memory, personal identification, orientation, retention, recall, thinking capacity, attention, insight, and judgment. The syndromes are in the form of psychotic (schizophreniform) episodes and *schizophrenic disorders,* the development of which probably requires a genetic predisposition.

3. *Internalization of hostility: Dysthymic disorder* may occur sometimes; when certain constitutional factors are present, *major affective disorders* and *bipolar disorders* may be precipitated. Suicide is common in these syndromes.

4. *Excited acting-out:* Hostile, sexual, and other repressed impulses may be expressed openly in the course of a psychotic reaction. Representative syndromes here are *manic disorder* and *paranoid disorder.*

The patient may manage to stabilize through fourth-line defenses at the expense of reality, while possibly still retaining some of the other three lines of defense.

Syndromes never occur in isolation; they are always contaminated with manifestations of other defensive levels. As stress is alleviated or exaggerated or as ego strengthening or weakening occurs, shifts in lines of defense upward or downward may occur, and changes in symptoms and syndromes will develop.

STANDARD NOMENCLATURE

As has been mentioned before, for insurance and medicolegal purposes, standard diagnoses will often have to be made. The American Psychiatric Association published in 1980 a revised handbook the *Diagnostic and Statistical Manual of Mental Disorders DSM-III* (Spitzer & Williams, 1985) that in 1987 underwent some alteration (DSM-IIIR). The resulting revision, like DSM-III itself, has precipitated a great deal of debate and heated discussion (Tischler, 1985). The World Health Organization also has presented a system with which not everybody is in agreement. One of the aims of DSM-III was to transcend the strictures of diagnosis by developing a multiaxial approach that (1) considers the patient's living environment as a source of psychosocial stressors, (2) attempts to predict future adaptation by examining how well the patient functioned in the past, and (3)

considers the impact on the emotional illness of physical, personality, and developmental problems. Recorded in axis I are the existing clinical syndromes, as well as conditions other than mental disorder that require attention and treatment; in axis II, personality and developmental disorders; in axis III, physical conditions and disorders relevant to the understanding and management of the psychological problem; in axis IV, the severity of the existing or, as in the case of post-traumatic stress disorders, past psychosocial stressors; in axis V, the highest level of adaptive functioning, rated from 1 (superior) to 7 (grossly impaired), in the past year. This biopsychosocial listing greatly expands the usefulness of the diagnostic system and may provide a basis for clinical research.

The standard nomenclature, it must be remembered, is merely a label used for convenience and tells us little about how the patient will respond to therapy. In addition to categorizing the patient in a special grouping, it is functionally useful to estimate (1) the degree of homeostatic imbalance as registered in tension and anxiety, (2) the mechanisms of defense that are employed to deal with anxiety and to gratify vital needs, (3) the personality distortions operative in terms of dependence-in-dependence continuum, the level of self-esteem, and the kinds of interpersonal relationships the patient habitually establishes, and (4) the potential disintegrative tendencies. Important, too, is an identification, if possible, of stress factors (situations and people) outside of the patient as well as internal stimuli (drives, defenses, and values) that precipitate and reinforce neurotic tendencies. This information will be useful in treatment planning and the setting of goals.

ILLUSTRATIVE CASE

The following case illustrates the process of making a diagnosis by studying the spontaneous verbalizations of the patient, as well as by asking pointed questions. It consists of a portion of an initial interview with a 34-year-old woman, married for 13 years, who has three children, ages 11, 8, and 4.

> *Pt.* I don't know where to begin. I'd rather you ask me a couple of questions.

> *Th.* It's a little difficult for you to pull things together. So suppose I do ask you a few questions.

Pt. Yes, so I can pull things together for myself, I mean. Technically, I'm suffering from an anxiety, I suppose, that goes back a long way.

Th. How far back?

Pt. It's always been the *same* thing, this terrific feeling of insecurity, or the tenseness, or the fear of death and not being able to breathe, and not being able to swallow and having palpitations of the heart, ulcers of the stomach, or fears of brain tumor. It takes on different forms. I suppose, depending on the season of the year. *[The patient describes symptoms of collapse in adaptation that have existed for a long time. These are in the nature of tension, frank anxiety, and psycho-physiologic phenomena.]*

Th. Mm hmm.

Pt. I rarely ever suffer from any two diseases at the same time.

Th. In other words, there's a whole succession of things.

Pt. Yes, but not all the time. Sometimes I've gone for months without these symptoms, but it's gotten progressively worse as the years go by. *[From time to time her symptoms abate, probably as her defenses are mobilized and restore her to a kind of equilibrium.]*

Th. I see.

Pt. I had it pretty bad about 12 years ago. I learned to fight it off. But in recent years it's just been too much, and I can't fight it off any longer. I used to be able to get relief by going to plays or movies, or by an occasional drink, or by sedatives. I still try these things, but it helps a little only temporarily. *[These first lines of defense were insufficient to control her anxiety. She still uses them, nevertheless.]*

Th. Can you give me an idea of when this thing got so bad that you decided to get further help for it?

Pt. You mean recently? Within the last year it crept on me very suddenly—well, not so suddenly. I developed a pain around my heart. It came to a climax one evening about a year and a half ago and I was positive at the moment that I was dying. Everything sort of blacked out. The feeling: "Oh, my God." *[This is an acute anxiety attack brought on perhaps by a crumbling of her defenses or the impact of stress too difficult for her to manage.]*

Th. This was brought on by the pain around the heart?

Pt. No, that's like an aftermath. Just that everything is blurry, and nothing is sharp. Everything closing in. I went to bed and called the doctor. He told me that I should rest up physically, because I was terribly run down. I do work hard, and usually I am able to pull myself together with a rest. But this time, in the middle of the rest, it got worse than ever before. I had a lot of worries and things. I was sure it was complete exhaustion and I knew what the doctor was going to say.

Th. What do you think caused this?

Pt. Well, my being overtired. I couldn't relax. I could hardly breathe. I was thoroughly exhausted. I've lost weight. I've gotten to a point where it's just too much for me to handle.

Th. I see.

Pt. It's either physical or it isn't. The doctor told me it wasn't. I know myself. I've read about this in books, and I believe in psychiatry. My husband, on the other hand, doesn't believe in it at all. He thinks I'm just about ready for an institution because of these attacks. I try not to have them when he is around. *[Conflict with her husband may somehow be involved in stirring up her difficulties.]*

Th. He doesn't understand this?

Pt. He gets furious. He stomps out, says he can't take it any more. I try to pull myself together. I'm scared of anger and any form of emotion at all. *[Her inability to deal with anger may be indicative of a personality disorder, other aspects of which will undoubtedly reveal themselves.]*

Th. Is there anything else that stirs you up?

Pt. The friction and tension in the house. The children are on the go all the time, and me not being able to stand friction or any kind of emotion at all.

Th. You're caught in the middle?

Pt. Yes, and the battles go on, and my husband can't stand it. It is horrible. Everybody gets on everybody else's nerves. I suppose I am responsible for some of it myself. But my husband won't understand. Personally, I think he's suffering from the same thing that I am, but he doesn't know it. He had a hell of a life himself. His mother is a nervous wreck, and his father is a tyrant. I think he needs to be built up, but unfortunately I'm so full of so many things myself that I can't do it. I suppose if I did do it, things would be better. He's popular outside; he's a lot of fun, jolly. People would be surprised to learn he had the problems he has. He's not mean, or anything like that; it's just that he won't take the time to be with me, understand me. I suppose he inherits that from his father. I don't dare tell him how I feel. I can't get reassurance from him. I have to get it from my mother. *[The patient is complaining here that her husband is not sufficiently kind and understanding and does not give her enough reassurance. She may be expressing frustrated dependency longings, either in response to a residual personality immaturity or because her adaptational collapse invokes characterologic defenses, among which increased dependency leanings are prominent. These second-level defenses are apparently not sufficiently adequate to neutralize anxiety.]*

Th. From your mother?

Pt. Yes. You see my father died when I was little, and my mother had to pursue her career. She was a career woman. She always felt that money was security. She was after me constantly to get out and get a job and earn money. But I suppose I was more secure than the average person—my aunt was wealthy. But I was sickly and always needed doctors. I had pneumonia and eye trouble and stomach trouble even when I was 14 years old. She then started dragging me around to see people, including psychiatrists. She must have been disappointed that I didn't turn out to be the way she wanted me. She was a great fighter, an

intellectual, and I'm not. *[Feelings of rejection, of not coming up to her mother's expectations, may be the background of her insecurity and devaluated self-esteem.]*

Th. She was disappointed in you?

Pt. Oh, definitely. I'm sure I don't come up to her standard. For many years we were estranged. She didn't approve of my marriage. I was the only child.

Th. You present the picture of being insecure as a child.

Pt. I'm sure I was. My mother always tried to push me into independency. I can see it now, in the light of looking back, that I didn't want to be independent.

Th. What about your husband when you first met him?

Pt. I was in love with him. But shortly after my marriage, my real trouble began. I was insecure before, but I got along. But after one year of marriage, things really got impossible. I had a terrible period with both our parents. My mother disapproved and so did his parents. He had an awful time at home. He never told his parents we married. I was upset and lost a lot of weight. Well, I suppose I should have seen at the time that he wasn't very strong and that he wanted someone to lean on. He was petrified of his father. He wouldn't set his foot in our house for years. *[One gets the impression that the patient resents her husband's weakness. As a dependent person herself, she would like a strong mate on whom she might lean. The fact that her husband did not provide this for her may have stirred up hostility and insecurity and, on the bedrock of her personality immaturity, created a collapse in adaptation.]*

Th. I see.

Pt. Well, anyways, things have gotten bad recently.

Th. Can you describe what trouble you have had recently?

Pt. I can't stay alone in the house for fear I'll jump out of the window. I can't take a bus; I have to take a taxi. I can't walk on the street for fear of falling on my face. Just fears of everything, especially of being alone or of walking on the street. *[These phobic symptoms are those of third-line defenses, representing a further breakdown in repression.]*

Th. This must really be very difficult for you.

Pt. It is, it is. I have this constant anxiety. Every minute of the day. I don't know whether I'll live or die. I can't breathe deeply; I can't seem to get enough air. I'm afraid of everything. I can't go out. I don't want to drive a car. I don't want to be alone in the house. I can't go to a theater. I can't eat in a restaurant. Eating seems to have something to do with it. *[These are manifestations of anxiety representing a breakdown of defenses.]*

Th. It does?

Pt. Yes. I seem to be worse at meal times. If I'm eating in bed, it's all right. I noticed that I get tense as soon as I sit up at the table to eat. If I eat in bed, I'm all right, but I can't eat up. I don't like a restaurant for that reason. *[This may be a further defensive effort toward helpless*

dependency, perhaps a regressive need to be fed like a child.]

Th. Are there any other symptoms?

Pt. Well, recently, thoughts come to me that frighten me. It started when first I was listening to the radio. First I listened to a murder program where a man murdered his wife, and then I was listening to the war situation. I don't know if that has anything to do with it or not. These thoughts seem to crowd in on me. If I pick up the papers and see that somebody got killed or that somebody died of a heart attack, I'm finished. I'm afraid to read the obituary. As long as they are over 65, that's all right, but anything under scares me. Two days ago I was driving with a friend, and she told me of a person she knows who had psychosomatic trouble with his heart and finally got heart trouble and died. This finished me. I couldn't think or anything. I went home to bed. *[These obsessional thoughts are indicative of a breakthrough of repressed conflicts, perhaps in relation to hostility.]*

Th. I see.

Pt. It's the funniest feeling; even though I tell myself it's all foolish, it doesn't help. Once it comes, there doesn't seem to be much I can do.

Th. Once it starts …

Pt. I can't fight it; I can't reason or anything.

Th. Like you're over a bank of snow on skis.

Pt. Yes. I have to let it take its course. I know it will end. I fight it, but I'm a wreck. I've tried sherry, I've tried phenobarbital, nothing helps. I don't even have enough nerve to commit suicide.

Th. What about other symptoms?

Pt. Like what?

Th. What about physical symptoms?

Pt. Well, when I am upset, I notice my stomach is upset. It's upset most of the time. *[This may be a somatoform disorder associated with her anxiety, or it may be a somatic conversion symptom.]* Also from time to time I get a nervous twitch of my eyes, like blinking. I had it also when I was a child. *[This sounds like a conversion symptom.)*

Th. What about sexual problems?

Pt. Oh, that. My husband thinks I'm a mess. I'm very frustrated. I'm not…I'm… what's the word I want… I'm … frustrated. I don't seek it. I'm always afraid, I'm always holding back. From the neck down I could see it might be a wonderful idea; but from here up something says, no. Once I get started it's all right, but I find it hard to get started.

Th. What do you think is involved?

Pt. Well I suppose it applies to all emotions. I don't cry, I don't get angry. I keep everything inside. A piece of music can make me emotional. I'm afraid I'll cry, so I don't do anything. I'm afraid. It scares me to death. *[Inhibition of emotions acts in the interest of maintaining repression.]*

Th. I see.

Pt. My mother had a violent temper, and I was scared of it. I'd rather do anything than have her lose her temper. I guess it's the same thing with my husband and his violent temper. *[The patient presents an aspect of the origin of her fear of hostility and its carryover into her present relationship with her husband.)*

Th. You're afraid of his temper?

Pt. I'm afraid of everybody. I'm one of the weakest people that ever lived. I can't stand up to anybody, which is another one of my mother's pet peeves about me.

Th. What do *you* think about that?

Pt. I think she's right, but I can't do anything about it. I feel guilty about it.

Th. Would you like to be able to emote and to express your feelings?

Pt. I suppose it would make me feel better. I'd like to be able to express myself. When my husband gets mad, I shrink up into a little ball. I can't be assertive with anybody. I feel hopeless.

Th. Hopeless as if you can't get over it?

Pt. That's what's worrying me because I can't go on like this much longer. *[One may suspect that her hopelessness may also be a defense against yielding her dependency need.)*

Th. Now what about dreams; do you dream a lot, or a little?

Pt. A little.

Th. Do you remember a recent dream?

Pt. Yes, I dreamed the Nazis came back and overran the country and it terrified me no end. There I was in a trap about to be annihilated.

Th. That's about how you feel literally.

Pt. Yes, it is.

In review, this is the case of a patient with a personality problem since childhood, consisting of dependency, insecurity, and devaluated self-esteem. She is still burdened by personality immaturities. Her present homeostatic imbalance is severe. Symptoms of collapse in adaptation are tension, anxiety, and psychosomatic symptoms. First-line

defenses are extraverted activities, sedation, and mild indulgence of alcohol. Submissiveness and heightened dependency may be regarded as manifestations of second-line defenses. Third-line defenses are in the form of phobias and conversion symptoms. A waning of repressive barriers is indicated by a breakthrough of obsessions. Her defenses are apparently inadequate in mastering her anxiety. The disintegrative potential is low. Following the principles of conventional classification discussed, we may diagnose her as follows:

DIAGNOSIS:

Axis I: 300.01, Panic disorder

Axis II: 301.60, Dependent personality disorder

Axis III: None

Axis IV: Psychosocial stressors: marital conflict Severity: 5—severe

Axis V: Highest level of adaptive functioning past year Severity: fair—4

Recommendations:

Antidepressant medication may be prescribed for the panic attacks. In vivo desensitization may be employed for the agoraphobia. Couples therapy indispensable for the marital conflict. Individual dynamic psychotherapy for the dependent personality disorder.

26
The Initial Interview: Evaluating the Problem

A tentative assay of the existing situation is helpful to the therapist in outlining a temporary treatment plan and in roughly prognosticating the extent of future change. This assay will need constant revision, in some instances radical alteration, due to the emergence of data during the course of therapy not available at the first interview. Nevertheless, it may provide a sort of guide for the initiation of treatment, without which the therapist may flounder about, adding to the patient's helplessness and confusion.

The formulation of the existing dynamics will vary with the therapist's perceptiveness, skill, training, and experience as well as theoretic bias. The same patient, thus, may be seen from different points of view. Each viewpoint will stress familiar aspects of data presented by the patient that substantiate a specific theoretical emphasis favored by the therapist.

For instance, let us imagine that a therapist who does supportive therapy is consulted by a male patient who complains of tension, anxiety, headaches, and gastrointestinal distress brought on by an address that he must make to members of his industry at a forthcoming convention. Discerning that the patient habitually gets upset whenever he is called on to make a speech, the therapist may formulate the problem as "stage fright" and correctly estimate that the symptoms will disappear after the patient has fulfilled the assignment. The therapist may then assert that there is nothing physically wrong with the patient and enjoin him to "ride his symptoms" since his reactions are "natural." A therapist who is a physician may prescribe tranquilizers, sedatives, or other medicaments to "tide the patient over" the crisis period; a non-physician may refer the patient to his family physician for such medications.

Another therapist, seeing the same person, would possibly formulate the problem as one in which the patient has lost faith in himself and offer him solace through personal

reassurance. A third therapist, psychologically trained, might conclude after testing the person's intellectual caliber, vocational interests, and aptitudes that the problem is essentially that of an individual pursuing an occupation in which he is not really interested, that public speaking is one of his weak points that he might best avoid, and that he is ideally suited for another occupation that will remove him from his present source of stress. A fourth therapist, with experience in social work, may regard the problem as that of a person who is constantly being called on to perform tasks that frighten him because he has never developed confidence in his ability as a speaker. The patient may then be advised regarding community resources for training in public speaking, and he may be guided toward entering into groups where he can exercise his skill. A fifth therapist, with a pedagogic bias, may approach the problem somewhat differently, considering that what has been lacking is adequate organization and preparation of his forthcoming talk. The patient may be shown how to outline his subject for presentation, how to arrange the material, and perhaps how to employ certain tricks to avoid fear, such as are practiced by public performers. A therapist trained in behavioral therapy may attempt assertive training and in-vivo desensitization by encouraging the seeking out of opportunities for public speaking.

If the therapist has been trained to do more intensive psychotherapy, say reeducative therapy, the problem may be formulated in a more incisive way. For example, strong perfectionistic traits may be detected that drive the patient toward exorbitant expectations of himself. He may believe that each projected talk constitutes a challenge that must be overcome by an extraordinary performance. The patient may feel unable to live up to merciless expectations that he imagines are demanded of him. Or the therapist may find evidence that the patient automatically anticipates criticism or hostility from people, his panic being a reaction to the ill will others bear toward him. Fear of failure or of living up to expectations may, in the opinion of the therapist, produce such strivings as detachment, dominance, competitiveness, aggression, compulsive ambition, grandiosity, and masochism. Many contradictions would, of course, be residual in the simultaneous operation of several of these traits, and the outcome may be conflict, with the result of inhibition of function such as is being experienced by the patient. A formulation in these

terms will be helpful in planning reeducative therapy during which the patient is brought to an awareness of how these traits disorganize him in his relations with people and in the achievement of essential goals. The therapeutic effort will then be directed along lines calculated to bring disturbing traits under control and to replace them with more adaptive ones.

If trained in reconstructive therapy, the therapist will undoubtedly organize a tentative formulation of dynamics in terms of this training orientation. The patient's stage fright may be regarded as a manifestation of deep feelings of self-devaluation, of self-contempt, of inferiority, or of residual dependence. Symptoms may be looked upon as an outcome of fears of mutilation that are residual from an unresolved Oedipal conflict that shadows the patient, threatening him particularly when he competes or exposes himself to the judgment of an audience. His striving to avoid talks and presentations may also be regarded as a cover for exhibitionistic tendencies, a yielding to which may bring fantasied havoc upon him. He may then seek refuge in a passive retiring manner, shrinking from public appearances. Yet this defense is inadequate since it convinces the patient that he is inept and mutilated. The therapeutic task here would be to bring derivatives of these unconscious tendencies to the patient's awareness until he recognized the raw conflicts that incited his fear. Once he knew his real enemies, he could cope with them in a manner more appropriate than his prevailing ineffectual infantile methods of defense.

No matter how skilled and well trained the therapist may be, it is not always possible at the beginning of therapy to obtain an understanding or even a perspective of the dynamics of the patient's problem from his verbalized complaints, his past history, and his reported present relationships. This is because many of his patterns are not identifiable to the patient, although he may act them out constantly. For instance, a man struggling with an urge toward homosexuality may have only a minimal idea of the degree that he fears and despises women, toward whom he professes a congenial tolerance and understanding. Another example: A woman, the only child of a couple who expected a male infant and did not hesitate to impress the little girl with their disappointment, as an adolescent and adult became fiercely competitive with males. She did not realize the true

depth of her fury at having been born a female nor the extent of her refusal to give up the hope of eventually becoming male. Sometimes it is possible at the start to get glimpses of repudiated trends. Yet the exact operation of repressed aspects of personality may escape definition and even detection until the therapeutic process has well begun and as repressions start lifting while the patient is helped to face himself or herself in an honest and resolute way.

Most patients, thus, are incapable, during the initial interview, of verbalizing sufficiently to give the initial interviewer an idea about the operative conflicts and the important mechanisms of defense. As a rule, many sessions of therapy will be required before the dynamics begin to unfold.

Patients who are able to talk freely about themselves and their feelings, however, are often capable of revealing sufficient clues about their deeper problems to enable an astute interviewer to make some hypothetical assumptions about the dynamics. Much will depend on the perceptivity and experience of the interviewer and upon the ability to pick up nuances from the verbal and nonverbal behavior of the patient.

Generally, little information about dynamics will be obtained from the statistical data, the elaboration of the chief complaint, the history and development of the complaint, and other associated symptoms. If the patient, however, reveals one or two dreams that are significantly imprinted on the patient's mind, discourses on feelings about and relationships with parents and siblings, it may be possible for the interviewer to make important connections between underlying mental processes and the surface symptomatology.

Projective psychological tests are sometimes valuable in formulating the tentative dynamics, especially for patients who are not able to verbalize freely and who do not remember their dreams. From the unstructured ink blots of the Rorschach it may be discerned how the patient handles anxiety, reacts to emotionally stimulating situations, and organizes a defensive facade. Revealed also are the intellectual operations of the individual, inner psychologic mechanisms, and the quality of fantasy life. From the

structured pictures of the Thematic Apperception Test there are elicited associations that are most revealing of basic characterologic attitudes and patterns as well as the interplay of emotion and personal interaction. The Man-Woman Drawing Test reveals reflections of the patient's body image, the emotional significance of various bodily parts and organs, and basic conception of "male" and "female." The Szondi Test is said to bring out the dimensions of the patient's basic needs and drives. Dynamics revealed by projective psychologic tests must always be validated by clinical corroboration.

27
The Initial Interview: Estimating the Prognosis

In textbooks of psychiatry there are many pages of index in closely packed fine print. Amidst the profusion of items there is, in most indexes, not a single entry under "prognosis." A search for synonyms of prognosis that would subsume similar prediction also yields nothing. This absence is probably not fortuitous; it indicates that the complexity of the problem is formidable and that reliable facts cannot be readily collated. A few bold authors have ventured opinions about prognosis, but on the whole little is available in the literature on this very important subject. An extensive study (the Penn Psychotherapy Research Project of Luborsky et al., 1980) found that not a single psychometric measure, demographic characteristic, symptom, psychological test, or interpersonal inventory was related to outcome. Among the crucial variables are the skill of the therapist and the nature of the evolving therapeutic relationship. These are merely a few of the factors that will affect outcome. The actual happenings in therapy cannot be predicted in advance. We might roughly say, however, recognizing that there are many caveats, that if a patient is highly motivated for therapy, has functioned well in the past, has had at least one good relationship previously, is uncomfortable with the symptoms or life situation, seems to be able to relate well with the interviewer, has a curiosity about personal psychological forces (psychological mindedness), and is reasonably intelligent, he or she has a chance of doing well in therapy with a good therapist.

No truly valid criteria have ever been designed that can serve as a basis of prognosticating the results in psychotherapy. Published material is not too helpful, and even simple studies on recovery rates with different psychotherapies pose more problems than they solve. Without a comparative assay of the standards used in rating reported results and without precise definition of the technical procedures employed, caution must rule in accepting the validity of any statistics on improvement and recovery.

If so seemingly uncomplicated a matter as success or failure in psychotherapy can be

estimated with no greater accuracy than present studies reveal, it is obvious that the myriad intangibles involved make any estimates of prognosis an even more difficult task. One reason for this predicament is that irrespective of syndrome or any characteristics displayed by the patient, success in therapy is predicated on the response of the patient to a therapeutic relationship in which there are two participants—the patient and the therapist. Unless it is known how the therapist will behave in the relationship, how objective and empathic he or she will be, only part of the equation is known. The other part, the activity and competence of the therapist, is the imponderable factor about which little is known but that will significantly influence the results.

If, however, the therapist aspect of the equation is accepted as a constant and we assume that the therapist can be therapeutically astute in all cases, it is found that some kinds of problems and some characteristics displayed by patients will make for a better response to therapy than other problems and characteristics. It is on these qualities that estimates of prognosis can be made.

In delineating prognostic signs it is necessary to qualify them in terms of the ultimate treatment goals. This is because some patients may successfully achieve the goal of stabilizing themselves at the level of their optimal functioning prior to the onset of their illness but may be unable to reach the goal of personality reconstruction. Prognostic estimates will, therefore, be different with these two objectives. For example, in a patient with marked disintegrative tendencies, who has manifested an acute emotional disturbance, we may perhaps prognosticate a recovery from, the immediate upset and restoration to the previous level of functioning. Yet the prognosis for eradication of the disintegrative potential, and for reconstruction of the personality, will be less favorable.

Prognosis may be approached by considering such factors as the age of the patient, the duration of the illness, the severity of symptoms, the diagnosis, the level of the patient's intelligence, the motivations for therapy, the depth of insight, the factor of secondary gain, the individual's ego strength or weakness, the current environmental situation, past therapeutic failures, and the response of the patient to the present

therapeutic effort.

AGE OF PATIENT

Flexibility of personality is more important than the age of the patient in determining responsiveness to therapy. Because individuals become more rigid as they grow older, and their personality patterns and defenses become more inflexible, it is more likely that the average individual can achieve extensive reconstructive changes with therapy before 45 years of age rather than after, other factors being equal. Responses to supportive or reeducative therapy, however, do not seem to be affected by age.

DURATION OF ILLNESS

The more chronic the illness, the poorer is the prognosis. Some ailments of more than five years' duration may be extremely resistant to therapy. The reason is that the problem has become highly organized over a period of time with defensive balances and counterbalances that tend to neutralize the therapeutic effort.

SEVERITY OF SYMPTOMS

The severity of symptoms seems to bear little relationship to how rapidly or how completely emotional problems are resolved. Thus, a mild phobia in some patients may be more resistant to treatment than a severe phobic condition in other patients. A person with an intense anxiety reaction may react more rapidly to therapy than one with a personality problem without disturbing anxiety manifestations. Indeed, the absence of severe symptoms may influence therapy in a negative way since discomfort and suffering provide many of the strongest incentives for getting well.

DIAGNOSIS

Some types of emotional disorders seem to respond to therapy more readily than other types. Although certain conditions may rapidly be restored to stability with

supportive therapy, they may resist vigorously the deeper changes wrought by reconstructive therapy. Among such conditions are organic brain disorders, schizophrenia, manic-depressive reactions, involutional psychotic reactions, chronic anxiety reactions, chronic obsessive-compulsive reactions, perversions, addictions, and a great many personality disorders, particularly those in which there is characterologic rigidity. The other syndromes, especially stress, anxiety, conversion, phobic, and psycho-physiologic reactions, are usually more amenable to reconstructive therapy, but coexistent factors of a destructive nature may possibly interfere with good results.

Neurotic symptoms occurring in the medium of a severe personality disorder and initiated, or sustained, by the disorder may not disappear until the personality problem itself is resolved. Thus, what may concern the patient most importantly, promoting the search for psychotherapeutic help, is the inability to enjoy sexual relations. The individual may ardently wish to get over the symptom. This, however, may not yield until the fundamental problem of detachment from women or men is corrected. Here the outlook is guarded, for the personality disorder will first have to be resolved before the sexual symptom disappears.

There are patients in practically all categories of illness who are sufficiently flexible to respond favorably to most therapeutic interventions. Diagnostic categories here, listed in DSM-III under Categories I and II, are said to have the best prognosis. Conditions of greater severity involve characterological and emotional problems that make for poor adaptation and include substance abuse or affective, anxiety, dissociative, paranoid, schizophreniform, schizoaffective, psychosexual, factitious (simulated), impulse control, psychophysiological, and personality disorders, as well as a variety of disorders of infancy, childhood, or adolescence as listed in Category III of DSM-III. Prognosis is less favorable here and requires therapy that is more prolonged and intensive. Even more incapacitating, and making for a worse prognosis, are bulimia, anorexia nervosa, atypical eating problems, Tourette's syndrome, pervasive developmental problems, intractable substance abuse, and paranoidal psychotic, affective, anxiety, somatoform, dissociative, psychosexual, impulse control, and personality disorders, listed in Category IV of DSM-III.

These syndromes may require periodic hospitalization and biologic and psychosocial therapies. At the bottom of the adaptive and prognostic scale are such chronic and recurrent disorders as autism, schizophrenia, paranoid disorders, affective disorders, and personality disorders listed Category V of DSM-III, which may need and sometimes respond to hospitalization and biologic and psychosocial treatments. The most pessimistic prognoses are for such mental disorders, listed in Category VI of DSM-III, as chronic unmotivated severe schizophrenia and paranoid disorders, which resist treatment and require constant supervision and perhaps hospitalization. These diagnostic formulations are helpful in estimating prognoses in a general way, but other factors can override these estimates.

LEVEL OF INTELLIGENCE

High intelligence is not positively correlated with good results in therapy, although verbal skill and the capacity for self-understanding are favorable ingredients. However, borderline or defective intelligence will make it difficult to use any other technique than that of supportive therapy.

MOTIVATIONS FOR THERAPY

Unless the motivation for therapy is present or it is developed, it may be difficult to treat the patient, or therapeutic goals may have to be rigidly circumscribed. Thus, an alcoholic may have no motivation for treatment whatsoever and may consult a therapist merely to please his or her spouse. As long as this lack of motivation persists, the prognosis with any kind of therapy will be poor. An individual with a psycho-physiologic gastrointestinal ailment may seek rapid, dramatic relief of symptoms but may not be motivated to explore inner problems and conflicts to arrive at their basis. It will not be possible, under these circumstances, to employ deeper therapy with reasonable success. A woman with a personality disorder associated with, for example, aggression may not be motivated toward changing her way of life no matter how skillful the therapist. She may, for instance, rationalize her refusal to change on the basis that an alteration in personality

would threaten her in the business world. She may believe that her livelihood is contingent on fierce competitiveness. She will, therefore, resist therapy that is aimed at reconstructive goals.

A patient, furthermore, may be motivated to find in the relationship with the therapist other things than emotional health. The patient may thus seek in it a means to power, success, or perfectionism. The patient may, out of loneliness or frustration, regard the relationship as a social experience. He or she may desire to convert the therapist into a parental figure to satisfy a dependency need. Or the patient may search for an idealized self-image in the therapist with which he or she can identify. Until these defective motivations are altered, the prognosis for sustained personality change will be guarded.

Among factors that support good motivation for therapy are suffering from symptoms, the realization by the patient that the neurosis is handicapping functioning, and a desire to be "normal" like other human beings. Among factors that oppose proper motivation are absence of symptomatic suffering, lack of handicap from symptoms, the fear of finding out something despicable about oneself in therapy, the reluctance to yield neurotic gains and values, the fear of exposing oneself to the unknown dangers of health, and the desire to be unique and unlike other persons.

DEPTH OF INSIGHT

The extent of insight may or may not exert some influence on prognosis. The patient may have no conception that one's symptoms are in any way related to basic conflicts within oneself and one's relationships with people. So long as this lack of understanding persists, reeducative and reconstructive therapy will proceed under a handicap. It is difficult to estimate how long therapy will go on before the patient develops this degree of awareness. On the other hand, the presence of such insight at the start of treatment, or its emergence during therapy, does not presuppose that the individual will be able to handle insight constructively or to utilize it in the direction of change. The patient will require considerable fortitude to help compensate for the spurious values arising from the neurosis, to master the anxieties related to the challenging of basic defenses, and to

experiment with normal values and goals that have up to this time been held in contempt or been considered to be beyond reach. While it is difficult to predict how long it will take the patient to develop insight or to use it, the existence of intelligence, sensitivity, creativity, and flexibility are favorable signs.

THE FACTOR OF SECONDARY GAIN

Secondary gain elements include the use of symptoms and disorganizing personality traits as means to security and self-esteem. Every neurosis possesses a certain protective quality for the patient even though it vitiates the patient's productivity and sabotages happiness. Indeed, the patient may resent abandoning spurious values that accrue from a neurosis. Thus, a psychosomatic illness may inspire sympathy from people, absolve the patient from responsibility, and perhaps serve as a means of punishing intimates in the environment toward whom the patient feels resentful. In stress reactions (traumatic neurosis) the factor of monetary compensation may make sickness a real asset to the individual. Personality distortions may constitute the only means that the patient knows of relating to people. The patient may, therefore, conceive of therapy as a means of exposure to dangers or deprivations that have so far been avoidable.

The stronger the secondary gain, the less favorable is the prognosis. During therapy, however, secondary gain elements may be handled and worked through as forms of resistance.

EGO STRENGTH AND EGO WEAKNESS

The concept of ego strength is an empirical construct that is useful in estimating prognosis. The ego may be conceived of as an integrating force that permits mobilization of adaptive resources. The ability in insight therapy to face inner conflict, to tolerate the intense emotions and anxieties liberated in the relationship with the therapist, to recognize the irrationality of these emotions, to understand their genetic origin, to abandon the spurious values and secondary gains of a neurosis, and to establish patterns of behavior in line with mature goals calls for a relatively strong ego structure.

Estimates of ego strength may be made from data in the following areas: (1) hereditary influences, (2) constitutional factors, (3) early environmental conditionings, (4) developmental history, (5) present interpersonal relations, (6) methods of handling stress, (7) ability to gratify vital needs, (8) symptoms, (9) precipitating environmental factors, (10) type of previous adjustment, and (11) prevailing level of social maturity. Zucker (1963) has outlined test procedures to determine ego weakness, which manifests itself in disturbances in screening of external stimuli, fusion of different realms of cognitive experience, tendency to multiple identifications, fluctuating body image, inability to segregate the consequential from the inconsequential, and the extension of the ego field into other fields or entities.

Hereditary Influences

The significance of heredity in fashioning ego strength is unclear. It may be speculated that a "neuropathic predisposition" imposed on the individual by heredity tends to influence negatively biochemical and neurophysiological systems, and to weaken the ego, but how this operates and the extent of its influence cannot be described. A family history of mental illness, especially manic-depressive psychosis, schizophrenia, alcoholism, convulsive disorder, and drug addiction must always be considered seriously; nevertheless, a favorable early environment may neutralize some destructive hereditary factors. On the other hand, absence of hereditary history of mental illness does not mean that ego strength is guaranteed.

Constitutional Factors

Like heredity, it is difficult to assign to constitution a definite role in the molding of ego strength. A constitutionally abnormal stature or physique or endocrine disorder, however, may create problems for the person and, in this way, indirectly influence ego functioning.

Early Environmental Influences

Both behaviorists and psychoanalysts agree on the decisive role of early childhood in molding and establishing the patterns of adulthood, both good and bad. Some therapists have a fatalistic attitude about this, as if all that matters is a salubrious early life for the creation of a happy, adjusted adult. On the other hand, a disturbed childhood, it was once thought, presumably predisposes to an inevitable destiny of doom. These concepts have in recent years undergone some revision, as it has been proven that children are sufficiently resilient in their reactions so that, given a reasonably constructive milieu following a deprived and destructive upbringing, surprising reparative changes are possible (Clarke and Clarke, 1976; Rutter, 1972; Thomas and Chess, 1980). The degree of change will depend on the severity of early damage and the opportunities for growth offered to the child. An impressive number of studies has also cast doubt on "critical periods" of learning and even the so-called irreversible effects of imprinting in animals, whatever implications these have for humans.

Longitudinal studies indicate that it is impossible to predict the degree of competence and maturity in adults from the severity of confusion and disturbance during the childhood and adolescent years. Growth is possible at every stage of the life cycle from infancy to maturity. Yet it cannot be guaranteed that memory traces of a cruel and destructive early existence can be entirely eradicated by a propitious later environment, nor that these do not surface in dreams and in certain emergency reactions. Nor is there assurance that crisis situations in which mature modes of coping are shattered will not sponsor some catastrophic reactions reminiscent of an earlier state of disorganization.

The fact that an individual disrupted in growth during early development *can* change in later life sufficiently to overcome early handicaps does not guarantee that the individual *will* change. Among the reasons for this inability are the continued existence of inimical environmental circumstances, and the individual's inherent characteristics, creating stressful conditions that resemble the traumatic happenings of the person's childhood, even though the milieu itself could be favorable in supporting constructive relearnings. We must remember that clinicians see a special subgroup of patients who have failed to change and that consequently false assumptions about capacities for change

may be generalized to the population at large. On the other hand, most surveys and research studies have dealt with an unselected population and are more apt to present a more accurate picture of what happens. This may account for the discrepancy in ideas between clinicians and researchers.

Severely traumatizing influences in early childhood in some persons may have impoverished ego development so drastically as to limit the extent of its potential growth. Where historical material during early childhood reveals great stress, an attempt should be made to ascertain the effect on the patient's ego. Among traumatizing influences are disharmony in the home; intense conflict between the parents or parental separation or divorce; tendencies in either parent that make him or her markedly authoritarian, domineering, excessively punitive, cruel, intolerant, unstable, immature, cold, neglectful, rejecting, weak, sickly, superstitious, overprotective, neurotic, psychotic, or alcoholic; and great rivalry with, or jealousy and dislike of, a sibling. The absence of such influences is not necessarily a favorable prognostic sign.

Developmental History

By the same token, certain findings in the developmental history are indicative of a potential stunting of personality growth. They are often insignias of possibly extensive and even irreparable damage to the ego. Among important findings are the following:

1. *Birth:* (a) Patient an unwanted child, (b) premature birth, (c) birth injury.

2. *Feeding problems:* (a) Great undernourishment, (b) vomiting spells or colic, (c) bottle fed after 1½ years.

3. *Early care:* (a) Mother sickly after patient's birth, (b) mother not involved in early care, (c) care by a succession of nurses.

4. *Physical development:* (a) Delayed growth, (b) deformity.

5. *Habits:* (a) Retarded dressing and toilet habits, (b) enuresis, (c) improper sleeping habits.

6. *Intellectual development and school adjustment:* (a) Delayed talking, (b) started

school when 7 years old or older, (c) got along poorly with teachers, (d) repeated grades, (e) got along poorly with schoolmates, (f) unhappy at school, (g) obtained low grades, (h) quit school before the eighth grade.

7. *Emotional maturity:* (a) Persistent temper tantrums, (b) continuing dependency, (c) unresolved sibling jealousy, (d) lack of assertiveness, (e) never self-supporting as an adult, (f) no effort to hold a job, (g) never married, (h) married, but divorced or separated, (i) no desire for children, (j) no group interests.

8. *Social development:* (a) Excessively selfish, withdrawn, timid, or seclusive, (b) no desire for friends or unable to form friendships, (c) unaffectionate and undemonstrative, (d) refusal to accept responsibilities.

9. *Sexual development:* (a) No sex education, (b) slept in parents' bedroom, (c) observed parents in sexual relations, (d) sexually stimulated by parent or nurse, (e) masturbatory intimidation, (f) intercourse before 16, (g) sexual seduction before 16.

10. *Illnesses and accidents:* (a) Convulsive disorder as a child, (b) "sleeping sickness," (c) poliomyelitis, (d) asthma, (e) fainting or dizzy spells, (f) migraine, (g) trouble with sex organs, (h) endocrine disease, (i) head injury, (j) several accidents, (k) several fractures, (l) cardiac disturbance, (m) stomach and intestinal illness.

11. *Neurotic traits:* (a) Peculiar toilet habits, (b) persistent thumbsucking, (c) nail biting, (d) easy crying, (e) persistent fears, (f) nightmares, (g) sleep walking, (h) speech problems, (i) tics, (j) compulsions, (k) excessive daydreaming, (l) cruelty, (m) excessive aggressiveness, (n) truancy, (o) hyperactivity, (p) runaway tendencies, (q) stealing, (r) fire setting, (s) detachment.

Current Interpersonal Relations

The nature of the patient's current interpersonal relations may yield some clues to ego strength. Human beings display an endless variety of interpersonal reactions. The intensity of such reactions rather than their quality is of pathological consequence. As a general rule, the personality distortions tabulated below indicate that long-term reconstructive therapy will be required to influence them significantly. They do not,

however, indicate how the patient will respond to treatment. The quality of interpersonal relationships the individual possesses will determine the capacity to establish a proper working relationship with the therapist. Severe difficulties will interfere with treatment (Kernberg, et al., 1972). Some of the distortions are more serious than others, for instance, detachment or open aggression. On the other hand, the relative absence of personality distortions is a good prognostic sign. The characteristics listed below must be considered of negative prognostic importance only when they appear in exaggerated form.

1. *Relationship with people in a superior or authoritative position:* (a) Dependency, (b) submissiveness, (c) shyness, (d) ingratiation, (e) fear, (f) dislike, (g) distrust, (h) aggression, (i) detachment.

2. *Relationship with friends and colleagues:* (a) Absence of close friends, (b) feelings of being disliked, (c) avoidance of people, (d) lonesomeness even when with people, (e) fears of people, (f) inability to mix, (g) fear of rejection, (h) dependency, (i) submissiveness, (j) distrustfulness, (k) aggression, (l) dislike of people, (m) inability to get along with women, (n) inability to get along with men, (o) fear of women, (p) fear of men, (q) feelings of difference from other people, (r) feelings of inferiority, (s) feelings of superiority, (t) jealousy of others, (u) suspicion of motives of others, (v) stubbornness with others, (w) insistence on having own way, (x) furiousness when crossed.

3. *Miscellaneous relationships:* (a) Dislike of younger, older, less attractive, or unfamiliar people, (b) suspiciousness, (c) self-consciousness.

4. *Group relations:* (a) Dislike, fear, and avoidance of groups, (b) shyness in groups.

5. *Attitudes toward self:* (a) Shyness, (b) lack of self-confidence, (c) avoidance of responsibility, (d) indecisiveness, (e) despising of self, (f) perfectionism, (g) meticulousness, (h) parsimony, (i) obstinacy, (j) self-dramatization, (k) narcissism, (l) grandiosity, (m) mysticism, (n) feelings of guilt, (o) need for punishment, (p) resentfulness.

6. *Emotional reactivity:* (a) Exaggerated, (b) limited.

Methods of Handling Stress

The adequacy or inadequacy of the defensive reactions of the individual may be of significance. Among the less favorable signs in relation to the handling of stress are physical withdrawal, emotional detachment, fantasy, acting-out, aggression, sadism, alcoholic overindulgence, excess sedation, intense dependency, self-punishment, self-aggrandizement, intellectual confusion, emotional shattering, physical sickness, compulsions, depression, feelings of unreality, and sexual perversions. Unfavorable also is an inability to face pain or to tolerate anxiety that will occur when the patient's resistances are challenged.

Ability to Gratify Vital Needs

The ability to gratify, in conformity with the mores, important biologic and social needs without guilt, aggression, or self-punishment are signs of ego strength.

Symptoms

Prognostically unfavorable symptoms are stammering, homosexuality, exhibitionism, fetishism, sexual sadism, sexual masochism, psychomotor retardation, violent rages, euphoria, apathy, fear of blushing, fear of germs, fear of soiling, fear of contamination, fear of poverty, uncontrollable impulses, handwashing, ritualistic acts, hair plucking, self-torture, delusions of influence, delusions of persecution, delusion of "thoughts being stolen," grandiose delusions, delusion of "mission to perform," delusion of body organs rotting, delusion of having committed an "unpardonable sin," delusion of "having lost one's soul," ideas of reference, hallucinations, impaired reality sense, depersonalization, impaired judgment, alcoholism, drug addiction, criminality, and hypochondriasis.

Precipitating Environmental Factors

Emotional ailments occurring in the medium of severe environmental stress, and directly related to the stress factor, may have a favorable prognosis, provided that the environmental difficulty can be resolved or that the patient is capable of making an

adjustment to irremediable circumstances. Illustrative are catastrophic life happenings, such as accidents, disasters of nature or those brought on by war, death of parents, mate, or children, abandonment, separation or divorce, and severe losses of prestige, position, or economic security. On the other hand, emotional illness developing in the face of a congenial environment has a less favorable prognosis.

An emotional problem brought on by severe environmental stress does not always indicate a good prognosis, even in the absence of maladjustment prior to the cataclysmic happening. In some instances the stress situation may touch off a residual neurosis by bringing into play repressive and regressive defensive techniques that persist long after the traumatic event has passed. Instead of recovering rapidly with therapy, the individual may exhibit an obstinate reaction of helplessness, as if he or she no longer trusts the world that has so abruptly shattered all sense of personal mastery.

Previous Adjustment

If the patient has, at any period in life, made a good adjustment, the prognosis would probably be better than if maladjustment were present continually from early childhood. In appraising the character of the patient's adjustment, the therapist should consider whether this was maintained at the expense of vital aspects of functioning. One should determine what it takes out of the person to make the kind of adjustment that is being made, even though made successful. For instance, a schizoid personality disorder may not militate against a social adjustment, provided that the individual is capable of avoiding situations of environmental stress and is able to be detached sufficiently from people to prevent close interpersonal involvements. An aggressive obsessive-compulsive individual may be able to carry on satisfactorily, with a modicum of happiness, if the environment and close friendships can be controlled. Or adjustment may be contingent on the gratification of immature dependency strivings, maladjustment ensuing upon withdrawal of the host. Thus, the quality of one's past adjustment and the areas of functioning that must be inhibited for purposes of adaptation will determine whether or not they can be considered evidence of a strong ego.

Level of Social Maturity

Estimates of personality maturity in terms of physical growth, educational achievement, resolution of dependence, sexual maturity, marriage, parenthood, quality of social relationships, and group and community participation are possible indications of ego strength. However, an individual who has achieved satisfactory interpersonal relationships and a good social adjustment, satisfying accepted criteria of maturity, may still be a seriously sick person emotionally, who, upon succumbing to collapse in adaptation, may offer strong resistances to psychotherapy. Thus, a person may achieve social maturity by repressing powerful anxiety-provoking conflicts and by evolving a personality structure organized around perfectionism, obstinacy, meticulousness, repression of hostility, and a compulsive need for order and precision in the immediate environment. Therapy may be a prolonged and difficult task, even though the individual may have operated in life on an apparently high level of maturity.

On the other hand, evidence of immaturity (impaired physical growth, low educational achievement, continued dependency ties, sexual infantility or perversions, distorted life goals, inability to accept marriage or parenthood, inability to coordinate ambitions with aptitudes and the existing reality situation, disturbed social relationships, and lack of community participation) may, if prominent, be regarded as direct signs of ego weakness.

THE CURRENT ENVIRONMENTAL SITUATION

Serious lacks and encumbrances in one's environment influence prognosis negatively. Thus, a disturbed environment that the patient cannot alter, and in which he or she is expected to function, imposes a burden on personal capacities for adjustment. A wife assaulted periodically and unexpectedly by an alcoholic husband from whom she is unable to secure a separation or divorce, and a dependent child reared in the home of acting-out sexually perverse adults are examples. Among inordinate environmental influences are economic stress; bad work, housing, and neighborhood situations; abnormal cultural standards and pressures; discordant family relationships; and

disturbed daily habits and routines.

1. *Economic situations:* (a) The patient is subject to desperate or poor financial circumstances; (b) is unable to afford adequate food, shelter, and clothing; (c) cannot support dependents, meet present indebtedness, or provide for appropriate education and recreation.

2. *Work situation:* (a) The patient is unemployed; (b) has made the wrong selection of an occupation; (c) is unhappy at work due to inadequate salary, inimical work conditions, and few opportunities for advancement.

3. *Housing situation:* The patient lives in an inadequate dwelling in terms of insufficient space, absence of privacy, and uncleanliness.

4. *Neighborhood situation:* (a) The patient is subject to malicious activities by delinquent or criminal individuals or gangs; (b) is exposed to racial, class, or religious discrimination; (c) is without neighborhood recreational and social facilities; (d) lives too far away from work and social activities.

5. *Cultural standards and pressures:* (a) The patient comes from a different background than people with whom he or she lives and associates; (b) feels discriminated against because of race, religion, color, or national background; (c) finds it difficult or impossible to adjust to the standards of the surrounding people; (d) refuses to conform with current cultural patterns; (e) experiences a clash between personal and community standards.

6. *Family relationships:* The patient (a) is unhappy at home; (b) is "ashamed of," "afraid of," or "hates" certain family members; (c) disagrees violently with people at home; (d) feels a threat to personal independence; (e) experiences constant insistence to "obey"; (f) is subjected to interference with legitimate social life; (g) one is criticized for personal appearances; (h) is subjected to angry displays; (i) though adult, is unable or unwilling to live away from his or her family; (j) has a difficult problem with family members living at home; (k) is financially dependent on parents.

7. *Relationship with mate:* (a) If married, the patient is unable to adjust to married life or to get along with his or her mate; (b) is not in love with the spouse; (c) fights constantly with the spouse; (d) has unsatisfactory sexual relations;(e) has an adulterous or emotionally ill mate; (f) is mistreated by the spouse.

8. *Relationship with children:* (a) The patient is having a severe problem with one (or more) emotionally ill offspring; (b) regrets having children; (c) the children are experienced as irritating; (d) mutual dislike between parent and children; (e) the children quarrel constantly and are refractory to reasonable discipline.

9. *Daily habits, recreations, and routines:* The patient is guilty of some of the following: (a) irregular meal times, (b) unbalanced diet, (c) excess coffee and tobacco, (d) improper body care and grooming, (e) insufficient sleep, (f) lack of exercise, (g) absence of interests, hobbies, or recreations, (h) few or no social or community activities.

PAST THERAPEUTIC FAILURES

One or more long unsuccessful psychotherapeutic experiences is generally an unfavorable prognostic sign. Exceptions to this rule include treatment by an unskilled therapist, by one who was unable to handle transference or to control countertransference reactions, or by one whose approach lacked flexibility. Because previous treatment had failed, the patient may have lost confidence in the efficacy of psychotherapy. This may act as resistance to treatment.

RESPONSE TO THE PRESENT THERAPEUTIC EFFORT

Once therapy has started, it may be possible to prognosticate the outcome with greater accuracy than from the appraisal of the past history. If the patient has or develops strong motivations for therapy, enters into a good working relationship with the therapist, is capable of understanding and resolving transference reactions, masters resistances to therapy, exhibits an ability to face anxieties associated with external stress and inner conflicts, shows a willingness to abandon the spurious values of the neurosis and to vanquish the secondary gain element, a reasonably good prognosis can be predicted. Table 27-1 summarizes the positive and negative prognostic signs.

It may seem odd to include the therapist in a prognostic index. Since psychotherapy is an interpersonal relationship, however, the therapist's attitudes toward a specific patient and capacity to understand the patient and to provide a meaningful relationship

for him or her are important in estimating what will happen in the therapeutic situation. It is difficult to predict from the general responses of the therapist whether it will be possible to establish a good relationship with a certain patient. The therapist may be able to relate better to some patients than to others. Furthermore, since empathy with a patient and his or her problems is mandatory for success in psychotherapy, the therapist may be able to work better with certain kinds of emotional ailments and not so well with others. Table 27-2 summarizes the prognostic signs for the therapist.

The Initial Interview: Estimating the Patient's General Condition

It is important to estimate how thoroughly prepared the patient is for psychotherapy prior to making arrangements for treatment. This necessitates a number of judgments, including the level of insight and the degree of motivation. Such judgments should be recorded in the initial interview form.

RESPONSE OF PATIENT TO THERAPIST AND VICE VERSA

The therapist will have observed at this point in the initial interview that the patient has responded in certain ways, such as by being cooperative, fearful, suspicious, or hostile. The therapist will also be aware of personal feelings about the patient—positive or negative. The patient's fearful, suspicious, or hostile responses will also have to be handled along the lines suggested in Chapter 32. Furthermore, one's own over-protective or rejecting attitudes toward the patient will have to be managed. Observations of reciprocal responses are important in deciding whether the interviewer will continue treating the patient or whether a referral will be made to another therapist.

PHYSICAL APPEARANCE

The patient's physical appearance—meticulous, presentable, untidy, or disheveled—and the manner of dress may give the interviewer some clues of how the patient feels about himself or herself. Thus, a woman with a short haircut who wears a manish suit may be dressing and grooming according to the latest style or attempting an identification with males. An unkempt personal appearance may be a manifestation of disintegrative tendencies. Pretentious apparel may be a surface indication of feelings of deep self-devaluation or of contemptuous attitudes toward conventionality. It is essential to consider the patient's grooming, hair style, and dress in relation to whether they

coordinate with or differ from the patient's subcultural group.

PATIENTS' ESTIMATE OF PRESENT PHYSICAL HEALTH

The degree of the patient's preoccupation with concerns of health may be diagnostically important. Thus, underconcern about one's physical condition, to a point where the patient neglects an illness, may be indicative of masochism. Overconcern about one's physical state may reflect fears of injury or of death, such as are found in obsessive-compulsive reactions.

COMMUNICATIVENESS

The way that patients communicate may suggest how they will relate in therapy, their emotional status, and their contact with reality. An unmotivated patient is usually underproductive. Underproductivity to a point of retardation is also often a sign of depression, especially of a depressed manic-depressive state. Garrulousness may be a manifestation of fear, or it may indicate a serious psychomotor condition, as in the organic psychoses. Overproductivity may additionally be a symptom of the manic phase of manic-depressive psychosis. Disjointed, irrelevant, and incoherent productions are sometimes found in schizophrenia. The choice of what a patient says at first, glaring omissions, attitudes of passivity, belligerence, apathy, inappropriateness of affect, and other signs will yield clues to the patient's personality problems.

INSIGHT AND MOTIVATION

For the patient to qualify best for successful therapy, each of the following conditions must be satisfied:

1. The patient must be aware of the fact that a problem exists.

2. The patient must desire to correct the problem.

3. The patient must be aware of the fact that the problem is emotional in nature.

4. The patient must be willing to accept psychotherapy.

5. The patient must be willing to accept help from the interviewer or from some other therapist.

6. The patient must be willing to accept the conditions of psychotherapy.

7. The patient must be able to arrange time for treatment.

8. The patient must be able to afford to pay whatever fee is decided on between the patient and the therapist.

The interviewing therapist must, therefore, search for answers to the following questions:

1. Is the patient aware that there is a problem? If not, why has the individual come for an interview?

2. Assuming that there is recognition of a problem, does the patient want to correct the problem? If not, what does the patient want from the interviewer? If so, what kind of help does the patient believe is needed and what help has been received to date?

3. Is the patient willing to accept the fact that the problem is emotionally determined? If not, how intense is the resistance? Does the patient know anything about emotional illness?

4. Assuming that the patient accepts the fact that the problem is an emotional one, is the patient willing to receive psychotherapy? If not, why not? Are there misconceptions about psychotherapy? Are these soluble with appropriate clarification?

5. Is the patient willing to accept treatment from the interviewer or from a therapist whom the interviewer suggests? If not, what resistances are displayed? Can these be handled during the initial interview?

6. Is there an acceptance of the conditions, the general arrangements, and the method of psychotherapy? If not, is it possible to deal with the objections?

7. Can the patient arrange the necessary time for treatment? If not, are the reasons

emotional or realistic? Can a practical means be devised for handling these problems?

8. Can the patient afford therapy? If not, can arrangements be made to obtain or borrow funds?

The management of the patient's resistances to any of the conditions essential for therapy is a responsibility of the initial interviewer. Ways of dealing with such resistance are indicated in later chapters, particularly Chapters 32 and 36.

The Initial Interview: Making Practical Arrangements for Psychotherapy; Treatment Planning

Before making any arrangements for therapy, it is advisable to give the patient a bird's-eye view of his or her problem in understandable and meaningful terms. The therapist presents a general statement of the problem, as the therapist sees it, and also what might be accomplished through psychotherapy. No interpretations are made; no outline of the dynamics are postulated; no promises of cure are extended; no pronouncements are expressed to the effect that the prognosis is bad. A possible statement might be, "Now I have a general idea of your problem, and I should like to give you some broad impressions of what might be done. Due to a number of factors, you have developed difficulties that 'tie you in a knot,' so to speak. You have some bothersome symptoms, and you are prevented from developing your potentialities. I think you need psychotherapy and can benefit from it."

Included in making of practical arrangements for therapy are choosing the therapist, choosing the type of therapy, deciding the frequency of visits, estimating the duration of therapy, arranging the fee, handling delays in starting treatment, and making final arrangements with the patient or referring him or her to another therapist.

CHOICE OF THERAPIST

By the time that the initial interview is completed, the therapist will usually have been able to evaluate whether he or she can, given the level of training and skills, handle the patient's problem. The therapist may, by virtue of training, be equipped to treat the patient. Whether or not the therapist decides to do so will be dependent on his or her emotional response to the patient, interest in the specific problem presented, and ability to make the proper time and financial arrangements with the patient. The therapist will also have to take into account the patient's own wishes.

The interviewer may not be trained to implement the kind of therapeutic approach best suited for the patient's difficulty. Thus, if formal psychoanalysis is decided on as the treatment of choice and the interviewer is not analytically trained, he or she will want to transfer the patient to a psychoanalyst.

If a dangerous depressive condition necessitates electric convulsive therapy, (ECT), and the psychotherapist does not use this modality in practice, or if one is a non-medical therapist, a suitable psychiatrist will have to be found who can give shock treatment. If hypnotherapy seems indicated, a specialist in this field will be required. If behavior therapy, cognitive therapy, family therapy, couples therapy, or group therapy are what will help the patient most, arrangements for these will have to be made unless the therapist is familiar with these techniques.

The patient may possess a type of problem that the interviewer does not care to handle. For instance, some therapists do not like to work with adolescents, older patients, borderline cases, schizophrenics, alcoholics, drug addicts, obsessive-compulsive neurotics, severe anxiety hysterics, or psychopathic personalities. Moreover, the emotional response of the patient to the interviewer, and of the interviewer to the patient, may be such that it is obvious that they cannot work together. Finally, the patient may decide against starting treatment with the initial interviewer, even though the latter is willing to accept the patient for therapy. While this contingency is rare in a properly conducted interview, the therapist should still be prepared to meet it on occasion.

The question is often asked regarding the preferred sex of a therapist for the handling of certain problems. Experience proves that the personality and skill of the therapist are more important than whether the therapist is male or female. Nevertheless, some patients seem to do better with therapists of one sex than the other. Thus, if the patient has had damaging experiences of rejection, neglect, or harsh treatment from his or her father and has later never been able to establish a good relationship with a man, severe problems of a transference nature are apt to develop with a male therapist. If the ego structure of such a patient is furthermore weak, treatment may stir up anxieties that

are beyond coping powers. Under these circumstances it is probably better to get the patient started in treatment with a female therapist. The opposite would be true if the prime problems were with a mother figure and were of such severity that the patient was uncomfortable with a female practitioner. Here a male therapist would probably be better for the patient. If, however, the ego of the patient seems strong, if reconstructive therapy is to be used, and if a transference neurosis is desired, the opposite choice might be indicated.

Certain kinds of syndromes seem to respond more readily in a relationship with a female therapist. Borderline cases and some types of schizophrenia, alcoholism, and psychopathic personality are often more easily handled by a female therapist, possibly because existing dependency (oral) needs are symbolically gratified and there is no potentially threatening masculine authority figure.

The age of the therapist may also influence the patient. Some patients are insistent upon an older therapist on the basis that age is an insignia of greater experience. An older female therapist is sometimes desired in cases where there is an urgent need for a mother figure, while an older male therapist may be sought by individuals who yearn for a relationship with a father figure.

There are specially gifted individuals who are remarkably ingenious, sensitive, and creative, and who, almost intuitively perceive the needs and potentials of their patients and are able to employ interventions and devise techniques that fulfill the requirements of any therapeutic challenge. Many therapists, however, are not so ably equipped. With adequate training, most aspiring practitioners, if they are not too handicapped by personality blights, can acquire adequate talents to do satisfactory psychotherapy. But there are some whose therapeutic ministrations leave much to be desired, and who manage to stay in business largely because of the placebo effect and the spontaneous remission rate.

CHOICE OF TREATMENT METHOD (TREATMENT PLANNING)

Treatment planning is a practice in which must be considered the immediate and ultimate goals to be achieved; the motivations of the patient to attain such goals; the intellectual and personality assets of the patient; the existing diagnosis; the flexibility, sophistication, and theoretical biases of the therapist; and many other factors. Lewis and Usdin (1982) have edited a book that constitutes a preliminary breakthrough on the subject. The future will undoubtedly witness additional contributions. Because emotional problems are so diverse and respond best to selective interventions, therapists wedded to monolithic approaches that work for some patients may organize a structured treatment plan around a modality that proves wholly unsuited for other patients. For example, a highly appropriate classical psychoanalytic treatment plan may be designed for a personality problem, and when applied to a borderline or schizophrenic patient will be as effective as shooting buckshot in the air.

In designing a treatment plan, it must be considered that most patients are anxious for as quick relief of their symptoms as possible. They see no need for an exhaustive probing of their patterns. Satisfying the demand for succor through supportive therapy is justified in certain situations. Supportive measures may be considered necessary where the patient's symptoms reflect an alarming collapse of coping capacities in the form of excessive anxiety, depression, and disintegrative tendencies with shattered capacities for reality testing. They may be indicated also in patients whose ego strength is doubtful and in whom adjustment to the existing neurosis, using available assets to the full and minimization of liabilities, is all that can be expected. Immature, dependent, antisocial, borderline, psychotic, alcoholic, drug addictive, and some compulsion neurotic patients often fall into this category. The therapist may have no alternative but to use supportive measures in patients who have no real motive for self-growth and who extract from their neuroses elements of profound secondary gain that they refuse to give up. Finally, supportive approaches are helpful in patients with adequate ego strength whose adaptive capacities are habitually good but who have crumbled under the impact of extremely severe environmental stresses and want to reconstitute themselves as rapidly as possible.

Irrespective of diagnosis and severity of symptoms, however, the therapist has a

responsibility to bring each patient as far along the path of maturity as possible by resolving resistance to the acceptance of more intensive help. This means that some form of at least modified reconstructive therapy will be indicated whenever feasible.

If the patient has a history of having made an adequate adjustment in early life and, until the onset of the present illness, has gotten along satisfactorily, the chances are that the individual can be brought back to previous levels of adjustment with an approach that is geared toward reeducative goals. Restoration of former status will generally not require a great deal of time. But where the patient has been seriously maladjusted since early life and later adaptation has never been adequate, therapy should be tried that is reconstructive in nature to promote in the patient a development of those capacities that have never previously existed. A less intensive form of therapy would achieve only abbreviated goals, which, of course, may be all that realistically can be approached in many cases.

For instance, a 48-year-old man successful in business, is referred for therapy by his physician because medications have failed to correct a painful gastrointestinal ailment that has persisted for eight months. During the initial interview, it is tentatively determined that the patient was severely neurotic as a child and that he managed to adjust satisfactorily as an adult only by assuming a detached attitude toward people. A bachelor, the patient's relationships with women were sporadic, superficial, and largely centered around temporary sexual affairs. Despite the yearning for "a real woman," who would be a "real" wife and lover, no such personage had ever presented herself. However, one year previously, following a short affair, the patient, in spite of the fact that his paramour did not completely come up to specifications, decided to experiment with living together. Shortly after the young woman took up residence with him, he began to develop symptoms. His loss of energy and his "stomach upsets" caused him to confine himself periodically to bed, from which he issued orders to his lover. Violent rages at her incapacity to supply his demands for service and attention were followed by bouts with apologetic self-reproach.

The patient's history revealed that he had been brought up in an atmosphere of relative emotional deprivation. Following the death of his father, his mother was forced to go to work, assigning the care of the three-year-old boy to an aunt who was not too happy with her charge. The boy grew up as a tough, detached individual with a deep craving for maternal attention, a distrust of women, and what seemed to be compulsive needs for self-reliance and independence. As an adult he maintained his detachment and independence, and as long as he limited his relationships with women to superficial contacts, he seemed to get along quite well. He was a successful, respected businessman, with many male friends and a reputation of being "quite a lady's man."

It can be theorized that need for a mother figure, who would perhaps make up for the dearth of love and care he experienced in childhood, drove him toward finding an idealized female love object. The possibility of his paramour fulfilling this role both intrigued and excited him. He related to her as a child might to a mother, demanding bounties of constant affection and attention. In the process, his protective character drive of detachment was discarded. Anticipating the same kind of rejection that he experienced as a child, and, no longer capable of marshalling detachment and independence as security props, he became filled with catastrophic feelings of helplessness. He became more and more demanding of attention. His hostility toward, and distrust of, this new mother figure furthermore threatened his security. The anxiety liberated was apparently converted into somatic symptoms.

In speculating on these dynamics for purposes of choosing the proper therapeutic approach, we may additionally theorize on the following:

1. It would be futile to treat the patient's symptoms with a supportive approach since he was living with conflicts that were stirring up symptoms. Attempting to remove or ameliorate his symptoms would be like blowing away smoke without smothering the flame.

2. Were it possible to remove the patient forcibly from his upsetting entanglement with the young woman, to restore his detachment, and to bring his relationship with her back to what it was before he got so involved, he would probably detach from his driving need for a mother figure and

maintain his distrust of women, but he would feel secure again and be capable of functioning with his habitual character facades. He might be helped to sublimate his need for dependency, perhaps in an affiliation with some group such as one devoted to community betterment. But, by and large, his adjustment would, for better or worse, parallel that which he possessed prior to his illness. Unfortunately, the helplessness inspired by the abandonment of his customary characterological drives of detachment, isolation and compulsive independence, and his awakened dependency, would probably preclude a forceful removal of the young woman from his life. Anxiety might precipitate that was so intense that he could not tolerate her absence.

3. A better approach would be reeducative in nature, aimed toward understanding the depth of his frenzied search for a mother substitute and the futility of satisfying his dependency needs in his present relationship. During treatment he would probably automatically transfer part of his dependency needs onto the therapist. He would, however, be brought to an awareness of how his desperate desire for security had caused him to make an alliance with a woman who could not supply the insatiable tenderness and love he demanded. He would be shown how this disappointment had undermined him, filling him with hate and despair. His having isolated himself from his customary friends and removed himself from his usual pleasures would be revealed as contributing to his insecurity. The patient might even acquire some insight into the origins of his dependency needs. These measures might suffice for him to break out of the relationship that he had developed during the past year and help him to return to his former level of adapatation, with its attendant satisfactions and dissatisfactions. The time required for this restoration would probably not be too long since he was satisfying his dependency in contact with the therapist.

4. For the patient to be more completely liberated, it would be essential to inculcate in him a deep feeling of inner security such as he has never had —a security bereft of dependency needs and involving measures of self-esteem and assertiveness. It would be necessary to promote the ability to establish warm relationships with people without desires to hurt and to enslave, or to be hurt and to be enslaved. These reconstructive goals would necessitate long-term insight therapy that might last years. The patient would have to be motivated to accept this level of help with all the time and financial sacrifices that were entailed. He would also require sufficient ego strength to endure a certain amount of anxiety.

Unfortunately, the patient may see no need for an extensive working out of his problems. He may be satisfied with the mere achieving of the adjustment that he had made prior to his collapse, even though he recognized its inadequacies. He may be unable to make the time or to gather sufficient funds for long-term intensive therapy. He may be unable to accept the treatment situation or the responsibilities that he must share in therapy. He may be incapable of tolerating the anxieties of transference or of withstanding an attack on his neurotic defenses and needs. He may be so rigid as to resist using insight in the direction of change, even though he has gained an intellectual understanding of his problem.

During therapy, this particular patient soon came to realize the operative dynamics involved. He then avowed a desire merely to return to his previous level of adjustment. Realizing that his paramour could not possible supply his dependency needs, he separated himself from her and resumed his previous activity. His adaptative equilibrium having been restored, the patient lost his symptoms and achieved as happy an adjustment as was possible with his underlying personality problem. This was considered an optimal goal in therapy since he had no motivation for more extensive change. Even with prolonged therapy there was no guarantee that personality reconstruction would have occurred in view of his age and the severity of his character problem. The kind of therapy employed was oriented around reeducative goals.

Once the category of therapy has been decided on—supportive, reeducative, or reconstructive—it may be wondered which of the many approaches are most suitable in a specific instance. Assuming, for example, that a patient requires and can use a reconstructive type of therapy, the best kind of reconstructive therapy is a questionable point. Should the therapy be Freudian psychoanalysis, organized around the establishment and analysis of a transference neurosis? Should it be a form of non-Freudian psychoanalysis, focused on the character structure and interpersonal relationships? Or should it be an active psychoanalytically oriented type of psychotherapy.

Since psychotherapy is a learning experience, one criterion of choice of therapies is the method best adapted to the learning aptitudes of the patient. Some patients are

capable of learning rapidly in the medium of an interpersonal relationship deliberately kept on a positive level by the therapist. In this medium they analyze their dreams and other unconscious productions and come to grips with their anxiety, without too severe resistances or too intense transference reactions. Here, psychoanalytically oriented psychotherapy may be remarkably effective. Other patients seem to learn better in a more formal analytic relationship, yet one that is not so intense as Freudian psychoanalysis. Such a non-Freudian psychoanalytic approach would concentrate on transference and resistance but avoid the setting up of a real transference neurosis. In other cases, particularly where repression is extreme, the only way that the patient can learn is through involvement in a transference neurosis, living through with the therapist important frustrations, anxieties, impulses, and feelings rooted in past conditionings with early authorities. Here a traditional Freudian psychoanalysis may be attempted.

Returning to the choice of categories of therapy, a rough index might consist of the following:

Supportive Therapy

Those who would benefit most from supportive therapy fall into seven categories: (1) patients who are in states of acute anxiety or depression or who have very severe disabling psychosomatic symptoms; (2) schizophrenics showing disintegrative tendencies; (3) patients with a history that points to good ego strength who have recently become ill and for whom the goal is merely a restoration to the previous adaptative level; (4) patients with problems in which a perverse environmental disturbance acts as the most significant stress source; (5) those who have severe character problems with obstinate dependency and immaturity; (6) those who suffer from severe obsessive-compulsive reactions; (7) those who suffer from especially obdurate habit disorders, alcoholism, and drug addiction.

Reeducative Therapy

Patients who will benefit from reeducative therapy are those with personality

problems expressing themselves in difficulties in work, educational, marital, interpersonal, and social adjustment—especially those patients who have fairly good ego strength.

Reconstructive Therapy

Problems initiated by severe distortions in the individual's past relationships with parents and significant others, which have produced blocks in growth, may respond well to reconstructive therapy. Difficulties in which repression is the chief defense are most responsive. Included here are anxiety disorders, phobic disorders, conversion disorders, some obsessive-compulsive disorders, some personality disorders, and certain somatoform (psychophysiologic) disorders in persons with good ego strength.

It is essential to remember that the type of therapy required may shift during treatment. For example, the patient may be extremely upset at the start and require supportive handling. After stabilization he or she may be able to benefit from reeducative or reconstructive therapy.

Therapeutic Approaches in Different Syndromes

A systems approach recognizes the many interrelated units that must be considered in dealing with the specific problems of any person. These units may be visualized, as constituting a chain composed of interacting links—biochemical, neurophysiological, developmental as well as conditioned, interpersonal, social, intrapsychic, and philosophical-spiritual—that influence how a person thinks, feels, and behaves. Some of these interacting factors are intimately associated with the complaint that has led the individual to seek relief. The most effective help will be rendered by diagnosing the implicated links and targeting treatment toward these.

The different links are so amalgamated that feedback occurs throughout the chain when any one link is functionally disturbed. What probably concerns an individual most are the symptoms, which are usually the end product of this feedback. At the outset we

would want to deal both with the consequences and sources of the patient's symptoms. But the person may be fully unaware of or may downplay sources. Thus an individual who seeks relief for depression and anxiety may not at all, or only indirectly, refer to marital discord. This is inspired by unsatisfied dependency needs, which promote hostility to the spouse when he or she fails to come up to the patient's expectations. The final result is hopelessness and depression. If the therapist focuses on the symptoms that disrupt the patient's well-being, e.g., depression and anxiety, and treats the disruptive biological link with an antidepressant, there should be some diminution of symptoms. But the intrapsychic and interpersonal links will probably be influenced only minimally and will continue to promote trouble. It would be appropriate then to consider marital therapy and individual psychotherapy in addition to psychopharmacologic treatment. The matter of motivation is important. In our appraisal of the therapeutic focus we should consider which of the incriminated link systems the patient is ready to deal with and which is most amenable to alteration. There are some systems that are more difficult to change than others or that require more extensive therapy than the individual may be willing to sanction. Therefore, a compromise will have to be settled on and a link chosen that is susceptible to influence, the therapist hoping that through feedback other upset systems would undergo beneficial change. At the same time an effort would be made to create motivation for dealing with the most culpable link that is implicated in the patient's illness.

The choice of therapeutic approach invites the examination of which syndromes are best suited for different therapies. Thus a scheme for some of the symptoms and syndromes might be formulated in a manner such as the following recognizing that other therapies may be coordinately used for special reasons:

1. *Affective disorders:* (a) major depressive disorder: tricyclic or other antidepressants, electroconvulsive therapy (ECT); (b) atypical depression: monoamine oxidase (MAO) inhibitors; (c) bipolar disorder-depression and mania: Lithium; (d) dysthymic disorder: psychosocial therapy, MAO inhibitors, Xanax (alprazolam);

2. *alcoholism:* inspirational groups (Alcoholics Anonymous), Antabuse;

3. *anxiety disorder:* anxiolytics (Valium, Xanax);

4. *attention deficit disorder:* stimulants (Ritalin, dexedrine);

5. *conduct disorder in children:* family therapy, behavior therapy;

6. *dissociative disorder* (hysterical neurosis): hypnosis, psychoanalytic therapy;

7. *educational problems:* counseling, guidance;

8. *enuresis:* behavior therapy (reconditioning);

9. *family problems:* family therapy, group approaches, hypnosis, behavior therapy;

10. *habit disorders* (food, smoking, nail biting, gambling): group, behavioral, and hypnotic therapy

11. *marital problems:* couples therapy, marital therapy;

12. *obsessive-compulsive disorder:* behavior therapy, antidepressants (Clomipramine);

13. *opiate addiction:* Methadone, inspirational groups (Narcotics Anonymous);

14. *panic disorder:* antidepressants; behavior therapy

15. *personality disorder:* psychoanalytic therapy, group therapy, cognitive therapy;

16. *phobic disorder:* behavior therapy—in-vivo desensitization (flooding);

17. *psychosexual dysfunctions:* sex therapy;

18. *schizophrenic disorder:* neuroleptics, rehabilitative therapy, day hospital care;

19. *sleep walking:* hypnosis, psychoanalytic therapy;

20. *somatoform* (psychosomatic) disorder: relaxation therapy (biofeedback, relaxation hypnosis, meditation);

21. *speech disorders:* speech therapy, behavior therapy;

22. *substance abuse:* inspirational groups (e.g., Narcotics Anonymous);

23. *tension states:* relaxation therapy (hypnosis, biofeedback, meditation);

24. *vocational problems:* counseling, guidance.

The choice of therapies for different syndromes is largely oriented around symptom control and problem solving. Ideally, there would also be some reconstructive personality change, which may, in certain cases, allow the use of a psychodynamically oriented therapeutic approach.

Although there are major exceptions to the outline that follows, some use may be found for classifying approaches, especially when referrals are to be made to therapists with different training backgrounds.

1. *Guidance:* Educational and vocational problems when treatment goals are abbreviated.

2. *Environmental manipulation:* Financial, housing, recreational, marital, and family problems when goals are abbreviated.

3. *Externalization of interests:* Detached and introspective patients when goals are abbreviated.

4. *Reassurance:* Patients who require rectification primarily of misconceptions related to heredity, physical illness, sexual functions, mental illness

5. *Prestige suggestion and prestige hypnosis:* Habit disorders such as nail-biting, insomnia, overeating, inordinate smoking; hysterical paralysis, aphonia, and sensory disorders when symptom removal is the only goal in therapy.

6. *Pressure and coercion.* Patients who act out or endanger themselves or others in situations when the treatment goal is limited.

7. *Persuasion:* Obsessive-compulsive personalities when no extensive treatment goal is intended.

8. *Emotional catharsis and desensitization:* Patients who have gone through traumatic experiences that have caused them guilt, fear, or suffering and who have not allowed themselves to emote sufficiently.

9. *Muscular relaxation* (biofeedback, autogenic training, meditation): Tension states and psychosomatic muscular conditions when an adjunctive paliative approach is indicated.

10. *Convulsive therapy:* Major and bipolar depressions; insulin shock in early schizophrenia; subcoma insulin treatment in severe acute anxiety states, toxic confusional conditions, and delirium tremens.

11. *Drug therapy:* Used in schizophrenia (neuroleptics); depression, bulimia, panic states (antidepressants); anxiety (anti-anxiety agents); tension and insomnia (benzodiazepine hypnotics); alcoholism (Antabuse); and attention deficit disorders (energizing agents).

12. *Brain surgery:* Restricted to patients with severe disabling schizophrenia, chronic disabling obsessive-compulsive neurosis, and hypochondriasis who have not responded to any drug therapy, psychotherapy, or convulsive therapy.

13. *Inspirational group therapy:* Dependent and immature personalities, drug addicts, and chronic alcoholics who need social contacts and benevolent parental figures to help them function.

14. *"Relationship therapy":* Personality disorders in which distorted attitudes and values are prominent.

15. *"Attitude therapy*Personality disorders in which there are cognitive distortions.

16. *Interview psychotherapy:* Various syndromes.

17. *nondirective or "client-centered" therapy:* Patients with relatively sound personality structures who require help in clarifying their ideas about a current life difficulty or situational impasse.

18. *Directive counseling:* Patients with personality problems who require a forceful parental figure to goad them to activity.

19. *Behavior therapy:* Phobias, habit disorders, obsessive-compulsive disorders; conduct disorders; lack of assertiveness.

20. *Semantic therapy:* Personality problems in patients whose difficulties in communication constitute a primary focus.

21. *Reeducative group therapy:* Patients with some degree of insight into their problems who need emotional catharsis and the experience of interacting with others while learning about themselves.

22. *Freudian psychoanalysis:* Personality disorders, anxiety disorders, phobic disorders, conversion disorders, obsessive-compulsive disorders, and some somatoform disorders (psychophysiologic reactions) in patients who have good ego strength, are motivated, reach for reconstructive objectives, and are able to establish and tolerate a transference neurosis.

23. *Non-Freudian psychoanalysis:* Personality problems are particularly helped, but other syndromes may be treatable.

24. *Psychoanalytically oriented psychotherapy and transactional analysis:* Various syndromes.

25. *Hypnosis:* Stress disorders, anxiety disorders, phobic disorders, conversion disorders, habit disorders, some types of alcoholism, antisocial personality, and somatoform disorders (psychophysiologic reactions)

26. *Narcotherapy:* Severe stress disorders, anxiety disorders, phobic disorders, and some somatoform disorders and conversion disorders.

27. *Art therapy:* As an adjunct in reconstructive therapy when the patient is capable of symbolizing problems in art productions.

28. *Play therapy:* As an adjunct in reconstructive therapy with children.

29. *Group therapy* Personality problems, preferably in conjunction with individual therapy.

30. *Couples therapy:* Marital problems.

31. *Cognitive therapy:* Depressions, some obsessive-compulsive disorders, adjustment problems brought about by faulty self-statements, values, and beliefs.

32. Sex therapy: sexual disorders.

Choice of therapeutic approach involves many considerations, including a consideration of ethics (Sider & Clamant, 1982). For example, is it ethical to insist on

electroconvulsive therapy (ECT) in an extremely depressed person when the family is against it? By the same token, it may be argued that it *is* ethical to prevent suicide. This, of course, is an extreme example because in most cases of therapy choice, other issues than the loss of life are at stake, such as the rapidity with which symptom relief occurs and the selection of a circumscribed problem area of focus. Thus relief of one selected symptom may be considered a priority, with sacrifice of urgently needed behavior change. Is this an ethical or unethical choice? On the surface it would *seem* to boil down to values. But it is not merely a matter of values when it is considered that there are many practical reasons for the selection of a particular treatment. Further argument of this point would involve endless philosophical debate. Therapists must sometimes make an arbitrary decision about treatment choice, and many will select the standard of what is considered best for the patient, recognizing that this may entail sacrifice of certain functions and responsibilities. An example from medicine may elucidate this point. In severe hypertension there are now many effective medications that will lower blood pressure. A side effect is a lowering also of sexual function, which may affect, for example, a man's relationship with his wife. We may lower the man's blood pressure, but at the expense of incomplete marital fulfillment because of ensuing impotence. Is it an ethical choice on the part of the physician to save the patient at the risk of stirring up trouble in the bedroom? Obviously good medicine would dictate prescribing antihypertensives but also dealing with side effect contingencies, such as providing counseling for alternate methods of marital satisfaction. This would be better than forcing on the wife the resolution that an impotent husband is better than a dead one.

Speculation that the patient can best use a certain approach does not necessarily mean that he or she will respond well to this approach. For instance, if a woman shows symptoms of adaptive collapse, like anxiety and depression, and has what is considered a weak ego, the therapist may decide to use a supportive technique, at least temporarily, in order to bolster her strength. The patient, though yearning for a supportive relationship may, however, rebel against becoming dependent. Indeed, some of her current symptoms may be a product of her fear that the only way that she can function is through dependency. Use of an approach that makes her feel dependent may create more anxiety

than it resolves.

Considering the case of another patient—with a fear of sexuality—the therapist may decide that only in using a reconstructive approach can the patient's essentially destructive attitudes toward sexuality be modified. As treatment begins, the therapist may discover that the patient is a detached, frightened individual who shies away from any form of human contact. A sexual relationship is particularly alarming to him since it is associated with fantasies of being trapped and injured. His impotency serves the important purpose of protecting him from imagined injury. So terrified is he of closeness that even a carefully regulated therapeutic relationship, with the mildest probing of his psyche, sets off fears of mutilation. His ego may not be able to tolerate the rigors of a reconstructive approach. The therapist may, consequently, have to employ a supportive technique that, while reassuring, will not bring the patient to the goal of adequate sexual functioning.

Therapists must, therefore, adjust the therapeutic approach to the patient's existing capacities. One cannot make a person with crutches run, no matter how earnestly it is wanted for that person to reach a desired goal without delay. The patient's legs must first be strengthened and not be forced to carry a load that is too great to bear. Working within the bounds of one's strengths and limitations, the therapist may gradually increase the burdens and responsibilities and help the patient to work toward a technique that will bring about the desired results.

Most people come to treatment with an incomplete or erroneous idea of the values inherent in different psychotherapies. They may have developed a conviction from newspaper or magazine articles or from listening to lectures or the accounts of friends, that there is only one kind of treatment that has any value—for instance, psychoanalysis or hypnosis. When the patient is informed that the interviewer does not practice these specialities or disapproves of such therapies or has something better to offer, the patient may become stubbornly resistant and refuse to enter into treatment.

If a patient does ask for any specific kind of approach, the therapist may inquire why

the patient desires this treatment and what the sources of information were. One must never depreciate or ridicule the latter sources, even though one may indicate that there are other treatment methods to be considered.

Ways of managing this situation are indicated in Chapter 23.

TREATMENT MANUALS

Several attempts have been made to standardize psychotherapy by preparation of treatment manuals, especially for purposes of research, e.g., Beck et al. (1978) on cognitive behavior therapy, Klerman et al. (1982), on short-term interpersonal psychotherapy, Strupp & Binder (1984) on time-limited dynamic psychotherapy aimed at reconstructive goals, and the impending new manual on psychotherapy published under the auspices of the American Psychiatric Association. The advantage of such manuals is that they enable judges to observe what therapists are doing and how closely the operations of a therapist are adhering to the form of treatment that is being prescribed. It is well known that what therapists say they do may only distantly resemble what they actually do with their patients and even more remotely how they follow the precepts of a designated treatment.

Putting aside the not so easily dismissed argument—in this day of epidemic lawsuits —that a treatment manual can provide a contentious lawyer with ammunition that impresses an unsophisticated jury with the defections of a therapist under fire, other cautions present themselves. No two therapists function exactly alike even when trained in the same school by identical teachers and supervisors or when primed by the same treatment manual. This is to be expected since psychotherapy like any other art is interpreted singularly by individual practitioners. Moreover, the personalities of therapists vary greatly. What they do with what they learn, how they relate to patients (the essence of therapeutic process), the patterns of establishing contact, the manner of exhibiting empathy, the form of communication, the mode of confrontation, and so on will vary. In exposing a trained therapist to a treatment manual, it must be kept in mind that following its directions precisely would cramp the therapists' style and spontaneity and put them into an operational straitjacket that defeats what the treatment manual is trying

to do. This does not invalidate the virtue of attempting to standardize the mechanics of a specified technique, but it points out the necessity of observing whether the technique unduly constrains therapists' patterns of therapeutic operation.

FREQUENCY OF VISITS

The number of sessions conducted weekly will depend largely on the patient's needs, on practical contingencies of available time and finances, and on the patient's special response to therapy. Some patients do well on a once-a-week basis; others have such intense anxiety or strong resistances that they require more frequent sessions.

Sessions on the basis of once or twice weekly are often prescribed in psychoanalytically oriented psychotherapy, reeducative therapy, and supportive therapy. At the beginning it is sometimes advisable to see the patient as often as three times weekly and even oftener, for instance if the patient is in a panic state. A short period of such intensity may enable the psychotherapist to establish a working relationship rapidly and to stabilize the patient sufficiently so that the number of visits weekly may be reduced. There is generally little association between the frequency of visits and the length of time it takes the patient to get well.

In formal Freudian psychoanalysis five visits weekly are the rule, although some analysts may reduce this number to four. An interval between visits is believed to water down transference and to interfere with the establishment of a transference neurosis that is considered an essential prerequisite for therapy. Three visits weekly and sometimes fewer are considered adequate in non-Freudian psychoanalysis, perhaps because there is not so much emphasis on the transference neurosis.

Some general rules for increasing or decreasing the frequency of treatment sessions follow:

1. A small number of sessions each week (1 or 2) are indicated:

a. In most forms of supportive and reeducative therapy.

b. In many forms of psychoanalytically oriented psychotherapy.

c. In dependent, infantile patients to prevent a hostile, dependent relationship.

d. Where a transference neurosis is to be avoided.

e. In patients who tend to substitute transference reactions for real-life experiences.

f. In patients who are not too disturbed and who seem to be able to discharge their responsibilities and to carry on satisfactory interpersonal relationships.

2. A larger number of weekly sessions (3-5) are indicated:

a. When Freudian and non-Freudian psychoanalysis are to be employed, particularly when a transference neurosis is desired.

b. When patients show signs of severe adaptational collapse—acute anxiety, depression, psychosomatic symptoms, and ego disintegrative tendencies requiring constant emotional support.

c. In patients with rigid character structures who have built a shell around themselves so thick that a concentrated attack on their defenses is essential.

d. When patients have no motivation for psychotherapy and when a consistent demonstration of therapy's value is necessary.

e. In patients who are intensely hostile.

f. In patients with a diminutive superego who need an ever present authority to check the acting-out of impulses.

The difficulty that arises in once-a-week therapy is that intense anxiety may be mobilized as patients come to grips with their inner problems. They may then use such props and devices as sedatives, tranquilizers, energizers, alcohol, acting-out, or escape from therapy to avoid coming to grips with the conflict. The problems inspired by very frequent sessions result from a perpetuation of dependency and a stimulation of a

transference neurosis that is not desired.

ESTIMATING THE DURATION OF THERAPY

In a sense, all therapy is interminable in that once it is started, the process of self-understanding and growth can continue the remainder of the patient's life. However, the actual time spent in a therapeutic relationship may be relatively short, lasting until symptoms are relieved, abnormal character patterns corrected, or blocks to maturation resolved. The time required to achieve these goals will depend on the nature of the patient's problem, how extensively the patient has worked through the difficulty independently, the patient's readiness for change, the flexibility of character organization, the intensity of resistance, the motivations for therapy, the astuteness and skill of the therapist, and the kind of relationship that develops in the therapeutic situation. It is difficult, therefore, at the start, to predict how long it will take for the patient to get well until his or her response to therapy has been tested. Nevertheless, a number of broad generalizations are possible:

1. When the patient's history reveals a good adjustment up to the time of the present illness, and when the latter is of relatively short duration, the chances of restoring the patient to the previous level of adjustment in a relatively short time are good.

2. When there is a long history of maladjustment and the patient's present condition appears to be an outgrowth of this, therapy will probably be prolonged.

3. As a rule, one is able to achieve with short-term therapy abbreviated goals—such as symptom relief—while more extensive goals, like modification of obdurate character patterns or expansion of personality growth, will require an extensive period of working through, ranging from 2 to 5 years in or out of therapy.

4. Some patients, such as those with borderline schizophrenic and dependent personality problems, may require therapy for five years, or even longer. Rarely, a patient may need a supportive therapeutic relationship the remainder of his or her life.

5. There are some therapists who believe that short periods of therapy that are focused on the immediate presenting complaints is the best model to follow. This philosophy follows the usual pattern of dealing with physical problems by consulting a physician for a period sufficient to control the symptoms. When there is an outbreak of the same or other symptoms, visits to the doctor are renewed. In dynamic short-term therapy this plan is sometimes also pursued, the patient being given home assignments to work through involving dynamic themes. When blocks occur, or when new problems develop, another interval of short-term therapy is arranged.

ARRANGING THE FEE

A frank discussion with the patient about the patient's finances and the expenses involved in therapy is very much in order. This is especially necessary when there is no insurance or reliable third-party payer and therapy will last for more than several months. The patient may be apprised of the fee per session and then asked whether the payments will be manageable in the event treatment continues as long as is estimated to achieve a desired goal. If the patient is unable to raise the required sum with present income, it may be possible for the patient to arrange to supplement the income by borrowing. It is important that the sum spent on therapy be available to the patient without too great sacrifice since severe financial pressures may negate the effects of treatment.

Many therapists have a sliding scale of fees, adjusting these to the income of the patient. This practice is a commendable one, but some therapists may not be able to afford reducing their fees to patients of low income. It will be necessary for the prospective therapist to face the fact that the patient may require therapy for a long time. The therapist who resents treating a patient at a fee lower than he or she believes is deserved is not playing fair with the patient; the resentment will come through in some form, if only in disinterest, boredom, and relief when the patient does not show up for an appointment. A dialogue concerning payments is indicated, and if the patient is unable to meet the proposed fee, the therapist either has to resolve his or her resentment or else refer the patient to a less exasperated, less expensive resource. Moral and ethical values come into play here that each therapist will have to resolve individually.

If the patient has a problem that will require long-term treatment, it will be important to determine whether the patient will be able to make the proper time and financial preparations. The patient may be approached as in the following excerpt:

> *Th.* Now in going over your problem, there are several approaches that we might use. In the first place, your present difficulty really goes far back in your life. As a matter of fact, it probably had its inception in your childhood. So, if you really want to untangle yourself more or less completely, it will take time. In other words, if you want to eradicate the basis of your trouble, it may take as long as 2 to 3 years.
>
> *Pt.* Does it have to take that long?
>
> *Th.* Well, it took you a long time to get tangled up. It may take you some time to get rid of your trouble.
>
> *Pt.* I know it goes far back.
>
> *Th.* Yes, and, therefore, if you want to untangle yourself, it will require time. As I said it may take as long as 2 years, and maybe even longer.
>
> *Pt.* How often would I have to come?
>
> *Th.* That would depend. In your particular case it would require two or perhaps three visits weekly. *[Should the patient have a problem that required fewer visits, he would be so informed.]* But, it may not be necessary to remake you completely. It may be possible to work on one aspect of your problem—the most disturbing aspect—so that you may adjust yourself better to life, making the most of what you have. In other words, if our goals are less extensive, it wouldn't take so long.
>
> *Pt.* I don't like to do things halfways. I'd rather do a complete job.
>
> *Th.* Of course, there is the matter of your being able to budget your finances to cover a long period of treatment.
>
> *Pt.* How much would it cost?
>
> *Th.* That would depend on who treated you. For instance, there are people who might be able to treat you for $25 a session, and others may charge as much as $60. But suppose you give me an idea of what you can afford to pay if you did have to come for a long period.
>
> *Pt.* Well, I could pay the regular fee, but I would like to have someone experienced. What about you?
>
> *Th.* Do you feel you can work with me?
>
> *Pt.* Oh yes, I believe I can.

Th. Well, I do have some available time, and I believe I will be able to work with you. As a general rule, a three months' trial period is best, to see how we work together. That is, at the end of three months we would mutually decide how we get on, and whether I am the best person to help you. My fee is $50 per session for 45 minutes.

Pt. Good, that sounds good.

Th. All right, now when can you come? At what times?

Pt. Generally, doctor, mornings are best for me.

Th. Well, let's see. *(referring to schedule)* I can see you Mondays at 11:40 and Thursdays at 10. If we have to arrange another appointment hour, we'll do it later.

DELAYS IN STARTING THERAPY

Sometimes the interviewer will have no time for the patient. Consequently, it may be necessary to postpone starting treatments until time can be made available. This is possible if the patient does not need therapy immediately. When treatment is urgently required or where an emergency exists, it is obviously essential to start therapy without delay or to refer the patient to a therapist who does have time. It is highly desirable here that the interviewer make provisions for the patient and not send the latter out on a blind mission to interview other therapists who may also have no time for him or her.

FINAL ARRANGEMENTS

If the interviewer has decided to start therapy with the patient and an agreement has been reached regarding time and fees, final arrangements may be made with the patient and an appointment date set. It is advisable to inform the patient regarding the length of each appointment, the need for promptness in appointment times, the way payments of fees are to be made, and whether or not the patient will have to pay for broken appointments. The following excerpt illustrates these points:

Th. Now I'd like to tell you something about your future appointments. They start promptly at the appointed time and last three-quarters of an hour. I'll send you a bill at the beginning of the month. Now, it's important that visits be consistent because it may set you back to skip visits. Of course, if emergencies arise or if you get ill, you can't help canceling one or more visits. If this happens, try to let me know at least 24 hours in advance. The custom is to charge for broken appointments where sufficient notice is not given, let us say 24 hours.

Some therapists demand a fee of patients who miss appointments for any reason, including illness and vacations that do not coincide with their own. Freud (1913) was firm about the "leasing" of an hour to a patient and the patient's financial liability for it even if the patient did not use the session. Many therapists accept Freud as a model for their business arrangements with their patients. Other therapists are more flexible and mindful of the patient's right to emergencies, illness, or vacations. In the former instance a full explanation of the rationale for the therapist's practice should be given to the patient, or resentments will be aroused about the patient's being exploited and treated unfairly. The image of the therapist may be damaged unless the therapist explains the accepted practice of charging for a "leased" hour. In most cases therapists are willing to forego holding the patient responsible for canceled individual appointments when sufficient notice is given in advance or for broken appointments in the case of emergencies. To forestall breaking appointments as a manifestation of resistance, the practice of charging for unjustified broken appointments may be advisable. In group therapy, patients usually pay whether they show up or not, and, since the fee is less, they are more likely to accept this without protest.

There is no standard length of a treatment session; the average time ranges from three-quarters of an hour to one hour. Practices of billing also vary. Arrangements for payment are usually made at the convenience of the patient. Some patients prefer to make payments at the end of each visit; others prefer a monthly billing.

REFERRING THE PATIENT

It is understandable that most patients will want to continue in therapy with the initial interviewer. Under certain conditions this may not be possible. Such instances occur when:

1. The interviewer may have no schedule time or available hours may not coincide with those that the patient can arrange.

2. The interviewer may not want to work with the patient because of the kind of problem the patient possesses or because of the patient's personality.

3. The interviewer may believe another therapist can help the patient more.

4. The patient may be unable to afford the interviewer's fee.

5. The patient may want to work with a therapist of a different sex, age, race, or orientation.

No matter how well trained and how experienced, the interviewer will be better equipped to handle some kinds of patients than others. With some persons, the therapist will feel very much at ease and will be capable of exercising that balance between sympathy and objectivity that makes for good therapy. With others, the therapist will feel less comfortable, more defensive, and less capable of exhibiting an adequate amount of interest. After acquiring a great deal of therapeutic experience and assaying the results, the therapist may come to the conclusion that it is not possible to work well with certain kinds of patients and problems. For instance, experience may lead a therapist to the conclusion of being unable to treat schizophrenics, or borderline patients, or compulsion neurotics, or individuals with strong phobias. One may get better results with women than with men, with young adults rather than with middle-aged persons. One may be unable to treat children or people in their later years. Another therapist may be inclined to select for patients those individuals to whom one responds positively and to refer others with whom a certain affinity cannot be felt. This selective process is to be encouraged since the emotional attitude toward the patient or the conviction that one is unable to do well with the problem presented may impose barriers on the relationship. This does not mean that the interviewer will not be able to work out difficulties in functioning; therapy will start out with an avoidable handicap, however, if there are other agencies to which the patient may be referred.

Another reason for referring the patient is that the specific training or experience of the interviewer does not permit the kind of therapy that the patient could best use. Thus, many therapists who do supportive therapy well are not equipped to do reeducative or reconstructive therapy; those who have been trained in reeducative approaches may not know how to implement supportive or reconstructive treatment; those who are trained to do reconstructive therapy may not know how to handle problems that require supportive

or reeducative measures. Certain aspects of the patient's difficulty may be tackled by any of the three approaches; however, when the therapist recognizes that the particular method practiced is not suited for the patient, the patient should be referred to someone from whom more appropriate treatment can be obtained.

When, for any reason, a referral is to be made, the patient is acquainted with the reasons for this in such a way that the referral is not interpreted as a rejection by the interviewer. If opening statements have been made to indicate that the purpose of the interview is to determine what approach would be best for the patient, with an implication that the interviewer may not continue as therapist, the patient will usually accept the referral without too much difficulty. When the possibility of another therapist has not been mentioned and it is felt the patient should be treated by someone else, the interviewer must carefully present to the patient positive reasons for the referral. For instance, if the interviewer believes that the problems of the patient can be more advantageously managed by a therapist of a different orientation, the following may be said:

> It will be important for you to be treated by a specialist who is best capable of handling your problem. I would like to refer you to someone who has had a good deal of experience with problems such as yours. I shall telephone several therapists who I believe can help you in order to make sure they have the lime. Then I shall telephone you, and you can make an appointment.

In the event that the interviewer simply has no time at present for the patient, remarks such as the following are appropriate:

> Unfortunately, I do not have time on my schedule right now, and I do not expect to have time for some period in the future. I believe you need therapy right away and since I know the facts in your case, I shall be glad to refer you to a therapist who can handle your problem adequately.

Referral to a low-cost clinic or psychotherapeutic center may be made when the financial condition of the patient precludes getting therapy on a private basis. Here it may be necessary to spend a little time preparing the patient for the routines of the clinic, which may otherwise be threatening.

In making a referral, the patient should also be told that the most important element in treatment is the relationship with the therapist. It is possible that the patient may not respond completely to the therapist to whom he or she is being sent. If, for any reason the patient does not have confidence in, or feels a block in, working with the therapist, it will be important to discuss these attitudes openly; if the patient cannot remedy these feelings, it might be necessary to find another therapist. The following excerpt illustrates these points:

> *Th.* Now I believe Dr. _ can help you, but your response to him will be important. Therapy is most successful where you have confidence in your therapist. If, after several sessions, you don't feel you can work with the therapist, it may be necessary to get someone else for you.
>
> *Pt.* I see.
>
> *Th.* But before that happens, it will be important to discuss your feelings about Dr._ with him. He will understand your feelings, and if you continue to feel that somehow he isn't the person for you to work with, he will help you find another person. Or you can call me, and we can discuss this matter further.

Unless one forewarns the patient that he or she may not "hit it off' with the therapist, the patient may become discouraged and discontinue treatments indefinitely. Moreover, the admonitions voiced may embolden the patient to discuss and to work through with the next therapist attitudes that are rooted in transference.

ANTICIPATING EMERGENCIES AND OTHER DIFFICULTIES

Plans may have to be made in advance for dealing with emergencies, should these arise. For example, an alcoholic patient may get into various difficulties and require hospitalization. A drug addict may need careful observation to detect a stealthy resumption of the drug habit. A psychopathic personality will constantly tend to act out personal problems and may get involved in difficulties with people and with the law. A patient who is seriously depressed must be considered a suicidal risk. One who has had a previous psychotic break may relapse into a psychosis. Patients with sexual perversions may get into serious legal and interpersonal conflicts. By anticipating emergencies the therapist may avoid serious trouble later on. An alarming recrudescence of symptoms is

also to be predicted in certain conditions. For example, patients with anxiety, phobic, or obsessional reactions will probably have bouts of anxious emotion that will disable them for a time and may undermine their faith in therapy. Patients with psychosomatic problems will repeatedly experience an upsurge of symptoms, which will tend to divert them from thinking about the dynamic factors that underlie their complaints. Thus, it may be necessary, in the early states of therapy, to prepare the patient for a possible relapse in symptoms.

ESSENTIAL CORRESPONDENCE

A brief letter to the individual or agency who referred the patient to the initial interviewer, or to the organization that the referring individual represents, is a courtesy that is usually much appreciated. It is generally unwise to discuss too many details of the case or to outline the tentative dynamics. Nor is a diagnosis indicated, except perhaps when the referral source is a physician. The disposition of the patient should, however, always be mentioned.

The following are typical letters, the first to a social agency, the second to a physician.

Dear_____,

> I have seen Mr. _____ whom you referred to me for consultation and find him to be suffering from an emotional problem for which psychotherapy is indicated. I believe he would do best with an analytically trained therapist and consequently have referred Mr. _____ to Dr. _____, who has been able to make time available for him at a fee satisfactory to Mr. _____. Mr. _____ responded well to the consultation, and there was no reluctance in accepting the referral to Dr. _____. I should like to thank you for sending Mr. _____ to me.

Sincerely yours,

Dear Dr._:

> I have seen Mr. _____ in consultation and agree with you that a strong emotional element is involved in his present somatic complaint. I believe psychotherapy definitely to be indicated; but I am not, at the present time, able to

prognosticate the outcome due to the incomplete motivation that exists for treatment. Mr. _____ responded satisfactorily to the interview and expressed a willingness to start therapy with me. I should like to thank you for the referral.

Sincerely yours,

Correspondence may also be required when it is necessary to get further information about the patient from former therapists, from clinical psychologists who have administered tests, from physicians who have rendered recent examinations, and from institutions in which the patient was hospitalized. A "release" form, such as in Appendix R, signed by the patient, will usually be required when requesting such information.

During the first interview, or later if needed, consultations with a number of professionals may be considered essential. When the therapist takes the time to explain the reasons for this, little or no difficulty will be encountered.

MEDICAL, NEUROLOGIC, AND PSYCHIATRIC CONSULTATIONS

It goes without saying that each patient under psychotherapy requires a thorough physical and neurologic examination to rule out organic somatic illness. If the patient has been referred to the therapist by a physician, the therapist may check with the former as to whether or not physical and neurologic examinations have recently been administered. If not, arrangements for these should be made with, or through, the patient's physician. A blank such as that in Appendix O should be filled out by the physician and filed in the patient's case record. For patients on whom a complete neurologic examination is done, a form such as in Appendix P may be found helpful.

Disorders of the cognitive, affective, and behavioral functions are usually psychologically caused but may be due to physiological disturbances whose existence, if suspected, should be ruled out. (See also the chapter on diagnosis.) Thus anxiety may be due to a certain tumor in the adrenal medulla (pheochromocytoma) or overactive thyroid (hyperthyroidism, Graves' disease). Conversion disorders (hysterical neuroses, dissociative disorders) may be mistaken sometimes for neurologic disease or gross brain disease; and somatization or somatoform disorders can be mistaken for actual physical disease. Depressions may be the product of (1) toxic substances (alcohol, sedatives, cocaine, antihypertensive drugs), (2) infections (viral hepatitis, infectious mononucleosis, tuberculosis, syphilis), (3) endocrine disorders (myxedema, Cushing's disease, Addison's disease), (4) neurologic illness (multiple sclerosis, Parkinson's disease, cerebral tumors, early dementia), or (5) nutritional problems (pellagra, vitamin B12 deficiency, collagen

disorders, or neoplasms). Schizophrenia may be simulated by some organic disorders such as drug toxicity (amphetamine), brain disease (neurosyphilis), and some types of hypothyroidism. Memory loss may be a product of early dementia (Alzheimer's disease, Pick's disease, multi-infarct dementia, infectious dementia, encephalopathy, sclerosing encephalitis, meningitis, or poisoning (lead or carbon monoxide). Amnesia may occur with cerebrovascular disease of the brain or lesions in the mamillary bodies and medial thalamus. Personality changes may develop with an expanding tumor of the brain or Huntington's chorea. Apathy, emotional lability, and various somatic symptoms (often considered a sign of hysteria) may be the result of multiple sclerosis. Impotence and inhibited sexual desire may be a manifestation of depression (expressed or masked), antihypertensive medication, psychotic drugs, diabetes, and some spinal cord diseases. Difficult or painful coitus (dyspareunia) may be a sign of suburethral diverticulum, retroflexion of the uterus, and pelvic inflammatory disease. When there are any signs of aphasia, apraxia, altered awareness of the body image (anosognosia), impairment of consciousness, syncope, or confusional states, there may exist lesions of the brain, epilepsy, diabetes, hypoglycemia, ingestion of exogenous toxic agents, or endogenous toxins and deficiencies (uremia, hyponatremia). A pain syndrome is sometimes psychogenic, but it may also be due to lesions in the thalamus. Vertigo may be a product of labyrinthine disease. Recurrent severe headaches necessitate a ruling out of expanding brain tumors, meningeal irritation (syphilis, tuberculosis), metastatic neoplasms, vascular disturbances, toxic states, hypertension, iritis, and glaucoma. Hiccups can be psychogenic but if prolonged may be due to irritation of the medullary centers controlling the diaphragm.

It may be seen from this that the list of maladies is long and discouraging because almost every symptom for which psychological treatment is sought may accompany certain physical conditions. When there are any doubts, consultation with a good internist or neurologist is important.

If organic illness is discovered on examination, the patient must be guided by the advice of the physician about required medical or surgical treatments. If no organic illness

is found, the physician should be used as a consultant whenever physical symptoms of any kind develop during the course of psychotherapy. Insistence that the patient see his or her own physician is not only good medicine but also makes for good public relations. Even when the therapist is a psychiatrist who has not lost the medical diagnostic skills, the rules outlined will be found helpful. To do physical examinations or to prescribe medications other than psychotropic drugs may not be prudent, except perhaps in supportive therapy and in the more superficial reeducative therapies.

The expediency of psychiatric surveillance of certain patients being treated by non-medical therapists has already been discussed. The results of the psychiatric examination should be filed in the case record, using an outline or a form such as in Appendix Q. The psychotherapist then may be advised how to handle any emergencies that develop during the course of treatment, such as severe depression, suicidal attempts, and psychotic outbreaks. The therapist can, when necessary, administer or refer the patient for narcotherapy, hypnosis, electroconvulsive therapy, or drug treatments, such as tranquilizers, energizers, antidepressants, endocrine products, or antagonists like Antabuse. The therapist may also arrange for hospital admission or commitment when required.

CASEWORK CONSULTATION

The therapist may desire a consultation with a caseworker from a local social agency when any of the following difficulties exist:

1. Severe financial problems requiring supplementary help

2. Need for job placement or relocation

3. Need for rehabilitative services

4. Need for special health services

5. Need for better housing or for neighborhood relocation

6. Need for recreational facilities

7. Need for special schooling and training

8. Social security problems

9. Need for referral to special clinics or hospitals for the management of physical illness when resources are unknown or financial difficulties prevail

10. Aid in placement of a child in a foster home or institution.

In supportive and some types of reeducative psychotherapy the patient may be referred for adjunctive therapy directly to the caseworker or a special social agency that deals with the particular problem. The caseworker helps the patient use the community resources best suited for the patient's needs. In reconstructive therapy this may also be done; however, the activity of a caseworker as an accessory helper may, in some patients, tend to disrupt the therapeutic relationship. Should such patients require casework services, the therapist may get the necessary information from the caseworker, such as the best available resources to meet the patient's needs. The therapist may then acquaint the patient with possible courses of action, encouraging the patient to make his or her own plans. The therapist handles therapeutically any delays or other resistances to effective use of the resources.

A caseworker may also be employed to deal with parents, mate, or children of a patient when such relatives require placement, hospitalization, counseling, or guidance as an aid in the treatment of the patient. Among the services rendered by the caseworker are the dispensing of information related to sexual problems, child-parent relationships, marital relationships, hereditary influences, budgeting, home management, housing difficulties, work problems, difficulties associated with alcoholism, and problems of old age. Premarital and marital counseling are other areas in which the help of the caseworker is often sought. Additionally, the caseworker may be used as a liaison between the patient and the patient's family, employer, teacher, and others when it is essential to interpret the patient's illness to them, to give them reassurance, or to enlist their active interest and cooperation.

In psychiatric clinics, caseworkers are often used for intake interviewing, to clarify

the service of the clinic to prospective patients or to the referral source, and to determine if the service offered by the clinic is consonant with the needs of the patient. In addition, they are employed to take case histories and to prepare patients for psychotherapy by dealing with resistances to and establishing the proper motivation for treatment. When indicated, they help, directly or indirectly, to manipulate the patient's environment. Lastly, they serve to interpret the work of the clinic to the community and to enlist the cooperation of the community with the clinic. Caseworkers act as a liaison between the clinic and community organizations that are implementing community programs related to health, welfare, and social security.

PSYCHOLOGIC AND RELATED CONSULTATIONS

A consultation with a clinical psychologist may occasionally be necessary if the patient requires intelligence tests, vocational tests, and tests for special aptitudes (Freeman, FS, 1962; Hoch & Zubin, 1951; Sundberg, 1962; Tallent, 1963; Cronbach, 1960; Schaefer, 1948; Anderson & Anderson, 1951; Abt & Beliak, 1959; Buros, 1953; Rapaport et al. 1946). These are used as an aid in planning a better environmental adjustment for the patient. Projective tests are also used as a rapid means of revealing important traits and tendencies. The test situation serves as a tiny segment of life, a kind of laboratory in which the individual divulges customary needs, hopes, impulses, and defensive drives. A trained, astute observer may analyze the strivings of the patient as they are projected into the test materials as well as the patient's defenses and may make remarkably accurate assumptions about the character structure and the unconscious conflicts of the person.

The most important tests employed by the psychologist are:

1. Measures of the ability to learn—Stanford-Binet Test (Terman & Merrill, 1960), Wechsler Intelligence Scale (Wechsler, 1955; Koppitz, 1963)

2. Personality questionnaires—Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & Meehl, 1952; Schofield et al., 1956)

3. Projective tests—Rorschach Ink Blot Test (Rorschach, 1942; Klopfer & Kelly, 1942; Beck, 1944, 1945, 1952; Ulett & Goodrich, 1956; Rickers-

Ovsiankina, 1960; Thorndike & Hagen, 1961), Thematic Apperception Test (Murray, 1938; Tompkins, 1947; Anderson & Anderson, 1951; Beliak, 1954), Szondi Test (Deri, 1949), House-Tree-Person Test (Buck 1950), Man-Woman Drawing Test (Machover, 1948, 1951)

Sometimes there is an examination of handwriting (Lewinson and Zubin, 1942; Sonneman, 1951), art creations (Lewis, 1925), manipulated play materials (Erikson, 1939), and word associations (Jung, 1919), cognitive functions (Folstein et al., 1975), psychiatric disorders (Wing et al., 1974), and alcohol screening (Selzer, 1971). Among the items of information revealed are clues to the intelligence, originality, creativity, and sensitivity of the person; the severity of anxiety; the defenses employed against anxiety, such as inhibition, repression, phobias, compulsive reactions, aggression, acting-out, somatic preoccupations, fantasy, and retreat from reality; the intensity of hostility and defenses against hostility; the nature of interpersonal relations and current disturbances of character, such as dependency, aggression, sadism, masochism, detachment, and paranoid tendencies; the quality of self-esteem and whether there are distortions in narcissism, grandiosity, and self-devaluation; sexual problems, inhibitions, fears, and perversions; masculine and feminine identifications; existing inner conflicts; schizoid and disintegrative tendencies; organic brain disease; and ego strengths and weaknesses. This helps in making a diagnosis and in differential diagnosis, in assessing personality, and measuring intellectual level.

The virtue of psychological tests is primarily in the diagnostic sphere. Attempts to evaluate ego strength and to predict the outcome of therapy by means of testing are usually speculative. If the clinical psychologist makes predictions about the quality of change that the patient will achieve in psychotherapy, estimates definite goals in treatment, and indicates the kinds of techniques to which the patient will best respond, he or she is straining the test materials, attempting to adapt them to areas for which they were never designed.

Prognostic estimates and predictions of what will happen in therapy on the basis of psychological tests are often fraught with disappointment. Although it is possible to

determine customary responses to authority, and the habitual interpersonal reactions that emerge in a relationship situation, it is not always possible to guarantee that these responses will develop with the therapist. Therapy involves a special kind of a relationship, the uniqueness of which may prompt latent or new responses. Much, of course, will depend on the therapist, on whether he or she falls in line with the role the patient expects him or her to play. Similarly, it is difficult to anticipate the interpersonal potential of the patient, since it is unknown how the therapist will manage the tentative thrusts of the patient toward a different kind of relationship. Finally, it is not easy to predict what the patient will do with insight, whether he or she can acquire insight or use it, once it is evolved, in the direction of change. For these developments, too, are largely contingent on the nature of the therapeutic relationship and the skill of the therapist.

All psychologic tests are brief samplings of the patient's reactions to a limited test situation, at a special time, with a specific test administrator. The patient may at another time, with a second test administrator and under changed conditions, respond differently. Test results must, consequently, always be correlated with clinical findings. The more experienced the therapist, the more the therapist will rely on clinical judgment and the less emphasis will be put on psychological test materials.

Beginning therapists usually feel more confident when they have in front of them a personality survey that describes some of the patient's defenses and conflicts. The contribution that the test makes to the therapists' feelings of security more than offsets the disadvantage of having a preformed opinion about the patient. As the therapists become more experienced, they find that psychological tests are not accurate in all instances. They then regard them as tentative blueprints of neuroses that will require more or less extensive alterations as they delve into the patient's problems. Finally, they may, if their experience is sufficiently extensive, rely much more on their clinical judgment than they do on psychological tests. They may heed certain warnings sounded by the tests, such as the presence of disintegrative tendencies, which will make them gauge carefully the interpretive pressures that they apply so as not to overtax the strength of the patient's ego. They will still grant priorities to clinical "intuition," however.

In the hands of an experienced clinical psychologist who is conservative in test interpretations, psychological tests are valuable aids to the therapist, provided the latter does not permit the tests to interfere with the spontaneous planning and execution of the therapeutic approach. Therapy is more influenced by the skill of the therapist and by the capacity to set up a good working relationship with the patient than it is by the existing clinical syndrome. Thus, psychological tests may reveal strong schizophrenic tendencies. This revelation may frighten the therapist, and, on the basis of warnings by the psychologist that the patient cannot stand a reconstructive approach, the therapist may smother the patient with supportive props. Were the therapist to gauge the depth of therapy by the strength and quality of the relationship with the patient, there would be a much more accurate measurement of the extent of stress that the patient's ego could tolerate. On the basis of a good relationship, reconstructive therapy might be possible, and the patient might be able to endure and to resolve considerable anxiety.

Some therapists, who have had training in the administration and interpretation of psychological tests, prefer to test the patient personally rather than to send the patient to a clinical psychologist. By doing this they are able to observe the behavior of the patient and the manner of the patient's approach to, and execution of, the tests, which may give them valuable clues in addition to those revealed by the test responses. Often therapists do not score the tests but rely mainly on a qualitative analysis of the responses. Some therapists use test administration therapeutically, accenting certain responses to encourage the patient's associations (Harrower, 1956).

Apart from these traditional uses of psychologic tests, there are some psychologists who advocate the employment of projective materials to provide for a more objective measure of therapeutic progress (Piotrowski & Schreiber, 1952). By taking a test at the start, during, and end of treatment, it is believed possible to validate clinical impressions of changes developing in psychotherapy.

If the initial interviewer decides in favor of psychological tests, it will be necessary to prepare the patient for referral to a clinical psychologist. An explanation may be given the

patient along lines indicated by the following excerpt:

> *Th.* I should like to get a psychologic examination. Would you have any objection to this?
>
> *Pt.* What is this examination?
>
> *Th.* Psychologic tests are like x-rays, they enable the therapist to see things about a person that would otherwise require many therapeutic sessions. In this way it helps to cut down the time of therapy.
>
> *Pt.* Are the tests expensive?
>
> *Th.* They cost more than a single treatment session, but they may save money in the long run.
>
> *Pt.* I want to do anything that is necessary, doctor.
>
> *Th.* All right, I'll make the arrangements for you.

Obviously the fee for testing must be within the financial means of the patient. Some patients may not be able to afford psychologic testing, and the therapist may then have to forego it.

The most common test employed in reconstructive therapy is the Rorschach. Sometimes the Thematic Apperception, the Szondi, and the Man-Woman Drawing tests are used. A complete battery of tests, which is the preferred routine, is prohibitive in cost for the average patient, although the therapist may be able to make special financial arrangements for this with the clinical psychologist. When only isolated tests can be afforded, the therapist should indicate to the clinical psychologist the special area of interest, such as diagnosis, dynamics, and so forth so that a proper selection can be made of the tests administered.

In recent years, divorce mediation has come into prominence and can be a productive alternative to adversarial proceedings in conventional divorce. The divorce mediator acts as a neutral party enabling couples to negotiate with each other on important issues of distribution of marital property, arrangement of family finances, child support, custody, and visitation. Clients are also helped to separate emotional from practical issues, such as to recognize tax consequences of options. Specially trained

counselors and lawyers may be found through local social agencies. Legal counseling in a variety of areas may be necessary and social agencies may also be of help here.

In addition to giving tests, psychologists are helpful when career planning and vocational and educational guidance are necessary as part of the treatment plan. Some psychologists are trained to do premarital, marital, adolescent, and old-age counseling. They also act as research supervisors in organizing and handling details of research projects.

Corrective work in the educational field, such as the treatment of reading and educational disabilities, may require the consultative services of special professionals such as remedial reading instructors. Rehabilitation workers may help in physical and sensory defects that interfere with the functioning of the patient. Speech disturbances may require the aid of a speech therapist.

The services rendered by such professionals as psychologists, remedial teachers, rehabilitation workers, and speech therapists are adjunctive to psychotherapy. Because prolonged contact may be required with adjunctive workers, it is essential that the workers be well-integrated individuals. It is important, too, that they recognize their limited role and not interfere with the therapist by giving the patient advice and interpretations that have nothing to do with their specific area of function. The therapist will always have to work out with the patient the matter of divided transference when consultants are employed. This need not constitute too difficult a hazard unless the consultants are themselves seriously disturbed emotionally.

The Initial Interview: Important "Don'ts" during the Initial Interview

1. **Do not argue with, minimize, or challenge the patient.** If the patient presents a point of view that is obviously prejudiced or distorted, one may be tempted to argue with or challenge it. These tactics are ill advised since the patient probably needs to maintain a distorted point of view to bolster defenses. Criticizing the viewpoint or theory may seem logical but, since there is no close relationship with the therapist, the patient may be unable to tolerate an attack on his or her defensive system. When the patient presents a fallacious idea and insists it is true, he or she may be told, "Understandably you may feel this way, but there *may* also be other ways of looking at this situation." Should the patient keep probing this point, the therapist may say, "I do not yet know enough about the problem to make positive statements."

2. **Do not praise the patient or give false reassurance.** Because the patient's self-esteem is so damaged, he or she will probably be unable to accept any praise even though it is sincerely offered and realistically justified. Actually, there is little reason for praising the patient for any virtues, such as appearance, poise, or accomplishments, since the patient is undoubtedly aware of these and has discounted them. Reassurance may also be a futile gesture, although some reassurance may be attempted when the patient shows symptoms of adaptive collapse and grossly minimizes chances for recovery with psychotherapy.

3. **Do not make false promises.** These will boomerang, and the patient will use them deftly in resistance. The interviewer has no way of knowing what the course of therapy will be, and to pledge results before observing how the patient works is folly. The same holds true for promises of special privilege. To make these hastily to lure the patient into therapy and then to withdraw them because they cannot possibly be fulfilled can be greatly damaging to the patient's trust in the therapist.

4. **Do not interpret or speculate on the dynamics of the patient's problem.** The patient is obviously unprepared for interpretations until a working relationship has been established with the therapist. To assault the

patient with explanations at the start is like attempting to plant a seed on untilled soil. Not only will interpretation not take, but its effectiveness will have been vitiated when an attempt is made to interpret later. Similarly, to speculate on the dynamics of the patient's problem is to bombard the patient with concepts that will do little except to mobilize resistance. If the patient asks for interpretations or wants an outline of the involved dynamics, the therapist may say, "It will be necessary to find out more about the problem before I can offer you a really valid opinion of it."

5. **Do not offer a diagnosis even if the patient insists on it.** This is because a diagnosis is often employed as a masochistic torture weapon. The therapist may provide an importunate patient with the explanation that an emotional problem is present that can be approached through psychotherapy. The type of problem is not important from a practical standpoint. Actually, it is impossible to make a complete diagnosis without studying the patient over a period of time.

6. **Do not question the patient on sensitive areas of life.** It is important not to interrogate the patient on sensitive points, particularly appearance, status, sexual difficulties, and failures in life. An opening may be given the patient to talk about these, but if blocking occurs, it should be respected until some later date when the relationship is sufficiently firm to countenance greater tension and anxiety. It is necessary in the initial interview, and indeed throughout the first phase of therapy, to avoid all comments that are offensive or humiliating to the patient. In fact, this should be the rule throughout therapy.

7. **Do not put the patient on a couch for the initial interview.** The establishing of rapport and the eliciting of important data are best accomplished in face-to-face interviewing. A great deal of anxiety is apt to be mobilized in a patient if the interviewer insists on the couch position.

8. **Do not try to "sell" the patient on accepting treatment.** Once the facts are presented to the patient, the choice of whether therapy is pursued must be the patient's. To force the patient into therapy may create insurmountable problems for both patient and therapist.

9. **Do not join in attacks the patient launches on parents, mate, friends, or associates.** Because the patient feels ambivalent about people he or she attacks, the therapist's criticism of these people may be resented. The

patient may consider the therapist impulsive, naive, or judgmental to join in an attack with as little information as has been revealed. The therapist's best response is sympathetic listening, not defending, condemning, or condoning the person attacked. If the patient complains about a remark that was made to him or her that was upsetting or about a bad situation, the therapist may say, "A remark like that would be disturbing to you," or "This situation must have upset you," or "Actions of this sort can be disturbing to a person." Examples of unsuitable and suitable responses follow:

Pt. My wife is impossible. She's always been this way—nagging, yelling, disagreeable. Nothing satisfies her.

Unsuitable responses:

Th. That's terrible. Doesn't she know what it does to you?

Th. That's bad. She's a destructive person.

Th. Maybe you're prejudiced against her.

Suitable responses:

Th. This must upset you.

Th. It must be difficult for you.

Th. A situation like this could be disturbing to any person. Do you think you get unduly upset by it?

10. **Do not participate in criticism of another therapist.** Even if the patient presents accounts of unprofessional behavior, it is bad practice to criticize another therapist. No matter how strong the evidence may be, one never knows how much of the patient's story is colored by misinterpretation or transference. In the event the patient complains that there was no progress with a former therapist, one must also not agree. Often, significant inner changes have occurred that are blocked by transference. A resolution of hostility toward the former therapist may bring out the fact that considerably more progress was made than the patient had estimated. It should be remembered that should the interviewer fail to help the patient, one may become the victim of accusations that are made to the next therapist whom the patient consults. An example of how criticism may be handled is given in the following excerpt:

Pt. When I say that for three years I wondered what the hell went on, it's true. I don't know what—I can't summarize what I learned or what happened for three years with Dr.____ I just didn't get anywhere, and I'm at a loss to say just what transpired all that time.

Th. You feel it was a waste of time?

Pt. Yes. I … I … I do feel that it was mishandled, and I do feel that it was time wasted, and in many ways.

Th. Perhaps certain problems came up in your relations with Dr.__

Pt. Yes, I know I'm as slippery as the next patient as far as being treated goes.

Th. Slippery?

Pt. Dr.____ always complained I just didn't catch on, didn't do the right kind of associating.

Th. Perhaps the situation just didn't progress for many reasons. At any rate we may be able to discuss your feelings about your past treatment in greater detail later on.

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The Initial Interview: Dealing with Inadequate Motivation

Patients who come to the initial interview with inadequate, little, or no motivation for therapy require special handling because their mental set makes them refractory to the usual interview procedures. Among such patients are those with psychosomatic problems referred by physicians; delinquents, criminals, psychopathic personalities, sexual perverts, and other individuals involved in legal difficulties who are sent in by courts or correctional agencies; husbands and wives whose mates threaten divorce unless their partners get treatment; clients of social agencies who have been inadequately prepared for therapy; alcoholics or drug addicts who are shepherded into the therapist's office through cajolery, threats, or exhortations; children with behavior and emotional problems brought in by parents or referred by schools; and psychotic persons out of contact with reality.

An inadequately motivated patient may utterly refuse to start therapy in defiance of the therapist and the referring agency. Or the patient may apathetically accept his or her plight, reporting as if to a parole officer, with no intention of cooperating or of conceding that help is possible. Accordingly, it is impossible to establish the kind of working relationship that permits the achievement of meaningful therapeutic goals. With proper handling, however, it may be possible to deal with defective motivation and to create the incentives essential for effective treatment. A general outline for the management of the poorly motivated patient follows;

1. Recognition and reflection of the patient's negative feelings about therapy and the therapist.

2. Indication of an understanding and acceptance of these feelings.

3. Display of a neutral attitude toward the patient's needing or being able to benefit from psychotherapy, until more facts are known about the

patient's problem.

4. Expression of the opinion, when sufficient facts are known to the therapist, that the patient requires psychotherapy and may benefit greatly from it. Attempting to establish some incentive for therapy.

5. Sympathy with the patient's feeling, if negativism prevents revelation of facts but attempting to handle what is behind this feeling.

6. Dealing with the patient's misconceptions about psychotherapy, answering questions as directly as possible.

7. Refraining from "selling" the patient on therapy; respecting the verdict should the patient decide against therapy.

8. Accepting the individual as a patient even if the patient's decision has been made reluctantly.

RECOGNIZING AND REFLECTING NEGATIVE FEELINGS

Because the patient is defensive, evasive, inwardly outraged, and perhaps expressively hostile, little will be achieved until these untoward attitudes and feelings are resolved. Therefore, it is urgent to focus on them as soon as possible. This is relatively easy when the patient verbalizes readily or otherwise is self-revealing. Often, however, disturbed feelings are not openly apparent and must be perceived from how the patient talks rather than from what is said, or they may be recognized from random gestures, mannerisms, and facial expressions.

For instance, a delinquent girl referred for treatment sulks silently in her chair, fidgets around when asked a question, then answers in an evasive way with apparent disinterest in the proceedings. The therapist may make one of the following remarks:

"Perhaps you feel you ought not to have come here."

"Perhaps you're angry about being sent here."

"I can understand that you'd be annoyed about this situation."

These responses may immediately cut into the underlying mood and enable the girl to comprehend that her feelings are recognized. The result may be an outburst of hostile emotion toward the referring agency and an opening up to the therapist.

A woman, suspected of being emotionally disturbed, is sent to the therapist by her assigned social worker after she applies to a family welfare organization for help. The only reason that she accepts the referral is to please the social worker through whom she expects to secure supplementation of her income. Her lack of motivation causes her to withhold as many facts about herself as possible and to be as evasive as she can without offending. Under these circumstances, once conscious of her attitudes, the therapist might say, "I can very well see that you would feel resentful or uncomfortable about coming here. You probably do not believe that it is necessary and might feel that you could very easily do without it. I do not blame you for feeling that way inasmuch as you didn't really come to the agency to seek any emotional help." This may relax the patient considerably, for she senses in the therapist a sympathetic person. She may then begin to express her feelings about the agency and finally to verbalize her problems quite candidly.

A man with a character disorder expressed in petulant, querulous, and sadistic tendencies comes in for an interview on the insistence of his wife, who threatens to leave him unless he gets psychiatric treatment. After spending 10 minutes or so disarming the therapist with a genteel account of how well adjusted he is, the therapist interrupts:

> *Th.* But there must be some reason why you came to see me?
>
> *Pt.* I wish I knew why. My wife insists that I'm cracked.
>
> *Th.* Cracked?
>
> *Pt.* Yes. (*laughs*)
>
> *Th.* Why does she make such a claim? *(The patient then irately expostulates on certain incidents in which he was unfairly treated by relatives of his wife. His responses, though retaliatory, were, he claims, tempered out of respect for his spouse. Yet she accused him of being cruel and irrational—tendencies he claimed, that were not an integral part of his personality.)*
>
> *Th.* Do *you* think that you have personality problems?

Pt. Not any more than anyone else.

Th. Then it must make you angry to have to come here to see me.

Pt. (pause) Well… she thinks I should go to you. I'm mad at her, not at you.

Th. Well, I would think you'd be as mad as the blazes to come here when you really don't see the need for it.

Pt. (laughs) I guess I am mad, but I don't blame you. Maybe I have been acting unreasonable at times. I suppose I'm hard to get along with sometimes.

Th. Everybody gets upset and acts unreasonable sometimes.

Pt. I don't know that I do any worse than anyone else.

Th. So that you'd resent being sent to a psychiatrist for no real reason.

Pt. Do *you* think there is anything wrong with me?

Th. From what you've told me, you seem to have a problem with your wife.

Pt. It's that she keeps picking and nagging and wanting to make me over. *[From this point on the patient's relationship with his wife is discussed and the patient participates enthusiastically.]*

INDICATING ACCEPTANCE OF NEGATIVE FEELINGS

By reflecting negative feelings, the therapist conveys an acceptance of them. The therapist, furthermore, may elaborate on the patient's right to feel the way that he or she does, demonstrating an understanding of the patient's mode of thinking. This is illustrated in the following excerpt of an initial interview:

(The patient stomps into the office with a swagger. She is a young woman with a short, cropped haircut and a severely man-tailored tweed suit. She radiates an air of masculinity and is obviously disturbed and hostile.)

Th. Would you like to tell me about your problem?

Pt. (rapidly and angrily) The first thing I'm going to tell you is that I am against psychiatry completely.

Th. Why?

Pt. Because of past experience. I'm coming here against my will.

Th. I see.

Pt. Definitely against my will.

Th. Can you tell me about that?

Pt. In the year of 1970 I had two psychiatrists working with me. One was a society doctor who got me in and gave me 10-minute sessions, talking about nothing, and charging me 35 bucks; the other was a complete ass, who just sat on a chair, did nothing. He said he would try to work with me twice a week. He didn't help me one single bit and I am against it because of that.

Th. Well it does sound like you had some ungratifying experiences.

Pt. The first doctor wasn't really a psychiatrist, but he posed as one.

Th. How long did you go to him?

Pt. Just went a few times, maybe 10, I don't know offhand, but I felt it wasn't doing me any good.

Th. What was the reason for going to him in the first place?

Pt. I was kicked out of school.

Th. College?

Pt. Yes. They promised to let me come back if I had psychiatric treatment. I used to go to see the guidance woman, and she said that I had to see a psychiatrist. One of the teachers complained—a special narrow-minded, bigoted woman who had the same affliction I did and that they had condemned me for. This was homosexuality, I guess. I don't know till this day. They got me into such a state that I was willing to do anything and everything. I had no psychiatric treatment; then I went to two of them. They were working with me, trying to get me back to school, and then after this year was up, the president talked to these doctors and everybody else. They started messing around, and then said they wouldn't take me back anyway, so that finished me up at college. That was the only reason I went for psychiatric treatment. I went in with an open mind. I said, "OK, if you can cure me and get me back to school," but it didn't work. And every since then, I mean, I don't particularly care for college; but I want my degree. I know what I want in life as far as a career goes. I am working toward it now. So I got to go back to college.

Th. So if you're antipsychiatry, why did you come to see me?

Pt. Well, that's not the point. I don't want you to cure me, as far as that's concerned. I talked to the guidance woman about the whole thing. She is a wonderful person and I adore her, except I think she is psychiatry conscious. She has been insisting on this and I am always trying to please her. In fact, it's not the homosexualism that bothers her, it's the way I dress and walk and things. I was a little out of hand at school.

Th. Is that what *they* say?

Pt. Well, no—that's what *I* say.

Th. What sort of trouble did you have?

Pt. Well, I don't smile enough; I look queer, I suppose; my mind is always a mile away, although I did good in school. I have an excellent mind and my marks showed it. I don't dress; I wear men's shirts; and I am always in this kind of an outfit, which is a little different from what the typical girl wears at college.

Th. I see.

Pt. Well, it looks different and my walk is terrific.

Th. You mean you walk with a swagger?

Pt. I do, definitely.

Th. Is that affected, or is that you?

Pt. I tried to calm it down, but it just doesn't work. You see, I was in physical education, and I am very athletically inclined, and the swagger does come, but it's not to the degree that I have. My voice is very gruff; in fact, my speech teacher gave me an E because he didn't like the way I spoke. And that's the lowest mark I ever got, and maybe I will be able to fix that up. It's just these little things—the way I smoke a cigarette. My behavior patterns that I have just don't qualify with the normal. I try to keep away from women 'cause I might be tempted, and as yet I haven't been.

Th. What do you mean as yet you haven't been?

Pt. Well, I haven't gone after women, to go to bed with me I mean.

Th. You never have had any homosexual relations?

Pt. Oh yes, but not at college.

Th. What they object to is just the fact that you dress in a certain way and talk in a certain way?

Pt. As this guidance woman puts it, they feel that in the state that I am in now, whatever that is— they have given me no definition of it— they feel that I am not a responsible person and that I may possibly forget myself and commit an act. Therefore, they feel I am not a good risk, but they don't know that I work well with children 'cause I have done a lot of field work, and I have done an excellent job. I have a good reputation at home. These college students and the professors, of course, can recognize the fact that I am queer I guess.

Th. Well, the business of working with children—your course is what?

Pt. It's educational sociology in group work.

Th. What would you like to do?

Pt. I thought about going back to physical education. In fact, I may start my graduate work in September.

Th. You don't see anything wrong with the things you are doing, do you?

Pt. Certainly I do.

Th. Well what's wrong with them?

Pt. Anything that doesn't conform to society is wrong in their eyes.

Th. But in *your* eyes—I'm talking about yours.

Pt. I got a conflict. I apparently have two personalities—one is the homosexual, the other is heterosexual. I can't make up my mind which personality I want to be. I think it's the homosexual because my relationships with men have been "snafu." I don't know. The guidance person thinks I hate women really. She has analyzed this thing with me, every time I talked to her. I always give the right answers as far as myself is concerned. I like women. I like to be with them, but I'm a very obvious homosexual and that's what's wrong with me.

Th. Well, when you are with them, how do you act with them, with the girls?

Pt. I'm aggressive, naturally.

Th. Do you ever take a passive role with them?

Pt. No.

Th. And what about your relations with men?

Pt. I am very much in love with one now, and he is also a homosexual. My only associations which are very satisfying are with gay boys. (*laughs*) If I talk to you much longer, you'll get my lingo. Isn't it awful?

Th. You seem to be ashamed of it.

Pt. I'm not ashamed of the fact that I'm a homosexual, but I am ashamed of the fact that I'm obvious.

Th. Well, would you like to change your being obvious?

Pt. Yes, that's the point. I don't particularly care about being cured as far as that's concerned. because a lot of great people were homosexual. If *they* could be homosexual, well *I* certainly can. I'm completely indifferent to that.

Th. Would you like to change some of these mannerisms that you talk about?

Pt. That's the point, if I can get out into society and work. In fact, my ultimate goals are to teach in a

college.

Th. I see.

Pt. Now, I'm not going to do anything—inflicting my behavior upon my students—but it is obvious, and that's where the drawback is. And ever since I started in this work, it's not the students. The kids love me. In camping experiences, too, it was always the counselors or the teachers that jump on me because they see something.

Th. Maybe you feel that if you expose yourself to therapy. I'm likely to try to change your preference for homosexuality.

Pt. Well, are you?

Th. I naturally won't change anything you don't want changed. As a matter of fact, you're the one that determines how far you want to change. Actually, I don't blame you for being mad at psychiatry, if you feel psychiatry is trying to force you to be something you don't want to be. But getting treatment merely to get into college may do *you* absolutely no good.

Pt. They don't exactly demand it; they haven't gotten to that stage. I don't want you to misunderstand. It was the guidance woman's idea, and she has been at me ever since I've known her. She has taken a keen interest in my work, and she feels that I'm good at it and that my future shouldn't be wasted because I am in this conflict. I am unhappy you see.

Th. What conflict are you in?

Pt. Whether I should go this way or whether I should go that way in sex.

Th. Well, maybe you'd like to work out which direction you'd really like to go, either the one or the other, as long as you are clear in your mind and convinced in your heart.

Pt. I think that I would be homosexual, *(pause)* because my whole environment as a child, and ever since I can remember, has been one that was conducive to homosexuality.

Th. Let's accept that; at least for the time being. Are there any other conflicts you might want to handle? *[attempting to discover some incentive for therapy]*

Pt. I sort of isolate myself, I'm afraid, and, as soon as I finish a class, I want to run home. Or I run down to the Village to this friend of mine, and I stay with him. What bothers me most of all is the way I look and walk and act. It upsets me.

Th. In other words, you feel the mannerisms and the gestures are not approved of?

Pt. That's right.

Th. And that's what bothers you more than anything else?

Pt. Yes.

Th. Would you like me to let us help you with *that* problem?

Pt. If you can; if not, I might as well go to the Bowery. Do you think you can? This problem of what I should wear, what I shouldn't wear. My sister is ultra, ultra feminine, and I have the clothes to wear, but I would prefer to be in this attire. *[The patient defines an area on which she wishes to work.]*

Th. I'll do what I can to help you understand yourself better. If you have the desire to work things out, I believe I can help you.

Pt. That's the whole thing except that there is this tremendous fear that I'm not myself. But, I'd like to get started if you can, as soon as possible.

MANIFESTING AN OPEN MIND ABOUT THE PATIENT'S NEED FOR THERAPY

Should the patient want to know whether the therapist considers the problem presented severe enough for psychotherapy, the therapist may say that a positive answer will have to be postponed until more information is obtained. Such an attitude helps convince the patient that the therapist is not an arbitrary authority. The patient may also be told that the therapist is not sure that the patient needs or does not need treatment, but that as soon as enough facts are available, the therapist will be better able to provide advice. The following excerpt is an example of this:

Pt. Do you think I need to get these treatments?

Th. I am not sure yet. Suppose we talk more about your problem; then I will give you an idea of whether or not I think you need psychotherapy.

CREATING INCENTIVES FOR THERAPY

When satisfied, during the interview, that enough facts have been gathered to justify a positive statement to the patient, the therapist may remark, "Now I know enough about the problem to give you one definite statement. I do think you can benefit greatly from therapy. Whether you want therapy is another matter; but it could be of help to you."

Should the patient demand a reason for the therapist's conclusion, the latter may frankly state that the patient is not as happy, or well adjusted, or creative as possible, or that the patient is being victimized by certain symptoms that are signs of neurosis. The

therapist must respect the fact that only the patient can decide whether or not to pursue therapy, no matter how much it may be needed.

It is necessary sometimes to attempt the building of incentives for treatment. Illustrative is the following excerpt from the first session with a single, 24-year-old woman whose mother was insistent that she see a psychiatrist because of attacks of moodiness and spells of depression. The patient sat forlornly in the chair, replying to questions with monosyllabic answers and denying that her symptoms were bad enough to warrant treatment.

> *Th.* Are you completely satisfied with your present life and adjustment?
>
> *Pt.* Yes.
>
> *Th.* It's very gratifying to be well satisfied. Understandably you wouldn't want any treatment if there is nothing wrong.
>
> *Pt.* No.
>
> *Th.* Your mother thinks you ought to get treatment. I wonder why?
>
> *Pt.* I don't know.
>
> *Th.* Maybe you're angry that she sent you here, if you didn't need treatment.
>
> *Pt.* I'm not angry.
>
> *Th.* Mm hmm. *(pause)* But there must be some area in which you aren't completely happy.
>
> *Pt.* Well … *(pause)*
>
> *Th.* Are you satisfied with the way everything is going in every area of your life?
>
> *Pt. (pause)* No, not exactly.
>
> *Th.* Mm hmm. *(pause)*
>
> *Pt.* It's that I don't go out much, not much. I don't go out with boys.
>
> *Th.* I wonder why?
>
> *Pt.* I don't know. I don't have a desire to go out, I mean the energy. I get tired.
>
> *Th.* Would you like to want to go out more? *[attempting to create an incentive for therapy]*

Pt. Oh, yes. I often wonder what I could do to make me want to go out.

Th. Well, if you really would like to work with me on that, maybe I could help you with it.

Pt. But could you do anything to make me want to go out?

Th. I wouldn't make you do anything, but if you were interested, we could explore this area and find out what it was that held you back.

Pt. I think I would like that, if you could do it.

To help promote motivation for therapy the interviewer may want to be alert to any of the following manifestations on which the patient's attention may be focused:

1. Distressing symptoms of failure in adaptation, such as tension, anxiety, and psychosomatic symptoms.

2. Incapacitation and inhibition of function produced by anxiety and defenses against anxiety, like phobic, conversion, obsessive, and depressive reactions.

3. Recognition by the patient that personal capacities are not being lived up to and that basic needs are being sabotaged.

4. Fear of the consequences of neurotic aims, such as retaliation for acting-out or detection of homosexuality.

5. A desire to be like other people.

ATTEMPTING TO DEAL WITH CONTINUED OPPOSITION TO TREATMENT

When the patient shows continued negative attitudes toward therapy and toward the therapist, it may be helpful to point out that many persons can be benefited by psychotherapy even though they do not see the need for it at the start. If the therapist, from personal experience, is able to relate in detail a case he or she has treated with problems resembling those of the patient, it may create a spark of incentive. Reciting a detailed history, such as the one described in Chapter 36, may give the patient an idea of how psychotherapy works.

Sometimes assigned reading of informational books on psychotherapy (see

bibliotherapy) may aid in the working out of the patient's blocks to treatment. Another helpful adjunct, available to the therapist who is acquainted with psychological testing, is to give the patient a projective test and then to discuss carefully and tentatively the test findings. Many patients open up remarkably when their problems are approached in this indirect way. Finally, if the patient is willing to risk personal exposure in an educational group, and if there is one available, the ensuing psychoeducational discussions in the group may resolve the patient's resistance.

CLARIFYING MISCONCEPTIONS

Throughout the interview it is necessary to clarify any misconceptions that the patient has about psychotherapy and to answer, as factually as possible, whatever questions the patient may ask.(See Chapter 34).

If the patient accepts psychotherapy but has spurious goals in mind in regard to what he or she wants to achieve from treatment, special handling will be required. For instance, a man applies for therapy with the complaint of tension that prevents the development of his singing voice. His ambition is to become an opera singer. As he elaborates on his problem, it becomes apparent that he is really searching for success in terms of his father's conception of achievement. A music teacher himself, the father had trained his son to be a singer. The boy was driven to practice incessantly to discipline himself for a great vocal career. His coming to New York at the age of 20 had a twofold purpose: first, to study with a famous voice teacher and, second, to get an audition at the Metropolitan Opera Company. Upon leaving home, however, the patient's vocal ambitions began to ebb, and he found himself increasingly engaged in social and intellectual pursuits that diverted him from voice exercises. Whenever he sang before a group, or even practiced singing for any length of time, he became uneasy, tense, and anxious. He came to therapy at the advice of a friend who was also receiving psychotherapy.

One might speculate that the patient was evidencing a delayed adolescent rebellion against his father that took the form of a desire for a self-appointed career. A reasonable objective in therapy, thus, would be the promotion of independence, even though this

might mean an abandonment of singing as a profession.

Yet to tell the patient that his goal to be an opera singer was neurotic and that therapy would bring him to an independent course might drive him away from treatment. A preferable approach would be to accept the patient's motivation to acquire a better singing voice but to avoid any intimation that his voice might improve in caliber. He could be told that therapy may help him understand the source of his tension and the basis of any other interferences with his singing ability.

In the actual treatment of this patient it soon became apparent to him that his value system and self-esteem were dominated by the goals of his father. Attitudes of submissiveness and reverence masked deep resentment and desires for freedom. Breaking away from his father in coming to New York released his aggression. His refusal to practice singing was one sign of rebellion. Tension and anxiety were the emotions consequent to this conflict. The patient was able to make a conscious choice of a career when he determined, in consulting with prominent critics, that his voice was not of operatic quality. He was surprised to find that his father accepted his decision benevolently after he had asserted himself and had insisted on giving up music in favor of a business career.

There are many neurotic goals that patients imagine will be realized from therapy, such as demands for power and perfectionism, a desire to endure hardships without flinching, and a yearning to remain poised under all circumstances. These motivations will not, of themselves, block entry into therapy, but they must be handled with determination at some point.

Among the most stubborn of inadequately motivated patients are those suffering from psychosomatic problems. Clinging to an organic etiology may be due in part to ignorance of how emotional factors can produce physical illness. In addition to the fear of being classified as a "mental case," the patient may consider that agreeing with a psychologic diagnosis is a sign that his or her suffering is regarded as "imaginary." When the patient is afflicted with disabling symptoms like blinding migraine headaches, intense

gastric pains, or diarrhea, he or she may not be able to countenance any other but an organic cause. Applying to a psychiatrist for help is to the patient a sign of weakness, an indication of lack of will power, and an insignia of defeat. Deep fears of revealing repulsive personal secrets or of being unmasked as a contemptible, perverse creature reinforce the patient's antagonism. The possibility of embarking on a long and costly therapeutic adventure, the outcome of which is not guaranteed, is additionally unsettling. Because of these resistances, the referring physician has a formidable job in getting the patient to accept a psychiatric referral. As general practitioners have become more sophisticated in their understanding of mental health, they have been able to deal more adequately with many of patients' objections to receiving psychotherapeutic help. A few articles have appeared in medical journals that outline techniques of referring a patient to a psychotherapist, and these can benefit physicians effectiveness considerably.

In spite of good preparation, nevertheless, the patient may cling desperately to a conviction that the ailment is organic in nature and that a doctor will eventually be found who can locate the lesion and prescribe the proper medicaments. The patient may insist that the therapist become involved in this search, and, despite the patient's understanding that no medicines will be prescribed in psychotherapy, there is an almost frantic plea in the patient's manner, if not in verbalizations, for a remedy that will spell the renaissance of hope.

While the patient may intellectually be convinced of the fact that emotions can influence bodily processes, he or she may be unable to apply this information. The therapist may have to reiterate the thesis of how being upset can produce widespread disturbance in every part of the body, inducing even greater discomfort and pain than organic illness. The therapist must, however, always leave the door open to the possibility of at least a partial organic factor. To insist on its complete absence is an indication to the patient of the therapist's arbitrariness and prejudice. The fact is that the patient *may* have a concomitant organic condition; indeed, it is hardly conceivable that there is no physiologic correlate in every psychologic disorder. The physical disorder may be completely reversible once the patient's emotional difficulty is ironed out. Yet it may exist

in fact and perhaps be demonstrated by laboratory and clinical tests.

A prolonged physical ailment may undermine the person and bring out associated emotional elements. The resulting turmoil will then accentuate the physical distress. As a matter of fact, a condition that starts out as physical may, after a while, incite emotional elements that persist long after the physical cause has disappeared. In the event that the patient seeks to know how emotions can cause bodily pains, the therapist may explain that the brain is connected to every organ in the body by nerves. When mental suffering occurs, the effects may be transmitted through nerves to the bodily organs, affecting their function and producing, for example, painful spasms. When mental or emotional relief eventuates, the organ may be restored to normal activity.

The patient will probably repeatedly have to be told that a reciprocal relationship exists between mental and physical processes—that nerves influence organs and vice versa. Sometimes a physical ailment touches off worry and other disturbing feelings, and the emotional disturbance then exaggerates the ailment. It would surely be remarkable if suffering from pain and other uncomfortable symptoms did not promote worry. Once anxiety is mobilized, a chain reaction begins, and the physical condition becomes more and more aggravated. Treating the physical condition with medicines or surgery may not remove the nervous component. Treating the nervous component, on the other hand, helps the organ return to its normal condition. This is why the treatment of the emotional part of the patient's trouble may restore physical health.

Because the patient may require the preservation of psychic integrity through a psychosomatic symptom, one must always cautiously and tentatively advance the possibility of emotional causation, always respecting the patient's need for refuge in a physical cause.

If the patient accepts the sincerity and authority of the therapist, he or she may be willing to explore the emotional aspects of the problem. Sometimes the patient will listen in a polite manner and then will insist on further medical consultations and tests before submitting to psychotherapy. The therapist here should respect the patient's wishes and

refer the patient back to the physician, with the comment that the patient is unwilling at present to accept psychotherapy. Often this tolerant and open-minded attitude evidenced by the therapist will inspire the patient to return, motivated for treatment, when an additional excursion for diagnosis has proven futile.

These principles may be illustrated by considering the case of a man who, because of a disabling gastric complaint, consults his family physician. A series of laboratory tests, clinical examinations, and x-rays reveals no discernible organic lesion. Alkalis, antispasmodics, vitamins, and sedatives are to no avail. In desperation the patient consults a number of specialists, and finally he makes the rounds of medical clinics but with no abatement of his symptoms. His suffering eventually drives him back to his original family doctor, who had intimated, to the dismay of the patient, that there might be psychological factors responsible for the patient's trouble. This indicated to the patient that the doctor considered him insincere and somewhat of a faker. But, having exhausted every possible avenue of traditional medical help, he finally is willing to listen to his physician and to consult a psychotherapist.

His approach to the psychiatrist at the initial interview is one of mingled disdain, fear, frustration, and hostility. Secretly he hopes that the therapist will produce some kind of magic pill that will allay his suffering. He has been willing to try something new, but he comes to treatment with his "tongue in his cheek." He is willing to give this strange doctor a chance to do something that the other doctors have not been able to do, but naturally he has his doubts. The slightest intimation that there is a psychological aspect makes him fear that his pain may be considered imaginary.

The following is an excerpt of part of a session with a patient of this type who has no wish for therapy, but whose lack of motivation is dealt with successfully by the therapist. After the patient discourses on his doubts that he has a psychological problem that requires psychotherapy, the interview proceeds:

> *Pt.* But how can stomach trouble be caused by the mind?
>
> *Th.* The brain is connected to every organ in the body, and when a person is disturbed, it is

understandable that the disturbance or worry or conflict can get into every organ of the body through nerve channels. And then the organ gets upset.

Pt. But there's nothing wrong with my mind. I'm not worried about anything except this pain and how to get rid of it.

Th. Perhaps that's right. As a matter of fact, you *may* have something really wrong with your stomach. Have you satisfied yourself that there is nothing wrong? [*Since patients are suspicious that the therapist will bend backward to label a condition psychological, this remark is intended to show the patient that the therapist is not eager to come to this conclusion without good evidence.]*

Pt. Well, the doctors all say that there is nothing wrong. They've given me all the tests. But I feel there is something. *[This conviction of the patient against all of the evidence may be obdurate resistance to his accepting psychotherapy.]*

Th. You've had all of the tests?

Pt. Yes, and they all add up to nothing.

Th. Perhaps you wouldn't be satisfied until you find someone who tells you there is something wrong. It certainly seems reasonable to exhaust every possibility to your satisfaction, that is, get the best doctors to look you over, before you get psychiatric help, *(pause) [This lack of eagerness on my part to accept the patient until he is convinced he wants psychiatric help may spur him on to accept it.]*

Pt. Do *you* think there is nothing wrong with my stomach?

Th. There *must* be something wrong; otherwise you wouldn't have pain. The question is whether the cause of the pain is emotional, or organic, or both. Frankly I don't know which it is, since I'm not acquainted too much with your condition. But from your account, nothing organic has been found. And you've had good doctors. Dr. _ is a good doctor; he's conservative, and he sent you to see me, which shows he feels there is at least the possibility of an emotional factor.

Pt. But what could it be, if it isn't my stomach?

Th. You mean what would the emotional factors be if your stomach trouble was not organic?

Pt. Yes.

Th. That's why you were referred to me. Perhaps we might be able to find out. You know, emotional trouble can give you a bigger bellyache than physical trouble.

Pt. As bad as mine?

Th. I don't know how bad yours is, but it can be mighty bad, even worse than organic trouble, *{pause)* Apparently you can't accept this fact as applying to you. Maybe you think it's disgraceful to have emotional problems?

Pt. Well, if I were that much out of control … Well, maybe it's so, but I don't, can't see how. Wouldn't I know if there is something wrong, with my mind, I mean?

Th. With your emotions, you mean? Well, usually not. But I don't know that there is anything wrong either. We'd have to give ourselves a little time and begin exploring, (*pause*)

Pt. Doctor, do you think *you* can help me?

Th. If you have an emotional problem that is causing this trouble, yes, that is, if you really wanted to be helped.

Pt. But I do want to be helped. I've spent a fortune of money, and nothing has been done.

Th. Maybe you'd rather wait and keep trying other internists until you're convinced the organic factors are the most important ones.

Pt. But I've tried and tried.

Th. Yes, but you are still not convinced. Why don't you think things over, and, if you'd like to give this a try—with an open mind, I mean—call me and we'll get started. *[Throwing the choice squarely on the patient's shoulders.]*

Pt. I get the pain over here, *[points to his abdomen)*

Th. It must be very distressing [*showing sympathy]*

Pt. Yes, doctor, it drives me practically out of my mind.

Th. You know, a person with even a real organic problem involving his stomach can get very upset. And his emotional tension can in turn stir up trouble for him.

Pt. This pain does upset me and I think it does make my stomach worse.

Th. So you see, emotional trouble, worry, and tension can upset your stomach.

Pt. Well, I do know there are some things my wife does that upset me. *[This is the first indication of the patient's desire to work with his emotional problem. He talks about his difficulty at home and then makes arrangements to start therapy.]*

Because the patient with a psychosomatic problem is often unconvinced that a physical symptom is or can be emotionally determined, the best way of losing such a patient is to insist that the problem is psychological. Since the patient may, at least temporarily, need the symptom, the therapist is wise at the start of therapy to allow the patient to retain the idea of its organicity. The therapist may inform the patient that any symptom, even an organic symptom, creates tension because of discomfort or pain. The

tension delays healing. What needs to be done is to reduce tension, and this can stimulate the healing process. Teaching the patient simple relaxation methods and allowing the patient to verbalize freely should soon establish a therapeutic alliance, and through this the patient may be helped to come to grips with worries and conflicts.

It is sometimes expedient within the first few minutes of the interview to try to get the patient to convince the skeptical therapist that a psychological problem exists in his case. Thus a patient appears for an interview arranged by his physician. After the usual opening formalities he states:

> *Pt.* Dr._sent me to see you.
>
> *Th.* Yes.
>
> *Pt.* He thinks my trouble is in my head.
>
> *Th.* Mm hmm.
>
> *Pt.* This pain in my head. Migraine.
>
> *Th.* What makes you think it is psychological and not physical?
>
> *Pt.* I'm not sure. In fact I don't think its psychological because I'm pretty well adjusted.
>
> *Th.* Perhaps it is physical.
>
> *Pt.* I've tried a lot of doctors and the only thing that helps a little is ergotamine.
>
> *Th.* It still may be physical. Tell me who you have seen for this and what they said. *(The patient enthusiastically for the next 10 minutes details his futile adventures with doctors. After this he pauses and asks a question.)*
>
> *Pt.* Could this be psychological?
>
> *Th.* I am not sure. But I can tell you one thing. Even if it is organic, and it may be, the pain and tension you have suffered can spark off attacks and prevent healing.
>
> *Pt.* I do get tense sometimes.
>
> *Th.* Tell me about this. *(The patient then launches off into various troubles he is having in his work and with his wife.)*
>
> *Th.* I'd say you have enough trouble to spark off migraine. But the basis may still be organic, although you've seen quite a number of good doctors.

Pt. Do you believe I can be helped?

Th. The best way to find out is to get started.

Pt. I'd like to do this.

Patients receiving disability payments for an injury are particularly unmotivated to give up psychological pain and other symptoms that complicate their problems. Here the factor of secondary gain appears through avoiding hard work, supporting dependency needs, and getting attention and sympathy. Such patients cannot be forced to change. The primary task here, as in the case of the psychosomatic patient, is to first establish a therapeutic alliance. No hard-and-fast rules can be given since patients will require innovative stratagems designed for their special situations. Patients receiving disability checks are particularly difficult to convince that anything psychological keeps them from returning to work. One tactic is never to imply that the patient is in any way psychologically manufacturing the symptoms because this will obstruct the establishing of a working relationship. The approach at first may, as in the psychosomatic patient, be organized around tension reduction to help the patient assuage suffering. As tension is lessened, the patient will begin talking more about himself or herself and perhaps about some family adjustment problems. The therapist may soon be able to inquire about the hopes, ambitions, and goals of the patient. Questions may be asked such as, "What would you like to do?" "How would *you* like to feel?" "What do you enjoy most?" Very often when the patient realizes that the therapist does not expect conformity to standards that others set for the patient, a therapeutic alliance will begin. Reflecting the patient's anger without condemning it helps convince the patient that there is nothing wrong with feeling the way he or she does. How the patient can go about fulfilling personal own goals is then planned. An interesting article on techniques of dealing with such unmotivated patients has been written by Swanson and Woolson (1973).

The therapist's handling of the patient's denial tendencies is crucial. Blank unbelief often operates as a primary defense to insulate the patient from the implications of the illness (Lindemann, 1944). Such denial, interfering with the true assessment of the reality situation, constitutes a great danger for the individual. In coronary illness for example, the

patient may engage in dangerous overactivity, neglect of diet, and absentmindedness about taking essential medications. It is, therefore, important to review with the patient his or her ideas of the illness and attitudes toward it, especially hopelessness. By careful clarification coupled with reassurance existing misconceptions and cognitive distortions may be corrected. The relationship with the therapist can greatly help the patient to accept a factual assessment of the patient's situation. The therapist here serves "in a role similar to the protecting parent who makes painful and threatening reality less intolerable to the child, thus enabling the child to accept and face reality, with its hazards, rather than having to deny and 'shut out' " (Stein et al., 1969).

Sometimes lack of motivation for treatment is predicated on a need to retain the boons bestowed by a neurosis. Thus the cement that holds a marriage together may be agoraphobia in a wife whose symptom binds the husband to the wife out of guilt and sympathy. Fear that the marriage will break up should she get well will be a formidable obstacle to a proper response to treatment. Here couples therapy may be mandatory before a good response to behavior therapy, individual psychotherapy, or group psychotherapy can be expected. This type of motivational lack may result in acceptance or indifference to one's symptoms, a patient going through the motions of exposure to treatment, even demonstrating interest in the dynamics without any impact on his or her dysfunctional behavior patterns.

Treatment guidelines using psychoeducation, family intervention, psychodynamic interpretations, paradoxical intention, and assertiveness training for the behavioral treatment of resistant anxiety-disorder patients have been suggested by (Hanrahan et al., 1984) to help patients learn new skills, to understand resistances, face anxiety-provoking situations, and complete essential homework assignments. A program to acquaint students with modes of managing unmotivated patients has been developed by Swanson and Woolson (1973).

AVOIDING THE 'OVERSELLING' OF THE PATIENT

Lack of on the part of the patient motivation may persist no matter how expert the

therapist. The patient may cling to the notion of self-reliance, believing that it is threatening to have to depend on the therapist. The patient may harbor a deep masochistic need for suffering and refuse to relinquish the symptoms. In addition, the patient may possess a contempt for normal values in life that he or she anticipates will be the outcome of therapy. The patient may suspect the intention of the therapist. Common fears are that creativity, talent, and uniqueness will be exterminated in treatment, that therapy sometimes wrecks marriages leading to separation or divorce, that life may become bereft of pleasures that are now derived from neurotic indulgences. He or she may fancy that getting treatment constitutes a hostile act against the family, which actively or indirectly opposes the therapy. The patient may contemplate with dread the overcoming of any ostensibly symptomatic handicap since this has justified failure in adjustment. There may be many other reasons for the patient's refusal to cooperate that will nullify the therapist's efforts to guide the patient into therapy.

From a strategic point of view, it may be argued that irrespective of how resistive the patient may be at the start of therapy, the developing relationship will eventually undermine such resistance. This is probably correct, and many patients who are initially unmotivated do eventually accept therapy. The great problem is to convince the patient to continue in treatment in spite of doubts. This is easier said than done, and the therapist may, in the eagerness to help the patient, try to "oversell" psychotherapy. The best practice is to present the facts frankly to the patient and then leave the choice of therapy entirely up to the patient. Under these circumstances the patient may decide not to start treatment but later may return motivated, having spontaneously worked out the resistance in the interim period.

The following case illustrates this. It is part of an initial interview with a patient with physical symptoms who was referred by a physician. An unsuccessful attempt is made to bring him to an awareness of possible emotional sources of his illness. Also unsuccessful is an effort to convince him to accept therapy for a potential psychological problem. Throwing the choice back at the patient makes him decide to get a further physical checkup. He is encouraged to call the therapist when he is ready to accept treatment.

Pt. I'm here because I've been working very hard, sometimes till 11 o'clock at night. I was so tired that I thought something was physically wrong, but I was told that there was nothing wrong with me. No matter what reassurance I get, I am still depressed. When I was coming to your office, I felt sort of a fear. I can't explain it, but if I was with my wife, I know that I wouldn't feel that way. When I walk by myself, I get that feeling and I can't reassure myself, but, no, I do reassure myself. I say to myself that this is silly and I have no reason to feel this way. I don't tell this to anyone, just you now, doctor. *[The patient has symptoms of somatic disturbance, depression, and anxiety—manifestations of a collapse in adaptation.]*

Th. You feel fearful? *[focusing on his anxiety]*

Pt. Yes, fearful; that's it. *(pause)*

Th. How long has this fear been going on?

Pt. Well I guess … I get up at night, and, and that's why my wife came here to explain what goes on at night. *[Patient's wife is in the waiting room.]*

Th. What goes on at night?

Pt. Well, I get up at night. I don't know what food I eat the night before that gives me a full night's sleep, but certain days I do get a full night's sleep, and I get up in the morning, and I still feel that jittery fearful condition. But if I get up during the night, and open up my eyes any time during the night, and I feel the taste in my mouth; if I feel that I'm nauseous, I'm nauseous—if I feel that I want to take an Alka Seltzer, first thing I wake her up out of her sleep. First thing I wake her up. Really, I shouldn't, shouldn't do it, but I know I shouldn't do it, but, if I do, for some reason I feel reassured if she's up. I tell her I don't feel good, and she says, "All right just forget about it, and just lie down on your stomach and force yourself to go to sleep." *[Feelings of anxiety and helplessness make him apply to his wife for succor and reassurance.)*

Th. Do you feel physically sick?

Pt. See, Doctor, the trouble is I still feel that I'm physically sick, in spite of the fact that I had an x-ray taken about a year ago. Dr.____ in the Bronx told me at the time, and he showed me the pictures right in front of me too. He says the x-ray shows that there's nothing wrong physically. However, year, maybe less than a year, I believe you can find out exactly just when it was, I was told by the doctor there was nothing they could find out about my condition, there was nothing there. You could call Dr._ You see, he'd probably have pictures and he could explain it better. But that's the way he explained it to me.

Th. Now this has been going on for how long?

Pt. Well, it isn't so very long. I'd say 3 or 4 years—I mean on and off; but the conditions, well from medical doctors I got examinations. They never found anything wrong during all those years. I did feel during that time, and I still feel during the present day, that it isn't mental, that it is something physical that I feel. I don't know how. I get reassured and reassured and reassured, and the only thing is that people confide and talk to me in a certain sense, and it immediately disappears. And then it comes back again almost right away.

Th. Anything else wrong?

Pt. No, everything is very, very nice. When I'm at home, we got a television set 9 or 10 months ago and I feel reassurance—we, we— the recreation, I mean. I feel wonderful at home, too, but I can be looking at the television, and if I distract my attention from the television, I still feel that feeling. I would say that 3 years ago, 3J, 4 years ago my boss says, "Joe"—well, they call me Joe for short, he says instead of Joseph—"Take 2 weeks this spring, take 3 weeks." I mean. I felt kind of run down, and I always felt that when I'm run down, you know, from continuous work, I should rest up more.

Th. What do you think this is all about?

Pt. Well I don't know. That's why I don't know whether it's my physical condition or whether it's my mental condition. I still feel that it's my physical condition for the simple reason that no matter how I feel, I always snap out of my mental condition. Because if I feel too depressed to a certain degree, I don't try to fight deeply against it. I try to get the help of people whether it's in the business or anywhere else. Or else I just cry it out and get the tension off my chest. I mean I don't try to fight it to the extent that it should get the best of me. You see, I got—to get it down to brass tacks, doctor, I have everything to live for. I have a wonderful, I've got a wonderful family, a wonderful family from my side, I mean my brother and my sisters, and my wife on her side, her brother, her father. My father-in-law lives with us, my daughter and her husband live with us. We have a pleasant environment. I enjoy coming home. I got everything to fight in the direction of health. And so it, that's really the root of it, it gives me the power to fight because I know that everybody is with me.

Th. You feel that there is a physical condition that's undermining you, that makes it hard for you to do things, particularly to work?

Pt. Yes, but when I get that mental condition, I do feel that it comes from something, something physically wrong. I don't know what it is. It might be, it might be the smallest thing, but still the smallest thing might be … *(pause)*

Th. Do you think there is anything seriously physically wrong with you?

Pt. I never feel that pain as I—I never feel any pain. The only pain is the usual condition.

Th. A physical condition, like you say you have, may still be there and undermine you emotionally. Also on the basis of your worrying, the emotional state may aggravate the physical state. It's a vicious cycle. It may be important for you to get physical treatment and also important for you to get treatment for your emotional state. *[This is a tentative attempt to soften the patient's resistance to psychiatric treatment.]*

Pt. Well I do feel, doctor, that all this condition is, is because of the continuous years of work I put into a career, like. Well, I've been working since 1919. In all the years I feel that 50 percent of that time I put two days in 1. Let's see, I've been working since 1917, which is 33 years. I put 2 years in 1, probably 10 years of it, so that 10 years I put in approximately 20 years of work. And I do know I have because I've been working at times 13, 14, 15, hours a day. I mean, not these last couple of years, but in this trend before. Because after all your machine is working, and if you put twice as much as you should, you pay for it. *[The patient is trying to justify his condition on the basis of overwork.]*

Th. Now look, do you feel that you want to get psychiatric help for this condition of yours. What do you think?

Pt. Well, I think I feel that when I go to my place of business, I have the desire to go, I have the desire to work, and I know that I have obligations. I've got to work to make a living for the family and to keep the respect of the people I associate with. I know my obligations and all that, and I know that if I don't work here I've got to work somewhere's else.

Th. Would you like to get some sort of help for this trouble of yours? *[Repeating my question that the patient dodged.]*

Pt. Well, the first thing I feel that if I got reassurance as to my physical condition, I'd be all right.

Th. The reason you were sent to me was Dr. _felt that there was perhaps an emotional problem in addition to any possible physical problem that existed. Now let's assume that you have a physical problem such as you say you have, there still might be an emotional condition superimposed on it. But you won't be able to benefit by help for an emotional problem unless you really want it. That's why I ask you, do you want help, do you want me to arrange for help for you? What do you think?

Pt. Well, I'd rather think it over a little. *(pause)*

Th. I tell you what I will do then. You think it over a little and I will get in touch with Dr.____ I will tell him what I feel. And then after you talk it over with him, and you decide you want help, call me.

Pt. You see, I don't know whether it's psychological or physical. You see I say that because I'm not convinced.

Th. Are you interested in what I think?

Pt. But, first, if I can be reassured as to the physical, then probably that can loose up the tension.

Th. Do you feel that that would be enough once you are reassured?

Pt. Well, I don't know. I just don't know.

Th. You know from your experience you've tried that over and over again, and it hasn't worked.

Pt. I've tried, but I still feel that in the physical, I feel there's so many other things that just an x-ray or that—it's just a complete checkup as to every extent of the individual—I haven't had a complete checkup for a long time.

Th. Do you think that the best idea is to go ahead and make arrangements for another complete checkup? Then when you are assured through that complete checkup to your satisfaction that there might be a good reason for you to get psychiatric help, give me a ring.

Pt. That's what I'll do.

Th. All right then. You may call me when you decide.

Pt. Yes, goodbye, doctor.

The contact with the patient was terminated at this point. The referring physician was told that the patient undoubtedly could use psychotherapy, but that he was not ready for it, not being convinced that there was a psychological factor in his ailment. Without a desire for treatment it was doubtful that the patient could derive any benefit from it.

Six months later I received a telephone call from the patient asking for an appointment. He was ready, he claimed, to start therapy. Treatment was started and carried on with satisfactory results.

TREATING THE UNMOTIVATED PATIENT

The unmotivated patient who feels obliged to continue in therapy because of external pressure or who is willing to experiment with treatment against his or her own judgment should be accepted without question. The best way to motivate such a patient for therapy is to start a good relationship immediately—one of frankness and sincerity. The patient, finding value in this relationship, may eventually accept therapy, using the therapist to bring some objectivity into his or her life.

This may be illustrated in the following excerpt of the fifteenth session with a woman of 30 whose husband had forced her to accept treatment under threat of divorce. The patient suffered from a phobic reaction that restricted her movements and caused her to cling fearfully to her husband. She resented his insistence on her getting psychiatric help, and the first sessions were spent accepting her resentment and pointing out to her that her disabling symptoms might provide an adequate reason for her personal acceptance of therapy irrespective of the wishes of her husband. Gradually she concurred with this idea.

Pt. Well, I feel that I am learning a lot. I don't know how it happened. It's been very subtle. I just don't know how it happened, but I don't think the way I used to. That's the only obvious thing that I can see. I think that I'm getting my feet on the ground; I'm thinking more realistically. I know that I did come here because somebody else wanted me to. I'd be telling

a big lie if I didn't admit that. But I had absolutely nothing to say about coming here in the first place, not a thing. And the only reason that I didn't like to come here, I thought of the stigma of having anything wrong with my mind. I'm reminded of it, and John *(her husband)* reminds me of the fact that I'm neurotic all the time, and I know it myself. I think that that has been my phobia, more than some of the other things.

Th. Don't you think you would have thought the same way about treatment if there was something medically wrong with you?

Pt. No.

Th. In other words, you put a special stigma on being neurotic as compared to having any other ailment.

Pt. Well, any other thing, I don't know. But Dad taught us ever since we were children about people being mentally off and that whenever we got married, that the one thing to be sure of always was that the other person was well balanced and didn't have any queer strains in him. That idea has kept on so long, that it has always seemed to me there were cures for physical things, but that something wrong with your mind you had with you until you died. If you think that for a long, long time, and then someone starts telling you you're queer, it accumulates like a snowball.

Th. Well, that made it difficult for you. You then came not of your own free will, but because your husband insisted on it. But you are beginning to see that coming here does not imply that you are seriously mentally ill. Many people come to therapy not because they have symptoms but because they want to improve on their potentialities.

Pt. I realize that they go because they themselves feel that, *(pause)*

Th. Because they themselves feel that.

Pt. And it isn't because someone else says they are queer.

Th. Precisely. If you continue to come to see me on the basis that somebody thinks you're queer, you won't get much out of coming. If you don't come of your own free will and feel that this is your project, that there are problems that *you* have, emotional conflicts that *you* want to work out, your treatment will be delayed.

Pt. No, I don't have that attitude, and you have gotten me over that feeling. I guess it's because of you. Well, your attitude isn't the kind that reminds me that I'm queer, nothing like that at all. It's entirely different. I think that I want to do things about myself.

From this point on therapy proceeded satisfactorily.

The following transcribed recording illustrates some of the processes of an initial interview.

> (The patient telephoned for an appointment stating that he had been referred by a psychiatrist in San Francisco. When he appeared, he presented the appearance of a pleasant, poised young man, somewhat timid in manner.)

Th. Hello, I'm Dr. Wolberg.

Pt. How do you do. *(extends hand)*

Th. Won't you sit down over there, please.

Pt. Yes, mm hmm.

Th. The purpose of this interview is to get a general idea of your problem so that we can decide the best thing to do for it. *[structuring the purpose of the interview]*

Pt. Well, it's a complicated matter, but I feel like I'm not as complete a person as I might be. In my associations with people I mean. *[chief complaint]*

Th. How far back does this go?

Pt. Doctor, now the best way I can preface what I want to say is that I went to see Dr. ____ in San Francisco. I did have a problem, sort of an immediate problem which in turn led to other problems. There was a girl with whom I had been going for the past year, and we had just broken off, and I was very upset about that. And, I had, we had been having an affair, which seemed to complicate the matter considerably, since I wanted to be married and she, in turn, had had a previous engagement which had been broken. She was apprehensive about such things. And my first really severe emotional, what I consider a bust-up, was when she broke off the affair, and I, I lost control of myself pretty well, *[beginning elaboration of the history and development of the complaint]*

Th. How long ago was that?

Pt. This was in early 1948. It just seemed that, as I talked this out with Dr. ____ that *(pause)* that she actually symbolized a type of security which, as we talked over my past and my growing-up process, I never had before.

Th. Mm hmm.

Pt. I can remember very, very well getting little from my stepmother, who raised me with my father since I was 4 or 5. A person who deprecated me and my accomplishments constantly; a person who, of course, took me to the dentist twice a year and performed all of the routine functions of a mother without really letting herself, uh, be a mother, uh … *(pause)*

Th. And your own mother?

Pt. No, my own mother was divorced from my father and she remarried, and my stepmother took care of me.

Th. I see. What about your real mother, did you see your own mother?

Pt. Oh yes, about once a week. We were living in San Francisco.

Th. Hm hmm.

Pt. Uh, I don't know if I've answered your question.

Th. Yes. *(pause)* Now to get back to the immediate problem.

Pt. That was the first time I had this kind of relationship. I had had various relations with a couple of prostitutes, and also with several girls, but they only lasted for a short time. This girl not only, she was, she was a brilliant girl in addition to being a, a wonderful partner sexually. And, uh, this really was the first experience of that intensity that I ever experienced.

Th. How old a girl was she?

Pt. She was younger than I was. She was 19.

Th. I see.

Pt. But very mature, I might add. As I look back on it now it seems to be almost a shadow. Oh, it comes back every so often. I think that my conduct today would be entirely different. I mean I can't visualize myself actually doing some of the incredibly insane things I did at the time, *(pause)*

Th. What did you do?

Pt. Well, I mean I, I persisted, I was jealous, I, I, I, uh, didn't know whether to phone her or not. I put her on the spot. I made things rather miserable for her. I made them miserable for myself. I …

Th. When was this?

Pt. Well, you see, there were actually two stages. About 4 or 5 months after I met her, we went back to college together where I was. We were both doing undergraduate work. And she decided to break off, and that was the first severe reaction I had. I mean, uh, I couldn't see that I was enjoying it too much, and it seemed to represent something very wonderful, and so, I protested loudly at that. I felt I lost everything, and I was very emotional and very, well, it's

just, it's just something that I look back on. It seems totally impossible to reoccur. It never had reoccurred. But we still went on after that, and we resumed the affair after a month, and everything was fine. But, when we finally did break up, it was because she had started going out with another fellow. We had not gone steady during this entire period, and I can remember one Thanksgiving evening—this was at the height of the affair—and she went out with other people. Well, this was absurd to me, since God only knows I couldn't see myself wanting to go out with four different girls for the following nights after Wednesday or Thursday night, whichever it was. I don't know if it was Thanksgiving or Thanksgiving eve. So, it was a pretty insecure relationship for me throughout, and finally when it did break off, it was because she had become interested in someone else, a fellow who had had an article published in a national magazine. She was sort of enthralled by this because she had a creative bug, even though she was a political science major.

Th. You felt inferior to him?

Pt. In terms of, in terms of suaveness, yes. Not in terms, not because he had published something, though I must admit that I imagined off and on that I would publish something someday.

Th. But it must have been a *terrific* blow to you.

Pt. Well, yes. This guy was a very ... he was very tall, slender, good looking guy. He sort of had a uh, uh, worldliness in general, or so it seemed to me, as I imagined, as I noticed him from afar. And I remember being rude to him one day, which, which again is inconceivable for me, because it not only is out of character, but I certainly don't have that confidence. Before I go on, I want to tell you something that the doctor in 'Frisco and I found out after a little while. I have a—I see it coming out of me now—I have a knack for glibness, and, sometimes, I talk —I'm able to talk very slick as I do now—as I seem to be able to do, go into a song and dance. And it's sort of tough to probe. He found it tough, because I, I was a little too glib. And I just want to tell you about that ahead of time.

Th. You want to warn me?

Pt. Yeah! I don't think that it's necessary, but ...

Th. You kind of suspect yourself.

Pt. Yeah, I definitely suspect myself of talking glibly and of underestimating, or trying to underestimate in terms of the person to whom I'm talking. I suspect that I try to make friends with the psychiatrist, instead of, instead of—well, (*laughs*) giving an objective account of my problems. *[This may be an awareness of certain interpersonal operations, and defenses, for instance, of a need to impress, to win people over, to befuddle them. The patient may be warning me not to allow him to fool or beguile me.]*

Th. Well, it's only natural for you to relate yourself to me in a way customary to the way you always relate to people. You might utilize, in talking to me, glibness or any other kinds of attitudes that are so often used. But if you want to be glib, there's no reason why you shouldn't be. If your glibness, however, does make problems for you, that may be something you may want to change. That would be something we could tackle right here in the therapeutic relationship. But let's get on to your problem again, if you'd like to resume the thread, *[accepting his glibness, but pointing out that it might be a focus for exploration]*

Pt. Sure. Uh, it seems that when my girl and I finally did break up, of course, I was, I was pretty crushed for several months, for almost a year. I had planned to go to Europe on one of these student ships. Several friends of mine and I got all the way to New York in the summer, three months after we had broken up, and I had what I call anxiety dreams at night, the dream of Joan, which was the name of the girl.

Th. Do you remember the content of the dreams?

Pt. Yes, I've had them off and on ever since, although they are fading out. I just don't have them too often any more. Uh, yes, uh, dreams in which I would see her marching off with some other guy, not at the altar, especially, but perhaps after they were married, and in which I, I seemed to sense that other people were taking her away. I remember one dream in which my stepmother and she were on the same side, and that was a blow. And, things like that. So I turned in my reservations. I didn't go to Europe, and I turned around and I went back. Meantime, she had split up with this other fellow, who, in turn, had another girl. Circumstances just seemed to create tragedies, at least *(laughs)* temporarily. So, I went back, and we went around that summer.

Th. You went back to the same girl?

Pt. Yes, but we could never pick up the thread. It was just passed. I found it very, I found it just in pieces. You just don't pick those things up again. So, it was one of those things, although she wanted to start all over again. Her parents had thought I was a nice boy, and that was a pressure on her which I think was an unfortunate thing. And when I went back, she became somewhat disillusioned with me. This comes into another issue of—we, together, the two of us, were the officers of a debating society on various issues, including political issues. After listening to the talk back and forth, I had undergone a transformation. I thought I was progressive, but I got disgusted with that philosophy, although I suppose I still am somewhat progressive. I don't know whether to bring it up because I always feel it creates bad feelings.

Th. You don't know whether to bring that up with me?

Pt. Yeah.

Th. You may not know how I might react to your political ideas?

Pt. Yeah. That's exactly it. *[The patient seems to be testing me here to find out how tolerant or judgmental I might be.]*

Th. Do you feel that I might perhaps judge you in a certain light, if you were either conservative or radical?

Pt. Yeah, I'm always scared of people who live too near Park Avenue. This is maybe because I come from a very wealthy family, and didn't like it. These people frighten me. I don't mean frighten me in a conventional meaning of the word.

Th. All I can tell you is that whatever your political convictions may be, they may be right for you. You don't have to tell me if you don't want to, just what your political orientation is. It really wouldn't make too much difference to me. *[attempt at reassurance and at creating an*

atmosphere of tolerance]

Pt. I believe you. This, uh, probably what I said was to, probably because I was grasping for information from *you*. I, actually, I had undergone a transformation.

Th. Uh huh.

Pt. I heard of a forthcoming convention, and I didn't like it. She asked me to participate, and I told her no, that I was at a former convention and I was a little disgusted at the goings-on, and I wasn't going to work in it. Well, that was the last straw. She had imagined me as the sort of person whose beliefs coincided with hers. And they did, actually, pretty much, except politically I suppose.

Th. What happened then?

Pt. Yeah, we broke up. We never started up from then. That was the last straw. We broke up. And that summer, I went to see Dr. _____ (*pause*)

Th. After the second break, you saw Dr._____

Pt. It was during that second break, *(pause)*

Th. What was the *reason* you saw Dr. ___?

Pt. Well, because, because of her in two ways. First, she wanted me to. Both my mother, my real mother, and Joan wanted me to see a psychologist. I had been toying with the idea myself, and one of the things that enraged me particularly was the fact that Joan said that the condition for our rapprochement would be seeing a psychologist.

Th. Why did she want you to see a psychologist?

Pt. Because she, because she, well, she felt—and she was probably quite right—that my emotional attitude was so unstable. I, I jumped back and forth so much that she couldn't see herself living in this, this uncertainty.

Th. I see, Did *you* really think you were unstable?

Pt. Oh, definitely.

Th. Well now, what happened since the breakup of your affair with Joan? Perhaps you could bring the situation up to the present. *[Because the patient may cover many minor facets of his relationship with Joan to the sacrifice of other important aspects necessary to cover in the initial interview, I attempt to focus the material.]*

Pt. Yeah, I shall. There has been one other item of major importance and that recently terminated, but I'll give you that very briefly because I think that's quite important. Well, right after that I transferred to a midwestern school. I missed Joan terribly, and I changed my major. So I changed it without any trouble, since I had another year before I took my Bachelor of Arts degree. So I did that, and I really had a fine time. I lived at the fraternity house, and I was

active there, and I did some debating there.

Th. This was '49?

Pt. This was '49, yeah, late '48 and mostly '49. Well, soon I met a girl named Philly, she shall be called, since that was her nickname. So Philly and I started seeing one another, and we started having an affair. She seemed to me, well, she again had interests much similar to mine. So we started going around together and had an affair, but she turned into, in the last analysis, possibly a repetition of what happened with Joan. She turned out not to know what she wanted, and we went around all summer and all spring of '49 last year. I went to school in the East last fall, and when I went home in December, I found out that in spite of the fact that we had been engaged since last May, she had gone out with a boy whom she had previously gone with when she was at college. This is getting complicated. He had transferred to the Midwest college where she was still a student in her senior year. He transferred there the same month last September that I had transferred East. And she had started going around with him, and she was wearing my ring, and although we had both been going out, I had been, had not been carrying on any promiscuous activities. It turned out that she became worried right after I left. She went to see a doctor, and it turned out that she was not pregnant, but, like a fool, she told him. Then it had got back to me, since we knew him mutually.

Th. Who told you this?

Pt. Well, you see, look, uh, here I go again, I'm skipping. This, this is getting complicated.

Th. We have so much to cover in the interview that it may perhaps be essential to cover highlights and then we'll be able to go into detail later, *[again attempting to focus on material pertinent to the initial interview]*

Pt. This is a highlight I'm going to have to tell you. I'm sorry to interrupt you, but I have to tell you this. She was pregnant last summer. I got her pregnant. And I was pretty shaken by it, and I brought my mother in who is a woman of the world.

Th. During this period was there a lot of turmoil in you, or were you more or less placid?

Pt. Placid, placid, surprisingly. You see, as soon as I met Philly, she was really why I seemed to get so secure, Joan faded from the picture, and it was like, it was like something fell off my back. It was like, I was like the man with the hoe. Well, anyhow, so I got her pregnant. Oh, that was a hell of a summer. So Mother, who had been circulating with the literati for many years, she knew I was carrying on an affair with Philly. Mother had, we, we, mother and I had talked everything out, and I had felt very close to her, so I brought her in on this. And she went down to Philly—it was probably a mistake—and we got her, well we got there, everything was all right. Then we went back together. It was very difficult after that, and I began losing a little interest. Well, when I left in September, right after I left, I phoned her, one night in October, and her landlady said she went to see her aunt.

Th. Mm hmm.

Pt. Well, she has two aunts there, three, so she said. My suspicions grew and when she came back, she told me that she had gone South with this fellow. But it was platonic; he had gone as a

friend. I accepted that. When I got home in December, Mother told me that she talked with Philly, and she said she didn't know if I was the one who got her pregnant or if it was the other fellow.

Th. Mm hmm.

Pt. And my opinion of her decreased considerably, since she had sort of done this thing without any responsibility. So, we broke up in December. It was a very terrible scene 'cause my mother got involved in it. My mother got involved, and she became just like every other mother, very possessive and jealous of her son. I had thought that she had a soul above it before this. But she didn't. She said, "She's no better than a whore." I took great offense to that. I got sore as hell.

Th. Did that knock you for a loop, too—the breakup of that situation?

Pt. Yes, yes, it did, for 2 or 3 weeks. Well, it really didn't by comparison with the first. I don't know whether it was because basically, because Joan was an unusual, extraordinary, uh, uh …

Th. An exceptional person?

Pt. Yeah, or because Philly was just a second. And the second is, didn't bother me so much. So it, so, it's, it's, it's during that time I went to see Dr.____ Now, why am I here today, I mean why I came to see you?

Th. Yes.

Pt. I know you want to get to that. Well, right now I have actually never felt in a way so confident except maybe when I was in high school or in the army. But it may be because I think introspectively. I guess introspection isn't too good either.

Th. Well, now, let me ask you this. What problems do you feel you have now that you'd like to modify?

Pt. Well, there are problems. Mostly they're in terms of pers-, my own personality problems.

Th. Do you want to tell me something about these?

Pt. Yeah, yeah, I will. Well, I find myself feeling at times that I do not, oh, have friends with whom I can possibly associate or, or be at ease with. I feel that I should always be making an impression upon them. Uh …

Th. Do you have any idea as to what goes on?

Pt. I have an idea why.

Th. Yes.

Pt. Well, I, uh, I think it's probably the fact that I had been deprecated; I had been deprecated by my stepmother throughout life. She had pointed to her own son as *the* one.

Th. What age difference is there between you and her son?

Pt. It was a year and a half. He was younger. Well, he turned out to be a complete dunce. (*laughs*) I say that literally. And it, it turned out that, that my father started looking toward me. And later on Dad was, Dad was always the most stabilizing influence in this whole set-up.

Th. Did you like him?

Pt. Oh, yes, Dad was wonderful.

Th. So, to come back to what we were talking about before, the basic problem you'd like help with is your relations with people.

Pt. Yes, and there are several other things I already mentioned that may be concomitants of this or other problems. *[Since the patient is garrulous, to allow him to explore this idea would divert us from important tasks.]*

Th. Now I'd just like to ask you a few questions rapidly.

Pt. Fire.

Th. Your full name is? *[getting statistical data]*

Pt. (Patient spells this out.)

Th. How old are you?

Pt. Twenty-five.

Th. Your address?

Pt. (Patient gives this.)

Th. Telephone?

Pt. (Patient gives this.)

Th. Is it all right to call you there?

Pt. Oh, yes.

Th. Are you living alone?

Pt. Yes.

Th. Now, you are single and a postgraduate student?

Pt. Right.

Th. What are the sources of your income?

Pt. Well, I was left a small amount of money; well, maybe, it isn't small, but it gives me enough to be comfortable with.

Th. You say you were in the army?

Pt. I was in the army, uh, 26 months between 1944 and '46. I think the army was intellectually regressive. I don't recall reading more than 3 or 4 books during that time.

Th. Now I'd like to ask you about other symptoms. How about tension, do you feel tense? *[inquiring about other complaints and symptoms]*

Pt. Well, now, if you are talking about now, I don't. Only when I am in certain situations.

Th. How about depressions, do you get depressed?

Pt. Once in a while when I think of the messes I've been in.

Th. But not habitually.

Pt. No.

Th. How about anxiety?

Pt. Oh, yes, I'm anxious, but I get out of it.

Th. What about physical symptoms?

Pt. Well, no.

Th. Any fatigue or exhaustion?

Pt. Yes, often that.

Th. How about headaches?

Pt. No.

Th. Dizziness?

Pt. I don't think so.

Th. Stomach or bowel trouble?

Pt. No.

Th. Any sexual problems?

Pt. Well, now, it's funny, when I first meet a girl, I can't, I mean I have no confidence, but later it's all right.

Th. I see. Any other problems?

Pt. I would say not.

Th. Any phobias or fears?

Pt. Just of speaking in public. Stage fright, I guess.

Th. Any other fears?

Pt. No.

Th. Any thoughts that crowd in your mind that frighten you?

Pt. No.

Th. Any compulsions—doing things over and over?

Pt. Well, no.

Th. How about sedatives, do you take them?

Pt. Only rarely when I can't sleep.

Th. How about alcohol, do you drink excessively?

Pt. No, but at parties I may have too much.

Th. You say you sleep well?

Pt. Oh, yes.

Th. Any nightmares?

Pt. No.

Th. You remember your dreams pretty well?

Pt. Generally.

Th. Can you tell me a recent dream?

Pt. I had one last night, but I can't remember the details.

Th. Any repetitive patterns in your dreams?

Pt. I couldn't say.

Th. Now a few items about your family. Your own mother is alive and well, *[obtaining family data]*

Pt. Yes.

Th. You say you feel different ways about her?

Pt. Yes, good and bad. I seem to miss her and get furious, infuriated with her. She is sophisticated as I say, but always gets into my life, interferes.

Th. Your father is in good health?

Pt. Yes, he's a person I always admired.

Th. And your stepmother?

Pt. As I said, we were strained. I don't think she ever liked me. She gave me physical care, but it stopped at that.

Th. Now what about brothers and sisters?

Pt. I have a half-brother, three years older than I am. He is a shy fellow. We got along badly, very badly all our lives. I joined in the cruelty kicking him around. It seems I emerged out of all this better than he did. And then I have a younger half-brother who turned into a sort of nonentity. That was fortunate for me because I felt that I had it all over them.

Th. Now previous to the two bust-ups you had with these two girls, were there any previous attacks of the same kind? *[questions as to previous emotional upsets]*

Pt. No, not that way.

Th. How about when you were little, any problems then?

Pt. I suppose I was a nervous kid, but I, uh, I mean, I never had any real trouble.

Th. You have had previous treatments as you said with Dr._____. Can you tell me a little more about these, *[questions as to previous treatments]*

Pt. Well, you see, I saw him for a month when I got upset, then, and then I had to go back to school. So I used to see him vacations, and never more than a couple of weeks at a time.

Th. I see.

Pt. And I saw him when I was in California in December, and, it's, well it's been a very short period.

Th. Did you get any psychologic tests of any kind?

Pt. I took some intelligence tests when I was in high school.

Th. Any Rorschach test at any time?

Pt. No.

Th. I'd like to get one on you. How do you feel about it? *[Securing a psychologic consultation. This is not absolutely essential here but it might give me some data about his ego strength.)*

Pt. Sure, if you think it's important.

Th. All right, then, my secretary will make the appointment and will call you. Now, how would you estimate your present health, physical health?

Pt. I'd say I was all right physically.

Th. Have you had a physical examination during the past year?

Pt. Only three months ago I had an insurance physical. The doctor said I was in good shape then.

Th. So to review, you'd like to get started in therapy for this personality difficulty. How urgent would you say your need for therapy was?

Pt. I'd say it wasn't an emergency, that is, I've lived with it for a time, and I suppose I could survive. But I want to be the sort of individual who can walk around in this complicated world without feeling that I somehow am, well, not apart from it. Now in my studies in school, I, I work in spurts. I find myself unable to study for a week. And, all of a sudden, I'll spurt. I do an enormous amount of work then.

Th. In other words, your efforts aren't consistent. Now, let's look upon the practical issues that are involved. You're up in the country, and you have a commuting problem. If you were to come here to see me, we would have to work out some sort of program for you. First, how would you feel about working with *me? [making practical arrangements for therapy]*

Pt. Fine, I find it easy to talk to you.

Th. Good. I believe I can make time for you on my schedule.

Pt. Well, now I have a car. It wouldn't be too bad. I have no classes Wednesdays and only one class on Friday from which I can come to and then come in. Those are really my best days.

Th. What I would really like to do is spend several sessions with you attempting to formulate a goal in treatment, and then outline a plan. I am not sure yet how deeply we want to go into your personality problem, or how extensive the process would be in terms of time. You know personality problems go so far back in one's life that it might take time to remove them. Sometimes it takes as long as 2 or 3 years. *[Since this is a personality problem, it is likely that therapy will take a long time.]*

Pt. Well, I know it must take time, and I suppose I am too anxious about it. But on the financial end, if I don't have to come too often, I think I can handle it.

Th. As far as frequency is concerned, we could try twice a week and see how things go. You may be able to do well on that. If any unusual resistances occur, you might have to come in more often, at least for a while. But we can't really tell without a trial. As a matter of fact, once we decide to go ahead, it might be a good idea to set up a trial period of say three months to see how we get along in therapy as a team. *[Setting the frequency at twice a week is conditioned partly by the fact that he can come in no more frequently, if he is to continue with all of his classes at school. On the other hand, because of his dependency problem, we may want to cut down on visits to once a week.]*

Pt. I think that's a good idea.

Th. Now my secretary told you my fee. I'd like to tell you about our appointments. They start right on time, and the sessions last three-quarters of an hour. I'll send you a bill at the end of each month. Once we set our regular sessions, you should keep the appointments consistently unless a real emergency comes up. If you have to cancel an appointment, please do so at least 24 hours in advance; otherwise I may have to charge you for the session since I set it aside for you. *[making final arrangements]*

Pt. All right.

Th. All right, then, how would 3:40 P.M. next Wednesday suit you for your next appointment and 2:50 P.M. the Friday after that?

Pt. That would be good for me.

Th. All right, my secretary will call you about the appointment with the psychologist for testing. So I'll see you Wednesday.

Pt. Goodbye, Doctor.

Th. Goodbye.

Tentative diagnosis: Passive-aggressive personality disorder.

Tentative dynamics: The patient seems to suffer from tendencies to relate in an immature way to women who take over a maternal role with him. Hostility is probably a concomitant of this relationship. Inevitably the patient is rejected, perhaps through his own participation. A rupture of the relationship produces great anxiety, with inability to function. The patient may try to avoid deep involvement by a detached relationship with women for whom he may have little respect. The origins of his problem are perhaps rooted in childhood insecurities in relation to an alternately rejecting and overprotective mother and a rejecting stepmother. Latent homosexual tendencies may exist associated with the dependency pattern.

Tentative prognosis: There are many positive things about this man, and he seems to have been able to adjust to many vicissitudes. For instance, his early childhood was not too tumultuous; he adjusted well to army life; he has progressed satisfactorily at school. With adequate therapy the prognosis is probably good.

Reciprocal response of patient and interviewer: The patient was cooperative and seemed to respond well to the interviewer. The latter, in turn, felt positive toward the patient.

Physical appearance: Meticulous, perhaps a little foppish.

Patient's estimate of his present physical health: Good.

Communicativeness: Somewhat garrulous.

Insight and motivation:

    1. The patient is aware of the fact that he has a problem.

    2. He desires to correct the problem.

    3. He is aware that his problem is emotional in nature.

    4. He is willing to accept psychotherapy.

    5. He is willing to accept help from the interviewer.

    6. He seems to be willing to accept the conditions of psychotherapy.

    7. He is able to afford the fee.

Choice of treatment method: Psychoanalytically oriented psychotherapy.

Frequency of visits: Twice weekly at the start.

Most patients harbor misconceptions about psychotherapy and its allied fields as well as about themselves. These are the products of ignorance, fear, superstition, or lack of proper information. The responsibility of the therapist here is to supply the patient with facts (psychoeducation). Although the patient may not believe or be willing to accept such facts at first, offering these facts gives the patient an opportunity to alter misconceptions.

It is often advisable to probe for the reasons behind certain questions before answering them. For instance, if the patient asks, "Do *you think psychotherapy could help me?*" various responses are possible:

    1. *Th.* You seem to have doubts about this.

    2. *Th.* I wonder why you ask that question?

    3. *Th.* Do *you* think psychotherapy can help you?

In the event a patient seems demoralized by fear and by doubts about personal capacities to get well as indicated by his or her questions, the therapist may reply: "Look, your problems are not unique. You are not the only one who has this kind of trouble. You are not weak and hopeless. You have a complex disorder, an illness that has a name. What you are experiencing are attacks of this illness. This is not under your voluntary control. It is not your fault. You are not incurable. With proper help and your willingness to cooperate, you should experience relief."

Once the patient expresses his or her ideas, the therapist may provide pertinent facts. The following questions are commonly asked by patients, and suggested answers to these are indicated:

    1. *Pt. Can I really be helped by psychotherapy?*

Th. Psychotherapy is designed to help a person overcome nervous symptoms, to adjust better to life, and even to modify the inner personality structure so that the person may live more harmoniously. If you have a desire for help and work with a trained professional person, the chances are psychotherapy may be able to help you.

2. *Pt. Can't I get over my trouble by myself?*

Th. Even if your problem is not too serious, it is hard for you to work it out without professional help. It is difficult or impossible to be completely objective about oneself because living so close to one's problems makes it hard to see them. It's like being unable to see the forest for the trees.

3. *Pt. Will not a change in my external life situation produce a cure in my emotional problems?*

Th. Occasionally this happens, but, unfortunately, not enough times. Problems are part of oneself and usually pursue one in all sorts of circumstances. Of course, bad external circumstances aggravate one's difficulties or bring them to the surface. Good environmental circumstances minimize them. But one's problems are always there, and they have to be dealt with therapeutically if any real modification or cure is to occur.

4. *Pt. Why is it that a person is unaware of factors that cause emotional trouble?*

Th. The reason a person is unaware of such factors is that they are associated with such hurtful emotions that they are automatically shut out of one's mind. The mechanism of keeping painful ideas from the mind is known as "repression."

5. *Pt. What is the real cause of emotional illness?*

Th. Emotional illness is the product of bad learning experiences. These create conflicts that interfere with one's relationships with life and with people. Some of these conflicts are unconscious, that is, the person is only partially aware of them. The mechanism of repression operates to push painful conflicts out of awareness.

6. *Pt. Can't I find out by myself what is causing my emotional trouble?*

Th. You might, but most people can't. Not only do we fail to see important issues, but we tend to distort them. For instance, it is hard to discard an image of oneself that one has maintained and enlarged from early childhood, even though the image is an erroneous one. Because we can't be objective about ourselves, we will need professional help.

7. *Pt. Do emotional problems start in childhood?*

Th. The personality structure is built up during childhood as a result of experiences with parents and other significant individuals. When one's early life has been unpleasant, the personality structure may be damaged. This may create trouble for one later on.

8. *Pt. I know my personality has not been what it should be, but how could this cause

my symptoms?

> *Th.* Personality problems create difficulties in getting along with people. They stir up unhappiness and initiate many conflicts. The upshot is tension, fatigue, depression, fears, as well as other symptoms.

9. *Pt. Doesn't my needing psychotherapy mean that I have a weak will or am on the way to a mental breakdown?*

> *Th.* No! More and more people, even those whose problems are essentially normal ones, are seeking help these days because they realize they can better themselves with treatment. The fact that you desire psychotherapy is a compliment to your judgment and is no indication that you are approaching a mental breakdown.

10. *Pt. If I have a nervous problem, doesn't that make me different from other people?*

> *Th.* All people have some neurotic problems. Their ability to live with these problems and to fulfill themselves creatively in spite of these problems constitutes the difference between "normality" and emotional maladjustment. Most persons whom we call "normal" actually have neurotic problems that do not interfere with their life adjustment or happiness. When such interference occurs, individuals will want to do something about themselves and their problems.

11. *Pt. Why do so many people have neuroses?*

> *Th.* It is impossible to escape conflicts in the process of living. The very act of growing up involves sacrifices and the yielding up of individual pleasures for the group interest. There are many deprivations and disciplines to which we all have to adjust. The price of such an adjustment is often frustration and tension. Mild neurotic symptoms are present in all of us; indeed, they are more common than the common cold.

12. *Pt. Am I not indulging myself by seeking treatment?*

> *Th.* If you were suffering from a physical ailment, you would not believe that you were indulging yourself by getting help for it. An emotional problem may be equally disabling or more disabling than a physical problem. It will need expert help and should not be regarded as a form of indulgence.

13. *Pt. Can all persons with emotional problems be cured by psychotherapy?*

> *Th.* All people can be helped in some way by psychotherapy. The extent of help will depend largely on how much the person desires help, and how much the person resists being helped. Some people do not really wish to be cured of their neurosis because it yields important dividends for them. Those who are willing to exchange health for the spurious pleasures of a neurosis have gone more than half way to a cure.

14. *Pt. Why are there so many different theories about emotional conditions?*

Th. The field of mental health is relatively new, and, consequently, new findings are constantly being uncovered. Actually, there are more areas of agreement than there are differences.

15. *Pt.* There is a history of mental illness in my family. Does this mean that *I will have a mental breakdown?*

Th. There is scarcely a family in the country that doesn't have some member or progenitor who has suffered from a serious mental illness. There is a great deal of disagreement in scientific circles as to the exact role of heredity in emotional problems. However, it is generally conceded that even though a person has a strong history of hereditary illness, this does not necessarily mean that he or she will develop a mental breakdown.

16. *Pt. Shall I get treatment now, or shall I wait?*

Th. The longer you wait the more ingrained your patterns may become. As in physical illness, so in emotional illness: it is prudent to get help as early as possible.

17. *Pt. Can physical symptoms be caused by emotions?*

Th. Many physical symptoms are psychosomatic in nature, which means that they have an emotional or nervous basis. When you come to think of it, it is not really so strange that emotional strains or worry should produce physical symptoms. After all, every organ in your body is connected with your brain by nerve channels; and so it is logical that when your nervous system is upset by some crisis or conflict, you may feel the effects in various organs of the body.

18. *Pt. What is a psychoneurosis?*

Th. A psychoneurosis is a very common form of emotional illness that indicates that the person is not adjusting to all phases of life. Among the more common symptoms of psychoneurosis are feelings of panic or anxiety, depression, fears of various sorts, compulsive acts, and physical symptoms.

19. *Pt. What is a character disorder?*

Th. Many people have a character disorder that consists of a warping of the personality brought about by early training. Character disorders are associated with feelings of insecurity, devaluated self-esteem, and other traits that prevent the individual from being as happy and productive as possible.

20. *Pt. Are alcoholism and drug addiction emotional problems?*

Th. Yes.

21. *Pt. What is insanity?*

Th. Insanity is a severe mental illness in which a person loses the capacity to distinguish between what is real from what is imaginary. While most people who are emotionally upset believe

they are going insane, they very rarely do so. Insanity, or psychosis as it is more properly called, is treatable even in its end stages with modern methods of therapy.

22. *Pt. How can I get the proper help for my problem?*

Th. It is extremely important that the therapist who treats you be a responsible person with sufficient training. Unfortunately, there are many charlatans who have had little or no real training and who advertise themselves falsely as "psychotherapists," "hypnotists," "counselors," and "psychoanalysts." It is unwise to consult any person for treatment unless referred to such a person by a physician or other professional person or by a reputable agency.

23. *Pt. Who is qualified to do psychotherapy?*

Th. Psychotherapy is an extremely complex skill and requires a great deal of specialized training. Psychiatrists, clinical psychologists, clinical social workers, and psychiatric nurses can do psychotherapy if they have had proper postgraduate training.

24. *Pt. What is a psychiatrist?*

Th. A psychiatrist is a medical doctor who specializes in the handling of nervous and mental illness.

25. *Pt. What is a neurologist?*

Th. A neurologist is a medical doctor who handles organic diseases of the brain and spinal cord, such as brain tumors.

26. *Pt. What is a psychoanalyst?*

Th. A psychoanalyst has had special training in the field of psychoanalysis. This involves an extended period of study and includes a personal psychoanalysis.

27. *Pt. What is a clinical social worker?*

Th. A clinical social worker is a graduate from a school of social work who has specialized in helping persons with emotional difficulties. Because of specialized training, the social worker is often used as a consultant in interpersonal, family, social, and community problems.

28. *Pt. What is a clinical psychologist?*

Th. A clinical psychologist is a graduate of an approved school of training in this discipline. The training of the psychologist enables him or her to handle emotional difficulties. The psychologist is often used as a consultant in diagnostic testing, rehabilitation, vocational guidance, and research.

29. *Pt. How does psychotherapy work?*

Th. Nervous symptoms and unwarranted unhappiness are caused by inner emotional conflicts, faulty learning, or objectional environmental circumstances. In psychotherapy you are helped to understand your troubles, whatever their nature. In this way it is possible for you to do something constructive about solving them.

30. *Pt. What kind of treatment will I need?*

Th. Different kinds of treatments are helpful in emotional problems, just as different kinds of medicines and operations are suitable for physical illnesses. But the goal is the same— to get the patient well. It's like the roads that lead to Rome. There are many different routes one can follow, and one can get there by different vehicles, from donkey cart to airplane. The goal, however, is Rome. The kind of treatment best suited for you can be determined only by a careful evaluation of your problem.

31. *Pt. What different types of psychotherapy are there?*

Th. Roughly, psychotherapy falls into three broad categories: first, supportive therapy, which aims for the correction of symptoms and problems in living without necessarily producing deeper changes; second, reeducative therapy, which helps a person to relearn and to correct certain patterns of behavior; and third, reconstructive therapy, which has as its goal some modification of the individual's personality. Needless to say, the latter kind of therapy is much more extensive and difficult.

32. *Pt. What are the most common approaches in psychotherapy?*

Th. Within the broad supportive, reeducative, and reconstructive groupings there are countless varieties of approach—for instance, interview psychotherapy, nondirective therapy, Freudian psychoanalysis, non-Freudian psychoanalysis, psychoanalytically oriented psychotherapy, group therapy, behavior therapy, and hypnoanalysis. These are different ways and means toward the same objective of helping a person get well.

33. *Pt. What is the best kind of psychotherapy?*

Th. The best kind of therapy is that which suits the needs of the person best. A good therapist modifies methods to suit the patient. Sometimes supportive therapy is most indicated; sometimes reeducative therapy is needed; sometimes reconstructive therapy is best. The type most suited for you will depend on the nature of your problems.

34. *Pt. What is psychoanalysis?*

Th. The word "psychoanalysis" has become so popularized that it has lost its original meaning. Psychoanalysis is the name given to a theory and a technique by Sigmund Freud. The original theory and technique, which is still in use, has been modified by some of Freud's contemporaries and students. Some of the principles of psychoanalytic thinking have been incorporated into modern psychotherapy, and the product is often called "dynamic psychotherapy" or "psychoanalytically oriented psychotherapy," which must be distinguished from formal or "classical" psychoanalysis.

35. *Pt. What is involved in a psychoanalysis?*

> *Th.* Formal psychoanalysis is a special treatment procedure that can be conducted only by those who have had specialized training in this particular field, that is, psychoanalysts. A psychoanalysis requires that a patient have at least 3 and preferably 4 to 5 treatment sessions weekly. Whether a patient should undergo a psychoanalysis rather than some other form of psychotherapy has no relation to the seriousness of the patient's case. Some very serious cases respond well to formal psychoanalysis, whereas others do much better with some other form of psychotherapy.

36. *Pt. What is the difference between psychoanalysis and other types of therapy?*

> *Th.* One of the fundamental differences is the emphasis in psychoanalysis on unconscious conflict as the source of emotional problems. The elucidation and understanding of unconscious conflicts, and the tracing back of conflicts to their origins in childhood, are the chief tasks in psychoanalysis.

37. *Pt. Isn't psychoanalysis the best kind of treatment there is for emotional problems?*

> *Th.* The best kind of treatment for an emotional problem is the treatment that is best for the patient. Sometimes the best treatment is psychoanalysis; sometimes the best treatment is another kind of psychotherapy such as behavior therapy, cognitive therapy, hypnosis, medicinal (drug) treatments, and others that are preferred in certain kinds of problems.

38. *Pt. If psychoanalysis goes deeper into a problem than any other kind of psychotherapy, isn't psychoanalysis to be preferred?*

> *Th.* Not necessarily; other techniques may be better for a person. We can take examples from the field of medicine. Most abdominal conditions can be handled with medicinal treatment; some require surgery. Those that need surgery should get surgery. Those that do not need surgical interference should not get surgery. While some emotional problems need psychoanalysis, others definitely do not. They should, therefore, get the kind of treatment that is best suited for them.

39. *Pt. What is the difference between psychotherapy and psychoanalysis?*

> *Th.* Psychotherapy is the general term applied to the overall treatment of emotional problems. One kind of psychotherapy is psychoanalysis. Psychoanalysis is helpful in certain kinds of emotional problems and not so helpful in others. Because it takes so long (3 to 5 times a week for from 1 to 3 years) and is so expensive, it should be used only where it is definitely required. Not all people can use psychoanalysis, nor do they need it.

40. *Pt. What is Freudian psychoanalysis?*

> *Th.* This is the technique originated by Dr. Sigmund Freud. It is helpful in certain kinds of emotional illness.

41. *Pt. What is non-Freudian or neo-Freudian psychoanalysis?*

> *Th.* This is a modified approach to psychoanalysis, which in the hands of competent, well-trained therapists yields good results in certain emotional problems.

42. *Pt. Which is superior, Freudian or non-Freudian psychoanalysis?*

> *Th.* More important than the kind of psychoanalysis is the experience and skill of the analyst. A good psychoanalyst can get good results with either procedure, while a poor analyst will probably fail irrespective of the kind of approach employed. Some psychoanalysts find that a Freudian psychoanalysis works better for them; others hold a modified psychoanalysis in higher esteem.

43. *Pt. What is psychobiologic therapy?*

> *Th.* This is an approach to psychotherapy originated by Dr. Adolf Meyer that uses a number of different techniques. It is helpful in certain kinds of emotional illness.

44. *Pt. What do you think about behavior therapy?*

> *Th.* The principles on which behavior therapy was founded have been known to psychologists and psychiatrists for years. Behavior therapy can be effective in certain conditions, and to remove symptoms, for instance, as in pathological fearful (phobic) states, and to modify bad habit and behavioral patterns.

45. *Pt. Is group therapy helpful?*

> *Th.* Yes, in many conditions both by itself and in conjunction with individual therapy. Sometimes an entire family, or selected members, are seen together in a group. This is called "family therapy." A husband and wife may also be treated together in certain marital problems in what is called "couples therapy" or "marital therapy."

46. *Pt. Won't hypnosis shorten my treatments?*

> *Th.* In certain conditions hypnosis is helpful; in others it seems to do no good.

47. *Pt. Will I need special treatments, like psychodrama or "truth serum"?*

> *Th.* That will depend on the nature of your problem. If your therapist believes any special treatments to be indicated, he or she will tell you about it.

48. *Pt. Will I need shock therapy?*

> *Th.* Very few people need shock therapy. Its use is limited to only special conditions. The probabilities are that you will not require this form of treatment.

49. *Pt. Will I get medicine for relief, for example, tranquilizers or antidepressants?*

Th. If your therapist believes that medicine will be of any benefit to you, he or she will prescribe it or have it prescribed.

50. *Pt. Are there any shortcuts to treatment?*

Th. A number of experimental methods are in process to see whether it is possible to cut down the long period of time required for treatment. This work is not entirely complete, but sufficient progress has been made to indicate that it may be possible to cut down on the treatment time in some cases. However, there are some forms of emotional problems in which time itself is the essence in treatment and shortcuts are not possible. Personality problems have been so much a part of an individual since childhood that it may take time to unravel them.

51. *Pt. Can psychotherapy make a person happy no matter how bad the person's situation may be?*

Th. Psychotherapy will not stop a person from reacting to a bad situation. It should, however, make it easier to deal with this situation in a more constructive manner.

52. *Pt. Am I going to be forced during therapy to give up pleasures in my life situation that I find valuable now?*

Th. Nobody is going to force you to do anything. If any of the pleasures that you enjoy at the present time are destructive to you, you have a right to know this. Once you are aware of all the facts, you will then be in a better position to judge for yourself whether you want to continue or discontinue certain pleasures. Many people have the misconception that psychotherapy will make them terribly serious and prevent them from enjoying themselves. On the contrary, psychotherapy releases inhibitions to enjoyment and pleasure.

53. *Pt. Is treatment likely to make a person immoral?*

Th. This mistaken notion is caused by the fact that in therapy an individual discusses problems of deepest concern to one, including sexual problems. Immorality is never produced by a proper understanding of emotional problems and drives. On the contrary, immorality is usually the product of misunderstanding. Once the individuals survey themselves honestly, healthy and constructive attitudes toward themselves and toward their basic impulses will develop.

54. *Pt. Will therapy break up my present marriage?*

Th. Therapy actually preserves many marriages. It is interesting that therapeutic changes occur not only in a person getting therapy, but also in the person's mate. This is because a personality alteration in one member of a family always affects the adjustment of people in close contact with the person. When a marriage seems hopeless, for example, the patient will be able to evaluate better its good and bad points.

55. *Pt. Will I lose my creative abilities if I get therapy?*

Th. Such an idea arises from a misconception that creativity comes from neurosis. Actually,

creative work is one of the most normal of human drives. It is crippled by neurosis. Experience shows that people are liberated from their blocks and actually become more creative after therapy.

56. *Pt. Are people supposed to fall in love with their therapist?*

Th. This is a notion that most people have from reading the existing literature. Actually, transference feelings, positive or negative, occur in varying intensities. The particular form that the transference takes will be dependent upon the individual's unique problems.

57. *Pt. What is transference?*

Th. Transference is the carrying over of emotions and attitudes from the past into relationships with present-day people. It is inspired not by the reality situation, but by previous happenings in former relationships that go as far back as childhood.

58. *Pt. Is transference necessary?*

Th. Transference is a part of every human relationship. For instance, you may have had initial impressions of people; these impressions are caused by the fact that the persons resemble somewhat those you have known. Sometimes one can get angry at a stranger, or one can like a person, for no apparent reason. Such irrational attitudes and feelings toward others go on all the time. They are caused by transference. Transference may be present in the therapeutic relationship. It enables us to see what unconscious attitudes and feelings are constantly being projected out toward other people and are stirring up troubles in adjustment.

59. *Pt. Can transference be at the basis of one's emotional problems?*

Th. Transference distorts logic and judgment and causes unfair and destructive attitudes toward people. These may actually interfere with one's ability to relate in a realistic way to people with whom one requires a good contact.

60. *Pt. Do I have to report my dreams in therapy?*

Th. Yes, if your therapist believes you should do so. All people dream; but not all people remember their dreams. Dreams are thought processes during your sleep that embody symbols and bizarre language forms that may seem meaningless. But woven into the fabric of dreams are attitudes, feelings, and memories that yield clues, to an experienced observer, regarding the individual's basic difficulties and conflicts.

61. *Pt. Can dreams really be interpreted?*

Th. Dreams are condensed symbols that can be interpreted by an experienced therapist. Do not expect that all your dreams will be interpreted for you by your therapist. This is both impossible and unnecessary. You may learn to understand the meaning of your own dreams, and you will then be able to see how closely related your dream structure is to your emotions and feelings.

62. *Pt. But my dreams seem so bizarre. How can they mean anything?*

    Th. The language of the dream, the peculiar symbols that dreams use may seem weird, but these can often be translated by trained therapists, and the significant meanings thereby understood. Freud called dreams the "royal road to the unconscious." The surface story told by dreams (manifest content) is not so important as what underlies the dream (latent content).

63. *Pt. What causes dreams?*

    Th. Dreams are a normal part of the sleep process. Some dreams serve as an outlet of tensions in expressing open and secret hopes as well as fears and conflicts. Such dreams are the mind's attempt to solve problems that disturb the individual, not only in present-day life but also those problems that had upset the person as far back as childhood.

64. *Pt. Is it necessary to recline on the couch for treatment?*

    Th. Reclining on a couch for treatment is usually desirable in formal psychoanalysis. It permits the person to concentrate much better on thought processes by minimizing the influence of external stimuli. It is usually unnecessary in most other forms of psychotherapy.

65. *Pt. What is free association?*

    Th. Free association is a technique used in formal psychoanalysis to discover certain deep unconscious associative links in the person's thoughts by letting the person's mind wander at random, verbalizing without restraint. Free association is not used in most forms of psychotherapy.

66. *Pt. Do I need psychological tests?*

    Th. Psychological tests are often helpful in arriving at a better understanding of the sources of tension and emotional stress. The fees for tests may sound expensive; however, in the long run, tests may prove economical, since by helping in the diagnosis they may facilitate the treatment process. Among the more common tests are the Rorschach, Thematic Apperception, Szondi, and Man-Woman Drawing tests. Your therapist will decide if any of these or other tests will be most helpful to you.

67. *Pt. Do I have to tell my therapist everything, even those thoughts and experiences that make me feel guilty and ashamed?*

    Th. Complete frankness and honesty are the keynotes in psychotherapy. While in ordinary relationships you are subject to existing moral and ethical judgments, this does not happen in the unique kind of relationship during psychotherapy. It may take you a while before you realize that the function of the therapist is not to judge or to criticize you, but rather to help you get well. The therapist actually does not regard your attitudes, your impulses, and your experiences as bad or wrong, but rather as items that yield clues about your basic conflicts and difficulties. An example may make this clear. If you were to visit a friend and tell that person that you had, prior to seeing him or her, an impulse to murder someone, your friend

might express horror and even be tempted to call the police. If you were to say the same thing to your therapist, the therapist would neither condemn nor condone your thoughts but merely inquire about the reasons why you felt inclined to act as you did. This example is grossly exaggerated to indicate to you the difference between a relationship with your therapist and any other relationship you have ever had. It is important to reveal as much about yourself to your therapist as you can, and your confidences will not be betrayed.

68. *Pt. Why does a therapist act so unemotional?*

Th. Psychotherapy involves participation on the part of the patient in arriving at the sources of a problem as well as in resolving it. To inspire the patient toward activity, the therapist may assume a passive role, guiding the patient only when the patient becomes blocked in thinking things through. Actually, the therapist is not so much detached but rather is purposefully withholding from carrying the chief responsibility for therapy, which, while temporarily reassuring to the patient, would ultimately hamper the patient in the quest for assertiveness and independence.

69. *Pt. Will my therapist tell me what to do and how I can best conduct my life?*

Th. Understandably you would want such guidance since life now seems to be so frustrating and difficult. When it is absolutely necessary, your therapist will help you decide on alternative courses of action. However, the primary object in therapy is to help you achieve a level of growth and development such that your own choices and decisions will bring happiness to you rather than grief. To do this, your therapist will have to help you understand what is behind your problems and the reasons it has been difficult for you to conduct your own life. You will also have to achieve a level of development in which you can make your own decisions rather than depend on others. In this way you will attain the most active and satisfying growth.

70. *Pt. Are there any rules I must follow in therapy about making crucial decisions that will alter my life situation ?*

Th. There are several rules. It is essential to understand that in the treatment process many aspects of your life will come up for review. It is important, therefore, not to make any crucial decisions or changes until the meaning of such a choice is fully understood. If you contemplate any significant alteration in your position or life situation, it is essential to talk it over with your therapist first to make sure that you are not being influenced by temporary emotional feelings stirred up during treatment.

71. *Pt. Is it all right for me to see my therapist socially?*

Th. One of the basic rules in therapy is that the relationship between patient and therapist be kept on a professional basis. This is extremely important inasmuch as you have a specific task to achieve in your treatment, and this task may be watered down by associations such as may occur in a nonprofessional relationship. Experience shows that treatments proceed most rapidly where the relationship is kept on a purely professional level. A social relationship with your therapist may create many stumbling blocks in your treatment that may actually destroy its effectiveness.

72. *Pt. How many times a week must I come for treatment?*

Th. There are some persons who come once a week and there are others who desire, or find it necessary, to come 2 or 3 or 4 times a week. Sometimes it is better to come more frequently than once a week to cut down the interval between visits and to gain the advantages of more concentrated work. At other times this is unnecessary. The frequency will depend upon the nature of your problems and the kind of therapy that is used. In most cases treatments can be administered on the basis of once, twice, or three times weekly. When Freudian psychoanalysis is used (that is, where your problems are such that your therapist believes a formal psychoanalytic technique is indispensable for you), you may have to come as frequently as five times weekly.

73. *Pt. Aren't charges for psychotherapy excessive?*

Th. It takes longer to make a good psychotherapist than a good surgeon. Fees for surgery and other specialities are so much higher than fees charged for psychotherapy that we cannot even make a comparison. Although the fees that are charged may seem high, they actually are reasonable considering the extensive training of the therapist.

74. *Pt. After starting therapy, will I be charged for broken or canceled appointments?*

Th. Since your appointment times are set aside and reserved exclusively for your use, you may be charged for a canceled or broken appointment, unless illness or a real emergency interferes with your getting to the therapist's office. Most therapists do not charge for canceled appointments when sufficient notice has been given them in advance so that they can fill in the session with another appointment. Another reason for charging for broken appointments is to overcome resistance to coming for treatment when basic problems are under discussion. As a general rule, group therapy sessions are charged for whatever the reason for canceling them.

75. *Pt. How long does it take to get well?*

Th. It is hard to estimate this. Much depends on how much you want to get well. Much depends, also, on how deeply it is necessary to influence your basic personality makeup. If you have a special problem or symptom that is not too complicated, this may be helped in not too long a time. If, however, extensive changes in your personality are required, treatment will take more time.

76. *Pt. Does it usually take a long time to influence personality in depth?*

Th. Emotional illness associated with personality problems that go far back in one's life, so as to produce habit patterns of a stubborn nature, take a long time to influence, sometimes 2, 3, or more years. It is impossible to estimate the length of therapy since this will depend upon the severity of the problems and upon the goals one wishes to achieve. In many cases alterations achieved in a short period of treatment will continue after treatment has stopped as a person puts into action things that have been learned.

77. *Pt. I would like to expedite my treatment.*

> *Th.* Your impatience is understandable. But your trouble did not begin last Tuesday. It may have been with you most of your life. It took time to develop your problem, and it may take a little time for you to get over it.

78. *Pt. Why does it take so long to get well?*

> *Th.* If you are like the average person who undergoes psychotherapy, you will probably be puzzled or upset when, after several weeks of treatment certain kinds of problems are not materially improved. You will wonder why this is so, and you may even believe that your treatment is not successful. There are two things you must consider in evaluating your progress. First, certain emotional problems go far back in one's life, even as far back as one's childhood. Therefore, it takes time to get to the core of the trouble. Second, even though your symptoms are still with you, progress is being made nevertheless. Before a seed can sprout, it is necessary to prepare the soil. Before all your symptoms disappear and you achieve health, it is necessary to work at and overcome resistances that block your progress. Often an understanding of oneself helps.

79. *Pt. Why do I need an understanding of myself?*

> *Th.* The first step in becoming well is to become aware of your basic problems—in other words to identify them. Your difficulty may be that your environment is bad and you are trying to adjust to an impossible situation; or it may be that you have inner conflicts and fears that make for difficulties in your relationships with people. Whatever your problem, your therapist will help you to understand it clearly. Then you will be better able to do something constructive about it. It is hard to fight an enemy who attacks you from ambush. It is the same with emotional conflicts. As long as these are only partially known to you, you are helpless. Becoming aware of them makes it possible to take a stand to overcome them.

80. *Pt. Is it possible that I may exhibit resistances to understanding myself?*

> *Th.* There is always resistance in tackling the real source of one's difficulties. The reason for this is threefold. First, a person may have absolutely no inkling that what he or she is doing is not normal. For instance, an individual who has acted submissive from childhood may do so because it is the only way the person knows of getting along with people. It may cause the individual anxiety, yet it constitutes the only way of life the person knows. It may take a long time before the person realizes that he or she does not have to be submissive automatically. Second, a person may be very reluctant to face inner conflicts because of a fear that he or she will find out something that is too horrible to face. This fear is universal and it may take a while before the patient overcomes it. Third, one may actually derive a benefit from being sick and for this reason be unwilling to explore existing difficulties. It may seem paradoxical, but being sick often yields dividends one may refuse to give up. An example of this is the person who keeps failing in work or studies and, as a result, becomes extremely insecure. On the surface the person wants to stop failing; yet deep down what is desired even more is sympathy and help from people. And the reason for this failure is that in failing, the person can be dependent on others. Such a person may be resistive to understanding these tendencies toward failure because it requires giving up a technique that yields many neurotic benefits.

81. *Pt. After I get an understanding of my problems, what else do I have to do to get well?*

Th. Getting insight into certain kinds of problems is the first step toward getting well. You must use this insight to achieve a more productive and happier life. An example may make this clear. Suppose you desire to fly an airplane. The first thing you need is the vehicle—the airplane itself. But having procured the airplane does not mean that you can fly. You still have to learn how to work the airplane. Insight is the vehicle that can transport you to health. But having insight alone will not give you health. You must learn how to use this insight toward a constructive end.

82. *Pt. What can I do to aid the process of recovery?*

Th. Most people are confused about what is supposed to happen in treatment. In a physical ailment, once the doctor knows your complaint, he or she can give you a medicine. But emotional complaints are not helped in that way. *You, yourself, must participate in the cure.* Your therapist will help you to help yourself. One of the best ways to cooperate is to tell your therapist about yourself—your fears, your hopes, your fantasies, and your expectations. If you have any dreams, report them. You will probably also have certain feelings about your therapist. Bring these to the therapist's attention—no matter how irrational they may seem.

83. *Pt. Can I expect to have ups and downs during treatment?*

Th. You can. A feature of all nervous problems is that they try to repeat themselves. Even when you gain insight into them and begin to readjust yourself to life and to people, they will still crop up from time to time. The reason for this is that they are like bad habits. You know how difficult it is to break so simple a habit as excessive smoking. Faulty patterns of living that are part of your neurosis are complicated habits of long standing and will try to cling to you stubbornly. With patience and determination you can overcome these patterns. The important thing is not to regard a recurrence of your symptoms during treatment as a setback. Take the attitude that temporary flair-ups are to be expected and that you will learn something valuable about yourself each time they occur.

84. *Pt. Need I have conflicting feelings about my therapist?*

Th. Some persons do; some don't. In a relationship situation, which is the essence of psychotherapy, it is possible that you may run the entire gamut of emotions in response to your therapist. The experiencing of these emotions is an invaluable part of the treatment process. Do not be ashamed to tell your therapist exactly how you feel about him or her, no matter how irrational your feelings, demands, or expectations may seem. At certain stages in treatment you will be very much tempted to discontinue therapy because of how you feel about your therapist. Sometimes these feelings may not even be conscious. Consequently, whenever you reach a decision to stop treatment before your therapist thinks that treatment should be ended, examine how you feel toward the therapist and, more important, mention these feelings. There are times, of course, when you may become angry at your therapist for realistic reasons. It is also possible that your therapist has a personality to which you are unable to respond. In the latter instance it may be necessary for you to change therapists. Do not hesitate to tell your therapist about these feelings and

to mention any complaints you may have. The therapist will help you analyze whether your feelings are rational or irrational.

85. *Pt. Is it advisable to talk things over with people other than my therapist?*

Th. It is generally not wise to confide your innermost thoughts to other people because it may prevent you from mentioning important things to your therapist.

86. *Pt. Is it all right to talk about what happens in my treatment to other people?*

Th. No, this is not advisable since an outside confidant may hurt the therapeutic work. You should consider the therapeutic relationship a completely private situation, in which confidences will not be betrayed.

87. *Pt. Doctor, do you really believe I can be helped?* [To tell the patient that help is a certainty would be false reassurance. The therapist may reply in the following way.]

Th. The desire to be helped is nine-tenths of the battle. If you really want help, you will probably be able to be helped.

88. *Pt. What do you think it is that has made me sick?*

Th. There are always reasons why you feel upset. Those reasons may not be clear to you because you are living too close to your troubles. During therapy your ideas, and particularly your feelings, will be explored and, in not too long a time, you should discover what is behind your difficulty.

89. *Pt. In psychotherapy how can you get well by mere conversations?*

Th. In discussing your reactions, your ideas, and your feelings, you will better be able to understand what is happening to you, and this understanding will permit you to take definite steps to correct your difficulties.

90. *Pt. What will my therapist do to help me if all I do is talk about myself?*

Th. The therapist will help you with your difficulty by acting as your third eye or third ear. Since you are living so close to your problem, you may not be able to see your basic troubles as clearly as someone who can be more objective and more realistic about what is happening to you.

91. *Pt. How can I be sure I can be helped through psychotherapy?*

Th. There is no guarantee that you can, except insofar as you make a positive effort to cooperate with your therapist. In a short time you will get a better idea about whether you can be helped or not. Most people can.

92. *Pt. Are you sure I can be cured if I cooperate?*

> *Th.* It is difficult to answer that. Much depends on how much you want to be cured. If you really have the desire to get well, there is no reason why you should not make good progress. Many persons with severely disabling emotional and mental problems have gotten well. Your progress will depend also on how well you work together with your therapist as a team.

93. *Pt. Won't I lose my independence and get dependent on my therapist?*

> *Th.* One of the aims of treatment is to expand your independence and make you less dependent.

94. *Pt. Won't I find out terrible and loathsome things about myself?*

> *Th.* The fear of finding out contemptible things about oneself is frightening to most people. In exploring your difficulty you may be surprised to find that things are not as horrible as you imagine. Indeed, you may discover that your guilt feelings are not justified by the facts.

95. *Pt. How well is a person after completing psychotherapy?*

> *Th.* If treatment is successful, the person should be relatively free from symptoms and healthier and happier than ever before.

96. *Pt. Why shouldn't treatment always be successful?*

> *Th.* Success depends on many factors, including how much the person wants to get well. If a person really desires health, he or she will be willing to endure the time and effort required to get well.

97. *Pt. Is it possible to rebuild an immature personality through psychotherapy?*

> *Th.* In reconstructive psychotherapy a prominent goal is resolving blocks to personality development so that the individual may proceed to emotional maturity.

98. *Pt. If a person is cured of symptoms and is made happier by psychotherapy, does this mean the person will never again be nervous?*

> *Th.* No, neurotic problems may develop later, but the person will be better able to cope with them and even to solve them without further professional help.

99. *Pt. What happens to the information about me?*

> *Th.* In scientific work, records are necessary because they permit a more thorough dealing with one's problems. It is understandable that you might be concerned about what happens to the information about you because much or all of this information is highly personal. Case records are confidential. No outsider, not even your closest relative or family physician, should be permitted to see your file without your written permission.

100. *Pt. How can I help to cooperate with the treatment plan?*

> *Th.* The general practitioner has medications; the surgeon works with instruments; the heart specialist has delicate recording apparatus. But for the most part, the therapist has only one aid besides knowledge—YOU. Your cooperation and trust in the therapist are essential. You must feel free to take up with your therapist anything about the treatment process that disturbs you or puzzles you in any way. By doing this you have the best chance of shortening your treatment and of ensuring its fullest success.

35
Establishing a Working Relationship

One great disappointment to the beginning psychotherapist is that painstaking and elaborate exploration of a patient's problem and a most thorough endeavor to reinforce constructive behavior may fail to influence the emotional ailment in the least. Even though the therapist seemingly has an understanding of the patient's difficulties and of the contingencies that aggravate them, the patient continues to suffer symptomatically, and there is no abatement in the distorted way that the patient relates to people. The therapist, as a consequence, may become frustrated and perhaps dismiss the patient from treatment on the basis of "unsuitability," or "severe resistance," or "negative therapeutic reactions," or "latent schizoid tendency."

When the causes of such treatment failures are explored, it is often found that the patient has been unable to take advantage of the benefits of therapy because of anxiety or because of the refusal to make any effort on the basis of an infantile magical expectancy. This militates against evolving more effective ways of adjusting to new modes of behavior by therapy. Further investigation usually shows that what is basically lacking in the therapeutic situation, and what probably has been missing from the inception of therapy, is the proper kind of working relationship between the patient and the therapist. This relationship ideally is a unique interpersonal experience in which the patient feels a quality of warmth, trust, acceptance, and understanding such as he or she has never before encountered with any human being. Patients who have in the past established mature, unambivalent associations with people are usually capable of developing working relationships with most therapists. Those whose contacts have been characteristically disturbed will require therapists who are skilled, experienced, and truly able to deal with transference distortions and their own countertransference (Kernberg et al., 1972).

A neurosis imposes on the individual distortions in the individual's sense of values that undermine security, depreciate self-esteem, and make the average pursuits of living

vapid and meaningless. Before any significant change can occur in the system of neurotic balances and counterbalances that has been erected, it is necessary to win the patient over to a willingness to experiment with a new way of life.

The cultivation of the proper working relationship between patient and therapist is indeed the primary objective of the first treatment phase. Without a working relationship the patient will not resolve basic resistance to the meaningful resolution of problems.

In some cases a working relationship develops as a projection of the patient's need for an idealized authority. In other cases the therapist will have to work hard at securing rapport. To illustrate, we shall consider an example from the sales field. In selling a product the salesperson is confronted with the universal phenomenon of sales resistance. Experience has taught that any attempt to force the product on the customer before this resistance is overcome will be futile. The salesperson has learned that the best way of resolving sales resistance is to sell oneself to the prospect. Once the prospect has developed confidence in the acumen and integrity of the salesperson, the prospect is more prone to accept any statements that the latter makes about the advantages of the product.

Although the therapist is not a salesperson who is trying to sell the patient a product in the form of a new way of life, there is still the problem of resistance even though the patient may seem eager to get well. Such resistance is often fashioned by a desire to maintain the status quo and yet rid oneself of suffering. The patient must be persuaded to accept conditions that will lead to health in the face of his or her resistance. To do this, the therapist must first win the patient's trust and confidence by establishing a working relationship. The relationship hopefully will enable the patient to overcome initial reluctance to face his or her problems and work toward rehabilitation. Without this the therapist may not be able to achieve the therapeutic goal, whether it be symptom relief, problem solving, restoration of a shattered sense of self-mastery, elimination of destructive feelings and attitudes, acquisition of a healthier feeling about oneself and one's past experiences, or achievement of more adaptive interpersonal relationships.

In reconstructive therapy, until a working relationship is constituted, the patient will

be particularly unable to handle anxieties associated with unconscious conflict, investigate genetic origins, resolve archaic defenses, challenge the spurious pleasure values of the neurosis, or develop more constructive modes of adjustment.

VARYING NEEDS OF THE PATIENT

Militating against the establishing of a working relationship is the fact that the patient always seeks to use therapy in a variety of ways, some of which are inimical to good rapport. Thus, the patient may desire dependence on the therapist to receive guidance, reassurance, and other bounties. The patient may search for unqualified sympathy and acceptance. The patient may seek factual understanding and objectivity to help evaluate his or her thinking and behavior patterns. The patient may want to express feelings that are turbulent and to act out impulses, demands, and other strivings customarily held in check. Finally, the patient may yearn for a cooperative give-and-take relationship without domineering or being domineered. Not only must the therapist be equipped, by virtue of personality makeup, to accept the patient's varied strivings but must be able to react to them in a therapeutic manner. The therapist must provide the patient with an experience that will act as a prototype of a different kind of human relationship—one that inspires new and constructive attitudes toward people. To do this, the therapist must deal with the constituents of each of the patient's needs.

The Need to Be Dependent

Because the emotionally ill person usually feels helpless, he or she wants a kindly agency to relieve distress, to give support and guidance, and to restore health. These regressive needs, conspicuous in many patients, are most extreme in those who are severely sick. It is impossible for the therapist to escape fulfilling some measure of dependency need. While the therapist may not wish to perpetuate the infantilism of the patient by playing the part of a "giving" authority, except perhaps in supportive therapy, this may temporarily have to be accepted without resentment, fear, detachment, or aggression. Astuteness will be required in diagnosing how much active help the patient

needs, matching the support given to the severity of the sickness, and imposing on the patient as much responsibility as can be tolerated. The therapist must know when to resist dependency demands and how to convince the patient that their fulfillment may interfere with the patient's capacities to develop assertiveness, strength, and independence.

The Need for Unqualified Understanding, Acceptance, and Condonation

Such yearnings are part of the social nature of a human being. They may be especially urgent in the emotionally sick individual who constantly anticipates rejection and condemnation. In response to the patient's need for understanding and acceptance, it is essential that the therapist be capable of empathizing with the patient, of giving warmth and understanding no matter how destructive and disturbed the patient may be. At the same time, the therapist must avoid overprotecting and smothering the patient with cloying kindness, which will tend to rob the patient of self-sufficiency. Any personality characteristics in the therapist, like detachment or hostility, that interfere with this empathic ability to feel and to communicate warmth will constitute insurmountable handicaps to the establishing of a relationship.

The Need to Relieve oneself of Painful Feelings and Ideas

The desire to unburden oneself of guilt, fear, and anxiety will often be overwhelming for the patient. Ventilation of suppressed and repressed feelings, attitudes, and past experiences is usually accompanied by immediate but temporary relief. The therapist must be able to endure cathartic outbursts of painful emotion that are delivered by the patient, displaying a non-judgmental, objective attitude, neither condemning nor sanctioning the behavior of the patient. Since some of the material divulged may be of an immoral or antisocial nature, the therapist must be able to handle personal untoward feelings that are inspired by such destructive and perverse recitations, avoiding rebuke and other culturally accepted responses to the material.

The Need for Factual Understanding

The patient always has a need for an understanding of what is happening to him or her in order to neutralize fears of the unknown. This requires objectivity on the part of the therapist. The ability of the therapist to remain objective helps to inculcate in the patient a factual appreciation of the existing problem in relation to inner beliefs and external reality. Essential is a good understanding in the therapist of human dynamics, interviewing techniques, methods of bringing to the awareness of the individual the meaning of the individual's behavior, and helping the patient work through resistance to insight and to the translation of insight into action. This knowledge must be tempered in the therapist with intelligent self-awareness to avoid contaminating the patient with personal prejudices and to allow the patient to develop a personal sense of values.

The Need for a Transference Relationship

Many patients seek media in which they can project and act out tendencies and feelings that relate to actual or idealized parental personages. The projection of attitudes and feelings that originate in past relationships (transference) requires for its appropriate handling an understanding of this phenomenon by the therapist as well as the ability to perceive, use, and manage manifestations of countertransference. The therapist must be able to manage any intense dependency needs, sexual demands, hostilities, and manifold misinterpretations that will be expressed by the patient in the course of therapy.

One of the fallacies in practice is the idea that it is possible to resolve past parental deprivations that have acted as the basis for the patient's psychopathology by supplying remedial nurturing or unconditioned love within the therapeutic situation or by encouraging the patient to indulge and gratify infantile need deficits. Sandor Ferenczi's original and failed attempts to put this principle into practice has not discouraged some therapists from repeating his disappointing experiments (Ferenczi 1950a, b, & c). A host of reparative procedures have evolved, ranging from open expressions of praise and affection to holding the patient on one's lap, bottle feeding, stroking, and using other physically soothing maneuvers. The result of these efforts, though temporarily reassuring, have failed miserably to relieve patients' pathology. Early deprivations and parental

malfeasance are so structuralized and stabilized by defenses within the intrapsychic organization that they defy alteration through environmental manipulation. Indeed, attempts to unsettle the neurotic equilibrium may threaten repressive mechanisms that have enabled the individual to function up to this time, albeit with neurotic safeguards, precipitating strong anxiety. The defenses that protect against anxiety and maintain the patient's illness yield slowly, and only as the rigid internalized object representations change their fearsome and punishing quality through constructive cognitive alterations and congenial sustained interpersonal relationships. Translated into clinical practice, this means that the therapeutic encounter, though empathic and understanding, avoids cloying, intimate parenting. It should be intellectually and emotionally appropriate to the patient's present age, not regressively patterned to some presumed past age level, however much the patient may want to live at this level. This does not preclude role playing and revival of past traumatic memories through psychodrama, narcosynthesis, or hypnotic regression and revivification, when such techniques are deemed essential to loosen repression. But the basic patient-therapist relationship should be reality, rather than phantasy, oriented.

The therapist's capacity to display warmth and to remain tolerant and yet firm and objective in the face of transference must be coordinated with skill in minimizing the intensity of transference and of working it through toward the objective of self-understanding such that it does not interfere with treatment objectives.

The Need for a Cooperative Human Relationship

Irrespective of how distorted previous relationships with people have been, the individual earnestly desires a wholesome relationship bereft of neurotic encumbrances. The effective management of the myriad demands of the patient will help to fulfill this basic need for a cooperative human relationship.

MULTIPLE ROLES OF THE THERAPIST

What then is a psychotherapist? A doctor who heals. A friend who consoles. An

authority who guides. A teacher who educates. A catalyst who accelerates growth. These and other pursuits constitute the tasks of the creative professional.

Therapists may show different responses to patients with varied personality constellations. For instance, one may be able to express warmth and to remain remarkably objective toward submissive and dependent persons, while being totally unable to express therapeutically constructive feelings when in contact with domineering or hostile patients. Understandably, the more thoroughly therapists have worked through their own personal problems, and the greater awareness they have of their own relationship difficulties, the more flexible each will be in responding to a variety of patients. Therapists who have little awareness of interpersonal difficulties will find therapeutic effectiveness circumscribed to those patients with whom they can feel most comfortable.

In order to express his or her diverse needs, the patient usually strives to force the therapist into multiple impersonations, namely, the following:

1. A helping authority

2. An idealized parental image

3. An actual parental representative

4. A representative of other important past personages

5. A cooperative partner

The Therapist as a Helping Authority

The traditional patient-doctor relationship is that of the therapist as a helping authority. As an expert, the therapist is credited with knowledge and skills that can help the patient out of the patient's dilemma. The therapist succeeds or fails in this role in accordance with the degree of manifest skillfulness and the patient's interpretation of the therapist's maneuvers.

The Therapist as an Idealized Parental Image

The patient seeks an idealized parental figure who will grant bounties without stint. The character of this giving image varies with the personal biases of the patient. It ranges from omniscience and omnipotence to mere kindliness and acceptance. Often there is combined in the fantasy image a fusion of ideal paternal and maternal qualities. Accordingly, the patient may desire paternal firmness, strength, wisdom, and power as well as maternal lovingness, support, and protection. The intensity of such attitudes as well as their specific content, will be determined by the kinds of early frustrations experienced by the patient. These attitudes will be enhanced if the therapist seems to be the sort of individual who fits the patient's designs. It will be minimized by the therapist's refusal or inability to play this role.

The Therapist as an Actual Parental Representative

On the basis of previous experience, the patient may project into the therapeutic situation expectations of being treated by the therapist as the patient had previously been treated by his or her parents. The patient will then adopt defenses against the therapist in accordance with these expectations and fears. Under certain circumstances the patient will even act out with the therapist a rather extensive series of situations representative of those that the patient experienced as a child. Such transference attitudes will be reinforced by a passive attitude on the part of the therapist or by the therapist's actually playing the kind of role with the patient that parallels the role of the parent. Transference will also be expedited by the use of certain techniques, such as the couch position, concentration on dreams, the use of free association, frequent visits, and a focusing on the past history and on conditionings in childhood. It will be minimized by the therapist's increased activity with the patient, the playing of a role opposite to that anticipated by the patient, infrequent visits, the use of the face-to-face position, the avoidance of dreams, fantasies, and free association, and a focusing on the current life situation and present relationships.

The Therapist as a Representative of Other Important Past Personages

The therapist may be employed as an object onto whom transference attitudes may

be projected related to other important individuals besides the parents. The therapist may, for instance, be identified with a sibling, an important relative, a teacher, or a friend who has played a signal part in the early life of the patient. The therapist's manner, behavior, and physical appearance may expedite the display of such attitudes.

The Therapist as a Cooperative Partner

The therapist may be regarded as an individual with whom the patient is able to establish a friendly, unambivalent relationship. The patient probably desperately seeks such a relationship, but, on the basis of previous conditionings, may feel that it cannot possibly come to fruition. An objective attitude on the part of the therapist sponsors this kind of relationship.

A blend of several of the above attitudes toward the therapist is usually present at the beginning of treatment. Conflict is inevitable by virtue of the mutual contradictory nature of such disparate attitudes. Which attitudes will prevail will depend on both their intensity and how they are handled by the therapist. It is important that the therapist be equipped by training and experience to recognize and to deal with the patient's multiple strivings so that a cooperative working relationship may eventually develop.

RESISTANCES TO A WORKING RELATIONSHIP

The length of time required to establish a working relationship will depend upon the skill of the therapist and also on the intensity of resistance exhibited by the patient. Among common resistances are defects in motivation and misconceptions about psychotherapy. Ways of handling such obstacles have been suggested in Chapter 32 "The Initial Interview: Dealing with Inadequate Motivation" and Chapter 34 "Answering Questions Patients Ask About Therapy." Even more important as a source of resistance are character problems that are parcels of the patient's habitually disturbed attitudes toward people.

Perhaps the most obstinate of these characterological, resistances is a clinging,

dependent attitude toward the therapist, who is overvalued as the embodiment of all that is good and strong and noble in the universe. This kind of striving is rooted in an intense feeling of helplessness, escape from which is sought in an alliance with a being who can in some magical way lead the person onto paths of health, glory, and accomplishment. Building this being into a power figure who can satisfy one's magical expectations, and allying oneself with the object of one's creation, provides a spurious sense of security and heightened self-esteem.

The patient must be weaned from the attitude toward the therapist as an omniscient personage who can produce a fanciful Nirvana in which all needs are gratified. It is important to convince the patient of his or her own abilities and strengths.

Although recognizing and accepting a patient's dependency need and refraining from insisting on a completely mature relationship, the therapist may give the patient a rational reason for refusing to take the bulk of responsibility and making godlike decisions for the patient. The therapist, in exhibiting an understanding of the patient's need, may explain that supplying the patient's demands will inhibit the patient's self-growth and that it is out of respect for the patient's growth potentials that the therapist is not more active. Such an explanation may help resolve some of the hostility at what the patient otherwise might consider negligence and rejection.

Another unfavorable form of relationship is fear of the therapist as a potentially destructive or malevolent being who threatens to injure or to engulf the patient by interfering with the patient's autonomy. Here the patient retreats whenever the patient feels the therapist is getting too close. A "testing period" precedes a final acceptance of the therapist as one who bears only good will toward the patient. During this period the patient will be torn between a desire to establish a gratifying relationship and an overpowering fear of injury. The outward manifestation of this struggle may be hostility to the therapist. Some patients may even attempt to provoke and to incite the therapist into acts of aggression to prove to themselves that all human beings are alike and are not to be trusted. This "testing period" will be especially prolonged in patients with immature

personality structures, and it may be many months before the therapist is accepted as a friend.

Because of hostility, fear, and guilt, the patient may automatically expect the therapist to be condemning, prohibiting, or punishing for past behavior as well as for present attitudes and impulses. The patient may, therefore, display fear, distrust, or rage toward the therapist as well as defenses against these emotions. When fragmentary revelations of the patient's inner life fail to bring forth the expected punishment or condemnation, the patient may feel contempt for the therapist for failing to respond as a strong authority should respond and may evidence a desire for a more competent—more punitive—therapist.

The patient will usually anticipate criticism from the therapist as merciless as the patient's self-criticism. Furthermore, while the patient has managed to conceal from people personal elements that he or she considers vicious or contemptible, it is difficult to do this with the therapist. The patient will, therefore, constantly anticipate attack or condemnation and will be nonplussed when attack is not forthcoming. The patient may await the evil day when the expected blow will fall or may even become resentful at the delay of the "inevitable." As the patient recognizes that he or she can speak freely and that the therapist considers such revelations as neither good nor bad, the patient may begin to reevaluate concepts of the therapist as an arbitrary authority. A feeling of warmth emerges that is mingled with confidence.

Other strivings in the patient that interfere with a good working relationship are intense sexual feelings toward the therapist, submissiveness, masochistic impulses, and detachment. The handling of a patient's detachment is of particular importance because of its prevalence as a defensive character pattern. With perseverance and tolerance, detached individuals may eventually be helped to enter a working relationship.

For example, a woman with a personality disorder of detachment comes to treatment because of depression, tension, and feelings of lonesomeness and isolation. She is aware of the fact that close relationships fill her with a sense of foreboding and that

soon after a relationship has started, she becomes anxious and wants to run away. In therapy, as she develops confidence in the therapist, the same kind of anxiety and terror emerges, and the patient is seized with an impulse to stop treatment. Her respect for the therapist, however, and her incentive to get well halt the escape. Manifesting warmth, acceptance, and understanding, the therapist interprets what is happening. From a dream in which she crosses a bridge and becomes the target of sharpshooting snipers, the patient learns of her fears of attack in a confining relationship. She recognizes that this fear has been with her for years—as far back as she can remember—and has created the impulse to escape from entangling alliances and even from the threat of coming close to a person. This knowledge enables her to discriminate her feelings in relationship to the new kind of authority that she has perceived in the therapist, to test her anachronistic fears of hurt against her knowledge that the therapist does not desire to injure her. She then veers in her struggle between her old conviction and her new. Temptation to break away from treatment is compelling, but the therapist forestalls escape by pertinent interpretations. Eventually, perhaps for the first time, the patient is capable of accepting a person, the therapist, as a friend rather than a foe. She takes a bold step toward a working relationship.

In helping a patient master fears of a working relationship, the therapist must allow the patient to set the pace. The therapist must respect the patient's hesitation and other defensive mechanisms issuing from the patient's terror of discovering the same destructive potentialities in the therapist that the patient has found in other human beings. The realization of a different type of authority permits the patient to abandon compromising facades that have up to this time served unsatisfactorily to keep anxiety in check.

BUILDING THE RELATIONSHIP

Skill as a therapist is measured to a considerable degree by the ability to establish relationships with patients that will be therapeutically meaningful to them. While no one is capable of establishing rapport with all people, the therapist should, if equipped with

the proper training and personality, be able to relate to the majority of persons who come for help.

Knowledge of interviewing techniques will foster confidence in the therapist and expedite a working relationship. Thus, by appropriate facial expressions, gestures, and sub vocal utterances, the therapist may convey an attentive and accepting manner. By asking pointed questions, restating, summarizing, and other techniques, one may demonstrate to the patient that one is interested and observant. By reflecting feelings and making cautious interpretations geared to the level of the patient's current capacities for understanding, the therapist may exhibit an astuteness and perceptiveness about knowing what is going on in peripheral areas of the patient's awareness.

Specific personality problems of the therapist may, however, inhibit the establishing of such a relationship. For instance, an inability to tolerate hostility may make it difficult for the therapist to develop rapport with a patient who displays hostile outbursts. Or personal sexual problems may cause the therapist to respond with anxiety when the patient tells of sexual fears or impulses with which the therapist is preoccupied or is avoiding. The therapist may then fail to show the necessary warmth, objectivity, and empathy.

From time to time the therapist may experience emotions toward the patient that, if unchecked, may hurt the relationship. Hostility, boredom, apathy, uneasiness, fear, or sexual interest may be provoked by the patient's behavior or inspired by countertransference. Should such emotions emerge, self-searching will be indicated. The following self-directed questions are important:

1. Is the patient doing anything that causes these emotions?

2. Does the patient resemble or remind the therapist of anyone the therapist knows or has known in the past?

3. What does the therapist really feel about a person like the patient?

4. Does the therapist anticipate that the patient will do anything disturbing or

upsetting while in therapy?

Arriving at answers to these questions requires a great deal of self-exploration in an attempt to understand any projections that are operative. For example, a patient talks about his deep problems of intolerance with people. As the patient relates several episodes illustrating his intolerance, the therapist becomes aware of a personal feeling of boredom and of not wanting to pay attention to what the patient is saying. She asks herself why such attitudes exist toward the patient, and she suddenly realizes that she considers the patient an extremely hostile person. She recognizes then that she fears a demonstration by the patient of hostility toward her. Knowing of her own problem in handling hostility, the therapist realizes that her boredom is a defensive means of avoiding closer contact with the patient and thus of circumventing any expressed hostility. Challenging the reality of her fear, she finds that she is able to overcome the response of boredom, and she becomes attentive to the productions of the patient. Another therapist may, in feeling irritable with a patient, examine this emotion. In so doing he realizes that he has had similar feelings of irritability with a brother with whom he was competitive and whom the patient resembles slightly. This insight results in a dissipation of the emotion of irritability. A third therapist observes that she feels resentful during a session. Thereupon she notices that the patient is talking about material that is stirring up anxiety within her. Under these circumstances, she may be able to handle her anxiety directly and thus overcome her resentment.

Where the therapist is unable to control disturbed emotions and attitudes by processes of self-observation, in fairness to the patient a referral to another therapist should be made.

There are a number of things that the therapist can do to sponsor a working relationship. Among these are communicating to the patient an understanding of the patient's problem and expressing toward the patient tolerance, empathy, and objectivity.

Communicating an Understanding of the Problem

Every patient wants his or her therapist to be intelligent, sagacious, and perceptive. It is generally not difficult to convince the patient of the therapist's competence by such simple techniques as reflecting unverbalized feelings and attitudes, putting into words the unexpressed worries and concerns of the patient, and displaying sensitivity to the patient's moods and conflicts. Although the therapist is fallible, it is essential to try to avoid expressions of confusion, such as acting bewildered and forgetting important items of information about the patient. Since merely mortal, the therapist is bound to make mistakes sometimes, but these are not fatal if they do not occur too frequently, and if there is a fairly good relationship with the patient.

An excellent way of demonstrating an understanding of the patient's turmoil is available to the psychoanalytically trained therapist through dream interpretation. Dreams during the first phase of therapy are never interpreted deeply. Since dreams are condensations of a variety of items, including early traumatic experiences, basic conflicts, habitual mechanisms of defense, and present characterological strivings, it is usually easy to select from the dream the kind of content that will satisfy the goals of a particular phase of therapy. In the first phase of treatment important goals relate to a recognition of attitudes and impulses that act as resistance to a working relationship. For instance, a patient presents a dream in which he is traveling on a subway, sitting next to a man who is busily engaged in reading a newspaper. The patient tries to attract the man's attention, but all of his efforts are rebuffed. He finally gets up and leaves the train feeling humiliated.

In examining the dream, we observe the patient attempting to make contact with a man who, detached and disinterested, virtually rebuffs the patient. The dream may reflect a general fear in the patient of being rebuffed by people. We may speculate further that the patient is expressing in the dream a feeling that he is being rebuffed by the therapist. Riding on the subway would then indicate the therapeutic situation. These formulations are, naturally, not communicated to the patient. The method by which they are brought to his attention is illustrated in the fragment of the actual interview that follows:

> *Th.* What thoughts come to your mind as you think about the dream?

> *Pt.* Why nothing. I don't particularly like riding on the subway, but that's nothing. It's the quickest

way of getting any place.

Th. Mm hmm.

Pt. And when you're in a hurry it gets you there, *(pause)*

Th. Any other thoughts about a subway?

Pt. No.

Th. Now, how about your feelings in the dream: what were your feelings?

Pt. I was anxious to talk with him, make friends, you see, but he was one of these types of people who was busy with his own things.

Th. What type?

Pt. Well, I should say studious type, not interested in me.

Th. Now what about this man; did he resemble anybody you know or knew?

Pt. Yes, he was like an uncle of mine. He is not too much older than I am. When I was a kid, he used to bring me things. I called him my second father.

Th. Mm hmm.

Pt. And when I was in boarding school, one of my roommates reminded me of him. That was the one I had that homosexual experience with I told you about.

Th. Was there any sexual feeling in the dream?

Pt. No, just that I wanted to know this person better.

Th. And when he didn't respond, how did this make you feel?

Pt. Terrible. I wanted to get out of the train.

Th. Angry?

Pt. No, just irritated.

Th. Now it's possible that when a person isn't responsive enough and giving enough, this may make you want to get out of the situation.

Pt. Yes.

Th. And that might also apply to me. [*a tentative probing for transference*]

Pt. Why … (pause) why … I don't think I should feel that way.

Th. After all, there is no reason why you shouldn't. But have you felt this way about me?

Pt. As you said, I shouldn't expect you to do everything for me.

Th. But you may resent the fact that I don't take over more responsibility.

Pt. I know I shouldn't feel that way.

Th. But you *might* feel that way *(pause)*

Pt. (*laughs*) Well I do ... sometimes.

Th. And even want to leave treatment.

Pt. (*laughs*) I did feel that I wanted to quit.

Th. Like you wanted to get out of the subway train in the dream.

Pt. (*laughs*) Yes, you mean you could be the man on the subway? Come to think of it, I do think it's you.

Th. Do you want to stop therapy?

Pt. Of course not.

Th. Do you feel that I don't want to relate to you, that I don't pay attention to you, or like you?

Pt. Well, as you say, I must think that, but it isn't true.

After several weeks the patient exhibited evidences of greater security in the relationship. This was accompanied by a dream in which the patient saw himself trying to use a pencil that had no lead. A man nearby offered him a new pencil, which he accepted. The patient associated having "no lead in the pencil" to his vitiated masculinity. The man nearby was the therapist who was offering him new masculinity.

Communicating Interest

Showing interest in the patient as a person rather than as a laboratory of pathological phenomena is an important way of helping the relationship. By paying close attention to what the patient is saying about his or her personal life, ambitions, likes, dislikes, and goals, the therapist may indicate nonverbally that the patient is considered a worthwhile individual. Remembering and repeating to the patient personal details that

the patient revealed in previous sessions impresses the patient with the genuineness of the therapist's interest. Sometimes the greater part of a session may profitably be spent talking about the patient's work, hobbies, or other random subjects, not for the purpose of eliciting information but to show the therapist's interest. Making necessary financial and time allowances for the patient, and a demonstrated willingness to do what one can for the patient within the bounds of therapeutic propriety, are other manifestations of interest.

Damaging to the relationship are evidences of disinterest, such as forgetfulness about important details that the patient has previously mentioned, reading of one's mail during a session, telephoning in the patient's presence, and other shifts of attention.

The therapist's attitudes toward the patient will, of course, not be the same from day to day. On some occasions, when feeling happy, inspired, and active, one will be responsive, alert, and sensitive to what is going on in therapy. At other times, when feeling slightly depressed, dull, and inactive, one will find one's mind wandering and will be somewhat insensitive to nuances in the therapeutic situation. Sometimes one will be pleased with the patient. Occasionally one may be irritated, particularly when the patient is hostile, aggressive, or accusatory. These ups and downs need not interfere with the setting up of a working relationship, provided that the therapist likes the patient and manages to communicate adequate interest.

Communicating Tolerance and Acceptance

The average patient comes to therapy at the mercy of a medley of moods and attitudes. Helpless in the grip of symptoms that are difficult to control, unable to conceal the resulting turmoil, alternating between arrogance and self-devaluation, the patient may interpret coming to psychotherapy as an insignia of defeat. Yet there is hope that the therapist will somehow magically wipe out existing troubles. Many defenses are mobilized against progress such as minimizing the seriousness of the problems, denying the depth of one's illness, plaintive self-abasing, diffuse expressions of resentment, and masochistic submissiveness.

No matter how mature appearing, the patient will always project into therapy some childish demands, needs, and misinterpretations. In casual relationships the patient may have these under control and may be able to disguise them with various blinds. But the therapeutic relationship will activate suppressed and repressed emotional foci. The patient's usual stratagems will be revealed for what they are. It is for these reasons that consummate permissiveness and understanding must prevail in therapy, with absolute avoidance of indignation and moralistic judgment. If the therapist is able to treat the patient as an adult in spite of the patient's immature feelings, respecting the patient's needs to display childish emotions and strivings and accepting them temporarily as inevitable, the patient will best be helped to a more mature expression of feeling.

In dealing with the ambivalent emotions of the patient, the therapist must express as lenient understanding and acceptance as possible, neither condemning nor condoning the patient for drives and desires but accepting the patient's right to experience them in their current form. Irrespective of how provocative the patient may act, it is essential that the therapist control personal feelings. Some patients will subject the therapist to a barrage of hostility, accusations, and demands. To respond with counterhostility may prove fatal to the establishing of a relationship. Criticizing the patient for the inability to verbalize or to think clearly about himself or herself must also be avoided. The therapist must evade considering the patient's problems as "faults."

Other activities that sponsor convictions in the patient of the therapist's tolerant, non-punitive, nonjudgmental attitudes are attentiveness to everything the patient says, a calm and accepting facial expression, absence of irritability and emotional outbursts, and lack of expressed or implied condemnation or reproach. The continuing or stopping of therapy should be regarded as a choice of the patient, and the patient should be encouraged in the point of view that coming for treatment is predicated solely on his or her getting something positive out of the experience. Should the patient actually decide to discontinue treatment, this must be handled by the therapist as a manifestation of resistance.

Respect for the patient's defenses and resistances is another way of expressing tolerance. There may be the temptation to charge the patient's resistance to displays of ignorance or stubbornness. But if the therapist realizes that the patient is guarding against a flood of anxiety, it may be possible to display greater forbearance. The therapist must be content at the start of therapy to move at as slow or as rapid a pace as the patient's reactions dictate. There are times, nevertheless, when outrageous and destructive behavior go beyond one's capacities for complacency. Here discriminative confrontation, non-condemning challenges, and interpretation will be necessary.

Communicating Objectivity

Objectivity is insured by a non-punitive manner in the face of any attitudes, demands, or ideas expressed by the patient. A sense of humor, the ability to take criticism, and an unflagging respect for the patient are other traits that help establish the therapist's objectivity. In handling personal feelings, the therapist should keep in mind the fact that the attitudes of the patient are not necessarily permanent ones.

Acknowledging the patient's right to opinions, even though they may be faulty, helps to convince the patient that he or she is not dealing with a despot. Other ways of demonstrating one's objectivity are by abstaining from imposing on the patient one's personal opinions, philosophies, judgments, and values and by observing the patient's right to self-determination, once the patient has become cognizant of internal motives. At all costs the therapist should avoid situations that make the patient feel that the patient must yield to the bias of a superior authority. This does not mean that the therapist condones or encourages neurotic tendencies; the therapist merely tolerates them temporarily, as long as they do not interfere with the treatment process. Should they obstruct therapy, the therapist deals with them actively as manifestations of resistance.

Communicating Empathy

All people have the craving to be liked. Neurotic problems make them feel unloved and incapable of evoking sympathetic responses from others. Yet they long to be

appreciated in spite of their convictions of having no worth. By communicating empathy, the therapist attempts to convey to the patient a feeling that the patient's turmoil is understood. But communicating empathy presupposes that one *feels* empathic. There are no general rules about how to turn on such feelings. When interviewing a patient for the first time one may ask: (1) What is there about this person that I dislike—facial expression, manner of speaking (complaining, attacking, obsequiousness, pleading), content of communications, bodily movements, eyes, gait, aggressiveness? (2) What is there about this person that attracts me—physical appearance, manner, seductiveness?

Analyzing those reactions, one speculates how these may impair one's judgment, objectivity, and neutrality. The therapist may ask: "How would I feel if I had gone through what the patient has experienced, and if I were in the patient's situation now?"

Among the measures that may be employed toward this end are verbalizing for the patient how upset the patient must feel; elaborating on some of the obvious conscious conflicts that plague the patient, explaining why these may be disturbing; recognizing the patient's feelings and seeing things from the patient's point of view; being frank and sincere with the patient and accepting him or her in spite of any "bad" qualities that present; and expressing warmth, not in words, but by gestures, facial expressions, and other types of nonverbal behavior. Nothing is more damaging to the relationship than displaying a stilted, detached, and cold attitude toward the patient. Sometimes such an attitude is practiced by certain therapists in an effort to maintain anonymity. Usually this kind of behavior is interpreted by the patient as evidence of the therapist's unfeelingness.

The therapist must be able to extend support and reassurance to the patient when these are needed. Such measures are, of course, graded to the degree of shattering of the patient's adaptive powers and are not to be confused with domination or overprotection. A strong deterrent to the giving of necessary support is a fear in the therapist of making the patient dependent on the therapist. At the inception of therapy all patients are dependent to a greater or lesser degree, irrespective of the activity of the therapist. The dependency is not avoided by a detached attitude, nor does it necessarily become

hypertrophied by a display of interest or warmth.

Empathy must also be demonstrated when the patient manifests hostility. One way of handling undifferentiated hostile feelings is by accepting them as inevitable. A casual explanation such as the following may be very reassuring to the patient: "People who suffer a great deal may become resentful toward the world and toward themselves. You may be angry at the fact that you are suffering, or that you need help, or that you have to come to see me. You may be angry at me for various reasons. And this is to be expected." Further responses will be determined by the reactions of the patient to this explanation.

Once empathy is communicated, the patient may experience considerable relief or there may be an abatement of symptoms. This may be due to a certain measure of psychological appeasement or to a feeling in the patient that he or she no longer is alone and helpless. It may be due to a concomitant emotional unburdening or because of the reassurance gained through contact with the therapist. This improvement, sometimes called a "transference cure," is usually temporary, lasting as long as the relationship with the therapist yields important satisfactions. The improvement may continue indefinitely if coincidentally there is an amelioration of the stress-producing circumstance or if the patient has been able to master the stress situation in some way. This may be the sole goal in supportive therapy. In reeducative and reconstructive therapies, however, any relief achieved by this means is considered inadequate unless it is accompanied by more substantial behavioral changes.

Not all patients respond eagerly to a caring attitude evinced by the therapist. There are some, admittedly few, who prefer to work with a distant and impersonal therapist. But here we usually find that this need for a detached therapist is probably a defense against involvement, dependency, and being controlled, the analysis and working through of which may be highly productive. Being caring and empathic, however, does not justify overly supportive and smothering behavior.

It must be remembered that years of bitterness in the patient's human relationships may have eroded the patient's confidence in people in general. The therapist should,

therefore, not be disappointed if the patient does not immediately become a confidant. It is necessary to prove to the patient by demonstrating through actions that the therapist is worthy of acceptance and trust. This may take time, particularly with the sicker patients and those who have severe problems with authority. Whether the therapist is capable of demonstrating empathy toward all patients is another matter. There is no valve that one can turn on to permit the flow of this feeling. The best one may be able to do if there is little interest in the case is to examine one's feelings.

SUNDRY RULES' FOR BUILDING OF THE RELATIONSHIP

It is not necessary to employ special tricks to establish a good working relationship. This will be readily forthcoming if the therapist has the proper training and personality. There are a number of rules that may help build a relationship more rapidly, however. These are illustrated in the following group of "unsuitable" and "suitable" responses to sundry questions asked by patients.

1. *Avoid exclamations of surprise.*

>*Pt.* I never go out on a date without wanting to scream.

Unsuitable responses

>*Th.* Well, for heaven's sake!

>*Th.* That's awful!

>*Th.* Of all things to happen!

Suitable responses

>*Th. I wonder why?*

>*Th.* Scream?

>*Th.* There must be a reason for this.

2. *Avoid expressions of overconcern.*

Pt. I often feel as if I'm going to die.

Unsuitable responses

Th. Well, we'll have to do something about that right away.

Th. Why, you poor thing!

Th. Goodness, that's a horrible thing to go through.

Suitable responses

Th. That must be upsetting to you.

Th. Do you have any idea why?

Th. What brings on this feeling most commonly?

3. *Avoid moralistic judgments.*

Pt. I get an uncontrollable impulse to steal.

Unsuitable responses

Th. This can get you into a lot of trouble.

Th. You're going to have to put a stop to that.

Th. That's bad.

Suitable responses

Th. Do you have any idea of what's behind this impulse?

Th. How far back does this impulse go?

Th. How does that make you feel?

4. *Avoid being punitive under all circumstances.*

Pt. I don't think you are helping me at all.

Unsuitable responses

Th. Maybe we ought to stop therapy.

Th. That's because you aren't cooperating.

Th. If you don't do better, I'll have to stop seeing you.

Suitable responses

Th. Let's talk about that; what do you think is happening?

Th. Perhaps you feel I can't help you.

Th. Is there anything I am doing or fail to do that upsets you?

5. *Avoid criticizing the patient.*

Pt. I just refuse to bathe and get my hair fixed.

Unsuitable responses

Th. Are you aware of how unkempt you look?

Th. You just don't give a darn about yourself, do you?

Th. That's like cutting off your nose to spite your face.

Suitable responses

Th. There must be a reason why.

Th. Do you have any ideas about that?

Th. How does that make you feel?

6. *Avoid making false promises.*

Pt. Do you think I'll ever be normal?

Unsuitable responses

Th. Oh, sure, there's no question about that.

Th. In a short while, you're going to see a difference.

Th. I have great hopes for you.

Suitable responses

Th. A good deal will depend on how well we work together.

Th. You seem to have some doubts about that.

Th. Let's talk about what you mean by normal.

7. *Avoid personal references or boasting.*

Pt. My six-year-old child is balking at going to school. It annoys me.

Unsuitable responses

Th. I know exactly how you feel; I went through that myself with my youngster.

Th. I'd feel exactly the way you do under the circumstances.

Th. I'm glad you bring that up because I'm kind of an expert on managing problems of this kind.

Suitable responses

Th. Annoys you?

Th. Do you have any idea why your child is balking?

Th. It must be upsetting to you.

8. *Avoid threatening the patient.*

Pt. I don't think I can keep our next two appointments because I want to go to a concert on these days.

Unsuitable responses

Th. You don't seem to take your therapy seriously.

Th. If you think more of concerts than coming here, you might as well not come at all.

Th. Maybe you'd better start treatments with another therapist.

Suitable responses

Th. I wonder why the concerts seem more important than coming here.

Th. Maybe it's more pleasurable going to the concerts than coming here.

Th. What do you feel about coming here for therapy?

9. *Avoid burdening the patient with your own difficulties.*

Pt. You look very tired today.

Unsuitable responses

Th. Yes, I've been having plenty of trouble with sickness in my family.

Th. This sinus of mine is killing me.

Th. I just haven't been able to sleep lately.

Suitable responses

Th. I wouldn't be surprised, since I had to stay up late last night. But that shouldn't interfere with our session.

Th. I've had a touch of sinus, but it's not serious and shouldn't interfere with our session.

Th. That comes from keeping late hours with meetings and things. But that shouldn't interfere with our session.

10. *Avoid displays of impatience.*

Pt. I feel helpless and think I ought to end it all.

Unsuitable responses

Th. You better "snap out of it" soon.

Th. Well, that's a nice attitude, I must say.

Th. Maybe we had better end treatment right now.

Suitable responses

Th. I wonder what is behind this feeling.

Th. Perhaps there's another solution for your problems.

Th. You sound as if you think you're at the end of your rope.

11. *Avoid political or religious discussions.*

> *Pt.* Are you going to vote Republican or Democratic?

Unsuitable responses

> *Th.* Republican, of course; the country needs good government.

> *Th.* I'm a Democrat and would naturally vote Democratic.

Suitable responses

> *Th.* Which party do you think I will vote for?

> *Th.* Have you been wondering about me?

> *Th.* I wonder what you'd feel if I told you I was either Republican or Democrat. Would either make a difference to you?

> *Th.* I vote for whomever I think is the best person, irrespective of party, but why do you ask?

12. *Avoid arguing with the patient.*

> *Pt.* I refuse to budge an inch as far as my husband is concerned.

Unsuitable responses

> *Th.* It's unreasonable for you to act this way.

> *Th.* Don't you think you are acting selfishly?

> *Th.* How can you expect your husband to do anything for you if you don't do anything for him?

Suitable responses

> *Th.* You feel that there is no purpose in doing anything for him?

> *Th.* Perhaps you're afraid to give in to him?

> *Th.* How do you actually feel about your husband right now?

13. *Avoid ridiculing the patient.*

> *Pt.* There isn't much I can't do once I set my mind on it.

Unsuitable responses

> *Th.* You think a lot of yourself, don't you?

> *Th.* Maybe you exaggerate your abilities.

> *Th.* It sounds like you're boasting.

Suitable responses

> *Th.* That puts kind of a strain on you.

> *Th.* Have you set your mind on overcoming this emotional problem?

> *Th.* You feel pretty confident once your mind is made up.

14. *Avoid belittling the patient.*

> *Pt.* I am considered very intelligent.

Unsuitable responses

> *Th.* An opinion with which you undoubtedly concur.

> *Th.* The troubles you've gotten into don't sound intelligent to me.

> *Th.* Even a moron sometimes thinks he's intelligent.

Suitable responses

> *Th.* How do *you* feel about that?

> *Th.* That's all the more reason for working hard at your therapy.

> *Th.* That sounds as if *you* aren't sure of your intelligence.

15. *Avoid blaming the patient for his or her failures.*

> *Pt.* I again forgot to bring my doctor's report with me.

Unsuitable responses

> *Th.* Don't you think that's irresponsible?

Th. There you go again.

Th. When I tell you the report is important, I mean it.

Suitable responses

Th. I wonder why?

Th. Do you know why?

Th. Perhaps you don't want to bring it.

16. *Avoid rejecting the patient.*

Pt. I want you to like me better than any of your other patients.

Unsuitable responses

Th. Why should I?

Th. I don't play favorites.

Th. I simply don't like a person like you.

Suitable responses

Th. I wonder why you'd like to be preferred by me.

Th. Perhaps you'd feel more secure if I told you I liked you best.

Th. What *do* you think I feel about you?

17. *Avoid displays of intolerance.*

Pt. My wife got into another auto accident last week.

Unsuitable responses

Th. Those women drivers.

Th. Women are sometimes tough to live with.

Th. The female of the species is the more deadly of the two.

Suitable responses

> *Th.* How does that make you feel?

> *Th.* What do you think goes on?

> *Th.* How did you react when you got this news?

18. *Avoid dogmatic utterances.*

> *Pt.* I feel cold and detached in the presence of women.

Unsuitable responses

> *Th.* That's because you're afraid of women.

> *Th.* You must want to detach yourself.

> *Th.* You want to destroy women and have to protect yourself.

Suitable responses

> *Th.* That's interesting; why do you think you feel this way?

> *Th.* How far back does this go?

> *Th.* What feelings do you have when you are with women?

19. *Avoid premature deep interpretations.*

> *Pt.* I've told you what bothers me. Now what do you think is behind it all?

Unsuitable responses

> *Th.* Well, you seem to be a dependent person and want to collapse on a parent figure.

> *Th.* You've got an inferiority complex.

> *Th.* You never resolved your Oedipus complex.

Suitable responses

> *Th.* It will be necessary to find out more about the problem before I can offer a valid opinion of it.

Th. We'll continue to discuss your attitudes, ideas, and particularly your feelings, and before long we should discover what is behind your trouble.

Th. That's for us to work on together. If I gave you the answers, it wouldn't be of help to you.

20. *Avoid a dogmatic analysis of dreams.*

Pt. I had a dream the other day. I was sitting in the kitchen and food was being spilled on the floor by someone. When I tried to pick it up, someone kicked me in the face, and then I saw a man standing with a knife ready to stab me in the back.

Unsuitable responses

Th. This dream indicates fear of a homosexual attack.

Th. You must feel orally deprived.

Th. Your mother must have been a depriving woman.

Suitable responses

Th. What does this dream seem to indicate to you?

Th. What associations come to your mind?

Th. How did the dream make you feel?

21. *Avoid the probing of traumatic material when there is too great resistance.*

Pt. I just don't want to talk about sex.

Unsuitable responses

Th. You'll get nowhere by avoiding this.

Th. You must force yourself to talk about unpleasant things.

Th. What *about* your sex life?

Suitable responses

Th. It must be hard for you to talk about sex.

Th. All right, you can talk about anything else that you feel is important.

Th. Sex is always a painful subject to talk about.

22. *Avoid flattering and praising the patient.*

Pt. Do you like this dress?

Unsuitable responses

Th. You always show excellent taste in clothes.

Th. I think you make a very excellent appearance.

Th. Any man would find you attractive.

Suitable responses

Th. Yes, but why do you ask?

Th. Do *you* like it?

Th. Perhaps you wonder what I think of you?

23. *Avoid unnecessary reassurance.*

Pt. I think I'm the most terrible, ugly, weak, most contemptible person in the world.

Unsuitable responses

Th. That's silly. I think you're very good looking and a wonderful person in many ways.

Th. Take it from me, you are not.

Th. You are one of the nicest people I know.

Suitable responses

Th. Why do you think you feel that way?

Th. How does it make you feel to think that of yourself?

Th. Do others think the same way about you?

24. *Extend reassurance where really necessary.*

Pt. I feel I am going insane.

Unsuitable responses

Th. Maybe you are.

Th. Sometimes this happens even with treatment.

Th. If you do go insane, you still can be treated.

Suitable responses

Th. I find no evidence of insanity in you.

Th. The feeling of going insane is one of the most common symptoms in neurosis. Fortunately, it rarely happens.

Th. I wonder if you aren't really worried about what may happen to you in other ways too.

25. *Express openmindedness, even toward irrational attitudes.*

Pt. I think that all men are jerks.

Unsuitable responses

Th. That's a prejudiced attitude to hold.

Th. You ought to be more tolerant.

Th. With such attitudes, you'll get nowhere.

Suitable responses

Th. What makes you feel that way?

Th. Your experiences with men must have been disagreeable for you to have this feeling.

Th. Understandably you might feel this way right now, but there may be other ways of looking at the situation that may reveal themselves later on.

26. *Respect the right of the patient to express different values and preferences from yours.*

Pt. I don't like the pictures on your walls.

Unsuitable responses

> *Th.* Well, that's just too bad.

> *Th.* They are considered excellent pictures by those who know.

> *Th.* Maybe your taste will improve as we go on in therapy.

Suitable responses

> *Th.* Why?

> *Th.* What type of pictures do you like?

> *Th.* What do you think of me for having such pictures.

27. *Clarify the purpose of the interview as often as necessary.*

> *Pt.* But what am I supposed to do to get well?

Unsuitable responses

> *Th.* Well, you just let me take care of that.

> *Th.* Once you get confidence in me, you'll start getting well.

> *Th.* The more cooperative you are, the quicker you will get well.

Suitable responses

> *Th.* We will talk over your problems and your ideas about them. Things will then gradually clarify themselves, and you will get a better idea of what to do about your problems.

> *Th.* In discussing your reactions, your ideas, and your feelings, you will be better able to understand what is happening to you, and the understanding will permit you to take definite steps to correct your difficulty.

> *Th.* It may puzzle you as to how talking things over helps, but that is the way to understand yourself and your problems. When all the facts are known to you, the solution to your troubles will become clearer.

28. *Make sympathetic remarks where indicated.*

> *Pt.* My husband keeps drinking and then gets violently abusive in front of the children.

Unsuitable responses

> *Th.* Why do you continue living with him?

> *Th.* Maybe you do your share in driving him to drink.

> *Th.* He's a no-good scoundrel.

Suitable responses

> *Th.* This must be very upsetting to you.

> *Th.* It must be very difficult to live with him under these circumstances.

> *Th.* You must find it hard to go on with this kind of threat over you.

SIGNS OF A WORKING RELATIONSHIP

Evidence of a working relationship are, on the part of the therapist, liking the patient, making emotional contact with the patient, eliciting good response from the patient, feeling able to help the patient irrespective of the syndrome or the severity of the condition. On the part of the patient there are verbal and nonverbal evidences of liking, feeling relaxed with, and being confident in the therapist.

The length of time it requires to establish a relationship will vary. With some patients a working relationship can be established in the first session. With many patients a dozen sessions may be needed. Occasionally, with patients who are fearful, detached, hostile, or unmotivated or with therapists who have problems in relating to patients, one or more years may be required before a relationship develops. When severe transference and countertransference reactions interfere with the setting up of a working relationship, they will have to be dealt with before any progress can be made.

The following is from a session illustrating the beginning of a working relationship. It is an excerpt from the sixth session with a divorced woman of 32, who came to therapy because of anxiety, tension, and feelings of detachment from people. The first four sessions were spent discussing her problem generally. During the fifth session she

introduced with some anxiety the idea that she believed her problem to be due to suspected sexual experiences in her childhood, when she might have been seduced by her father, her mother, and perhaps her sister. She has no recollection of such experiences, but this was, in her opinion, due to amnesia, since her dreams were often about sex with members of her family. Although I was tempted to underplay the possibility of such a situation, I listened attentively to her theories and remarked that a situation about which she felt so strongly must be taken seriously. The attitude I evinced was one of neither endorsement nor rejection of her theory, but one of acceptance of her right to entertain the ideas that she had, which we were obliged to explore. This attitude seemed to precipitate the working relationship since it apparently meant that I was tolerant and accepting.

> *Pt.* I don't know exactly where to begin because I don't feel as desperate as I did the last few times.

> *Th.* Mm hmm.

> *Pt.* I certainly have a feeling. I'm grateful for the last, the last session because you went out of the way, as far as I was concerned. I'm glad you had me speak it out, because if I hadn't done it, I probably wouldn't have mentioned it again, because it was fresh then and it did mean a lot to me.

> *Th.* In what way?

> *Pt.* That you understand what I'm thinking about and how I feel about things, and so on.

> *Th.* I see.

> *Pt.* And you took me seriously. Whether you believed it or not is beside the point, but you did take me seriously, which is very important to me.

> *Th.* Mm hmm.

> *Pt.* And I felt relieved that you understood me. It's so hard to find anybody who really understands. I realized that the fact that you took me seriously was important to me. If you take *me* seriously then I can take *you* seriously. Not that I didn't think that before, but it gave me a certain base. Then I went further and realized something I had, of course, known before, and that is if a person has faith in me, or believes in me, not me, but in me, that's the biggest compliment they can give me. And then I will do anything for them. It must be I want to have that feeling toward you.

> *Th.* Mm hmm.

> *Pt.* And then I can in turn respond. But I can't give it first. I mean I have to see that my basis for

exposing myself emotionally, so to speak, is respected.

Th. Yes.

Pt. So that's how it is. *(pause)*

Th. Apparently you had a suspicion when you came here that I might not understand how you feel, that I might not understand you.

Pt. Yes, I was aware of that, and the reason I felt anxious about it was that I just didn't know if you would reject me. And another thing, when you keep emphasizing that I should tell you about anything I feel about you, whether you do anything in any way to annoy me, I felt, it occurred to me, that maybe you meant that you wondered how I felt about you being Jewish. I don't know if you are or not, but you know it would be a sensible thing to think about. But I wouldn't think two minutes about it. Each time I come it is a good experience. I thought maybe you were referring to whether I had any feelings for, or against, or about Jewish people. *(laughs).*

Th. Do you?

Pt. Why no, of course not.

Th. Actually I didn't have that in mind, but it's important to express whatever thoughts you may have about our relationship.

Pt. That's interesting. I'm very glad.

Th. It is possible that you might have certain prejudices about Jewish people, which are, as you know, common; or, it may be, as you say, that you do not have prejudices.

Pt. Oh, those feelings are nonexistent in me.

Th. Do you have other feelings about me?

Pt. My feelings about you are very good. I have come in contact with other people. I am opinionated. But nothing could have set us on firmer ground than by my walking in here, and you took me as I was. You didn't question, you didn't probe about all sorts of things. I mean my seriousness about it; many things that you could have in the best of faith, but you didn't. That could not have made me feel better. I walked in as a stranger, and you accepted me. I know you are important in your profession, and you have to be selective in a certain sense. I didn't come here with any recommendations. I didn't write you a letter; I just picked up the phone, feeling I've got to do something, and I got an appointment. I walked in and felt very relaxed and very easy. I know that I can feel that way, and I know that I'm not unselective myself. There were things, many things that were bothering me, but you let me choose my words and didn't interfere.

Th. Your feeling is a good one and will help us work more readily with your problem.

Pt. I feel that if a person has faith and respect for me and I can give it back, that I will really be able to get help. I have a full acceptance of you. There are things within me, but they don't

concern you. You, yourself, don't cause me anxiety.

Th. Well, if I ever do, I'd like to have you tell me so that we can try to iron out our relationship.

Pt. It's very necessary to keep myself straight in all relationships, and I'm sure it would be doubly necessary with you. I feel I can do it with you although maybe things may happen later on in our relationship. [*It is possible that the patient is anticipating transference, which actually developed quite strongly as we began exploring her problem in the second phase of therapy.*]

Th. What do you think may happen?

Pt. I don't know, *(pause)*

Th. Something I may say or do?

Pt. I have no idea except that anything I would tend to take exception to would be something you would say. *(pause)*

Th. Mm hmm. *(pause)* About you?

Pt. No not necessarily. You seem to be very sensitive, and you seem to have omitted all the little difficulties that could arise from a person being somewhat insensitive and not being aware of the condition the patient is in, being pretty much on the defensive. You never violated anything like that. And what I like about it is that you act natural, as if you're not putting on an act to get along.

Th. All right, now that we seem to have a good understanding, we can talk about what we will do in approaching and understanding this problem of yours. *[The therapeutic situation is structured for the patient at this point.]*

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Structuring the Therapeutic Situation

During the first phase of therapy the patient becomes aware of the routines, requirements, and responsibilities of psychotherapy. The patient relinquishes the idea that things will be done for and to him or her and accepts the patient's role as active participant in the therapeutic process.

Some patients assume the obligations of the therapeutic situation with scarcely any direction from the therapist. Other patients balk every inch of the way, resisting the conditions with a doggedness that seems borne of perversity. Research data exist which that certain procedures as facilitative of a therapeutic alliance (Goldstein, 1980, Goldstein & Wolpe 1971). First, preparatory structuring for the patient by the initial screener of what to expect from the assigned therapist and from therapy itself, couched in enthusiastic constructive terms, has a beneficial influence on the patient. If the initial interviewer will not continue with the case, but will make an assignment of a therapist after the patient describes the kind of therapist desired, assurance that the therapist to whom one will be assigned actually possesses the desired qualities appears to promote expectant trust. The screener, in further describing the assigned therapist, makes the patient additionally receptive by indicating the latter's expertise, warmth, and capacities to help. When the therapist comes from the same background as the patient, a statement to that effect has also been shown to facilitate the forthcoming relationship. Finally, role-expectancy structuring can be useful in terms of what the patient and therapist will do and what the patient may expect from therapy. This helps eliminate surprise, confusion, and negative feelings.

A recommended article is that by Orne and Wender (1968), which details the words to use in a structuring interview. In my 1980 (pp. 41-42) book there are also precise ways of structuring the therapeutic situation. Sometimes a cassette tape is given to the patient that contains clarifying instructions of how the patient and the therapist are to behave

with each other. Research studies show that modeling or observational learning can add to the attraction potential the patient has for the therapist. Here an audio-or videotape that is played containing an actual or simulated session that brings out the therapist's sympathetic and caring qualities in relation to a patient seems to have an impressive effect on some patients. According to some studies, the higher the expertise and status of the therapist in the mind of the patient the greater the patient's confidence in what the therapist is doing; the stronger the activity level and degree of demonstrable conviction, the more manifest the empathy with the patient's feelings, the more attracted the patient will be to the therapist and hence the more likely a therapeutic alliance will develop.

As long as the patient is observing the "rules" of therapy, there is no need to emphasize any aspect of procedure. When, however, the patient seems confused or shows resistance, clarification will be necessary. Among areas that may require structuring are the manner of communication, the general routines of therapy, the responsibilities of the patient, the role of the therapist, and a description of the psychotherapeutic process.

EXPLAINING THE MANNER OF COMMUNICATION

The Focused Interview

The kind of communication that is used in psychotherapy is generally that of the focused interview, which has been described in Chapter 19, "The Conduct of the Psychotherapeutic Interview." It is usually unnecessary to instruct the patient on what to say and how to say it since the therapist will, by skillful focusing and by the use of other techniques that have been described, manage any problems in this area that develop. If the patient does specifically ask what topic to bring up, the therapist can say to report on any present thoughts and ideas including those that are fleeting, seemingly insignificant, or repulsive, or might ordinarily be suppressed. Also, the patient may be told that it is important to mention any tensions or physical symptoms that occur during the session as well as anxieties, fears, or feelings of resentment. The patient may be enjoined to observe the relationship between symptoms and environmental happenings. The patient may also

be asked to indicate if he or she has ever had thoughts, feelings, and anxieties similar to those being experienced at present, and, if so, under what circumstances these occurred.

The following are excerpts from sessions with patients who required instruction in the manner of communication:

Example 1:

    Pt. I don't know what I should say.

    Th. It is important to talk about anything that is immediately pressing on your mind no matter what it might be. This refers to your feelings and your ideas. If there is an immediate problem you are facing at your job, with your family, or in any other area, talk about that. The best rule to follow is to talk about things that are bothering you most.

Example 2:

    Pt. Is there anything special you want me to talk about?

    Th. I want you to tell me what is mostly on your mind. You may have to face yourself to tell me things that are painful or shameful. Talking about these things may be hard, but it will be most helpful to you.

    Pt. But how do I do this?

    Th. Try to "think out loud" and not hold anything back. In the process of "thinking out loud," you may want to express what you have been thinking or feeling about me.

Example 3:

    Pt. What should I talk about?

    Th. Anything that is on your mind is important.

    Pt. Like what?

    Th. Well, any factual observations that you make as well as irrational ideas or feelings that come to you. For instance, you may go out with your girl and then get furious with her or indifferent to her, for little apparent reason. Mention these things to me. If you are emotionally bothered by anything at all, talk about it. If you have fantasies or daydreams or dreams at night, these are very important. If there is anything good or bad that you feel about your treatments here, or good or bad thoughts about me, bring these up too.

Example 4:

Pt. I just don't know what's causing these feelings. I get so frightened and upset, and I don't know why.

Th. That's why you are coming here, to find out the reasons, so you can do something about your trouble.

Pt. But why is it that I can't sleep and concentrate?

Th. That's what we'll begin to explore.

Pt. But why?

Th. What comes to your mind? What do you think?

Pt. I don't know.

Th. You know, there are reasons for troubles like yours, and one must patiently explore them. It may take a little time. I know you'd like to get rid of this trouble right away, but the only way one can do this is by careful exploring.

Pt. Yes.

Th. And to take your anxiety feelings, for example, you may not be aware of the reasons for them now, but as we talk about you, your ideas, your troubles, and your feelings, you should be able to find out what they are.

Pt. How do I do this?

Th. When I ask you to talk about your feelings and thrash things around in your mind, you won't be able to put your finger on what bothers you immediately, but at least you will have started thinking about the sources of the problem. Right now, the only thing you're concerned with is escaping from the emotion. That's why you're just going around in a circle. While you're operating to seal off anxiety, you're doing nothing about finding out what's producing this anxiety.

Pt. It sounds sort of clear when you say it. (*laughs*)

Th. Well, do you think you understand what I mean?

Pt. What you're explaining now?

Th. Yes.

Pt. Yes. *(pause)* The point is that I keep thinking about myself too much. It's that I feel inferior to everyone. I must win at rummy. When I play golf, I practically beat myself red if I don't get the low score. And this is silly.

Th. What happens when someone beats you at golf?

Pt. I get upset and these feelings come.

Th. Now there seems to be some kind of connection here; let's talk some more about that.

Free Association

Except in Freudian psychoanalysis, free association will rarely be employed. When the therapist uses it as a means of communication, the patient may be given the following explanation:

> The kind of communication that we will use here is different from the ordinary back-and-forth talk. It is called "free association." To do free association, you just talk about whatever comes to your mind without censoring anything. Try not to hold things back, including any ideas, feelings, or impulses, no matter how insignificant or ridiculous they may seem. If you think that something is too trivial to report, it may be doubly important to mention it. If you notice any tension in your muscles or if you experience fear, happiness, excitement, or resentment, tell me about these. In other words, I'd like to explore with you thoughts and feelings that are sort of on the periphery of awareness. In this way we will be able to understand some of the problems and conflicts that are hard to get at by ordinary conversations.

In using free association, it will be necessary to give the patient a reason why the therapist does not respond constantly to the patient's productions with comments and explanations. The following exemplifies how this may be done:

> Another important thing for you to know is that I will not interfere with your flow of ideas by interrupting with comments. This may puzzle you, but if I don't keep up a conversation with you and enter into back-and-forth talk, there's a good reason for it. I will, of course, occasionally bring important things to your attention. But don't be upset if I fail to respond to everything you say.

Dreams

When the therapist uses dreams, it will be necessary to request that the patient recount dreams. The patient may be told:

> I should like to have you try to remember your dreams and tell me about them in as full detail as possible.

In the event that the dreams cannot be remembered, the patient may be asked to keep a pad of paper and a pencil next to the bed and to jot down any dreams the first thing

in the morning before they are forgotten. Often this safeguard helps the patient to remember dreams that otherwise would be forgotten.

Should the patient ask why dreams are important, the following might be the reply:

> Dreams are important because the mind asleep thinks thoughts in dreams that tell a story about inner problems and conflicts. Sometimes dreams tell us a clearer story than can be told in ordinary conversations. It's hard to understand this, but the best way you can find out how dreams work is to bring them in so we can talk about them.

It is generally not wise to encourage the patient to write dreams down in detail unless there is a tendency to forget them. Some patients get so immersed in detailed dreaming, which they record painstakingly, that the entire session may be spent on dream material to the neglect of other aspects of the psychic life. This activity may be a subtle form of resistance by the patient to avoid talking about anxiety-provoking reality situations.

EXPLAINING GENERAL ROUTINES IN THERAPY

Explaining the Time Limits of the Interview

A brief explanation may be given the patient regarding the duration of a treatment session, the fact that sessions begin and end promptly at the appointed time, and the need to keep appointments regularly. If the patient challenges these limits or defies them, the resistance must be handled.

Informing the Patient of Expected Delays in Getting Well

Early in treatment the therapist may discuss the expected ups and downs in treatment and the possibility of temporary relapses. The patient may also be told that alleviation of symptoms may not come immediately and that there might even be a slight setback before improvement occurs. This helps to forestall untoward reactions to delays in achieving relief, and to mollify the inevitable suffering associated with the giving up of neurotic patterns.

Discussing the Confidential Nature of Communications

It is usually advisable to explain to the patient that any information revealed to the therapist is completely confidential and will, under no circumstances, be divulged. This allays the patient's fear that the therapist will discuss the patient with others. The same reassurance may be given the patient about the patient's case record, pointing out that it will not be released, even to the patient's personal physician, without his or her permission.

Explaining the Use of the Couch When It Is to Be Employed

There are advantages and disadvantages to the recumbent position in psychotherapy. Lying on the couch out of visual range of the therapist enables the patient to delve into personal aspects without restraining the thought processes. Reality is tempered for the time being, and the patient is less apt to respond to what he or she believes the therapist demands or to modify thought content in accordance with the facial responses and nonverbal gestures of the therapist. However, the couch position is not indicated in most forms of psychotherapy because of the very fact that it removes the patient from reality. Lying on a couch may furthermore mobilize anxiety in some patients. It may foster silence or a senseless rambling of fantasy material. Face-to-face interviewing, thus, is generally preferred, and, since this is the natural conversational position, it will not have to be explained to the patient. In reconstructive therapy, however, when free association is to be employed, the couch position may be desired. Here the patient may be told:

> Now in talking about yourself, it is helpful to use the couch. The reason for this is that when you face me you are apt to be distracted by what I say and do, and by my facial expressions. This restricts you and makes it hard for you to concentrate on deeper feelings. We can make faster progress by your reclining while you talk.

Planning for Vacations

It is necessary to inform patients well in advance regarding any vacations or extended absences the therapist plans to take. This enables patients to handle their

emotions in advance and minimizes their feeling of being deserted when the time comes for vacation. "Springing" a vacation or recess on a patient without prior notice is apt to precipitate anxiety and to stimulate conceptions of the therapist as a rejecting or irresponsible person. Most therapists urge their patients to plan for their own vacations at a time that coincides with the therapist's absence.

Smoking during the Interview

The presence of ash trays generally invites the patient to smoke, should the patient desire. Sometimes the patient asks permission when it is noticed that the therapist does not smoke. To forbid the patient to smoke imposes what to the patient may look like authoritarian pressure. Should the therapist be sensitive or allergic to smoking, a good ventilation system will be helpful. If the therapist is unable to tolerate smoke or is dead set against smoking, the reasons should be explained to the patient and the patient asked how he or she would feel about not smoking. If the matter is tactfully presented, the patient may willingly forego the indulgence during the treatment session.

The Taking of Notes

Some patients object to the taking of notes. If the therapist explains the purpose of note taking and confines it to recording only important data such as dreams, the patient will generally adjust to this practice. If the patient continues to object, even after such feelings have been discussed and the reasons for the objections explored, the therapist should confine entries in the case record to the period following the session.

Accounting for the Long Time It Takes to Get Well

If the patient is insistent on knowing how long it will take to get well and if, as in some cases, long-term therapy is necessary, an explanation is helpful, such as the one given to the patient in the following excerpt:

> *Th.* Now your problem seems to have originated way back in your life, as far back as childhood. It will, therefore, require a little time to correct.

Pt. How long would I need?

Th. That will depend on your cooperation and desire to get well.

Pt. I do, I mean I want to get well. But could you tell me approximately how long it will be?

Th. Now, because the problem goes so far back it may need 2 or 3 years of treatment.

Pt. As long as that?

Th. Unfortunately, deep change takes time. Actually, it's not so long. It took you all your life to get tangled up in a knot. It's been with you for a long time. And a couple of years of treatment is short compared to how long you've had it.

Pt. Aren't there any shortcuts like hypnosis?

Th. Yes, there are, and we'll use whatever techniques are best for you to cut down the time. But hypnosis does not shorten the period of treatment in a problem such as yours. Time itself seems to be an element of cure. You know how hard it is to overcome a tobacco habit?

Pt. Yes, I know.

Th. Well, personality habits require even more time, because they are part of a person from childhood on.

Pt. Yes, I see.

Handling Consistent Lateness

If the patient is consistently late, this may indicate resistance and will necessitate an inquiry. The therapist may ask, "I wonder if there is any reason why you have come so late the last few times." The patient may possibly then bring up an area of resistance. If the patient is defensive and insists on explaining the lateness on the basis of a reality factor, it is best not to challenge this. Instead one may say, ''Let us see what happens in the future." If lateness persists, the patient may be more directly challenged.

Handling Broken Appointments

If the patient breaks an appointment without telephoning, this must be considered seriously and discussed thoroughly at the next session. If two successive appointments are broken, the therapist may advantageously telephone the patient and inquire as to the

reasons. Should the patient remark that he or she has decided to terminate therapy, it is advisable to invite the patient to come in to talk things over. Consistent breaking of appointments is a critical matter and calls for active analysis of prevailing resistances.

Handling Too Frequent Cancellations

When the patient calls in advance to cancel an appointment, there is generally no charge for the session, provided the reasons for the cancellations are valid emergencies. Should cancellations be too frequent, resistance is probably operative, and the patient may be reminded that interruptions in therapy are not only expensive but also detrimental to the progress of treatment.

Handling Nonpayment of Bills

Most patients pay their bills promptly if, during the initial interview, mention is made of the fact that bills are sent out at the end of the month. Should a considerable time elapse without payment, and without mention by the patient of the reasons for this deficiency, the therapist may discuss the matter frankly in a manner such as the following:

> *Th.* I noticed that you haven't paid your bill for the past two months. I wonder if there are material reasons for this or whether you have forgotten.

> *Pt.* Oh, I just don't think of it; haven't gotten around to it.

> *Th.* Do you have any feelings about paying the bill?

> *Pt.* Why no. It's that so many other expenses have come up.

> *Th.* Well, look into it anyway. There may be emotional reasons for your forgetting. Are you at all irritated with me or uncertain about your treatment?

> *Pt. (pause)* Maybe, in some ways. I feel we haven't been going fast enough.

> *Th.* Let's talk about that.

The subject of nonpayment of bills may open up a pocket of transference. Should there be realistic budgetary problems, it is incumbent on the therapist to make as liberal allowances for the patient as circumstances permit. On the other hand, not too much time

should be permitted to elapse without some arrangement being made for the liquidation or other disposal of the bill, otherwise the therapist may become resentful and lose therapeutic objectivity.

DELINEATING THE PATIENT'S RESPONSIBILITIES

Most patients will proceed to work actively in therapy without too much prodding or too extensive a definition of their responsibilities in the treatment situation. In some patients, however, confusion about their role or resistance to activity may require that the therapist delineate their obligations.

How best to present the matter of the patient's responsibilities will depend on the kinds of resistances displayed. In addition to dealing with a specific resistance, the patient may be told that comprehending the problem is the first step in its control. It is often hard for the patient to do this independently because of a lack of objectivity. In treatment the therapist can help the patient find out the cause of the trouble by guiding the patient along certain paths of thinking. The patient and therapist act together in a sort of partnership in the project of exploring the patient's patterns. Knowing what is behind the difficulties will help the patient to do what is necessary to be rid of them. The therapist may say:

> Perhaps we can regard therapy as an arrangement in which we both are participants. You will help me understand you by telling me about your thoughts and feelings, and I will help you understand what goes on inside of you that creates your trouble. Together we can work this thing out.

When the therapist informs the patient that the therapeutic situation is one in which the patient is expected to work out the problems independently, resentment, depression, or panic may be mobilized, because the patient feels that this has already been attempted and not been unsuccessful. The patient may then look upon the therapist's refusal to take complete responsibility as a dereliction. Consequently, it is best not to stress too much, at the start, the obligations that the patient must assume. Instead, it is best to let the relationship develop naturally, helping the patient slowly to accept more and more responsibility. It is, of course, essential that eventually the patient come to an understanding that the extent of his or her participation will determine the ultimate goal.

If the therapist makes decisions for the patient and gives directives on how to conduct his or her life, this will delay the development of essential inner resources that enable the patient to manage problems constructively. If the aim is for goals of assertiveness and independence, it will, therefore, be necessary for the patient to treat the treatment situation as a medium in which independent decision-making capacities can be developed.

One way of insuring the patient's cooperation is to present the process of working in psychotherapy in terms that will be at least partially cogent to the patient. For instance, a patient during the third interview expresses confusion about what to say. He then expostulates that he would like the therapist to do something positive for him. An excerpt of the interview follows:

> *Th.* I know how difficult this has been for you. Were it possible to remove your trouble immediately, I would want to do it. But this thing has been with you for some time, and it may require a little time to get at the bottom of it.

> *Pt.* How can I get well, then, how?

> *Th.* There are ways of working in psychotherapy that will help you get well. Let's look at it this way: you've learned patterns of feeling and behaving that have gotten you into trouble. These patterns are part of you. What we'll do is examine these patterns and see why they've failed and have gotten you into a mess. After that you'll be able to learn new patterns that will make it possible to enjoy life.

> *Pt.* But how do I do this?

> *Th.* Now, learning new patterns is like learning a new language. If you were going to learn a new language, you would have to start talking that language. It would be difficult at first and you would make mistakes, but you would eventually learn it through practice. I'll be like a teacher helping you when you make mistakes. But if I were to do all the talking in this new language, you would never learn how to talk.

> *Pt.* I see, but how do I start?

> *Th.* The best way is to tell me what is on your mind, what you feel, what bothers you. I'll ask you questions from time to time. Now I'm not going to give you the answers, for if I did, it wouldn't help you. But I'll help you find the answers for yourself.

> *Pt.* I see.

> *Th.* It's like doing algebra. To learn algebra it wouldn't help you if I gave you the answers. The important thing is to learn how to get the answers. In problems like yours, learning *how* to arrive at the answers to your disturbing feelings and patterns is as important as getting the

answers themselves.

Pt. Yes.

Th. This may sound mysterious, but as we go on, it will become clearer.

Assigning Tasks to the Patient

Sometimes it is feasible to assign certain tasks to the patient to work on between sessions, such as observation of dreams, and attitudes toward the therapist, which situations exaggerate or alleviate symptoms, and to execute certain behavioral assignments essential to acquire new patterns. The patient may deny that there is any connection between his or her life circumstances and symptoms, but the therapist must insist that the patient keep watching for a relationship between the severity of the symptoms and provocative environmental happenings. Whenever the patient brings up the circumstance of exacerbation of symptoms, it will be important to explore the conditions associated with it. Should the patient balk at performing this assignment, the resistance must be thoroughly explored.

Explaining the Need Not to Make Important Decisions without Discussing These with the Therapist

During therapy the patient's values are in more or less of a transitional state. Extremely important decisions, like changes in occupation or marital status, must be considered very carefully before acting on them. Tragic consequences may follow impulsive decisions. For these reasons the patient may be told that a rule in therapy is that the patient must not spontaneously and impulsively make any radical changes in his or her life situation and that all important actions be discussed with the therapist first.

DEFINING THE ROLE OF THE THERAPIST

In supportive therapy it is usually unnecessary to define the role of the therapist, since the latter consciously functions as a "giving" authority. In deeper therapy, on the other hand, as has been explained above, the therapist's role may have to be delimited

when the patient protests the apparent lack of direction. The patient must be apprised of the fact that the therapist's giving advice and guidance will block the patient's development and prevent achievement of strengths essential to independent functioning.

Psychotherapy calls for respectful listening and a communicating to the patient of an understanding of the patient's turmoil and of a desire to help the patient's plight. This process is different from an artificial cultivation of dependence on the therapist. No promises are made to the patient, nor is the therapist held out as a savior. Rather, the therapist indicates that there are ways of getting relief for one's problems contingent on the patient's active cooperation in therapy.

Partly because the patient puts the therapist in the traditional role of magical healer and partly because the patient's helplessness inspires regressive dependency impulses, he or she demands or secretly expects immediate and dramatic relief. The patient is bound to feel resentful and hopeless if this relief is not immediately forthcoming. The patient may be unable to understand why a rapid cure is not possible, why therapy requires frequent sessions over a prolonged period, and why the therapist displays minimal activity, expecting the patient to shoulder the brunt of the work.

As soon as possible, the therapist must clarify these doubts and hopes to help prevent the experiencing by the patient of too great disappointment and to thwart the patient's leaving therapy in confusion.

The following excerpts from early sessions illustrate the defining of the therapist's role:

Example 1:

> *Pt.* I'd like to know, doctor, what makes me feel so sick.
>
> *Th.* There are reasons why you feel the way you do. Those reasons may not be clear to you, because you are living too close to your difficulties. We will discuss your ideas and particularly your feelings, and in not too long a time, we should discover what is behind your problem.
>
> *Pt.* Yes, but what would you like to know? I mean what do you want me to talk about?

Th. Just anything that bothers you, that's on your mind. In discussing your ideas, reactions, and feelings, we will gradually be able to understand what is happening to you, and this understanding will permit you to take definite steps to correct your difficulty.

Pt. And you'll tell me what is wrong?

Th. Not exactly. I'll, of course, help you with your problem, by acting as your third eye, so to speak. You may not be able to do this for yourself because, as I said, you are living too close to your problem to see the forest for the trees. But I can be more objective, and I shall direct your thinking along certain lines.

Pt. You mean you will not do the work for me; you'll just show me what to do.

Th. Yes. You see, if my doing the work and telling you what to do would really help you, I'd do it. But experience shows that emotional problems are not helped this way. In being told what's wrong with you and what to do, you may never be able to develop as much personality strength as in working things out with my help. Together we can work out a logical and constructive solution for your problem.

Example 2:

Pt. But aren't *you* able to take these fears away from me?

Th. Your fears bother you a great deal, and you want to get rid of them as soon as possible, don't you?

Pt. Yes.

Th. Now it would be natural for you to expect me to give you medicines or some other remedy, or to do something forceful to make your troubles disappear. Believe me, I would do this for you if they *would* disappear this way. But experience shows that you *can* get rid of them by first finding out what they mean, how they got started, and why they continue to bother you. This will take time, and you're likely to get impatient with the slowness of the process.

Pt. (*laughing*) I hope it isn't too slow.

Th. (*smiling*) Well, we'll go as fast as *you* can travel.

Verbalizing the permissive nature of the relationship is not advisable since the patient may interpret this as a lure. Rather, it is important that the patient, on the basis of personal experience, spontaneously arrive at the conclusion that the therapeutic situation is unique in its permissiveness, that things that are ordinarily censored can be talked about, that he or she will not be held in judgment, and that reprimand and punishment will not be forthcoming. The permissiveness of therapy does not presuppose that the

patient will receive unmitigated support and reassurance. Things will not be done for the patient; rather, the patient will be helped to decide the best course of action. As has been mentioned previously, in reeducation and reconstructive therapy especially, it is important to explain to the patient, as soon as the patient expresses disappointment with the amount of direction the therapist is giving, the reasons for the seeming passivity of the therapist. To delay this explanation is apt to result in feelings of helplessness, hopelessness, and despair. Dependent patients will, of course, be loathe to accept the defined limits in therapist responsibility, but they will be much less hostile if they understand that the role of the therapist is a deliberately cultivated one rather than one of neglect.

Limits of Demonstrativeness

Displaying acceptance does not mean that the therapist should behave too demonstratively toward the patient. Such acts as putting one's arm around the patient, comforting the patient solicitously, helping with the patient's coat, and other pleasantries are not to be encouraged. Should the patient wait for such attentions or show expectation of amenities from the therapist, the therapist may briefly explain that it is not the custom in psychotherapy to treat the patient in a conventional sense. For example, a female patient, having placed her wrap on a chair in a male therapist's office, walks over to it at the end of a session and then waits for the therapist to help her with her coat. To respond by doing this would be a normal thing in the ordinary social atmosphere or when purely supportive approaches are employed. To act this way, however, may cause the patient to regard the therapist as a person who should act in other conventional ways toward her. Generally, when the therapist, at the end of the session, does not offer to help the patient with her coat, the patient will do this for herself. Should she ask the therapist to help her, the therapist may do so, remarking, "Much as I'd like to do this regularly, it is customary not to do this in therapy. It tends to put the therapist and patient in a sort of conventional relationship that may interfere with your progress. If I don't help you with your coat from now on, you'll know that it's because it isn't wise to do so."

Limits in Gift Giving

The same taboo is extended toward giving the patient gifts. There are times in supportive therapy when a small gift may be tendered the patient as a demonstration of the therapist's thoughtfulness and desire to bring comfort to the patient. In insight therapy, gift giving puts an artificial bias on the relationship and may be harmful. Similarly, accepting gifts from the patient must be handled carefully. Even small gifts must be questioned. Should the patient offer the therapist a small gift, the therapist may accept it appreciatively but ask why the patient gave it. An excerpt from a session illustrates this point:

> *Pt.* I thought you would like this necktie.
>
> *Th.* Thank you very much. I appreciate your thoughtfulness, but I wonder why you got it for me.
>
> *Pt.* (*blushes*) Oh, I just thought you'd like it.
>
> *Th. (smiling*) You know in therapy one has to look a gift horse in the mouth, and inquire into the meaning of everything that happens, including bringing gifts. For instance, let's try to figure out why you gave me this tie.
>
> *Pt.* (*laughing*) I suppose it's because I wanted to. I noticed that you wear drab ties.
>
> *Th.* You thought I might look better in a snappy tie?
>
> *Pt.* (*laughing*) Not that you haven't good taste, but ... *(pause)*
>
> *Th.* Perhaps you're not quite sure of my taste.
>
> *Pt. (laughing)* Come to think of it, maybe I'm not.

Under no circumstances should the therapist accept a large gift, for this is generally a manifestation of resistance or a way of bribing the therapist. When a patient offers the therapist such a gift, the therapist must refuse it without rejecting the patient. The following excerpt is illustrative:

> *Pt.* I brought you a little something, *(gives therapist a box)*
>
> *Th.* Thank you, very much, but I wonder why you got it.
>
> *Pt.* Oh, I know you'll like this. It's a very nice thing.

Th. What is it?

Pt. A fine watch.

Th. Well, now I do appreciate your thoughtfulness, but one of the rules of therapy is not to accept gifts. It may interfere with your treatment. If I don't accept it, it's because of this rule. But tell me, why did you get it for me?

Pt Well, does there have to be a special reason?

Th. There usually is. You know, in therapy one looks a gift horse in the mouth. Mind you, I think it's very fine of you to bring me a gift, but let's explore this a little. We may learn something important from it.

Avoiding Social Contact

Meeting the patient on a social basis may be destructive to the relationship. The patient may employ his or her observations of the therapist's behavior as a weapon to reinforce resistance. The patient may use the social relationship as a means of neutralizing the therapist's effectiveness. On the other hand, if the therapist happens to meet the patient at a party or function, there is no reason to make a hasty retreat, although there may have to be some restraint on the therapist's spontaneity.

Avoiding Physical Contact

It goes without saying that physical contact with the patient is absolutely taboo. Rubbing, stroking, or kissing the patient may mobilize sexual feelings in the patient and therapist or bring forth violent outbursts of anger. Should the patient approach the therapist sexually, this must be handled as a manifestation of transference, and the patient should be encouraged to verbalize his or her feelings. Were the therapist to respond to the patient's gesture, therapy would terminate immediately with perhaps disastrous consequences for both patient and therapist. The utmost care must be exercised to avoid mobilizing guilt in the patient if the patient makes a physical gesture toward the therapist. Occasionally an enthusiastic patient may embrace and kiss the therapist. This embarrassing situation will call for the greatest tact. If the patient is pushed away harshly and scolded, the patient will feel rejected and resentful. To respond by embracing the

patient may be interpreted as a seductive lure for which the therapist will pay dearly later on. The best way to handle this contingency is to stand one's ground, smile, and ask, "Now, I wonder why you did that?" By facial expression the therapist must convey no embarrassment, fright, hostility, or excitement. If the embrace is during a session, the focus of the session should be on the meaning of the gesture to the patient. If it is at the end of a session, the therapist may add to the statement made, "Suppose you think about why you kissed me, and we'll talk about it next time." Therapists who advocate sexual relations with their patients as a therapeutic measure deceive themselves about their designs, which are usually countertransferential and exploitative.

Avoiding Business Dealings

Sometimes patients will offer the therapist opportunities to enter into business dealings with them. The temptation may be great, since the therapist may assume that an investment in the patient's enterprise will be helpful to both of them. Such business arrangements will usually be very destructive to therapy and should be resisted unequivocally. Similarly, one must never take advantage of patients' professional or social contacts, if they happen to be prominent because this again will dilute one's therapeutic impact.

<div align="center">EXPLAINING HOW PSYCHOTHERAPY WORKS</div>

A case history explaining how another patient developed an understanding of oneself in therapy, and of how that patient achieved relief or cure, is a dramatic way of persuading the patient to accept the treatment situation when it is stubbornly resisted. The following is an example of such a history. Undoubtedly, the therapist will be able to present examples from personal experience. These should be sufficiently disguised so that the discussed patient's identity will not be revealed. In the case that follows, of a patient with migraine, symptomatic treatment along medical lines and brief supportive therapy with a counselor had failed to bring relief.

The patient was referred to me for treatment of migraine headaches that did not

respond to medication. It was apparent to me that the patient did not really want psychotherapy because he was not convinced that the headaches were caused by psychological factors. What he really wanted from me was a prescription for another more powerful medicine. When I suggested that there might be a connection between his tension and his headaches he replied that this might be so, but that the headaches came first and gave him tension.

At the next visit he described his having suffered from an especially bad headache during the past week. When I asked him to describe the circumstances that immediately preceded his headaches, he said, "I can see no reason why I had the headache from the different things that happened during the day. I went to work, and everything went along pretty well. I did a job that was assigned to me with no trouble at all. That night I had a bowling date with a friend. Now this friend called me up, and we were supposed to go out on a date. He said, 'Suppose I meet you at eight o'clock.' Right at that point my wife, who had been coming down with a head cold, says to me, 'Why don't you postpone your going out until later on, after the kids are in bed or tomorrow?' And she did have a terrible cold. So I told my friend we'd go out the next day. I didn't want the youngsters to catch my wife's cold, so I helped them. Then I sat on my wife's bed. She was sniffling, and I began getting an awful headache right at that point. And there was no reason for it." When asked whether he might have resented the fact that he had to stay home and put the children to bed, he remarked, "No, why should I? The kids would have gotten a cold, I could have bowled the next day; there's no reason why I should." The patient was assured that perhaps there was no cause for the headache that we could see at this time but that it was necessary to continue observing the circumstances under which his headache developed.

One week later the patient reported a severe migrainous attack. "Again I had an awful headache. Things went around. I had a bunch of junk last night, and it was probably what I ate." When asked to talk about the events that had occurred, he said, "We went over to call on some people we know. They are nice people, but I don't care very much for them. But my wife thinks that because he is my superior at work, we've got to cultivate them; and I suppose if I really want to go along, get ahead in my job, that I might as well try to be

friends with him. So I went over there, and sat there, and we drank a while and we talked. They're terrible bores. I really don't like being with them. Then it started, an awful headache."

When asked whether he resented making the visit, the patient replied, "Sure, I didn't want to be there. I just resented being there." He was then reminded that he had presented two instances in which his wife had asked him to comply and that in each case a headache followed. "Yes," he admitted, "I don't know; maybe you've got something."

That he had made a connection was evidenced by his reaction to his next headache. He said, "By George, you know what happened? My wife asked me to stay at home again and not go bowling, but afterward I got a bad headache." Almost excitedly he continued, "When I look back, I can see the headache just comes like that. There have been innumerable times when automatically I feel as if I have to do what my wife asks me to do, that I can't say no. I say she is a reasonable person and a nice person, and I get a bad headache every time. Now, why should that be?" What we had done was to make a connection between the patient's symptoms and some life events that at the time did not seem too important.

Therapists can refer to cases such as this and note to their patients: "This is what we shall try to do in your case in the event there is such a connection. We will also try to figure out if we can deal directly with the symptom and with problems in your life situation through various symptom-relieving or problem-solving interventions, or whether it is necessary to deal with some carry-overs in your early development that are causing your trouble now."

In the case of the man with migraine, it became apparent that he had never gotten over his strong dependency on his mother whose dictates and demands he followed punctiliously, even though he resented yielding to her wishes. His passivity led to the choice of a wife who was strong and who, with his cooperation and even insistence, took him over the way his mother did. This wife, of course, had gotten herself into a no-win situation. Because he idealized his mother, his wife could never come up to his

expectations. When he forced her to make decisions, he resisted her interfering with his independence. When she tried to shift responsibility onto him he resented her ineffectuality. The resulting anger was not expressed outwardly but was turned back on himself and resulted in tension and migraine. Naturally he acted the same way with other people, and he did it even with me. This is a transference reaction, and it was possible to point out during our sessions how he was trying to force me to make decisions for him and then resenting whatever I did. Sometimes these activities are not at all conscious to the person. This is what happened to our man, but he was able to recognize from his dreams, fantasies, and feelings toward me that his world was populated with good mothers, bad mothers, and in-between mothers who dominated or rejected or loved or hated him and that he was responding to all their actions, good and bad, with physical symptoms.

Knowing this was only half the battle. The important thing was doing something with this insight. This involved changing habit and behavioral patterns that were about as old as he was. First, he had to get over his demand that I act like his mother. Next we had to involve his wife in treatment so that she could resist his demands that she be like a mother figure. We worked together, the man, the wife, and I in "couples therapy" and some of the sessions were stormy, resulting in *her* getting headaches. But before her husband could get well, she also had to get over her own bossiness so that she would not reinforce her spouse's passivity. The end result was a better and much less headache-ridden marriage. The man achieved enough personality reconstruction so that he functioned, for the first time in his life, with freedom and assertiveness and without debilitating headaches.

The therapist may remark, "This prolonged description illustrates how psychotherapy works. What happened to this patient naturally does not apply to you. But by examining *your* ideas and feelings, and talking about *your* problems, we should be able to help you too."

SIGNS OF ACCEPTANCE OF THERAPEUTIC STRUCTURING

Signs of acceptance of the structuring of the therapeutic situation are reflected in greater participation and activity. This is illustrated in the following excerpt. The patient is a 40-year-old married woman with a hysterical symptom of vaginal burning, which, since its inception eight years previously, had been increasing in severity until she could no longer tolerate it. It was apparent that she had magical expectations of my removing her difficulty in a few sessions. When I structured the ideal way of working in psychotherapy, she responded with silence. At the sixth session, she complained of intense burning and remarked that she was thinking of stopping therapy. I attempted to analyze her resentment at my passivity and tried to justify my stand on the basis that if I could remove her trouble by waving a wand, I would do so. I explained that emotional problems like hers could be resolved—but that it was necessary for the patient to work hard and to cooperate actively. During the next session, the seventh, she seemed to be resolving her resistance to accepting the way that we were supposed to work together. A part of the session follows:

> *Pt.* Today I'm 40 years old.
>
> *Th.* Are congratulations in order?
>
> *Pt.* No, nor commiserations. But I never thought I'd spend it here in New York getting treatment away from home. (*laughs*)
>
> *Th.* You never realized 10 years ago, or even 5, that at your fortieth birthday you'd be sitting opposite a psychiatrist.
>
> *Pt. (laughs*) I finally had a dream. I didn't have that dream until this morning. It was the silliest thing. I was living in this large room. I was living there with a man. He looked like a combination of an old boyfriend and a man who works in the same place I do. And we weren't sharing the same bed for some strange reason. And there was a double cot over on one side of the room and a double cot on the other side. And there was a sink, and there was a bunch of people there having a party for some reason. I was supposed to wash up the dishes, and I was very resentful of the fact that everyone was having a good time and I wasn't. In fact, I had to go out to go to work, and the dirty dishes were going to be left for me to do. And all of a sudden I realized that the man in the room had taken the sink out and put it up so high that I had to stand on my toes to reach it. Then I realized that one of the cots had been taken out. I was shocked, as if I was being eliminated. *[This dream seems to reflect a feeling of rejection and resentment at being made to do "dirty work." The idea occurs to me that this is a transference dream.]*
>
> *Th.* What does that make you think of? Do you have any associations?

Pt. Why no. I just awoke and was going to go to work.

Th. But the emotion in the dream. What was that like?

Pt. Well, there didn't seem to be any love involved.

Th. Here was a man doing peculiar things?

Pt. Well, it didn't seem to be a man I was emotionally involved with, yet I was sharing the room with him. *(pause)*

Th. And what was he trying to make you do?

Pt. The dirty dishes while the others were standing around, talking and having a good time. *[Could this possibly refer to my wanting her to do the "dirty" work in therapy?]*

Th. Mm hmm.

Pt. And I was under strain. I had to stand on my toes to do that, and it was hard. He had put the sink up too high. I could see the bolt holes where the sink had been before. He put it up too high, *[indicating that I was making the therapeutic task impossibly hard for her?]*

Th. He was making you do the work.

Pt. Yes, and when I noticed the other cot gone, I said, "What the hell does he think he's doing?"

Th. Why would he take the cot away?

Pt. I don't know; maybe so the woman sharing the room would sleep with him.

Th. What kind of person was he?

Pt. He reminds me of two people I know: one, handsome and charming; the other, boorish and vulgar. He clowns around, but he's a good Joe.

Th. I see.

Pt. And something very peculiar happened last week, something I couldn't quite figure out. First, I realized I wasn't so frightened as I used to be. And I wasn't complaining as much. And I said, "Won't Dr. Wolberg be pleased to hear that," and all of a sudden this vaginal burning that I have went away completely. It made me chuckle. (*laughs*)

Th. All right, how do you make the connection?

Pt. I don't make any connection *(laughs)* except that maybe the treatments are doing me good in spite of myself.

Th. In spite of the fact that you may be a little annoyed at the way the treatments are going. *(pause)* *[It was hoped here that the patient would verbalize her feelings of resentment or*

disappointment. Because she did not do so, the next comment was made.] Perhaps you feel disappointed that so much responsibility is being put on you?

Pt. Possibly, possibly. (*laughs*)

Th. Like being made to do the dirty dishes. *[interpreting one aspect of the dream]*

Pt. (*laughs uproariously*) I just hate to do dishes. That's my mother's fault. She wanted me to be a pianist and not spoil my hands. I was always annoyed at doing dishes. What you say is right; I don't want, didn't want, the responsibility of figuring things out myself.

Th. Are you annoyed at accepting responsibility?

Pt. Well… not exactly, that is, when I am not under tension, I don't mind responsibility. But since this tension started, I have tried to evade responsibility as much as possible, because I felt I couldn't accept it or carry it out.

Th. And how do you feel about accepting responsibility in our therapy here?

Pt. I am a little confused about that. (*laughs*) Less than before though. I just didn't feel as if I was capable.

Th. You see, if it were possible for me to remove these symptoms from you myself, I would do it. I would want to do it. But we find that cures are not accomplished this way. As a matter of fact, the more active a person is in working out the sources of a problem, even though the person has to sweat it through a little, the quicker one gets well. In the long run this is what strengthens the person. The ability to understand the sources of one's problem and to handle the resistance in working things out for himself or herself … [*I continue to structure the therapeutic situation.]*

Pt. (*laughs*) It's not conscious resistance I assure you.

Th. I know.

Pt. I want to tell you what happened last night. This symptom that I have had is associated with sex in my mind, for some reason. I started thinking about my husband and all of a sudden this burning began to loosen up and to become a sexual feeling. Ordinarily I would have stopped thinking right there, because in the past if I started thinking about the person involved and couldn't do anything about it, the burning would keep on, and keep on, and only go away when I slept. So I just decided that I would keep on thinking about it just to see what would happen. *[This is an excellent sign of her beginning to accept responsibility by working on a problem.]*

Th. Good.

Pt. And I didn't get a sexual craving and I started being able to think about something else and I wasn't afraid of what would happen … and, for heaven's sake, the burning went away.

Th. It sounds as if you've been afraid to let your mind wander in the past.

Pt. I see. You mean if I'm afraid to think about sex, I might get pain there instead.

Th. Yes, perhaps in the future you could let your mind wander and see what you think about.

Pt. I guess I'm afraid to think because, after all, it's been seven years that I've lived with this thing. If I thought it would clear things up, I wouldn't be afraid to think anything I want. Mother was very moral about sex, and I could never bring it up. Oh, yes, after I left you, I went to the store to get groceries. I wanted to get out so I got in line ahead of other people and the burning started. Then it went away. I went to sleep and had a dream I forgot. When I tried to remember the dream, the burning returned and my mind got hazy.

Th. Now it's important for you to continue thinking about yourself, like making a connection between your symptoms and your thoughts, you may not at first see the connection, but you will, after a while, see a trend developing, a connection. Now one impression I get that I can offer to you is that every time you feel you've done anything that's "bad," the burning comes on you.

Pt. When I ever did anything bad as a child, mother would scream, bang her head against the wall, and practically have a breakdown. *[Patient continues to associate to her early relations with her mother.]*

From this session on the patient accepted the conditions of therapy and worked actively and successfully.

37
Selecting a Therapeutic Focus

Psychotherapy is much more effective when a focal topic is selected by the therapist. Once the therapist has determined why the patient has come for therapy and explored the patient's account of the situation and the patient's treatment goals, the focal topic can be chosen. A too early concentration on the patient's psychopathology and past conditionings that have created the troubles, however important this inquiry may be, will support regression and encourage long-term lingering in treatment. Rather, the therapist should begin to focus on what is of *immediate* importance to the patient, such as incidents in life that have precipitated the symptoms for which the patient seeks help. In focusing on precipitating factors one must gauge the patient's vulnerability to stress as well as the virility of the stress factors themselves. In focusing on symptoms the therapist should view them as an assembly of reactions to anxiety as well as consequences of defense mechanisms elaborated to control the symptoms.

During the explorations it is important try to actuate to problem solving, while examining, encouraging, and helping the release of whatever positive adaptive forces are present in the patient, as well as studying the resistances that block their operation. In the course of doing this the therapist may be confronted by the patient with some early formative experiences, but these are not explored in depth. They are handled in the context of explaining obstructions to effective functioning in the present. Ample opportunities will be found later on to switch the focus to areas related to some central dynamic theme by establishing a connection between it and current problems and concerns, should this be deemed desirable. In some cases, powerful initial resistance to treatment may make an early focus on dynamics essential. Obviously, the therapist will deliberately have to select dynamic aspects that can be worked with expediently, while avoiding or dealing tangentially with even noticeable conflicts that do not seem too noxious or would be difficult or impossible to handle in the first part of therapy. In most cases, however, dynamic causative issues are not concentrated on during the first part of

treatment.

FOCUSING ON PRECIPITATING EVENTS

Many patients come to therapy convinced that their problems were brought about by some precipitating factor in their environment. An alcoholic husband, a disastrous investment, a broken love affair, a serious accident, these and many other real or exaggerated calamities may be blamed. What people usually want from treatment is help in getting rid of painful or disabling symptoms that are often ascribed to such offensive events. The symptoms are varied and include anxiety, depression, phobias, insomnia, sexual difficulties, obsessions, physical problems for which no organic cause can be found, and a great many other complaints and afflictions.

Even though the therapist may be correct in assuming that the basic troubles reside elsewhere than in environmental or symptomatic complaints, to bypass the patient's immediate concerns is a serious mistake. Later when there is firm evidence of the underlying causes, for example, faulty personality operations or unconscious conflict, a good interviewer, as has been mentioned, should be able to make connections between the precipitating events or existing symptoms and the less apparent dynamic sources of difficulty. There will then occur a change in focus. This shift, however desirable it may seem, is not always necessary because it may be found that therapeutic objectives are reached with symptom-oriented and problem-solving methods and that the patient achieves stabilization without delving into corrosive conflicts or stirring up ghosts of the past. It is only when goals go beyond symptom relief or behavioral improvement that the therapist will, in the hope of initiating some deeper personality alterations, delve into dynamic problem areas. Even when the objective is mere symptom relief or behavioral improvement, however, resistance to simple supportive and reeducative tactics may necessitate a serious look at underlying personality factors that are stirring up obstructive transference and other interference to change.

In practically all patients some immediate stress situation, usually one with which the individual is unable to cope, sparks the decision to get help. Usually the patient feels

like the victim rather than perpetrator of his or her identified troubles. This, in some cases, may be true; in most cases it is false. It is necessary, therefore, in all patients to appraise the degree of personal participation in their difficulties.

Since we are actually dealing with situations that generate tension and anxiety, it is essential to view environmental incidents through the lens of their special meaning for the individual. What may for one person constitute an insurmountable difficulty may for another be a boon to adjustment. During World War II, for instance, the London bombings for some citizens were shattering assaults on emotional well-being; for others they brought forth latent promptings of cooperation, brotherliness, and self-sacrifice that lent a new and more constructive meaning to the individual's existence. Indeed, wartime with its threat to life marshalled an interest in survival and subdued neurotic maladjustment, which returned in peacetime to plague the individual.

The understanding of stress necessitates acknowledging that there is no objective measure of it. One cannot say that such-and-such an environment is, for the average adult, 70 percent stressful and 30 percent nurturant. No matter how benevolent or stressful the environment, the individual will impart to it a special meaning as it is filtered through the individual's conceptual network. This shades the person's world with a significance that is largely subjective. Conceptual distortions particularly twist feelings toward other human beings and especially toward the self. A self-image that is hateful or inadequate may plague the individual the remainder of his or her life and cause self-devaluing interpretations of events. Most of what happens to the patient will be viewed as confirming a sense of low self-worth and that nothing that he or she does will amount to anything. Such a pervasive belief, of course, makes nearly any occurrence productive of considerable stress.

It is rare then that environmental stress alone is the sole culprit in any emotional problem. Inimical, frightening, and desperate situations do arise in the lives of people, but the *reactions* of the individual to happenings are what determine their pathological potential. Under these circumstances minor environmental stress can tax coping

capacities and break down defenses so that an eventuating anxiety will promote regressive devices such as protective phobias. It is, therefore, essential that any precipitating incident that brings a patient into therapy be regarded as merely one element in an assembly of etiological factors, the most important variable being the degree of flexibility and integrity of the personality structure. It is this variable that determines a harmonious interaction of forces that power intrapsychic mechanisms when security and self-esteem are threatened by adversity from the outside and by common developmental crises that impose themselves from within. Through focusing on what is regarded as a precipitating incident, the therapist may be able not only to initiate remediable environmental corrections but also to open a window into hidden personality resources.

From a practical viewpoint, therefore, any environmental stress warrants close examination for its influence, good or bad, on the total resources of the patient. An understanding of the how and why of its impact may prove invaluable. Sometimes the initiating factor may seem like a trivial spark to the therapist, but an exploration of the patient's history, attitudes, and values may reveal the emotionally explosive mixture that awaits detonation.

FOCUSING ON SYMPTOMS

Most patients are concerned with disturbing symptoms, which is the chief reason for their coming to treatment. The relief of such symptoms sometimes constitutes a legitimate beginning objective, particularly if the therapist employs a systems theory design that focuses on the causative link responsible for the current difficulty. One reason a systems approach has been resisted by some authorities is that in describing it, confusing language has been employed that is closer to theories of engineering and communication than to psychological constructs (e.g., "morphostatic principles," "negative feedback loops," "cybernetic regulation," "servomechanisms," "morphogenesis"). In the mental health field, a systems viewpoint shorn of these vertiginous linguistics can prove useful. Such a viewpoint would consider behavior a long chain of a number of operative units linked

together. In psychotherapy, the focus can be on the particular unit link in the chain that is creating the greatest disturbance for the individual: biochemical, neurophysiological, developmental, conditioning, intrapsychic, interpersonal, social, philosophical-spiritual. Thus if the symptom is a product of a biochemical problem that produces an imbalance of neurotransmitters and hormones, the therapist may, after establishing a proper diagnosis that implicates biologic factors, attempt to deal with the *biochemical link* by prescribing appropriate corrective medications. In this way the therapist may relieve some disturbing symptoms of schizophrenia with neuroleptics, of depression with antidepressant drugs, mania with lithium, and anxiety with antianxiety medications. The mechanism of the action of psychotropic drugs in panic, bulimia, obsessive-compulsive, and attention disorders is not known, but apparently the biochemical link is somehow involved and antidepressant medications may be effective. More is being discovered about how the mind and brain work through modem neurophysiological research (e.g., nuclear magnetic resonance, imaging techniques, position emission tomography (PET), and studies of neuropsychological deficits brought about by lack of coordination of the right and left hemispheres, defective brain metabolism, and impaired cerebral circulation. Psychopathology brought about by structural defects and malfunctions of the *neurophysiological link* has been ameliorated through psychopharmacology, relaxation techniques, and biofeedback.

Problems related to the *developmental-conditioning link,* e.g., disorganizing patterns due to improper early child-rearing practices and disruptive conditioning, and which manifest themselves as phobias, habit disorders, behavior problems, adjustment difficulties, and developmental retardation are sometimes definitively helped by behavior therapy, cognitive therapy, and hypnosis. Problems in the quality and flexibility of defenses, which are mediated by the *intrapsychic link* and register themselves as disturbances in the self-system and other components of the psychic apparatus, are best approached with dynamic psychotherapy. Insofar as the *interpersonal link* is concerned, personality, as well as marital, family, and other relationship factors may be optimally engaged by cognitive learning, transactional analysis, experiential therapy, psychodrama, dynamic psychotherapy, and group, marital, and family therapy. The *environmental-social*

link involved in situational problems may best be dealt with by counseling, social casework, environmental manipulation, and milieu therapy. Finally, the *philosophical link* of belief systems, values, standards, and ideals when distorted make for a wealth of problems and may require concentrated attention through techniques like cognitive therapy and existential analysis.

Behavior can be looked upon as a mixture of these intimately connected systemic links, each of which is bracketed to specific areas of dysfunction and pathology for which special corrective modalities, as indicated above, are suggested. Rarely if ever is pathology confined to one system alone. Because biochemical, neurophysiological, intrapsychic, interpersonal, social-environmental, and philosophical-spiritual systems are interrelated, difficulties in one system inevitably will by feedback involve some or all of the others. By the same token, disruptions in any one system that have been corrected through therapy will probably have a congenial effect throughout the systemic continuum. An example of how approaches on different system levels may accomplish similar results is provided in depression. Cognitive and pharmacological approaches deal with opposite ends of the behavioral continuum, and yet, from the available research, depression is relieved with both methods. This lends credence to the hypothesis that a feedback occurs throughout the behavioral chain. Alteration of one link influences the other links. As Beck and Young (1985) have expressed it, "Our experience suggests that when we change depressive cognitions, we simultaneously change the characteristic mood, behavior, and (we presume) biochemistry of depression." It is for this reason that an organizing framework such as suggested above can be useful in treatment planning and in providing a productive focus for therapeutic intervention. Moreover, such a framework substantiates multifaceted therapeutic modes that are targeted on specific zones of pathology. This can be especially helpful in short-term therapeutic approaches in which time is of the essence. It can also be useful in longer kinds of treatment.

FOCUSING ON DYNAMICS

Sometimes an individual presents a problem during the initial interview that

ostensibly is the product of intrapsychic malfunctioning (i.e., the intrapsychic link). As an example, the most effective therapeutic focus is one that deals with a basic repetitive conflict, the manifest form of which is being expressed through the immediate complaint factor. To illustrate, consider the situation of a patient of mine, the mother of two small children, who was insisting on a divorce because of continuing disenchantment with her marriage. The divorce decision appeared to be the terminal eruption of years of disappointment in her husband's failure to live up to her ideal of what a man should be like. After we cut through endless complaints, it became apparent that the standard against which she measured her husband was her father, whom she worshiped as the epitome of success and masculinity. This idealization I discovered later, actually had little basis in fact, being the remnant of an unresolved Oedipal conflict. Be this as it may, her idealization had thwarted her ability to make a proper adjustment to her marriage, and with the decision of a divorce the integrity of her family was being threatened. She came to therapy at the urging of her lawyer, who realized that she was too upset to make reasonable decisions.

A therapist who minimizes the importance of dynamic conflicts may attempt to deal with a situation of this nature by invoking logic or appeals to common sense. The therapist may suggest ways of patching things up, insisting that for the sake of the children a father, however inadequate, is better than no father. The therapist may, upon consulting with the husband, point out various compromises the husband can make, and after the wife has verbally disgorged a good deal of her hostility in the therapeutic session, she may be willing to cancel her divorce plans and settle for half a loaf rather than none. The reconciliation is executed through a suppression of her hostility, which finds an outlet through sexual frigidity and various physical symptoms. On the other hand, should the therapist recognize the core conflict that is motivating her idea of divorce, there is a chance that the patient may be helped to an awareness of her merciless involvement with her father and the destructive unreasonableness of her fantasies of what an ideal marriage is like. She may then allow herself to examine the real virtues of her husband and the true advantages of her existing marriage.

A dynamic focus should, therefore, be prospected in the course of exploring the immediate complaint factor. Such a focus is often arrived at intuitively (Binder, 1977). The more empathic, skilled, and experienced the therapist, the more likely he or she will be to explore the actual operative dynamics. No matter how firmly convinced the therapist is in his or her immediate assumptions, however, it is with a realization that these are being predicated on incomplete data. The therapist theorizes the patient may deliberately withhold important information, or though the patient may recognize certain conflicts, she is still oblivious to their significance or completely unaware of their existence. Whatever tentative theories come to the therapist's mind, he or she will continue to check and to revise them as further information unfolds. Interviews with relatives and friends are extremely valuable since they may open facets of problems not evident in conversations with the patient. Moreover, once the patient during the first encounter has divulged data, later interviews will help uncover rationalizations, projections, and distortions that will force the therapist to revise the thesis and concentrate on a different focus from the one that originally seemed so obvious.

No matter how astute the therapist has been in exposing a truly momentous focus, the patient's reactions will determine whether the exposure turns out to be fruitful or not. For example, even though an underlying problem is causing havoc in a person's life and is responsible for the crisis that brings the person to therapy, this does not imply that the patient will elect to do anything about it. Its emotional meaning may be so important to the patient, the subversive pleasures and secondary gains so great, that suffering and misery are easily accepted as conditions for the indulgence of destructive drives even when the patient has full insight into the problem, recognizes its genetic roots, and realizes the complications that inevitably indemnify the indulgence. I recall one patient whose yearning for revenge on a younger sibling produced a repetitive series of competitive encounters with surrogate figures toward whom retaliatory hostilities and violence brought forth punishment by employers, colleagues, and friends. A series of abuses culminated in a disastrous incident in which a physical assault on a fellow employee resulted in the patient's discharge from a promising executive position. This happening was so widely publicized in the industry that the patient was unable to secure

another job. During therapy the patient was confronted with the meaning of his behavior and particularly his revenge and masochistic motives; he readily recognized and accepted their validity. This did not in the least deter his acting out on any occasion when he could vent his rage on a sibling figure. At the end of our brief treatment period, it was recommended that he go into long-term dynamic therapy, which he bluntly refused to do. He seemed reconciled to pursue a damaging course for the momentary joy that followed an outburst of aggression.

Experience with the addictions provide ample evidence of the futility of focusing on the dynamics of a dangerous and what appears on the surface to be a disagreeable way of behaving. But that some patients disregard logic does not nullify the need to persist in making careful interpretations in the hope of eventually eroding resistance to the voice of reason.

We may expect that a patient seeking help will communicate sufficiently to supply essential material from which a focus may be extrapolated. Understandably, there will be differences in emphasis among therapists, even among those who have received similar theoretical grounding. The available material is usually sufficiently rich to enable therapists to identify ample aspects that synchronize with their intuitions, ideas, and biases.

Since all people share certain conflicts that are basic in our culture, some of these can constitute the dynamic focus around which interpretations are made. Thus manifestations of the struggle over separation-individuation following the ideas of Mann (1973), persistence of Oedipal fantasies as exemplified in the work of Sifneos (1972), and residues of psychic masochism such as described by Lewin (1970) are some of the core conflicts that may be explored and interpreted. Sensitized to indications of such conflicts as they come through in the patient's communications, the therapist may repeatedly confront the patient with evidence of how the patient is being victimized by the operations of specific inner saboteurs. There is scarcely a person in whom one may not, if one searches assiduously enough, find indications of incomplete separation-individuation,

fragments of the Oedipal struggle, and surges of guilt and masochism. It is essential, however, to show how these are intimately connected with the anxieties, needs, and defenses of each patient and how they ultimately have brought about the symptoms and behavioral difficulties for which the patient seeks help.

Lest we overemphasize the power of insight in bringing about change, we must stress that to a large extent the choice of a dynamic focus will depend on the therapist's seeing the presenting problem of the patient through the perspective of certain theoretical convictions. A Freudian, Jungian, Adlerian, Kleinian, Horneyite, Sullivanian, Existentialist, or behavior therapist will focus on different aspects and will organize a treatment plan in accordance with personal ideologies. Although the focus, because of this, will vary, there is considerable evidence that *how* the focus is implemented and the quality of the relationship with the patient are at least as important factors in the cure, if not more so, than the prescience of the therapist and the insightful bone of dynamic wisdom given the patient to chew on. That implantations of insight sometimes do alter the balance between the repressed and repressive forces cannot be disputed. How much the benefits are due to this factor and how much are the product of the placebo effect of insight, however, is difficult to say. When a therapist is firmly convinced of the validity of the focus chosen and convinces the patient that neurotic demons within can be controlled through accepting and acting upon the "insights" presented, tension and anxiety may be sufficiently lifted to relieve symptoms and to promote productive adaptation. Even spurious insights if accepted may in this way serve a useful purpose. Without question, nevertheless, the closer one comes in approximating some of the sources of the patient's current troubles, the greater the likelihood that significant benefits will follow.

In this respect for some years I have employed a scheme that I have found valuable in working with patients. This, which is certainly not original with me, consists of studying which resistances arise during the implementation of any of the techniques that I happen to be employing at the time. The resistances will yield data on the existing dynamic conflicts, the most obstructive of which is then chosen as a focus.

Experience with large numbers of patients convinces that three common developmental problems initiate emotional difficulties and create resistance to psychotherapy—first, high levels of dependency (the product of inadequate separation-individuation), second, a hypertrophied sadistic conscience, and, third, devaluated self-esteem. Coexisting and reinforcing each other, they create needs to fasten onto and to distrust authority, to torment and punish oneself masochistically, and to wallow in a swamp of hopeless feelings of inferiority and ineffectuality. They frequently sabotage a therapist's most skilled treatment interventions, and, when they manifest themselves, unless dealt with deliberately and firmly, the treatment process will usually reach an unhappy end. Dedicated as the therapist may be to their resolution, the most the therapist may be able to do is to point out evidence of these saboteurs, to delineate their origin in early life experience, to indicate their destructive impact on the achievement of reasonable adaptive goals, to warn that they may make a shambles out of the present treatment effort, and to encourage the patient to recognize his or her personal responsibility in perpetuating their operation. The tenacious hold they can have on a patient is illustrated by this fragment of an interview.

The patient, a writer 42 years of age, who made a skimpy living as an editor in a publishing house, came to therapy for depression and for help in working on a novel that had defied completion for years. Anger, guilt, shame and a host of other emotions bubbled over whenever he compared himself with his more successful colleagues. He was in a customarily frustrated, despondent mood when he complained:

> *Pt.* I just can't get my ass moving on anything. I sit down and my mind goes blank. Staring at a blank piece of paper for hours, I finally give up.
>
> *Th.* This must be terribly frustrating to you.
>
> *Pt.* (*angrily*) Frustrating is a mild word, doctor. I can kill myself for being such a shit.
>
> *Th.* You really think you are a shit?
>
> *Pt. (angrily)* Not only do I think I am a shit, I am a shit, and nobody can convince me that I'm not. [*The self-devaluation could not be more clearly expressed.*]
>
> *Th.* Frankly, Fred, I'm not even going to try. But you must have had some hope for yourself,

otherwise you never would have come here.

Pt. I figured you could get me out of this, but I know it's no use. I've always been a tail ender.

Th. (*confronting the patient*) You know, I get the impression that you've got an investment in holding on to the impression you are a shit. What do you think you get out of this?

Pt. Nothing, absolutely nothing. Why should I need this?

Th. You tell me. *[In his upbringing the patient was exposed to a rejecting father who demanded perfection from his son. The father was never satisfied with the even better than average marks his son obtained at school and compared him unfavorably with boys in the neighborhood who were prominent in athletics and received commendations for their school work. It seemed to me that the paternal introject was operating in the patient long after he left home, carrying on the same belittling activities that had plagued his existence when he was growing up.] Pt. (pause)* There is no reason, *(pause)*

Th. You know I get the impression that you are doing the same job on yourself now that your father did on you when you were a boy. It's like you've got him in your head. *[In the first part of the session the patient had talked about the unreasonableness of his father and his own inability to please his father.]*

Pt. I am sure I do, but knowing this doesn't help.

Th. Could it be that if you make yourself helpless somebody will come along and help you out? [*I was convinced the patient was trying to foster a dependent relationship with me, one in which I would carry him to success that defied his own efforts.*]

Pt. You mean, you?

Th. Isn't that what you said at the beginning, that you came to me to get you out of this thing? You see, if I let you get dependent on me it wouldn't really solve your problem. What I want to do is help you help yourself. This will strengthen you.

Pt. But if I can't help myself, what then?

Th. From what I see there isn't any reason why you can't get out of this thing—this self-sabotage. *(The patient responds with a dubious expression on his face and then quickly tries to change the subject.)*

In the conduct of psychotherapy, especially in its briefer forms, one may not have to deal with the underlying conflicts such as those above *as long as the patient is moving along and making progress. It is only when therapy is bogged down that sources of resistance must be uncovered.* These, as has been indicated, are usually rooted in the immature needs and defenses staged by dependent, masochistic, self-defacing promptings. At some point an explanation of where such promptings originated and how

they are now operating will have to be given the patient. This explanation may at first fall on deaf ears, but as the therapist consistently demonstrates their existence from the patient's reactions and patterns, the patient may eventually grasp their significance. The desire to make oneself dependent and the destructiveness of this impulse, the connection of suffering and symptoms with a pervasive desire for punishment, the masochistic need to appease a sadistic conscience that derives from a bad parental introject, the operation of a devalued self-image and the subversive gains that accrue from victimizing oneself, must be repeated at every opportunity, confronting the patient with questions as to why the patient needs to continue to sponsor such activities.

Sometimes a general outline of dynamics, such as will be detailed later (illustrated in Fig. 37-1) may be offered the patient with the object of either stirring up some anxiety for analysis or of providing the patient with an interpretation that fosters better self-understanding. Although some neurotic drives and defenses are probably typical in our culture of both "normal" and neurotic individuals, the specific modes of operation and the kinds of symptoms and maladjustments that exist are unique for each individual. Every person has a thumb, but patterns of thumbprints are all different. The therapist, employing a blueprint such as Figure 37-1 may try to fit each patient's problems into it and then choose for focus whatever aspects are most important at the moment. For example, a man may during a session complain of a severe headache and thereafter proceed to beat himself masochistically, blaming himself for being weak and ineffectual. The therapist should then search to see how this trend affiliates itself with guilt feelings and what immediate situation inspired such feelings. The therapist may discover that what is behind the guilt is anger in the patient at his wife for not living up to his expectations in executing her household duties. Further probing may reveal anger at the therapist for not doing more for the patient. Such transference manifestations may enable the therapist to make a connection with the patient's mother, toward whom there has existed since childhood a good deal of anger for her neglect and rejection. This will open up a discussion of the patient's excessive dependency needs and the inescapable hostility, low independence, and devalued self-esteem that dependency brings about. An association may be established between the patient's hostility turned inward and the

migraine headaches for which therapy was sought in the first place. The therapist should in this way take advantage of every opportunity to show the patient the interrelationship between the various drives, traits, and symptoms, keeping in mind that though a certain trend may encompass the patient's chief concern at the moment, it never occurs in isolation. It is related intimately to other intrapsychic forces even though the connection may not be immediately clear.

An individual can make a reasonable adjustment for a long time even with a vulnerable character structure. The patient's personality, defective as it may have been, still operates harmoniously; various balances and counterbalances maintaining the psychological equilibrium. Then because of the imposition of an external crisis situation or because of stresses associated with inner needs and external demands, anxiety, depression, phobias, and other symptoms appear. The patient may consider that adjustment prior to the presence of some precipitating factor was satisfactory if not ideal, with no awareness of how the tenuous personality interactions have been sponsoring various symptoms and ultimately had produced the patient's breakdown. The patient is very much like a man with back pain who credits his "sciatica" to one incident of lifting a weight that was too heavy, oblivious of the fact that for months or years he has, through faulty posture and lack of exercise, been accumulating weak and strained muscles.

Thus patients whose self-image is being sustained by a defense of perfectionism for as far back as they can remember will have to perform flawlessly even in tiny and most inconsequential areas of achievement. To perform less than perfectly is tantamount with failure and signals inferiority and a shattered identity. The merciless demands they keep making on themselves may be impossible to fulfill. At a certain point when unable to face up to demands in some truly important situation, the failure will act like a spark in an explosive mixture. The resulting symptoms that finally bring them into treatment are depression and insomnia. It will require little acumen for a therapist to spot the perfectionistic trends around which the patients fashion their existence. But to argue them out of the perfectionism and to counter the barrage of rationalizations evolved over a lifetime are difficult, if not impossible, tasks. We may, nevertheless, attempt to work with

cognitive therapy and select perfectionism as a focus, pointing out the distortions in logic that govern the patients' thinking process. Not all therapists have the skill and stamina to do this, nor is there yet sufficient data to testify to the efficacy of this approach in all cases.

What would seem indicated is to review with the patients the implications of perfectionism, its relationship to the defective self-image, the sources of self-devaluation in incomplete separation-individuation, the operations of masochism, and so forth. Obviously, the therapist must have evidence to justify these connections, but even though the therapist presents an outline to patients of possibilities and stimulates the patients to make connections for themselves the therapist may be able to penetrate some of the patients' defenses. In the first part of therapy, psychodynamic explanations usually have little corrective influence. They simply may stir up the patient's curiosity and perhaps mobilize some defensive resistance, which may become a productive focus. Giving the patients a general idea about personality development may be occasionally helpful, especially when insufficient time is available in therapy to pinpoint the precise pathology. Patients are usually enthusiastic at first at having received some clarification and they may even acknowledge that segments of the presented picture relate to themselves. They then seem to lose the significance of what has been revealed to them. In my experience, however, later on in follow-up many patients have brought up pertinent details and have confided that psychodynamic explanations stimulated productive thinking about themselves. (See also Chapters 39 and 44.)

Part III.
The Middle Phase of Treatment

Once the working relationship is consolidated, and patients accept a more active role of working on their problems, we enter the middle stage of treatment. This has as one of its objectives the revelation of what is behind the patients' symptoms and behavior. It embraces a more precise delineation of behavioral excesses and deficits as well as the internal and external reinforcing agencies that enervate them. The extent of such determination will depend on the goals of our therapeutic effort. In supportive therapy we may merely seek to identify and to bring patients to an awareness of discordant elements in their environment that activate their turmoil, so as to help us in their control. Here, an examination of factors that promote the situational entanglement and study of the effects on patients of their disturbance may be all that is attempted. In reeducative therapy there may be an exploration of the patients' more conscious interpersonal reactions, the ensuing difficulties that follow expression of their personality patterns, and the provocative individuals and situations that keep existing distortions alive. These therapeutic tasks are implemented by the conventional interviewing techniques.

In reconstructive approaches, the task is more ambitious since the level of exploration is on unconscious strata of mind. The symbolic extensions of unconscious conflicts are explored through a number of techniques that will presently be described. The contamination of rational behavior with derivatives of the unconscious is investigated and analyzed. There is also an inquiry into the genetic origin of the individual's conflicts, the determining childhood experiences that initiated and produced character distortions and maladaptive mechanisms of defense.

The underlying dynamics as they disclose themselves during the middle phase of therapy will be specific for the individual. While a great deal of variation exists in patterns of defense, it is possible to propose a few general propositions.

In the main, the individual who possesses an emotional problem is suffering from defective conditioning that cripples the capacities for adaptation. Conditioning is a universal process in learning. From birth on, the individual is constantly reacting to primary (unconditioned) stimuli that occur jointly with secondary (conditioned) stimuli. If this linkage continues for a period, the secondary stimulus, though adventitious and unrelated, is apt to evoke the same response as the primary stimulus. This association tends to become reinforced or to diminish and become extinct according to how consistent the two stimuli appear together. A generalization of the conditioning may occur, the individual responding to parts of the unconditioned stimulus. For instance, in learning any language there is a constant reinforcement of the conditioning of words (written or spoken) to objects and feelings until the word evokes the same responses as the objects and feelings. Attitudes and values likewise evolve from conditioning to rewards and punishments that are presented for specific kinds of behavior. Soon a host of external reinforcing situations, objects, and people accumulate that provoke various reactions. They may serve in this way as realistic sources of stress, promoting symptoms and defenses.

Symptoms and defenses are also the outcome of many conditioned inner reinforcers that affect the person's feelings of security, self-esteem, relationships with people, and capacity to express basic needs and demands. The primary sources of these inwoven mischief mongers are disorganizing life experiences that date back to the very earliest contacts of the child with parents and other important persons in the past. Distortions in values and attitudes engendered by unfortunate conditionings with parental agencies remain even in maturity, and the person usually reacts to life with archaic fears, frustrations, and hostilities, many of which singularly are little modified by adult experiences. It is as if the epoch of childhood creates the paradigms in adult life that reflect the very values and contain the same expectations of injury that the individual had as a child.

The consequence of disturbances in security feelings, self-esteem, and interpersonal relationships caused by unfortunate early conditionings is to make the individual

vulnerable to even average deprivations and vicissitudes. This is registered in terms of a failing life adaptation, when inner conflicts exert their pressure and external demands tax the coping capacities of the person. Earliest signs of adaptive disorganization are tension, anxiety, and the psychophysiologic components of anxiety. The latter symptoms, universal phenomena in neuroses, provoke the ego into marshalling all the defensive instrumentalities it has at its disposal to bring the individual to a psychic equilibrium. Anxiety and its attendant physiologic reactions are so destructive to the person that attempts to cope with it are always made.

Many symptoms the individual displays in response to the stimulus of anxiety serve to defend against the effects of this emotion. They defend also against the initiating conflicts themselves. Why different symptoms and syndromes are elaborated in different people to cope with essentially the same kinds of conflicts is a challenging question, the answer to which is not entirely clear.

The knowledge that symptoms arise out of failure of the individual in dynamic dealings with life, has, in recent years, tended to displace the emphasis in treatment from symptomatic relief to reconstructive betterment of relationships with other people. What a therapist hopes to effect in reconstructive therapy is a building of security in the person so that an individual no longer feels menaced by fears of the world. In addition, self-esteem must be enhanced to the point of self-confidence, assertiveness, and creative self-fulfillment. Each individual must gain self-respect without striving for perfectionism or superiority. Relationships with people must become harmonious and shorn of such impulses as dependency, detachment, and aggression. Finally, one must become capable of satisfying inner needs and demands without anxiety and in conformity with the standards of the group. Not every patient is capable of achieving the ideal goal in therapy of major personality rehabilitation; yet the therapist has a responsibility in promoting in each individual as extensive a growth in personality as is reasonably and practically possible.

Personality change is catalyzed by helping the patient in psychotherapy to arrive at an awareness of the operative forces within the self. This process is characterized by

progressive stages of self-understanding and steps of adaptive action, which, in the main, may be delineated as follows:

1. Elaboration by the patient of symptoms and complaints

2. Discussion of feelings associated with symptoms

3. Relation of feelings to dissatisfactions with the environment.

4. Recognition of repetitive patterns of behavior and appreciation of their responsibility for disturbed feelings

5. Awareness of dissatisfaction with behavior patterns, but realization of their compulsive persistence

6. Cognizance of the functional nature of behavior patterns

7. Exploration of preponderant patterns and the determination of their origin in early relationships

8. Disclosure of the archaic nature of the patient's disturbing life trends and mechanisms of defense

9. Challenging of early attitudes

10. Serious consideration of rights to a more productive life

11. Intense dissatisfaction with current patterns, insecurities, and devaluated self-esteem

12. Experimentation with new modes of behavior

13. Liberation from old values and types of action

14. Evolution of greater security, assertiveness, self-esteem, and a sense of mastery

15. Development of a different conception of oneself, of more constructive interpersonal relationships, and of greater capacities for the expression of personal needs

These stages of understanding and adaptive action are never pursued by the patient

in as rigidly sequential a manner as has been outlined. There is generally a shifting back and forth, and, as one pattern is discovered and explored, new discoveries are made that call for further elaboration.

The principle techniques by which the therapist helps the patient to the acquisition of self-understanding are (1) interview procedures, (2) free association, (3) dream analysis, and (4) the examination of attitudes toward the therapist, including transference.

39
Identifying Important Trends and Patterns: The Use of Therapeutic Interviewing

In all forms of psychotherapy, except Freudian psychoanalysis, the focused interview is the chief exploratory vehicle. From material obtained in the initial interview and during the early sessions the therapist will have some idea of the sources and dynamics of the patient's symptoms. Of these the patient may be fully conscious, partially conscious, or, more rarely, completely unconscious. If our goal in therapy is at least some personality reconstruction, underlying causes and dynamics are investigated through such techniques as maintaining the flow of verbalizations, directing their course through selective focusing, and devices like accenting, summarizing, restating, reflecting, establishing connections, and maintaining tension in the interview. It is imperative to become thoroughly conversant with the principles of interviewing that have been described in Chapter 19, "The Conduct of the Psychotherapeutic Interview." For without a good understanding of interviewing, the therapist will be handicapped in carrying the patient through the middle phases of therapy.

In attempting to identify important patterns during the interview, the therapist may listen carefully for a dominant theme that tinctures the patient's verbalizations. Sometimes unexpressed feelings are as significant or more significant than the verbalizations themselves. The patient's nonverbal behavior also reveals many important clues. Slips of speech, hesitations, blocks, evasions and changes in content may furthermore give warning of conflictive areas. The therapist must constantly be sensitized to evidences of conflict in the various concerns of the patient.

The following excerpt is an illustration of how insight may be gained through focused interviewing. The patient, an associate editor on a magazine, interested in music as a possible profession, brings up an incident in her work with an orchestra that arouses in her a destructive neurotic pattern.

Pt. I was getting along fine, but then things started to go wrong, *{pause)*

Th. Wrong? (*repeating the last word to focus on the source of the difficulty*]

Pt. Everything went bad. My head hurt and my stomach kicked up badly.

Th. How long did this go on? *[attempting to focus the patient's attention away from symptoms]*

Pt. It all started vaguely about 2 days ago. *(pause)*

Th. Anything happen at that time? *[probing for a cause]*

Pt. Nothing unusual … I've been menstruating and have a lot more pain than usual. I listened to a recording of our orchestra last Tuesday, and it sounded very bad, particularly in parts where I came in. [*The patient advances environmental happenings that may or may not be causative.]*

Th. How did this make you feel? *[focusing on feelings]*

Pt. Well, I'm disgusted. I wonder why they have to have a group of inexperienced people with us. It makes me feel no good, too. *[What comes to mind at this time is, first, that the patient is resentful and cannot adequately express her resentment and, second, that she is blaming and devaluating herself.]*

Th. This disgusts you. *[repeating the patient's expressed feeling]*

Pt. Yes, I'm furious at them, but it's impossible to say anything. *[This sounds like suppressed or repressed hostility.]*

Th. That must be very frustrating *[expressing sympathy with how the patient feels]*

Pt. Yes, it is. How can they expect to have a good orchestra if they include beginners? *[The patient apparently seeks approval here for her resentment.]*

Th. It does sound unreasonable, *[backing the patient up in her feeling]*

Pt. I am so mad that I feel like quitting. *(clenches fists)* *[Apparently my encouragement helped to mobilize this aggression.]*

Th. Mm hmm.

Pt. But I know I won't, *(pause)*

Th. You must get something out of wanting to stay in the orchestra in spite of how bad things are. *[inquiring about positive values in here present situation]*

Pt. I don't think anything is worth what I go through.

Th. Then you may have the temptation to give up your place in the orchestra in spite of any

possible good it does you.

Pt. But why should I be pushed out of a good thing? *[Apparently there are many positive values in her present situation.]*

Th. Yes, why should you? *[supporting the patient in her determination]*

Pt. (pause) You know, I ordinarily would get mad and then quit. I've done this about many things all my life—school, jobs, everything. I'd get mad and then blow everything up. It's awful. *[Patient recognizes a destructive pattern related to how she handles frustration and hostility. This insight should be of value to her.]*

Th. There must have been a reason why you did this, *[focusing her attention on causes]*

Pt. I'd get so mad, I'd be willing to blow everything up, including myself. I'm not going to let myself be maneuvered out of the orchestra though. I'm not going to be that silly.

Th. But your anger may be hard to control *[warning her of possibilities of repetition of her neurotic behavior]*

Pt. Yes, I know, but I won't let it—at least now I won't *[Her understanding of her resentment encourages more rational behavior.]*

The focus in interviewing may be on the patient's symptoms, feelings, environmental dissatisfactions, interpersonal relationships, past history, and slips of speech and on the therapist's intuitive understanding of the patient's problems.

FOCUSING ON SYMPTOMS

Concentration on symptoms is of primary concern in supportive and some reeducative approaches like behavior therapy. While some symptoms are surface manifestations of deeper problems, a careful exploration of their content and function and of the patient's attitudes toward them may reveal important facts about past conditionings, reinforcing situations and people, repudiated impulses, as well as defenses against the impulses.

Focusing on symptoms in reconstructive approaches is largely for the purpose of demonstrating their relationship to underlying feelings. Sexuality seems to be overweighted in our culture and many patients concentrate on their disturbed or inhibited sexual life when they come to therapy. Since sex may preoccupy them, they may

not be aware that this aspect of their functioning is only one dimension of their problem. This will be apparent in many of the interviews reproduced in this book. The therapist should at all times never be sidetracked by this focus and should attempt to place sexual and other symptoms into proper perspective. In order to do this, the patient's attention should be brought to undercurrent emotions whenever sexual and other symptoms are brought up. It is important also to explore the relationship of symptoms to definite life situations. If the therapist knows how to employ dreams, these may be used advantageously to establish the connections of symptoms with feelings and causal life situations.

A patient who had come to therapy because of depression following the rupture of a love affair started a session with the complaint of a skin symptom. Focusing on the symptom brought out the fact that it was a conversion phenomenon, resulting from certain conflicts of which the patient became aware during interviewing.

> *Pt.* Margaret was in my apartment no more than 2 hours when I noticed my arm itching. I took off my jacket. *[Margaret is the young woman with whom the patient is having an affair, after the violent rupture of a relationship with another young woman.)*
>
> *Th.* Where was the itch?
>
> *Pt.* On both arms, the round surface up here just below the elbow, like a band.
>
> *Th.* I see.
>
> *Pt.* It started in the left arm, and then it spread to this arm in the same place.
>
> *Th.* Exactly the same kind of band?
>
> *Pt.* Yes, and several hours after that I noticed a band about the size of 6 inches over the ankle on both sides. Almost like a wide bracelet.
>
> *Th.* Mm hmm.
>
> *Pt.* And immediately I thought, "Jesus Christ I'm itching." Funny I hadn't had it before. And Margaret said, "What are you so nervous about?" And then I started on her, "I don't know," I said, "I don't know what it is." *(pause)*
>
> *Th.* Now suppose you talk about the things that happened to you just before you got this itch, *[focusing on possible causes]*

Pt. Well, I was coming home from work and I decided to walk on Harriet's street where she lives. *[Harriet is the young woman with whom the patient was in love and who broke up the relationship.]* I passed Harriet's house and looked up and saw the light on and figured what's going on there. I'm itching like hell now. There must be a direct connection. This proves it. This itching is bad. I scratched so furiously I drew blood. So I said, "Jesus Christ that's stupid." So I put some salve on. Then I went to sleep with Margaret. I went to sleep, and I dreamed about Harriet. I dreamed I was back with her and I was suspicious as to what she wanted from me. She seemed to want to screw me, that is, get physically in me. I don't know if she was on my back, on the side, or what. She was bent forward in what I suppose was her driving position. I asked her why she was back, but she gave me no clear-cut answer except that she wanted "to get laid." Then I realized that she wanted to reduce me to impotence. I played along with her even though I didn't trust her. Then, in another room another girl came into sight. I thought I can lay this other dame. Do I owe Harriet anything? No. I don't trust her. I'll do as I want. I felt, the hell with her. *(pause)* That's all. *(pause)*

Th. I see. What are your ideas about that?

Pt. Well, you see, Harriet did make me impotent. That is, I got impotent with her. She kept comparing me with the other guys she screwed. She'd say, "Be a man and fuck me like the others did." It would make me furious. I'd compare myself with them, and ask her about them. She kept telling me that I didn't rate much when it came to fucking.

Th. What do you think this did to you?

Pt. I got so I couldn't function with her and I got impotent.

Th. And then she threw you out.

Pt. That goddamn bitch. I hate her. Margaret is such a better person. Considerate and kind, but … *(pause)*

Th. But … *(pause)*

Pt. I shouldn't feel so dissatisfied with her.

Th. But you do.

Pt. I must. I keep on thinking about Harriet. The other days when I walked by her house—I do that now a lot—I would look up at her room and feel relieved that the place was dark. Then I'd figure where else is she, and I'd say that she must be screwing in somebody else's apartment, not her own. But I'd push that out of my mind. This time when I saw the light, I felt very upset. I said to myself that she is half undressed or she's all undressed. She's in bed with a guy. He's undressing her or she's undressing him. I don't know who the guy is. He's probably a son of a bitch who doesn't look anything like me.

Th. What emotional effect did it have on you?

Pt. I thought to myself, it's amazing how little it concerns you: you have no reaction.

Th. It astonished you?

Pt. Where is the reaction there, I said. I'm going with Margaret. I've got a better girl. I thought I'd go home and make love to Margaret. So when I got home, there was Margaret, and then I got that goddamned itch.

Th. Mm hmm.

Pt. I kept thinking about what time this man with Harriet went home. Then I began to resent Margaret. I felt why can't Harriet be with me.

Th. In other words, Harriet still has more value to you than Margaret.

Pt. (scratching his arms) This itch is awful. I gradually moved into the position of asking Harriet to marry me. Every time I built up to the point she greeted me with complete silence.

Th. How do you feel about being with Margaret now?

Pt. I feel like I've got chains on.

Th. What kind of chains?

Pt. Tying me down, *(touches itching area of arm) (pause)* You know I just thought of something. I thought of chains in Egyptian times used to tie down slaves. You've seen pictures of them. I have seen pictures of them.

Th. What do the pictures look like?

Pt. Either there or here—bands of iron with the chain between them and anklets governing the size of the step. And, you know, the bands of irons on the arms and legs are like, in the same position as the areas of my itching!

Th. So the conclusion would be what?

Pt. That I'm wearing chains.

Th. And the scratching?

Pt. (excitedly) I want to tear them off.

Th. But these emotional chains you're wearing are what?

Pt. Jesus Christ, I feel a defiance. This thing is building up with Margaret. I was getting to think I was comfortable, but I resented the comfort. She's giving up her job, fluttering around, looking for this, looking for that. Basically she's here to stay because she wants to be with me. I feel as if I'm in chains with her. I don't want to marry her.

Th. So Margaret is your chain and you want to get rid of her. [*interpreting*]

Pt. But I know what is enslaving me. I don't want chains on me so I can go back to Harriet. But, shit, I don't want to go back to her; she's chains for me too. *[We thereafter discuss his masochistic*

FOCUSING ON FEELINGS

Feelings that are openly manifested or that lurk unexpressed behind verbalizations are extremely important aspects of the inner life of the person. Feelings cannot be isolated from intellectual and behavioral components, although anxiety may cause a dissociation. By constantly focusing on feelings and encouraging verbalization, a reunion of dissociated elements may be effectuated. Awareness of feelings and their meaning brings patients to an understanding of their relationships with people and to some of the basic sources of their symptoms.

Thus, patients may talk about their work situation. Sympathizing with their employer, they present an account of how difficult things must be for their employer. The responsibilities that confront the employer are so pressing that they would make anyone irritable and hard to approach. They feel sorry for their employer on this account, and they forgive the employer's rudeness. The therapist, legitimately suspecting that patients feel resentment they do not dare to express, or of which they are unaware, may decide to focus on latent hostility by saying, "Doesn't such behavior on the part of your employer irritate you?" or "I should imagine that your employer's attitudes would sometimes make you angry." This may liberate an acknowledgment of resentment and a more precise investigation of attitudes toward the employer and toward other authorities.

Other patients may be aware of strong sexual feelings in relation to a teacher. Such feelings preoccupy them a large part of the day. They have no idea of why the teacher has made so vivid an impression on them. The therapist, in order to help patients connect their feelings with attitudes toward the teacher, may say, "The teacher arouses certain feelings in you. Have you had similar feelings toward other people?" A description of previous situations in which sexual feelings were intense may reveal a succession of men or women with certain qualities. Asking patients what all of the men or women have in common may bring out the fact that they all resemble their older brother or sister of whom they were enamored as a child, and toward whom they had strong sexual feelings,

which made them feel guilty.

> During the treatment of a patient with a psychophysiologic intestinal disorder, a session was occupied listening to explosive outbursts directed by the patient at her children who were going through a recalcitrant, defiant stage in their development. She brought out several incidents in which one of her children demanded attention and she pushed him away. The patient berated herself for acting so heartlessly. As she spoke, I noticed what seemed to be a frightened expression on her face. Bringing this to her attention, she smiled with relief, and said, "You're right. I just realized that I am afraid, as if I expected you to beat me." She then revealed incidents where her father beat her for doing "wrong things."

In focusing on feelings, it is essential to help patients to a realization that many of their emotions are not rooted in reality, but rather they are derived from misconceptions about life, about people, and about themselves. The patients' attention may be directed toward a variety of aspects, such as the relationship of feelings to disturbing symptoms, the environmental situations that stir up untoward emotions, the repetitive patterns of behavior that provoke destructive feelings, and the relationship with the therapist.

In the following fragment focusing in the session on the patient's feelings of tension and discomfort helps to bring the patient to an awareness of how disappointed he is in his progress and how resentful he is toward me. He realizes that his resentment conflicts with the pattern of constant need for approval and that his inability to express resentment fosters his symptoms.

> *Pt.* I have a funny feeling of uneasiness that's been with me all day, all week, I mean.
>
> *Th.* Any clues to this feeling?
>
> *Pt.* No, just my feeling bad. Even yesterday I felt like throwing up.
>
> *Th.* When did this uneasiness get most uncomfortable?
>
> *Pt.* Just before coming here, *(pause)*
>
> *Th.* Just before coming here?
>
> *Pt.* I think I'm disappointed that I'm not better than I am. I've been coming here 2 months now. I feel I've accomplished nothing. I can't put it more bluntly.
>
> *Th.* Well, you have a right to feel disappointed if you expected an immediate cure. Sometimes, rarely, this happens, but usually it takes a period of time before a person learns about

patterns that stir up symptoms.

Pt. This whole week of complete tension made me think. But I could only think of my tension. I can't organize my thoughts. These thoughts are meaningless to me until I get so bad I have to force myself to think and try to solve my problem.

Th. Mm hmm *(pause)*

Pt. I feel insecure and inferior, and I need approval. Why do I need this approval? Because I have no security in myself. So I need somebody else's approval. So I don't act on my own motives. I try to be a smiling servant to everybody, to gain their good graces, to gain their approval. I lower myself to kiss everybody's behind to get their approval. Now why I haven't I got confidence in myself?

Th. That's a good question. If you need approval from the outside and have no confidence from within, there are reasons for it.

Pt. Why don't I have that self-security or self-approval?

Th. Well, what do *you* think?

Pt. I don't know, *(smiles)* But I do think you are helping me.

Th. But that isn't what you were just telling me.

Pt. Well … *(pause)*

Th. Could it be that you tell me this to get *my* approval—right now, I mean?

Pt. I know I told you I was disappointed in therapy. Maybe it doesn't make any difference what you think. I'm coming here and paying my hard-earned money and I have a right to say it.

Th. You have a right to say what you feel.

Pt. Maybe … wouldn't it be enough to cause tension for me to want to criticize you if I needed your approval, like I need everybody's approval? *[This sounds like insight.]*

Th. It might be.

Pt. So, if I get furious with you, that would be enough to make me feel that you wouldn't give me approval if I told you. And that could upset me like I was upset. But now that I've told you, I feel relieved and not upset any more.

FOCUSING ON ENVIRONMENTAL DISSATISFACTIONS

Environmental problems are suitable foci of attention; however, only rarely are reality circumstances entirely responsible for the patient's condition. Catastrophic life

happenings occasionally do occur in the form of accidents, inclemencies of nature, disasters of war, death of close relatives and friends, and financial and prestige losses. Operative also are pressures of desperate economic circumstances, unemployment, inimical work conditions, unhappy choice of occupation, bad housing, disturbing neighborhood, abnormal cultural standards and pressures, and exposure to destructive family members and mate. The *reactions* of the patient to the environment, however, are usually more important than the environmental distortions themselves.

Most persons project their insecurities, fears, guilt feelings, and hostilities onto their environment. The presence of disturbing life circumstances that seem to justify these attitudes and emotions may satisfy needs and expectations; their absence may create a void in life and perhaps incite one toward involvement in some situational difficulty. Thus, individuals who are intensely hostile may manipulate their environment in such a way that they can conveniently vent their hostility on it. They may entangle themselves in relationships with aggressive or domineering people or get engulfed in situations in which they are exploited. These conditions will tend to justify to themselves their own outbursts of hostility and to support their protestations that they are being misused. They will bitterly protest their plight, little mindful of the fact that they have created the very conditions of which they are so indignant. Indeed, where there are inadequate circumstances to warrant the deep hostility that they feel, they will experience depression, tension, anxiety, and various psycho-physiologic reactions. Environmental manipulation and other supportive efforts directed at the milieu rather than at the individual may fail utterly in their effectiveness here, or they may precipitate neurotic symptoms more incapacitating than those for which therapy was originally sought. Even in severe environmental distortions the personality of the patient must be taken into account as an important concern.

The following excerpt brings out how a patient gains an awareness of patterns of aggression through the consideration of her immediate life situation.

> *Pt.* My husband has been acting up constantly. Just doing mean things. I asked him if he would go out with me, and he said in a nasty way, "Don't intimidate me." Then he said, "Goodbye, you bitch." I had no desire to look at that bastard after that. Then I visited some old friends and

stayed out until 1 A.M. When I got home, he was waiting up for me. He screamed at me, "What the hell do you think you are doing." The nagging continued. He said, "A fine household I have." I told him to go the devil. He shook his finger at me. I pushed his hand away and told him to just stop that. I was going to hit him before he hit me. This marriage of mine is what's causing all my trouble, *(pause)*

Th. You must have felt very upset.

Pt. I was. He is so insulting all the time. I called him a son of a bitch, and then told him to go to hell and went to bed. I woke up 4 A.M. crying, and went over to him and woke him up and warned him. I said, "Why should you sleep when I can't." I shook him and told him I'd break his head open if he repeated it.

Th. You didn't want to let him get away with anything?

Pt. You're darned tootin'. And I won't. I won't with anyone. Anybody starts anything, and I finish it.

Th. What usually happens after you finish it?

Pt. That's just it. Nobody seems to understand. I make enemies.

Th. It is possible that any aggression toward you sets a process into motion where you explode a little too much? *[a tentative interpretation]*

Pt. I have to do what I do to protect myself.

Th. Mm hmm. *(pause)*

Pt. Maybe I *do* go to extremes though. *(pause)*

Th. Perhaps to protect yourself, you feel you have to go to extremes, *[more interpretation]*

Pt. But I do see that it can give people the impression that I'm an attacking bitch. I think I do go to extremes. Maybe I shouldn't explode the way I do. Maybe I cause some of my own troubles.

Th. Is this something you'd consider a pattern?

Pt. I can see that it's been with me many years. I used to be a timid thing, but my marriage made a change. I seem to have gone to the opposite extreme.

FOCUSING ON CURRENT INTERPERSONAL RELATIONS

Identification of basic patterns in relationships may be achieved through an examination of the patients' dealings with other people. The characterologic strivings of the patients in relation to authority, to compeers, and to themselves are, in addition to environmental happenings, a dominant theme in the interviews. Such strivings may

indicate why the patients' adjustment is being sabotaged. For example, they may anticipate criticism and attack from others. Accordingly, their life will be spent in fearful waiting, in detaching themselves from others, or in retaliatory counterattack. They may, in contemplating exploitation, assiduously avoid intimate contact with people and then act outraged at their isolation. They may feel forced to assume a submissive and ingratiating role and then burn inwardly at the indignation of needing to humiliate themselves in this way. They may be consumed by a power drive and want to domineer all persons with whom they have dealings. These aberrations will become evident as the patients talk about daily concerns and tribulations.

The relationship disturbances manifested by the patients will usually be vigorously defended by them, and they will attempt to justify such disturbance with rationalizations. They may even incite the individuals with whom they relate to provocations that precipitate the very reactions about which they complain. Repeated demonstrations are usually required before the patients recognize how they distort reality in line with their expectations.

It may be possible, therefore, by considering their immediate relationships with people, to bring the patients to an awareness of how their patterns influence their adjustment and maladjustment. Sooner or later they may express dissatisfaction with their patterns, but they will recognize the compulsive hold that such patterns have on them. They may realize, too, that their patterns serve a spurious and temporary function of enhancing their security and of bolstering their self-esteem.

The following excerpt illustrates how a consideration of current interpersonal relations may bring a patient to cognizance of important inner strivings. In the session the patient exhibits tension, and he relates it to a recent meeting with a woman who had attracted him. He becomes aware of ambivalent attitudes toward certain women.

> *Pt.* I just don't know what it is that upsets me, and I've been having lots of trouble.
>
> *Th.* Let's talk about it, and maybe we'll learn something about it.
>
> *Pt.* I don't know what it is. My wife is having trouble with the kids. She thinks I'm not sympathetic.

It's like I fear she'll attack or criticize me.

Th. Mm hmm.

Pt. And I met this woman and I found myself thinking about going with her. *(pause)* Having an affair, I mean.

Th. Mm hmm.

Pt. But I don't want to go out with her. *(pause)*

Th. Why?

Pt. I don't know. She's very attractive, but still … *(pause)*

Th. Anything to do with your wife and how she would feel?

Pt. Oh, no. It's more to do with her—the woman. I feel like irritating and teasing her.

Th. What does she mean to you?

Pt. I have a picture of her as a big wheel in the community. I think she is a person who likes to control things with men. I feel she doesn't want to be at home, wants to be a big wheel in the community.

Th. I see. *(pause)*

Pt. I'm a sucker for this kind of woman. Before I know it I'm up to my neck in trouble. I go for them, and then I can't get away. I feel like digging at this woman. Not that I'm mad at her personally, but she does something to me.

Th. The fact that you feel she's a big wheel in the community seems to have something to do with it. *[making a connection for the patient]*

Pt. I hate women who try to wear the pants. My first wife was like that. My mother was like that. Never home, always telling you what to do.

Th. But this type of woman seems to attract you.

Pt. Yes, that's the peculiar thing. I smell them out. At any party I make a beeline for certain women, and by gosh, there I am.

Th. What do you think this means?

Pt. Well, there's only one conclusion. I must be crazy about them and hate them too. I must want to suffer to get involved with them, but that's what I keep doing. *[This is the first inkling of awareness the patient had of this problem.]*

Th. It sounds like a vicious circle.

Pt. But I'm not going to call this woman I met (*laughs*) although I must admit the temptation is great.

Th. Well, that will at least give us an opportunity to investigate this attitude you have toward certain kinds of women.

FOCUSING ON PAST HISTORY

In supportive and reeducative therapy the past is relegated to a secondary position compared to events in the here and now. Yet inimical influences in early childhood, sometimes produced by improper handling by parents, sometimes by unfortunate experiences in relationship with other persons, can be catastrophic. Children whose experiences during early life are harmonious usually are able to evolve a system of security that permits them to regard the world as a bountiful place and to develop self-esteem that encourages assertiveness and self-confidence. They will be convinced of their capacities to love and to be loved. They will most probably possess character strivings that enable them to relate constructively to other persons and to express, through culturally condoned outlets, important needs. On the other hand, for those children who have been rejected, overprotected, or unduly intimidated, the world will constitute a place of menace. They will be devastated by fears and tensions. Their self-esteem will be warped to a point where they are overwhelmed by feelings of helplessness, by lack of assertiveness, and by loss of self-confidence. Relationships with people will be disturbed with the harboring of destructive attitudes toward others. Finally, inner strivings and demands will suffer repression in greater or lesser degree.

It usually will be discerned during interviewing that the patient projects onto others attitudes and impulses derived from relationships with important past personages. Thus, the individual may regard and treat certain people as rejecting mothers, punitive fathers, and jealous or hostile siblings, irrespective of the reality elements in the existing relationships. If early experiences with mother had conditioned the patient to expect that women are overprotecting, there is apt to be an automatic transfer of this attitude toward all women, or specifically toward those persons who symbolize in the patient's mind a mother image. As defensive gestures, one may observe in the relationships of the

individual toward others such attitudes as detachment, resentment, aggression, submissiveness, and masochism that have no affinity with the reality situation. Where the patient has been unfavorably conditioned by strong sibling rivalry in childhood, the response to people might be as if they were facsimiles of destructive brothers and sisters. The individual's social and work relationships will possess a pervasive competitive tinge that expresses itself in fears of being vanquished or in triumphing over others.

Other aspects of the past history are also important in understanding the life circumstances under which adjustment is most adept and maladjustment most apparent. Repetitive patterns will clearly be evident as one focuses on different epochs in the patient's past.

Through proper interviewing the patient may be brought to an awareness of trends and mechanisms of defense as they have manifested themselves in the past. The tracing of interpersonal patterns to their origins in childhood, their disclosure as archaic and destructive to reality functioning, will also enhance a challenging of early attitudes and a new conception of the self.

A patient with a personality problem of detachment, which had interfered with her capacity to establish a relationship with men, came to therapy because of a feeling that she would never get married because of her attitudes. Focusing on her past life brought out certain trends that were operating in the present.

> *Pt.* I feel that I have the capacity to feel, but I feel impersonal about everything. I've had this feeling as far back as I can think. With my father I was given the basic necessities of life—food, clothing—but aside from that there was nothing.

> *Th.* Nothing?

> *Pt.* One never dreamed of going close to him for anything. I remember when I was little I would run to him, but he would keep pushing me away. I felt it was wrong to need him. I felt awful when I was little, but then I felt all right. At school I had some friends, but I never felt close to them.

> *Th.* Did you ever feel warm and close to any person in your past?

> *Pt.* Yes, I had a music teacher. I felt he knew me and understood me. I felt that he was like God. But I hated him too. He seduced me. I couldn't resist him. I felt awful about the thing.

Th. Mm hmm.

Pt. I remember once my father came home with a box of candy. He handed it to me, and I was so happy I cried. Father asked me why I was crying and I didn't know.

Th. Do you know why now?

Pt. I believe that meant to me he preferred me. But he didn't. He said, "That's for your mother, bring it to her." I cried and cried and never got over it. I felt it was better not to expect anything.

Th. Not to expect *anything?*

Pt. From people I mean.

Th. Could that account for one of the reasons why you can't feel anything now? *[interpretation]*

Pt. You mean a feeling I might be disappointed. *(cries)* I do expect that all the time.

OBSERVATIONS OF SLIPS OF SPEECH

While slips of speech do not happen frequently, focusing on them when they do occur may reveal significant patterns. A young woman, in a defiant relationship with her father, showed a poor response to therapy during the first few months. During one session she exhibited a slip of speech that revealed rebellious attitudes toward any type of control.

Pt. I just don't know what I'm getting out of life right now.

Th. What are you getting out of coming *here* right now?

Pt. I come here to get well—that's my *blame, [slip of speech]*

Th. That's your *blame?*

Pt. Did I say that? I mean that's my *aim.*

Th. You said "blame." I wonder if you blame yourself.

Pt. (blushes) Maybe I'm ashamed of myself.

Th. Ashamed of coming here?

Pt. I just think I don't want to get well to annoy you.

Th. To annoy me?

Pt. You know that I'm capable of doing anything, and I slop around so.

Th. Maybe you are slopping around for my benefit, *(smiles)*

Pt. (blushes) I don't want you to get too controlling. I feel if you would only leave me alone.

Th. You feel I control you?

Pt. Yes, I do.

Th. How?

Pt. Not so much control as I need to do things for myself. I don't want you to interfere.

Th. Am I interfering?

Pt. This is what's funny. You don't, but I think I do feel you do. I don't like anybody controlling me.

Th. But why do you come here then if I do these terrible things to you?

Pt. I look on you as my bridge to health. I don't want to be this way. I don't like to slop around. I can see this is something I do all the time. Even good things I throw away because the goodness spells danger in my standing alone.

Th. So that your "blame" in coming here is in not wanting to do what part of you wants, which is health? *[interpreting the slip of speech]*

Pt. I'm being a horror by fighting everybody. I know. Why do I act so rebellious?

Th. That's a good question. Let's start investigating that.

USE OF INTUITION

Sometimes therapists have to depend on hunches and intuition in perceiving what is going on in the patient. By self-observation therapists may recognize certain emotions in themselves that are evoked by what the patient is saying or not saying (countertransference). They may use this intuitive feeling in various ways, as by questioning, reflecting feeling, focusing, and interpreting. A sensitive therapist with a great deal of experience may be able to perceive nuances through this use of intuition that escape the usual observational methods. *Intuition* is probably a misnomer, for the skill alluded to does not just automatically happen; it is acquired by a sensitive and astute therapist with good clinical judgment who has had extensive clinical experience. A

seasoned therapist is best capable of utilizing countertransferential feelings constructively. These are especially important indicators of what is going on unconsciously in the patient, being manifestations of projections from the patient that are subtly being communicated to the therapist.

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Identifying Important Trends and Patterns: The Use of Free Association

Free association is rarely employed in psychotherapy, except in some forms of reconstructive therapy especially classical psychoanalysis in which it may constitute the primary kind of communication. The use of the couch position, the extreme passivity of the therapist, and the removal of the therapist from the line of vision of the patient reduce the influence of reality to a minimum. This encourages internally inspired stimuli. As a result, thought images reflect unconscious dynamic conflicts and impulses that come to the surface in a more or less direct form. The therapist listens to these with what Freud referred to as an "evenly-hovering attention," without selection of material. The therapist sensitizes himself or herself to what is behind the verbalizations and to the appearance of unconscious derivatives.

Free association also encourages transference reactions, grist for the psychoanalytic mill. Patients must be trained to associate freely. Verbalization of thoughts without restraint is often very difficult, because obscene ideas, distressing recollections, and offensive notions concerning the therapist may press for expression. As a defensive gesture, patients may exhibit blocks in their stream of thought, or they may try to protect themselves by going off into reverie. Impulses and strivings even at the periphery of awareness may be so repulsive that the person may not dare to permit himself or herself to think of them.

Some resistances to free association are relatively superficial. Patients may believe that the therapist considers their fears and fantasies absurd because they, themselves, consider them ridiculous. They may want to analyze their impulses and actions beforehand, since they anticipate censure, or they may feel that the therapist will think more of them if they analyze their problems without help. There may be a conscious need to maintain control, with resistance extended toward the revelation of significant material.

An intense fear of failure may foster an inability to utter what comes to mind.

By far the majority of resistances to free association are unconscious in nature. Patients may want to cooperate, but whenever they attempt to verbalize fantasies and thought images, they experience, to their consternation, anxiety that blocks their efforts. They may not even be aware of anxiety because memory of the traumatic material is so fleeting that it never actually occupies the field of attention. In some cases the character structure acts in resistance to free association. The individual's pattern of life, for instance, may be so stereotyped that little or nothing spontaneous is allowed to intrude itself. Fear of expressing hostile or erotic impulses may prevent letting oneself go, or that exposing one's thoughts will reveal one's ineptness or contemptibility. On this basis, one may exhibit a mental or vocal inertia that can develop into mutism.

The following example of free association demonstrates how a 38-year-old female patient with a phobic disorder gains an understanding of certain unconscious conflicts.

Pt. So I started walking, and walking, and decided to go behind the museum and walk through Central Park. So I walked and went through a back field and felt very excited and wonderful. I saw a park bench next to a clump of bushes and sat down. There was a rustle behind me, and I got frightened. I thought of men concealing themselves in the bushes. I thought of the sex perverts I read about in Central Park. I wondered if there was someone behind me exposing himself. The idea is repulsive, but exciting too. I think of father now and feel excited. I think of an erect penis. This is connected with my father. There is something about this pushing in my mind. I don't know what it is, like on the border of my memory, *(pause)*

Th. Mm hmm. *(pause)* On the border of your memory?

Pt. (breathes rapidly and seems to be under great tension) As a little girl, I slept with my father. I get a funny feeling. I get a funny feeling over my skin, tingly-like. It's a strange feeling, like a blindness, like not seeing something. My mind blurs and spreads over anything I look at. I've had this feeling off and on since I walked in the park. My mind seems to blank off like I can't think or absorb anything. *[This sounds like a manifestation of repression, with inhibition of intellectual functioning, perhaps a way of coping with the anxiety produced by a return of the repressed.]*

Th. The blurring of your mind may be a way of pushing something out you don't want there. *[interpreting her symptoms as resistance]*

Pt. I just thought of something. When father died, he was nude. I look at him, but I couldn't see anything, I couldn't think clearly. I was brought up not to be aware of the difference between a man and a woman. I feared my father, and yet I loved him. I slept with him when I was very little, on Saturdays and Sundays. A wonderful sense of warmth and security.

There was nothing warmer or more secure. A lot of pleasure. I tingle all over now. It was a wonderful holiday when I was allowed to sleep with father. I can't seem to remember anything now. There's a blur in my mind. I feel tense and afraid.

Th. That blur contaminates your life. You are afraid of something or afraid of remembering something, *[focusing on her resistance]*

Pt. Yes, yes, but I can't. How can I? How can I?

Th. What comes to your mind?

Pt. Sunday I got stomach pains. I was depressed and frightened. I started crying. I wanted to hold onto mother. What is the use of becoming aware of needs if you can't satisfy them. I had a dream that night. A group of army officers in my sister's room. I felt jealous. They weren't interested in me. Then I was on the water. One man was walking on water with no legs. He walked confidently. I asked him where his legs were, and he said that when he had legs, he felt strong and masculine. Then I see flowers and I feel lost. Then I am on a ruined street. I see an old horse, emaciated, waiting to be slaughtered. I'm horrified, sick, upset. I have flowers, but everybody criticizes them. I felt they weren't good. And that's all.

Th. What do you associate to the dream?

Pt. I felt the officers kissed my sister and mother and not me. I feel father give my sister and mother everything and not me. I wanted to look into the room where the officers were with my sister, but my mother wouldn't let me. I was mad. I remember a part of the dream where I saw condoms in a box. I felt my sister could have it and not I. I feel deprived and helpless, like a mutilated person. That must be me walking on the water. I walk, but like a cripple. I want to be strong and not weak. Men are strong. My father wouldn't let me grow up. My sister has a husband and I don't have one. She has everything. I have nothing. Not anything that is worthwhile. What I have is not much. I always wanted to be strong. I used to fantasy being a boy and having a penis. I suppose the flowers in the dream are my femininity. I put little value on myself. I realize now how bitter I feel toward father for not devoting himself to me. [*The patient goes on to correlate her incestuous wishes, her castration fears, and her penis envy.*]

Free association, despite its serious limitations (Marmor, 1974), is one avenue to unconscious sources of problems that may be essential in the more formal analytic procedures.

Identifying Important Trends and Patterns: The Use of Dreams and Fantasies

In all forms of psychotherapy dreams give the therapist important clues—not only about dynamics, but also about the therapeutic process itself. The use that is made of dreams will depend largely on the skills of the therapist. In supportive therapy dreams help the therapist perceive more accurately the inner responses of the patient; however, the dream material itself is not usually discussed. In reeducative therapy therapists who are adequately trained may utilize dreams with the object of detecting resistance. In reconstructive approaches dream analysis is constantly employed and is considered indispensable for the proper implementation of therapy.

Properly utilized, dreams illuminate the existing dynamics of emotional illness. They reveal conflicts, coping mechanisms, defenses, and character traits. Most importantly, they reflect what is going on and the patient's responses to the therapeutic process. Thus, where therapy is not proceeding well, dreams may reveal more than any other form of communication what resistances are obstructing progress. Even if the therapist does not laboriously work out the meaning with the patient, as in supportive and reeducative therapy, dreams may still provide guidelines for circumventing roadblocks to the most effective use of techniques.

What are dreams? We may conceive of them as images or fantasies that are an intrinsic part of normal sleep. We know from human experiments that dream deprivation (interfering with dreaming by awakening the subject when there are physiological—REMS [rapid eye movements]—or electroencephalographic evidences of beginning to dream) can produce personality aberrations. We have learned a great deal about dreams from contemporary dream research. The REM periods during sleep that are accompanied by dreaming have been found to be associated with activity in the limbic system, the primitive portion of the brain associated with the emotional life of the individual. This

lends emphasis to the theory that the dream is a regressive phenomenon. However, we are merely talking here of the neurophysiological activity that sponsors the formation of dream images, not of their specific content or significance, which may involve other dimensions than regressive emotional ones.

Relaxation of ego controls liberates needs and impulses that, lacking opportunities for motor release, find access in sensory discharge. The content of the dream draws from past impulses, memories, and experiences as far back as early childhood. The conversion of repudiated drives and desires into dream images sets into motion oppositional defenses and prohibitions that may appear in the dream in a direct or masked way. Immediate experiences and current conflicts participate in the structure of the dream. It is likely that a happening in daily life that the individual interprets as significant serves to stir up important needs, frustrations, memories, and drives from the past. The latter, constantly dormant, invest certain immediate experiences with special meaning, alerting the individual to signals that in other persons would go unnoticed.

Some years ago, I initiated a group of experiments in the hypnotic production of dreams. Dreams under hypnosis range from fleeting fantasy-like productions in light trance states to, in deeper stages of hypnosis, highly distorted symbolizations akin to regular dreaming during sleep. I found that hypnotic dreams could easily be triggered by immediate stimuli and that from the content of the dream one could not always identify the specific provocative stimuli that produced the dreams. Thus bringing an open bottle of perfume under the nose of a person in a trance, with no verbal suggestions to influence associations, would in some individuals inspire a dream that revived memories of previous experiences. At different times the same stimulus acted to provoke different kinds of dream content. For example, in one subject the perfume initially touched off a dream of being scolded by a maternal-like figure, the subject crouching in guilt. No other dreams or fantasies were recalled. On rehypnosis the subject was asked to redream the same dream and to reveal it in the trance. She brought up a pleasurable sexual dream, which was followed by a second punitive dream identical to the one previously described during the waking state. Apparently the subject had repressed the initial part in the first

trance, denying the content and reprocessing it by elaborating the punishment scene. The punitive dream might be considered equivalent to the manifest content, those manifestations acceptable to the patient. The repressed portion could be regarded as the latent content that the patient could not accept. On another occasion the perfume stimulus created a dream of wandering through a botanical garden.

The mood of a dream also fashions the dream content. An upset patient during hypnosis utilized the sound of a bell that I rang to elaborate a dream of fire and fire engines with reactions of anxiety. At another session, during a quiescent period of this patient's therapy, the same sound produced a dream of worshipping in a church. A disturbed female patient at the beginning of therapy interpreted my touching her hand during hypnosis adversely by dreaming of a man choking her. Later in therapy the same stimulus produced a dream in which her father was embracing her tenderly.

The dream content is additionally subject to changes of attitude on the part of the dreamer. For example, a patient on being asked to bring in dreams responded with the following written comments to this suggestion:

> The doctor requests that I dream. He is interested in helping me, so I better dream. In dreaming I am pleasing his authority, so why should I dream just because he asks me to. He is trying to force me to do what *he* wants. But I want to do what *I* want to do. I may not want to dream. But if I don't bring in a dream, the doctor will be displeased. Should I defy him or should I please him? What will happen if I don't dream? What does he want me to tell him? If I dream and confirm what he has said about me, he will like me. If I dream opposing his ideas about me, he will not like me or he will punish me. If I don't dream or I dream something that opposes his ideas, this will make me feel strong and superior. I do want to find out about myself so I can get well, since my therapist tells me this is how I can help him help me. This is why I should dream. But I am guilty about some things and afraid of some things, and I am afraid of what I will find out about myself if I dream. So maybe I better not dream. Maybe I'll find out something about myself I don't like. It is normal to dream, and I want to be normal. But if I do dream, I have a better chance of getting well, but getting well will throw more responsibility on my shoulders. I'll have to be more independent, take responsibility. Maybe I better not get well so fast. Therefore, I shouldn't dream. Or maybe if I do dream, I can mention only those things that please him and that don't scare me and don't make me get well too fast.

Not all patients are so obsessively stimulated by a casual suggestion. But in all patients the act of dreaming does involve varying motivations that are incorporated in the

dream work and fused into a complex kind of symbolism, distorting, repressing, displacing, and otherwise disguising the content. What may come through is a compromise of part forgetting and part remembering, of primary and secondary process thinking, of present and past, of impulse and defense.

THE STRUCTURE OF DREAMS

Dreaming is, according to F. Snyder (1965), a distinctive physiological state related to but different from sleep or waking. It is associated, in the majority of dreamers, with a phenomenon discovered by Aserinsky and Kleitman (1953, 1955) of REMS. A basic and unitary biological process, REMS occur ordinarily in the midst of sleep and are characterized by unique electroencephalographic patterns. Since REMS are found in subhuman species, it is postulated that this aspect of the sleep phase, and perhaps the dreaming experiences affiliated with it, plays a prominent role in all mammalian life. Dreams occur occasionally also during non-REM sleep, from the closing (stage I) to the deep (stage IV) states. Even nightmares can appear in stage IV (Fisher, C, 1970).

The exact function of dreaming, however, is not fully known. Is it a homeostatic device to keep the nervous system in balance? Does it serve an anxiety-binding function? Does it have a synthesizing and restorative effect preserving the emotional balance? Since dreams are an intrinsic part of normal sleep (Dement & Kleitman, 1957; Kleitman, 1960), their functional utility in the psychic economy may be assumed. This is particularly credible in view of the experimental evidence that deprivation of REM sleep is followed by definite personality aberrations (Dement, 1960, 1966). Moreover, if REM sleep is blocked, it is made up "in amounts distinctly related to the amount of deprivation."

Dreaming as a safety value for the discharge of instinctual pressures has been hypothesized for many years by psychoanalysts. As far back as the turn of the century, S. Freud pointed out that the prime function of dreams was to safeguard sleep by fostering solution in fantasy of powerful needs, fears, and conflicts that were too dangerous or repulsive for resolution in reality. Dreams apparently helped in the psychic mastery of seemingly insoluble situations, providing for a discharge of tension, a propitiation of deep

wishes and demands, and a fantastical working through to a conclusion of destructive experiences that defied the coping capacities of the individual in the waking state. The wish-fulfilling drives represented in dreams were compromised by the demands of the repressing forces. What the dreamer then tended to satisfy was not the raw wish, but a compromise made necessary by the repressing elements. An important effect of dreams was to discharge the emotion that was associated with deep conflicts in the personality. "Dreaming has taken on the task of bringing back under control of the preconscious, the excitation in the unconscious which has been left free; in doing so, it discharges the unconscious excitation, serves it as a safety valve and at the same time preserves the sleep of the preconscious in return for a small expenditure of waking activity."

Ella F. Sharpe (1931), expounding Freud's ideas, considered dream interpretation the cornerstone of psychoanalytic technique. Dreams, she said, are sensitive indicators of the individual's unconscious and offer a means of exploring the dreamer's current conflicts through the elaboration of preconscious thoughts. The latent content of dreams is arrived at through free association. "Dreams may prove of value apart from or in addition to the significance of the latent content. They may be used as a means of unconsciously placating the analyst, as symbolic of power, of control over faecal product, as proof of control over the analyst. The dream may represent a love gift." T. M. French (1952) and French and Fromm (1964) stated that, in addition, dreams, reveal old conflicts, reflect hope and introduce new solutions.

Classical ideas about dreams revolve around the contention that with the shutting out of sensory receptors and the progressive cortical inhibition induced by sleep, a number of important changes occur in the operative psychic processes. These changes, reflecting themselves in dreams, consist of the following:

1. Visual images rather than words are employed to represent concepts.

2. The mind becomes contaminated with an archaic, pre-logical kind of ideation that utilizes perseverations and stereotypes. There is a replacement of abstract conceptual for concrete thinking and an abandonment of accepted rules of time and space.

3. Certain distortions prevail in dreams, probably conditioned, first, by a need to evade the psychic censorship that continues to operate in sleep, though to a lesser degree than in the waking state, and, second, by a primitive type of thinking that seems to be released by inhibition of the higher cortical centers. Inacceptable and repudiated aspects of the personality are, through distortions, made acceptable to the dreamer's ego.

4. Among the mechanisms serving the interests of distortion are symbolization, displacement, condensation, representation by multiples and opposites, secondary elaboration, and substitution for people of emotionally equated objects.

5. Symbolic representations are unique for the person, although there is some universality of symbols. Because primitive processes permeate the thinking process in sleep, there is a tendency toward a universal language in dreams. The similarity of experiences of the average person within a certain culture also makes for some unity of symbols.

Not long after Freud published his revolutionary discoveries about dreams and dreaming, defections from Freudian formulations began to appear. Rejecting the concept of wish fulfillment as the prime determinant of the dream, Jung (1960) approached dreams from the phenomenological level. Dreams were not, he claimed, disguised symbolizations of irrational childish impulses. Rather they were experiences in self-confrontation; their symbols were explicit metaphorical referents. Dreams were compensatory and rectifying rather than irrational "whereby those thoughts, inclinations and tendencies which in conscious life are too little valued, come spontaneously into action during the sleeping state when the conscious process is to a large extent eliminated." Jung ascribed to each dream image a special significance of its own: "from the final standpoint the symbol in the dream has more the value of a parable: it does not conceal, it teaches." It was a spontaneous self-portrayal in symbolic terms.

Adler also veered away from Freud's explanation of the dream as a symbolic vehicle for wish fulfillment. Rather, he declared, the dream was the key to the understanding of an individual's life styles and the choices available to that person in social situations.

The adaptive and problem-solving functions of the dream have fashioned its uses by

neo-Freudians. Instead of being the royal road to the unconscious, it is regarded as an attempt at solution of conflicting needs, an expression of unified personality structure (Horney, 1950). The neo-Freudian viewpoint is developed in Walter Bonime's book (1962), *The Clinical Use of Dreams.* Bonime contends that since the character structure evolves through interpersonal interaction, its manifestations in dream symbolism have a specific meaning for each individual in terms of that person's unique life experience. "Human emotions have conceptual and communicative implications which arise out of social interaction" and their identification and evaluation through dreams and other communications constitute an important focus of the therapeutic work. The dream must be related to the characterological and social realities of the patient's life. In the context of self-confrontation, the dream registers the interplay between genuine awareness and neurotic techniques of avoidance. Rational and irrational can be split apart by applying the metaphor of the dream to the concrete life situation implicated in the dream. The dream yields clues to how a patient is coping with a particular problem at the moment.

Classifying dreams into categories of action, individuals, surroundings, and feeling, Bonime puts emphasis on an interpretive hypothesis in which patient and therapist make a collaborative effort at meaning, rather than the therapist giving a pointed interpretation to the patient. The dream, consequently, becomes a medium of relationship between patient and therapist. In this interaction transference is regarded as an obscuring rather than illuminating concept toward understanding the total characterological contours of the individual. "The clinical problem is to investigate the kind of personality the patient has today, to seek out precisely what he is experiencing in reaching to the analyst and to discover the elements of the immediate situation which are engendering the irrational" feeling.

Contemporary dream research suggests dreams as products of neurophysiologic-biologic processes rather than unique responses to specific psychological-experiential factors (Trosman, 1963). What initiates the dream is physiology, not conflict; however, physiologically induced alterations in the state of the psyche during the night result in shifts in emotional equilibrium. At a critical point in this imbalance the dream begins and

operates to reestablish homeostasis. If anxiety is neutralized in this process, sleep continues; if too much anxiety is released, and it cannot be handled in the dream work, a nightmare may result with possible awakening. Unconscious wishes then ride on the back of neurophysiological-biochemical mechanisms, their representational forms being conditioned by the dream work.

THE CONTENT OF DREAMS

A dream is a mosaic of diffuse symbolic conceptualizations, recruited from recent and remote memories and fashioned by current feelings, attitudes, motivations, and values of the individual. Each dream is a fragment of the total life experience, distorted in accordance with the regressive thinking process that prevails in sleep and shaped by the immediate psychological needs of the person. It is doubtful if the function of the dream is to preserve sleep; rather it appears to be a processing of the day's experiential residues with attempts at problem solving.

In examining any dream, two kinds of content are apparent. The first, the *manifest dream content,* is an overlay of situations and events that mask more fundamental latent meanings. The manifest content is constructed out of events in the recent past, usually events of the previous day, blended with remembered situations in the distant past. The second, the *latent dream content,* which is determined by decoding the dream, embraces some or all of the following:

1. Early memories or experiences, perhaps long forgotten, that have made a significant imprint on the person

2. Attitudes and fantasies in relation to parental agencies and siblings

3. Defenses that were elaborated against early experiences, conditionings, and fantasies

4. Emotionally important immediate life experiences

5. Current wishes and demands in open or disguised form as well as defenses against these

6. Interpersonal strivings and attitudes

7. Unconscious repudiated impulses and needs

8. Nascent conflicts that agitate the person and create tensions and anxieties

9. Patterns of reaction and mechanisms of defense habitually utilized by the person to resolve troublesome conflicts

10. Latent character strivings and latent mechanisms of defense

11. Representation of different aspects of the self, as well as disparate interpersonal drives, through such symbols as multiple characters

12. Attitudes toward therapy, including resistances to the various phases of treatment, and defensive reactions that are marshalled by interpretations

13. Attitudes toward the therapist including transference manifestations

THE THERAPEUTIC USE OF DREAMS

There is a difference between decoding a dream as part of a scientific endeavor and utilizing it as a therapeutic implement, which is an artistic, intuitive task. The ideal approach to dreams is a collaborative working together during which the therapist studies the interaction between the patient and himself or herself and utilizes the dream as one form of communication both to understand the needs, conflicts, and defenses operating in the patient as well as to facilitate the therapeutic interpersonal relationship. Before this ideal is reached, the patient will require help toward being motivated to remember, to report, and to examine dreams critically. The patient will need education regarding the conflict-solving function of dreams. The therapist may, therefore at the start have to be quite active in showing the patient how one goes about working with dreams and in explaining how they lend themselves toward exploring distortions in the relationship of the patient with other human beings, including the therapist. The patient not only will learn that the dream is a repository of archaic attitudes but also will discover that it points out potential avenues of growth. As soon as the significance of dreams is grasped, the patient will be able to explore them with minimal activity on the part of the therapist.

In requesting the patient to report dreams, one may give an explanation such as in the following excerpt:

Th. I should like to have you try to remember your dreams and bring them to me.

Pt. I never dream. Are dreams important?

Th. Dreams are important because when the mind is asleep, problems that bother it are brought up more openly. In the waking state a person pushes those problems away.

Pt. I suppose I dream, but I can't remember my dreams.

Th. All people dream, but many people don't remember their dreams. If you find it hard to remember your dreams, keep a pad of paper and a pencil at the head of your bed and jot down any dream fragments you remember the minute you get up. Otherwise they are likely to slip out of your mind. If you wake up in the middle of the night and have had a dream, take the time out to write it down.

Simple suggestions along these lines often induce dreaming. Should the patient persist in being unable to remember dreams, the therapist may remark, "I wonder why it is that you have no dreams. It's possible that certain things are bothering you so much that you just don't remember what you dream." Mention of possible resistance sometimes promotes enough tension in the patient to force a breakthrough of a dream. Some therapists attempt to stimulate their dreamless patients through hypnosis during which it is suggested that the patient be able to recall important dreams. Fantasies and dreams may also be suggested during the trance state itself and discussed if desired during or after the hypnotic session.

It is, however, generally unnecessary to employ adventitious methods to promote dreaming, for the patient will readily relate dreams once told that the discussion of dream material is helpful in therapy. If the patient refrains from mentioning dreams spontaneously, the therapist may ask at each session whether there are any dreams to report.

The first dream after therapy has started is frequently of great moment, sometimes containing a cross section of the patient's problem. It may require many months before the patient and the therapist will appreciate the full importance of the material portrayed

in the dream.

During the third therapeutic session a female patient presented her first dream:

> My husband's family took suitcases to the station in a streetcar. I thought this was grubby.

> Then I dreamed of an old woman who invited me to eat roast lamb. It didn't seem good, and I wouldn't eat more. I said it was spoiled, and if you kill and eat lamb that's led a lonely life, that makes you sad. And then—this is the horrible part—she prepared to kill another lamb. She got it partly skinned and the skin was up over its head, but it was alive. It kept looking at me for protection, linking its head in my arm and pulling me, as if to say, 'Please get me out of this,' And I thought, 'Oh god, I wish I could help this poor creature, but the only way to help it is to kill it.' But I didn't want to tell the lamb that. And I couldn't kill the lamb myself.

> Then I dreamed I was on a cloud, high up: but it wasn't a cloud, it was terra firma. I was on the edge and with me on the earth-cloud was a young man. I didn't know what he looked like or who he was. I kept slipping off the cloud with a dreadful fear of falling off. He couldn't support me and I was panicky.

> Then I dreamed I was in bed with my husband, Dick. A sex dream. We just had an affair. He got up, but I stayed in bed and hid back under the bed covers. He came back with his penis erect. I wanted another affair, but he started horseplaying like a frisky kid.

Associations to the dream were barren. Even mention of the similarity between "kid" and "lamb" brought little response. The patient's feelings about her husband were hesitantly expressed, but they were on the positive side. It was many months before the patient realized her ambivalent attitudes toward her husband, her pity for him as a "poor lamb" she felt she was destroying, and her murderous rage, mobilized shortly after her marriage, because her husband and his family were "grubby" people. She believed that she had demeaned herself by a mismated alliance. Appreciating that she had been "up in the clouds" about her marriage, she realized that she was very much dissatisfied with the sexual aspects of her relationship. Her hostility had been self-directed and had expressed itself in depression and psychosomatic symptoms for which she sought psychotherapy. Her responses to her husband, positive and negative, were shown to be part of a larger pattern in her relationships with men that went back to her relationship as a child with her father. Her dream brought out many aspects of her problem, but her ego needed strengthening in therapy before she could accept the full implications of the dream.

THE TECHNIQUE OF DREAM INTERPRETATION

Once the patient has presented a dream to the therapist, it may be handled in a number of ways. Some therapists ask the patient to associate to the different objects, people, and incidents in the dream. Others pick out a general theme from the content and then present this to the patient as a focus on which to concentrate. Still others formulate their impressions of the dream for the patient's benefit. Finally, there are therapists who do not direct attention to the dream or ask for associations; they merely listen, attempting to connect preceding statements and those that follow the dream in the hope of identifying the initiating precipitants of the dream.

Because the dream embodies so much material, therapists generally select aspects for discussion that accord with what they are trying to emphasize at a specific session: inculcation of insight, confirmation of a hypothesis, probing of past traumatic events and memories, defensive operations, transference manifestations, resistances to the therapist and to the techniques, fears of utilizing insight in the direction of change, and so forth. Sometimes a therapist will merely listen to a dream for his or her own information: at other times interpretations are given the patient. In advance of this the patient is asked for associations to a dream and for formulation of impressions about it. Many patients rapidly become skilled at understanding the meaning of their dreams. To facilitate associations, some therapists summarize the dream events and ask the patient specific questions in relation to people and incidents in the dream. Dreaming about different people is occasionally a way of representing different aspects of oneself. The therapist, if the meaning of the dream is not clear, may ask about the setting of the dream. Does the patient recognize it? Is it in the past or present? Does it have any significance for the patient? Do the characters in the dream have any meaning for or relationship to the dreamer? Do any of the characters represent the patient's parents, or the therapist, or oneself? Are any underlying wishes or needs apparent? What personality traits are revealed in the characters? What mechanisms of defense are displayed—flight, aggression, masochism, hypochondriacal preoccupation? What conflicts are apparent? What is the movement in and the outcome of the dream incidents?

Therapists interpret dreams in line with their theoretical persuasions, some treating a dream like a Rorschach, projecting into it their own special fantasies. While this may be effective for highly skilled, experienced, and intuitive professionals, it is better for most therapists to work out the meaning together with the patient. It is a poor tactic to interpret dogmatically the latent content of the initial dreams revealed by a patient. First, the therapist does not know enough about the patient and the operative defenses. Second, to penetrate into the unconscious prematurely will merely promote greater repression of and distortion in later dreams as a way of avoiding anxiety. One may, however, productively search for current reality reactions (e.g., resistances to the therapist or to the techniques; fears, or misinterpretations the patient may harbor about therapy) or for bizarre hopes and expectations that could result in a defeat of the therapeutic attempt. Or character drives may be explored advantageously as they exhibit themselves in the dream, provided that the patient is already aware of these.

Resistance is apt to occur as the treatment process proceeds. It may appear in relation to the setting up of the working relationship at the start of treatment, to the exploration of the dynamics of the inherent neurotic process, to the putting into action of insight, and, finally, to the termination of therapy. Manifestations of resistance may first appear in dream structure. The dream provides a great opportunity to deal with it before it becomes an irreparable obstacle to treatment. Of confounding concern, however, is the employment of dreaming itself as a form of resistance as the patient becomes aware of the importance of dreams. The patient may thus use dreaming as an outlet to frustrate or impede the therapist. The patient here may dream incessantly and try to flood the therapeutic hour with an avalanche of dreams, or may unconsciously elaborate the symbolism of the dream as a way to confuse the therapist and to divert from central issues. Some patients bring in pages of written dreams, which may overwhelm the therapist, and this may be one way of avoiding dealing with reality problems. These resistances should be interpreted.

Of vital importance are the revelations in dreams of transference in which impulses, experiences, and defenses in relationship to important past personages are revived

through the agency of the therapist. A wealth of information can be exposed in such dreams, and opportunities are afforded the patient and therapist for understanding of how early attitudes and patterns disturb the patient's present existence. This provides a means to work through transference distortions. In the process of interpreting transference, one must always search for reality provocations that are initiated by the therapist personally. The way transference in dreams is handled will depend on when it appears and its function as resistance. A demand for infantile gratification in terms of complete givingness, lovingness, and understandingness, an expectation of hurt and condemnation for the revelation or expression of impulses of which the patient is ashamed, can serve as blocks to therapeutic progress. Such demands and expectations will require careful interpretation. On the other hand, a delving into genetic foci, into important early formative experiences, if employed at all, may require tact and great patience. Premature or too forceful interpretations may do more harm than good.

One of the ways that the dream can help the therapeutic process is by revealing signals of anxiety before it becomes too intense and interferes with therapy. Where the dream brings out anxiety in relation to important incidents, past or present, it may be possible to help the patient endure it enough to avoid the upsurge of too great resistance.

Often the dream will reveal the nascent drives that marshall anxiety. These may be imbedded in a pregenital fusion of sexuality and aggression. Their emergence in symptoms and in acting-out tendencies may be responsible for the patient's current difficulties as well as for a pervasive inhibition of function and other ego defenses. The studied interpretation of dream elements will do much toward clarifying the punishing and masochistic reprisals of the superego. By ferreting out projective, denial, isolating, and repressive defenses, as they come out in the dream work, one may occasionally liberate early memories that concern themselves with the fantasies or actual experiences associated with the patient's sadistic and masochistic maneuvers. Obviously, the interpretations preferred must take into account the patient's readiness for change and the intensity of anxiety. Above all, the manner of interpretation serves as an important factor in helping or retarding the patient in accepting and integrating the significance of

the dreams.

Techniques of dream interpretation in the early phases of therapy may advantageously concern themselves with teaching the patient how one may approach one's dreams. They include:

1. Summarizing for the patient the basic trends in the dream

2. Asking the patient for spontaneous associations

3. Making a tentative, unverbalized formulation of the dynamics

4. Encouraging further associations through focusing

Summarizing for the Patient the Basic Trends in the Dream

Although the routine of summarizing is not absolutely necessary, it may conveniently be employed at the beginning stage of working with a dream especially where the patient does not spontaneously associate to it. To illustrate this and other routines in dream interpretation, we may consider the following dream of a depressed woman with whom I was employing dynamic psychotherapy:

> A person—I don't know who it is—wants to kill me and my child. The room I'm in has a double dormer window, but the furniture is modern. I can't get out. I try to escape and can't. Then the next part is that I am somewhere with two men. One man wants me, but I don't like him and feel contempt for him. I like the other person, but he doesn't want me. I say to him, "I'm sick and going to die in 2 weeks." He reassures me and tells me he loves me and everything is sad and beautiful.

In summarizing the trends in the dream, the therapist may remark:

> Now here is a dream that takes place in a room. A person is there who threatens to kill you and your child. You try to escape and can't. Then you are with two men. One you like, and one you don't. The one you like doesn't want you. You say you are sick and going to die. Then he tells you he loves you, and everything is sad and beautiful.

Asking the Patient for Spontaneous Associations

Following the summarizing of the dream, or if summarizing is not employed as a

routine, the patient may be asked to associate to the dream immediately after it has been reported. The following excerpt of the session with the patient whose dream was just described is illustrative:

> *Th.* What are your associations to the incidents and people in the dream?
>
> *Pt.* I don't know who the person is, but it's a man, like an ogre. I was frightened of him. He was making frightening gestures to us. *(pause)*
>
> *Th.* What about the room?
>
> *Pt.* There is something familiar about it. It's like the room I had when I was a girl. This was in North Carolina. The room I shared with my sister. It had a dormer window like the one in my dream. I'm sure this was the room.
>
> *Th.* What about the furniture?
>
> *Pt.* We had this curly maple old American furniture. But the furniture in my dream was modern, like *(looks around the room)* in your office, *(pause)*
>
> *Th.* What about the rest of the dream?
>
> *Pt.* Yes, this man who didn't like me was a very desirable man, the kind I feel so embarrassed with and uncomfortable. And the last part gives me a quiet, wonderful feeling as if everything is going to be all right.

Tentative Unverbalized Formulation of Dynamics

On the basis of what knowledge has already been gained of (1) the patient's problem, history, current life situation, and dream symbols employed in the past, (2) the patient's associations to the present dreams, (3) what is happening immediately in the therapeutic situation, and (4) the therapist's intuitive feelings, the therapist will be able to develop some tentative formulations of the existing dynamics—these *are not to be conveyed to the patient*. They are concocted in full recognition of the fact that they may later have to be radically revised.

In organizing the material of the dream for purposes of this formulation, it is often helpful to employ a certain framework that considers the setting of the dream, the characters, the underlying wish, the revealed personality traits, the apparent mechanisms of defense, the ostensible conflicts, the movement, the outcome, and resistance and

transference phenomena.

The Selling of the Dream

One may ask oneself a number of questions concerning the patient's dream's setting. For example, What is the locale of the dream—outdoors, indoors, a changing setting? Does the patient recognize the locale? Does the locale have any special significance for the patient? Is there an indication as to the temporal setting—past, present, or both?

In the dream we are using as an example, the setting seems, according to the associations of the patient, to be a fusion of the past (the room shared with her sister as a child) and the present (the therapist's office). One may speculate that the patient is talking about a situation or about feelings that are equally applicable to the past and to the present or that, originating in the past, are being projected in the present.

The Characters in the Dream

Who are the characters in the dream? Are they identifiable people; do they resemble in appearance or behavior people the patient knows or has known in the past? What is the relation of the patient to the characters in the dream? How does the patient feel about the various characters? Are they possibly parental or sibling representatives? Are the characters in the dream representative of various aspects of the patient? Are any of the characters symbols for the therapist?

Referring to the dream that we are considering, the characters are the patient, her child, a hostile unidentified man, a man who likes her whom she rejects, and a man whom she likes but who rejects her. From her past history there is a suggestion that the hostile man in the dream is representative of her father, whom she considered a person one could never approach closely enough to know. She remembered him as one who was disposed to hostile outbursts. There is a possibility also that the man may be representative of the therapist (transference), since the patient had for several weeks manifested resistance in therapy and had on several occasions mentioned that I seemed distant from her and that it

was hard to get to know me. The other two men are probably representations of a dualistic attitude she displays toward men. In response to those men who express a liking for her, she exhibits coldness and contempt. On the other hand, she manifests a keen interest in men who are not approachable.

The Underlying Wish or Need

A search will usually reveal one or more deep wishes or hidden demands as the base of the dream. These may consist of early repudiated impulses and strivings, or of later wishes, or of current demands. Sometimes the wish is an extremely concealed one that is hard to detect in the dream content. At other times it is very clearly defined.

In the dream under discussion the wish is perhaps to win the love and approval of a rejecting, aloof man, in this way breaking down the barrier to a warm relationship with a father figure. There is a desire to be accepted for herself and to be the preferred one in any competitive struggle (originally with her sister or mother?).

Personality Traits as Disclosed in the Dream

What personality traits are divulged in the dream? What is the nature of the patient's relationship with other persons in the dream? What are the patient's feelings about himself or herself? What are the patient's attitudes toward authority? Toward subordinate persons?

In the dream that we are reviewing the patient shows great fear in relation to a hostile male figure, contempt toward a person who likes her, and feelings of rejection when she approaches someone she admires. These tendencies are actually substantiated by studying her real life adjustment. They explain why it is difficult for her to relate well with people. Strong people are overvalued; she fears their hostility and rejection, and she tends to detach herself from them. Toward weaker people she feels contempt and hostility, and she removes herself from their presence out of fear of being exploited. On those who avoid or reject her she places special values.

What are the mechanisms of defense that are exhibited in the dream? How do these compare with the defense mechanisms the patient habitually employs in life? Are there any evidences of anachronistic defense mechanisms that issue out of early life experiences and impulses?

In our patient's dream the defense mechanisms suggested are those of (1) flight from hostility or from a hostile authoritative person, (2) disdainful and perhaps aggressive attitudes toward individuals who are fond of her, and (3) masochism and hypochondriasis in relation to rejecting personages, the latter tendencies perhaps serving as means of winning sympathy and love. These mechanisms are essentially those that the patient exhibits in her reality adjustment.

Conflicts Expressed in the Dream

What conflicts are manifested in the dream? Do these result from clashes with or stress from special situations? Are these a consequence of incompatible relationships with people or contradictions of various character traits? Are there evidences of deep inner wishes and needs that come into opposition with moral prohibitions?

Returning to our patient's dream, we find a number of conflicts that suggest themselves. The attitudes of flight, contempt, admiration, and masochism are mutually contradictory. Her relationships with people are fertile sources of conflict since she constantly anticipates attack or she may desire to attack others. Her need for a close relationship conflicts with a fear of being hurt or of hurting. There are hints of an Oedipal conflict.

The Movement and Outcome of the Dream

What is the drama enacted in the dream? What emotions are associated with the actions? Does the dream reveal any important early memories or situations? Does it reflect emotionally significant immediate experiences? What is the outcome of the dream?

In our patient's dream the drama is, first, a fear of being destroyed and helplessness in escaping destruction. The emotion here is terror. The outcome of this episode is not defined. Second, the patient plays a rejecting role with a man who seeks her companionship, and she is rejected by someone she likes who does not want her. Her protestation that she is sick and about to die incites the man to profess love for her, and she feels emotions of contentment, but also sadness. The outcome, though satisfactory to her, is actually a neurotic masochistic solution to her feelings of being unloved and unworthy in a relationship with a "superior" man.

Resistance and Transference Manifestations

What manifestations in the dream are reactions to therapy and the therapist? Are there any evidences of fear, antagonism, detachment, or sexual interest in relation to the therapist? Are there any responses that seem oppositional to the therapeutic effort?

The fact that our patient associates the furniture in the room in which she is trapped with the furniture in my office suggests a transference situation. She perhaps feels trapped by therapy as she was trapped in an untenable relationship with her father in the past. She may fear attack from me as she feared attack from her father. It is possible that she exhibits resistance to therapy in the form of fear or helplessness. There is a possibility also that the last part of the dream reflects an impulse to win my affection by displays of illness and depression. Actually, the patient started the session by complaining that she felt physically ill. Emotionally she appeared listless and depressed.

Encouraging Further Associations by Focusing

Once we have come to certain tentative conclusions about the dream, we may want to direct the patient's associations toward certain parts of the dream in order to validate our own formulations and to help inculcate insight in the patient. The process of focusing will depend in part on the dream material and in part on the specific phase of therapy in which we are engaged.

Because the dream is so highly condensed a production, it is possible to extract from it material that will fit in with the objectives of our immediate therapeutic effort. Thus, if we are in the opening phases of therapy, our chief goal is to establish a working relationship. An attempt is made to discover in the dream evidences of resistance to a working relationship, defective motivation for therapy, and transference blocks to the full acceptance of the treatment situation. For example, were the dream that we are studying presented during the first therapeutic phase, we might perhaps consider the patient's fear of the man in the dream and her terror of being trapped as symbols of a fear of therapy and of me. We may speculate from this that she would, during therapy, try to get me to express my liking for her so that she could reject me; or, that, convinced of my aloofness, she would employ a masochistic reaction in order to get me to profess my fondness for her. With these factors in mind, we would try to focus her attention on her feelings toward me, in order to work through her resistances to a working relationship.

Were the patient in the exploratory phase of therapy, we would utilize her dreams as a means of investigating the dynamics of her disorder. Thus we would focus on, and attempt to demonstrate, provocative elements in her immediate environment that activated basic conflicts. Actually, the patient was in this treatment phase. An excerpt from the interview follows:

> *Th.* Perhaps, if you tell me about any special things that happened to you the day before, or a few days before the dream, we may learn something important. *[Events of the day before, which had an emotional impact on the patient, consciously or unconsciously, may have detonated the tensions revealed by the dream. Focusing the patient's attention on possible stimuli may enable her to make certain connections.]*

> *Pt.* There were several things that happened. I got a letter from Sally (*her sister).* She rarely, if ever, writes. Since my divorce, I don't think I have gotten more than three letters from her. She told me about how wonderfully she and John (*her sister's husband)* were getting on, and how well her two children were doing in school. I felt she was needling me, blaming me for making a mess of my life. *[The resentment evoked by her sister's letter may have touched off early competitive feelings. I decide to explore these.]*

> *Th.* How did you get along with your sister before?

> *Pt.* As I told you, we hated each other when we were little. My father told me I used to admire her when I was a tot. She was 3 years older and I tried to do everything she did. The only thing I remember is fighting with her. She considered herself wonderful and would tell on me. I'd get spanked plenty, [*Is it possible that unresolved sibling rivalry still continues?]*

Th. How did your father feel about her?

Pt. After mother died, she was the favorite. She used to do everything with dad. I used to get the spankings. They told me I had an awful temper. That amuses me because I'm such a Casper Milquetoast now. *(pause)*

Th. How do you feel about your sister's taking your father away? *[This is a very provocative question and is actually intended as an interpretation.]*

Pt. I guess I accepted it. There was nothing else I could do. *[The patient is probably unaware of her deep resentment about being rejected and of her intense desire for a good relationship with her father.]*

Th. But it would seem natural to resent such a situation, *[more interpretation tentatively given]*

Pt. Well, it was a bad situation all around. And I was difficult, I suppose. There were times when dad was very sweet though. When I was sick for instance. *[Could this be a genetic determinant of the masochistic impulse ? Her present tendencies toward depression and psychosomatic illness may be a result of a pattern of sickness that in her childhood invoked her father's attention. This is the mechanism that seems so clearly portrayed in the dream.]*

Th. This must have made sickness a premium for you? *[I am attempting here to get her to think about this mechanism.]*

Pt. (*laughs*) I was a sick child they tell me. Even now I don't feel good. I don't think I ever felt like I was all together.

Th. There may *still* be dividends that you get out of your being sick or feeling sick, *[a tentative interpretation of her hypochondriac pattern]*

Pt. (pause) Say … well, I wonder. Do you think I make myself sick so people can feel sorry for me? *[This sounds like emerging insight.]*

Th. There is *some* reason why you feel sick.

Pt. I did feel like hell yesterday and today. My back is killing me. I dosed myself up with aspirin, *[deviates into talking about her symptoms]*

Th. (interrupting) Now let's look into this thing. If you got dividends of love and attention from your dad by being sick, this could have started off a pattern. Do you have any idea whether you got sick with people you want attention from?

Pt. All I know is that I make a nuisance of myself with people. I guess I make them sick. *[The patient is resisting here.]*

Th. Well, now the dream brings out the fact that you tell the man who is hard to get that you are sick and going to die, and then he tells you he likes you, and everything is sad and beautiful. That sounds like the same thing, doesn't it?

Pt. (excitedly) Yes, I see. The night before the dream I went to a party. There was this very attractive man there who was taken over by another girl. I tried to engage his interest. He was polite, but I didn't get too far.

Th. Mm hmm.

Pt. The nice men are always in demand and married, or something.

Th. Sounds like nobody takes any interest in you.

Pt. The men who are attracted, I feel there is, I know they are castoffs. They are either people who want a mother or are married and want an affair. And that's not for me.

Th. Maybe you undervalue people who like you. *[This is more tentative interpretation.]*

Pt. I don't know, but I must attract the wrong people. *[The patient is apparently not ready for the interpretation.]*

Th. You know, the dream seems to bring out your pattern of disinterest in men who want you, and hopelessness with men you want.

Pt. Yes, it does, *(pause)*

Th. But what do you do in the dream to get the person to tell you he loves you? *[attempting to stimulate thinking about her pattern]*

Pt. (laughs) I tell him I'm sick and going to die.

Th. Like you did with *whom* before, as far back as childhood? *[more questioning to promote thinking]*

Pt. With father, of course.

Th. It sounds as if you are using this pattern constantly, whenever you are up against a situation where you feel you are second best. It's like you are still living with a sister your father prefers, and you have to use drastic measures to win out. *[interpreting her pattern]*

Pt. It's true; that's what I must be doing. In everything I feel hopeless, in everything, *(cries)*

Th. But is it *really* hopeless or do you *feel* it's inevitably hopeless because this has been the pattern of your life?

Pt. Just look at how my sister is, and look at me.

Th. You are still pitting yourself against your sister. Let's take the letter she wrote you, which seems to have stirred up the dream and the old conflict of being preferred or not. Now you read into it something she may not at all have intended.

Pt. Of course, that's possible.

Th. Or take your feeling about me. If the pattern we talked about is there, it may come up with me too. Have you felt that I didn't like you or didn't pay attention to you? *[probing for possible transference reactions]*

Pt. I have felt you were distracted and not interested in what I was saying.

Th. Perhaps I did something that gave you that impression?

Pt. Well, you changed my appointment last week.

Th. What did you think that meant?

Pt. Nothing, I suppose, but (*laughs*) I'll tell you what I thought about.

Th. Yes.

Pt. I thought you were seeing somebody in my place, more important or attractive.

Th. Like your sister? *[accenting the transference element and the possible misinterpretation]*

Pt. (laughs loudly) I suppose so. It seems like I keep doing the same thing all over.

Were the patient in a phase of translating insight into action, the focus would be on resistances to activity, normality, and the abandoning of primary and secondary neurotic gains. The dream material would be utilized in such a way that any possible resistances or defenses against utilizing insight constructively would be accented in order to expedite the therapeutic process. If the patient, finally, were in the terminal phase of treatment, the dream would be searched for evidences of resistance to termination or for refusal to yield her dependency and to exercise assertiveness. In this way the greatest good would be derived from the interview.

DEALING WITH RESISTANCE

An insidious form of resistance is forgetting dreams. This, often a maneuver to keep the therapist at bay in order to avoid anxiety and to retain the secondary gains of the neurosis, may remove dreams as a form of communicative interaction. Focusing on the possible reasons for not dreaming may enable patients to recover their dreams. Sometimes as mentioned before, hypnosis helps to break through the dreaming block. Another resistance is that of bringing in reams of written dream material and filling the

session with intellectual recitations about possible meanings. Enjoining patients *not* to focus on dreams serves to bypass this defense. A third resistance is disavowing the significance of dreams, and of the characterizations and actions that are taking place. Here the therapist may point out that what the patients have presented is *their* dreams, that they had a free choice of portraying what they felt, and that they selected their own script and characters. Repudiating their own creations is a means of trying not to take themselves seriously to avoid anxiety or to retain the pleasures of their neurosis.

FANTASIES

Fantasies or daydreams are almost as important as night dreams in reflecting deeper mental trends. While fantasies are influenced more by conscious ideational processes, they follow many of the laws of dreams. They may be handled in a manner similar to that in working with dreams. Of particular importance are masturbatory fantasies, which embrace some of the most disturbing conflicts of the person. The individual's emotional reactions to fantasies may be as significant as their content and should, therefore, always be taken into account.

ILLUSTRATIVE CASES

Example 1

A patient with an anxiety reaction came to therapy partly because of distressing symptoms and partly because of a realization that she was unable to get along with people, particularly with those in authority. She felt great envy toward persons who possessed more material things than she had, or who knew more than she knew, or who happened to be in any kind of superior position. She feared expressing her hostility and, in defense, adopted a compulsive ingratiating attitude. Her relationships with men were characterized by an initial period of temporary enthusiasm and passionate involvement, followed by disillusionment, resentment, and an inevitable rupture of the friendship. During the thirty-sixth session, she presented the following dream.

> I am in a field, but instead of there being grass, the earth is blanketed in a cloth cover with a peculiar design. I see an animal in the distance coming toward me. I don't know if it is a cow or a bull. I somehow have the power to make it either, by looking at it a certain way. I make it a bull and run away as it charges me.

> Then I see myself in a room. A woman is about to leave two little children. They are good children and I feel angry that they are left alone.

In her spontaneous associations the blanketed earth resembled the cover of the couch in my office. During her last visit, as she entered the waiting room, she ran into my wife who was on the way out. She had a transient fantasy then that my wife was abandoning my two children in protest over my working constantly and, therefore, having no time to devote to my family. Associating to the animal in the dream, the patient described a recurrent fantasy of being caught some day on a field by a bull who charged her while she was completely helpless.

A tentative unverbalized formulation on the basis of what I had learned about her in therapy was that she related in two distinct ways to people. First, she would idolize any person whom she could identify as a powerful authority. She needed to convince herself, however, of the omniscience of this authority. Any flaws or weaknesses that she detected in personages whom she endowed with superior virtues resulted in her losing respect for them and rejecting their friendship. Second, she would, in association with a weaker person, assume command and insist on the person's complete submission to her When this happened, she would develop contempt for the individual's weakness and then feel repulsed by any contact with the person.

In her relationship with me the first pattern had prevailed. I was elevated to the position of the invincible authority who knew all and could do no wrong. From time to time I challenged this attitude, attempting to show her that her notions were based on a need for a power figure. While she accepted this idea intellectually, emotionally she clung to the feeling that I was a kind of demigod, possessed of varied virtues, including superb judgment and exquisite intelligence.

Several days prior to the dream we had, during a session, discussed her relationship with her fiancé, which had followed along the lines of her typical pattern and now was in

the final stages of disintegration. I had given her several strong interpretations, her response to which was that I was criticizing her. I had a feeling that she resented my intimation that discharging her fiancé might not be the best solution for her present plight.

Focusing on her present dream, I suggested that the blanketed earth on which she stood in the dream and which resembled my couch cover was probably a symbol of the therapeutic situation. Her emotion in the dream might then relate to therapy or to me. This remark sponsored associations to the effect that she had been angered by my comments of the previous session. She confessed that as she left the office, she had begun, for the first time, to doubt my competence.

The meaning of the dream then became more apparent. She viewed me, first as a cow, tearing me down as an incompetent, weak person over whom she could ride roughshod. Second, she regarded me as a "superior" ferocious bull who could hurt her. In this way she symbolized her conflict between wanting to tear me down, as she had torn down all other authorities, or making me even more invincible, and hence potentially dangerous. She chose the latter in the dream. Envisaging escape from therapy, she rationalized her contemplated move with the idea that, in providing me with more leisure, I could devote myself to my wife. This would prevent my wife from leaving my children, who did not deserve a broken home. The last part of the dream was a partial expression of this notion. The interpretation of the dream helped the patient to realize that she was expressing in her dream structure a symbolized version of many of her basic life patterns. This insight proved of great value in promoting progress in therapy.

Example 2

Sometimes spontaneous associations to a dream help the patient gain awareness of inner conflict with dramatic force. In the following excerpt a male patient achieves insight into fleeting homosexual impulses:

> *Pt.* I dreamt my father was quite ill and I was taking care of him. I don't know what was the matter with him, but he was ill. I guess my sisters were around there somewhere, but I seemed to be feeding him and giving him his medicine. And there's one thing that sticks in my mind—a view of a spoon, an ordinary tablespoon, leaning up against something—in jelly or

something along that line, something gelatinous. And I thought I was sort of half awake and I thought: "Well, Jesus Christ what am I doing— what can I say to that dream? It means that I am being my mother; I'm carrying out the functions of my mother, taking care of my father." And this is what I know it means: I have a desire or fear of being homosexual. I'm taking my mother's place. It hit me hard between the eyes, and I almost fainted. And the next night I dreamt about a hasp, kind of lock—you know, the kind where the hasp drops over a part when you drop a padlock into it. And I thought there was something about the hasp, and I thought I'm on the outside of it; somebody is on the other side and can't get in, and I can't get over there. It could be turned around the other way. I could be over there, couldn't get in, and *he* could be here and not get out. It was not in any way a menace or anything like that, but it was that I'm here, and the presence of this hasp keeps *him* out and keeps *me* in. I can't get to him, and he can't get to me. It's possible that you can turn it around, and the same thing would be true. In other words, it's an equation, *(pause)*

Th. What are your associations to this dream?

Pt. That is, if I were on the other side, the hasp would prevent me from getting inside. He would be inside, and he would be prevented from getting outside. I just remembered that I had another dream. I dreamed about a man I worked for about the time I got married the second time. I had worked for him once before. He was very fond of me, and I of him. Now I suspect there was a funny component in that relationship. He was, himself, in analysis. We had a lot in common for artistic reasons, philosophic and political reasons. However, in the end he turned out to be a heel. In spite of this guy's glowing promises, and so and so on, I hadn't been married a month before I was fired. It wasn't his fault; he was just going broke. But the slob didn't even buy me a drink when I got married. This was a pal, wept on my shoulder when his wife left him, and I used to go up there to spend all the evenings with him. When he was very bad, I'd stay over, you know, that kind of thing. He was going through what I went through with Anna, only I didn't know it then. You know I'd get flashes —now I know what they mean—that maybe he and I would be better off without women.

Example 3

The following portion of a session with a man suffering from impotence illustrates the value of focusing associations to a dream for the purpose of inculcating insight:

Pt. I have sort of a feeling of frustration at the business of looking around for an appropriate woman. This is partly the result of the fact that it's such a time-consuming operation and rather unrewarding unless one actually, until one actually, finds the appropriate person. And there is, there was one such futile evening which I spent yesterday. I suppose you may say that this is in the nature of resistance, but it generates feelings of how much more profitably I could have spent my evening yesterday had I not had to waste it looking for some woman. *(pause)*

Th. Some woman?

Pt. Yes, some girl I had never met before. She was a close friend of other close friends of mine. I called her up, you see. I had a fairly elaborate description of her. But the situation produced was that it was not something I could pursue very far because I was not substantially

interested in her. I suppose I had a strong negative reaction, that I felt that she was tightly absorbed in her family, which produced a negative reaction. *[This reaction is typical of the patient's responses whenever he attempts to relate to a woman. He finds some objective reason to justify his apathy and disgust. He is not aware of more fundamental fears and conflicts that condition his desires for flight.*]

Th. Could there possibly be more basic reasons why you found her unattractive? *[attempting to focus his attention on deeper conflicts]*

Pt. Well, I keep thinking that what I want from a woman is to find her substantially attractive, but more than just a sexual relationship. It is one in which there is substantial frankness. She should have a substantial intellectual capacity. Since those don't abound in very large numbers, that reduces the field very much, uh uh, especially if you, uh, introduce the factor that there is some sort of automatic resistance which would, in any case, reduce the attractiveness of most women on the sexual level. *[The patient dodges my question, but he does bring in the factor of his sexual resistance.]*

Th. Well, what about that automatic resistance? *[another attempt to focus on his conflict]*

Pt. Why, there is this impotence problem I came to you for, which is still with me. This substantially reduces my effectiveness with women.

Th. It doesn't seem to have made you unpopular. After all, there are many women after you, in spite of the impotence.

Pt. I suppose so. *(laughs)*

Th. I wonder if all of the specifications that you have for an ideal woman, and the lack of feeling for women, may not be indicative of certain fears? *[focusing still on basic conflicts]*

Pt. I suppose they must be.

Th. Like what, for instance? Do you have any ideas or feeling about this?

Pt. Frankly, no. Except that there is this lack of enthusiasm, *(pause)*

Th. What about dreams; have you had any since our last visit?

Pt. Yes, quite a few. On Tuesday night I dreamed I was in some sort of a revolutionary turmoil, and some dictator had his arm torn off. Then I became the dictator, and my arm is attached. As I proceed somewhere, each time someone touches my arm, I feel it's going to be torn off. This is followed by a dream in which I and a girl are going somewhere, and running to catch a bus, and my hand begins to bleed. I'm becoming covered with blood, and she says, "Look what's happening." I say, "It doesn't matter; let's get there in a hurry." Then I exclude from an appointment I had arranged with people, this girl.

Th. Exclude her?

Pt. Yes, she was excluded in some way.

Th. By whom?

Pt. By me.

Th. Mm hmm.

Pt. I was in considerable turmoil. And then I dreamed of my cousin, my young cousin at school. He reports that a number of children at school have succumbed to some epidemic, to some disease. Following this, I help him conceal a knife that he's to use illegally in fights with other boys, and I instruct him how to use it. Then I walk along a dark street alone and see adults discussing something. Then these adults transform into a group of children. I walk along in imminent fear of attack. I pass a boy with a large hound. At first the dog appears planning to attack me, and he does, and the dog jumps on me and seizes me by the arm, and, oh, I had a painful sensation in my arm. *(pause)*

Th. Is that all?

Pt. Yes.

Th. What do you make of it, the dreams, I mean?

Pt. I suppose I am upset and afraid. I must be the dictator whose arm is hurt.

Th. Yes, as if you are in jeopardy of being attacked as a dictator and physically hurt.

Pt. Yes.

Th. What about being a dictator?

Pt. That's what some girls call me, when they fall in love with me and get angry. This dream followed this date with the girl.

Th. I see. Perhaps your feelings about this girl touched off the dreams. It's significant that in the dream you are running with the girl to catch a bus and your arm is bleeding.

Pt. Yes, we are going somewhere, and I want to get there in a hurry.

Th. Where do you think you want to go in a hurry?

Pt. *(pause)* To get sex I suppose. I am in a rush to get this thing settled.

Th. But perhaps this dream tells us why it's difficult to get things done in a hurry. After all, your arm is mutilated. Could it be that in rushing into sex you feel you might be mutilated in some way?

Pt. *(emotionally*) There must be something that scares me. I feel anxious as I talk now.

Th. In what way could you be mutilated? Who would mutilate you and why?

Pt. I don't know. In the dream I help my cousin fight off an attack. This must be an aspect of me. Then I am attacked by a boy and dog who jumps me.

Th. And you get a painful sensation in your arm. The arm that bled in the other part of the dream?

Pt. Yes.

Th. But what about the part of the dream where you exclude her?

Pt. I don't know.

Th. Why should she be excluded?

Pt. I might want to exclude her, I suppose, from myself.

Th. That's what you actually did in your feelings toward her during the date.

Pt. Yes.

Th. And is what you do with other women?

Pt. I suppose so.

Th. Is it possible that you exclude her because of feelings, indicated by the dream, of fear, of bloody mutilation?

Pt. If I were to expect attack from this source, I can see that.

Th. One way to escape attack is to give up the sex object, remove yourself from her, become impotent and apathetic, *[interpretation]*

Pt. I just remembered. I had a dream the day before I saw the girl.

Th. Mm hmm.

Pt. A series of two dreams, not entirely clear. There's a small girl who demonstrates strong friendship feelings toward me and offers something valuable which, in the dream, is a source of energy which she tells me to take from a series of intangible columns of materials. Later in the dream a small girl is very friendly to me. However, she transforms into a small boy who then picks up my pack of cigarettes and throws it out of the window, despite my protests. Then I'm with a police officer, and he hides a pearl necklace in the files. I'm interested in it, but tell him I'm not, and I just want to go to some town. I go to the railway station, check my suitcase, and enter the train car. Then some woman rushes out with a suitcase that looks like mine. I follow her, but we investigate and find the suitcase is hers. I return to the car and find my suitcase. The contents are all female articles, and I think to myself it will be difficult to prove that this is my suitcase, *(pause)* And that's all.

Th. I see. What do you think of that?

Pt. (*laughs*) Well, I suppose my impending date got me to dream of this girl. I think of this treasure, the pearl necklace.

Th. The treasure being hidden by a police officer?

Pt. Yes, keeping it from me.

Th. What is the most previous treasure you can think of?

Pt. What I want here. To have sex with a woman. Sex must be locked away from me, if we are to believe the dream, by some authority.

Th. Mm hmm.

Pt. The recognition of that by the woman— the suitcase—is rather puzzling. It apparently involves some uncertainty in my, uh, virility and masculine qualities, as much as the woman had the same suitcase as I.

Th. As if she's a counterpart of you, as if you don't know your identity—male or female. *[interpretation]*

Pt. Yes, I can see something now; it occurs to me that the arm in the dreams is a symbol of my genitals.

Th. Mm hmm.

Pt. And the dictator, being in the position of dominance like a male, can leave his genitals hurt and not be a man. If I try to be a man, I may be hurt—my superiority and power torn off so to speak.

Th. And sexually mutilated.

Pt. Yes, undoubtedly.

Th. And in a sexual role with a woman?

Pt. I'll be sexually hurt, hurt.

Th. Now, if it's true that you could be hurt for trying to be a man, what defense would you use?

Pt. To get away, run away, or to be a woman and not have to face it.

Th. What about fighting back?

Pt. Yes, yes. The aggression. Like in the dream, the attacking with a knife.

Th. Your dreams seem to bring out mechanisms of why you act the way you do.

Pt. I can definitely see that, but it's so peculiar. I know it's true. I feel it. But it's so strange.

Th. It would explain your coldness with women, the impotence. If you expect to be castrated, that's no fun.

Pt. (*laughs*) Gosh, uh, yeah, uh, I had one reaction of this sort, which I became conscious of, and that is that in playing with my girl friend, the old one, she accidentally hurt me very slightly around the genital region, but it was very slight. And, nonetheless, it, for a while, caused a complete disappearance of sexual desire.

Th. When did this happen?

Pt. A number of days ago.

Th. Before or after the dream?

Pt. Before.

Example 4

The fragment of a session that follows is an illustration of the active working out by a patient of an anxiety attack with psychosomatic symptoms through an analysis of her dreams:

Pt. After I left you the last time I felt good, but it didn't last. The next day I awoke and felt tense and bad all over, physically sick. I wanted to go to my desk and do that work; I could have made myself do it. So I gave myself the only therapeutic treatment I know of. I just went to bed. I stayed there all afternoon.

Th. Did you feel better?

Pt. I still felt awful when Mark got home last night. Janet, my friend, came in about 4 o'clock, and I had had nothing to eat all day, you see.

Th. Mm hmm.

Pt. Well, I started to figure out things in bed, and I apparently figured out some things because I had some good results. I didn't order groceries. I didn't do a goddamned thing. But I did get up, and we ordered Chinese food in, last night; and I did get up and fix that and ate dinner. First meal in almost 24 hours.

Th. What have you figured out?

Pt. This morning when I awakened, I felt fine. When I say fine, I mean as fine as I can feel. And I've been doing everything in perfectly normal order all day. Almost called you yesterday; then I thought no. It's absolutely ridiculous; this thing is my own doing. I might as well try to figure it out myself.

Th. Did you?

Pt. No, I don't think I have completely, but I think I worked some of it out though.

Th. Well, let's talk about it.

Pt. Well, would you rather hear some dreams first or second?

Th. Whichever you want.

Pt. There was one damn dream that was important that I forgot. All these things happened one on top of the other. For instance, when I went to bed yesterday at 12 o'clock, with the exception of phone call interruptions, which I talked perfectly normally on, I'd go right back to sleep. When things get too tough, I can go to sleep. That's what I did yesterday. Things got too rough to stand it, so I went to sleep, but all that time I had one dream, after the other dream, after the other dream; and the night before, that would be Sunday night, I had a dream about you. It seemed that you must have been visiting me, or else you had taken over my production, I don't know. But anyway it was a big house, and we were in one small room of it with a table between us, a regular interview setup like this. There was a table between us, and on one side was a sort of a rack where equipment could be put. And, although I never saw this in my dream, I knew that in the other room, it was a large room, you were helping me prepare a product and you were in charge. And you had something to do with that. Then that room opened off onto several other rooms which we never got into; we were still in this one room. And every so often we could hear the clatter of the girls who were also making the product. Finally, at about 4 o'clock, quitting time, these girls came in, a couple of them, and rolled this piece of equipment thing used in the product and put it in this rack right next to us. And at that time you were telling me that you didn't think my behavior was very good, that you did not like me to call you by your first name, that you felt that until our relationship was established on a firmer foundation, that I should at least give you the courtesy of calling you by your second name. And about that time I was feeling sort of slapped down about it, Mrs. Wolberg came through. It seemed that she kept the books, and she said to me, "Well, besides that, you won't have much more credit up here." Then yesterday afternoon I dreamed of a marriage. Elsa Maxwell handled all the arrangements for the thing, and so forth. And someone else was going to be the overseer and the participant in the affair to replace me. And I saw all this very clearly, the arrangements and the publicity and the beautiful church and the gown; and I felt very much left out of it, and very resentful of the other woman. That's when I awoke and realized it was nothing but a dream. I guess they're all anxiety dreams, but that was a dream that showed to me at least what my feeling was.

Th. Which was?

Pt. That I feel very rejected by you and left out of things. (*laughs*)

Th. You feel rejected by me?

Pt. Then I dreamed of a room full of little girls, blondes and brunettes of different ages, but all within say, 3 to 6 years old. Going into this room was like going on the boat that goes to Catalina where they have all these benches. You know what excursion boats are like. That's what the room looked like. The benches were all full of these little girls. I went in with these attendants, and I was told to pick out the child that I thought I should have had. The phone rang and I never got to picking her out, and that was that.

Th. What do you think this all means?

Pt. This morning after I awakened I tried to piece this stuff together with what little I know about it. I usually think, well, what's my day going to be, the first thing when I wake up in the morning. How soon do I have to get up? How soon do I have to dress? Who do I have to phone? And so forth and so on. This morning I thought: "What is my day today and what is going to be pleasant in it." And the first thing I thought of being pleasant this morning was to come up here! And I had to have my hair done, and I had a certain amount of desk work to do, which to me isn't particularly pleasant or unpleasant. It's something that has to be done, and that's that. It never bothers me too much, but neither do I look forward to it. But I looked forward to coming up here.

Th. It's interesting in the dreams you put me in a certain role with you.

Pt. As if I want to be in Mrs. Wolberg's place.

Th. Do you?

Pt. Yeah, and very much so. (*laughs*) I'd like to have you take me over, I guess.

Th. So that here you're shoved out, and it's almost as if you tentatively have a place and don't have a place. You just don't know. As long as you pay your bills, you have a place. If you don't, god knows what will happen to you. You may be thrown out on your ear. The role that you play with me is not defined. The corollary of that is that you may want me to play a masterful role with you. *[interpretation]*

Pt. And yet I'm the very person that fights against any authority.

Th. That's the annoying part of it. You may not want an authority, but when it isn't there, you may feel insecure, *[giving her more interpretation]*

Pt. I think ... I know you're absolutely right. Because right after our last session, I said, "Goddamn it, why doesn't he do more for me." Then I started getting angry at your wife. I felt like killing her. That made me laugh, because after all, I'm not 20. Why should I feel this way about you? But I do, and I know damn well that your not telling me what to do, and your not letting me figuratively move in with you, bothers me like hell. I know it's silly, but that's how I felt. And it made me feel guilty.

Th. And crowding these things out of your mind must have brought on some reactions.

Pt. It made me sick, I know it did ... *(pause)* It's so silly. (*laughs*) I feel better now.

Perhaps the most important use of dreams in therapy is toward recognizing the signals that they emit pointing to the beginning development of a negative transference reaction that, if unheeded, may expand to block or destroy progress in therapy. Where a therapist does not encourage the patient to report all dreams, the patient may forget or

repress them, and the only sign the therapist may notice that things are not going well is that the patient's symptoms return or get worse, that disturbing acting-out behavior appears, or, worse, that the patient simply drops out of therapy. Where dreams are regularly reported, the therapist will have available a sensitive barometer that indicates the oncoming of an emotional storm. A patient in the middle stages of therapy began coming late for appointments. Only upon urging did she report the following dream:

> *Pt.* I was asleep on a desk or table in your office. I was lying on my side with my knees bent. You walked over to me. You were a shadowy figure that I could barely see through closed lids. I knew I should wake up, but I was curious to see what you would do and I lacked the will to awaken. You touched me. I had been covered, but you removed the cover and I remember thinking "I hope I have a pretty slip on." At first your touch was pleasant, sexual-like, and I felt rather guilty for not letting you know I was really awake. Gradually you began to turn into a sinister figure. You looked into my eyes with a light and said, "That's a lovely blue eye." I barely mumbled, "It's green," feeling that if you didn't know the color of my eyes it meant you didn't know me. I realized with a shock that I didn't know the color of your eyes, either. Brown, I thought, but I wasn't sure. Then you said to me, "What are the things I've told you?" I started to mumble, "Many things." You said, "No, I have told you nothing." I took this to mean that you are absolutely not responsible for anything I might do. These things made you seem sinister to me. You slowly began to change into another man who seemed to be a derelict, and I know I *must* get up. I struggled to awaken myself, and I finally succeeded. I ran to the door and ran out of the room, but there were a lot of people. In a mirror there I saw an utter ruin—I looked 80 years old and terribly ugly and I believe scarred. All the people were old and ugly. It was a village of discarded useless, and helpless people. A feeling of horror overcame me, and, as I stared at that face, I tried to comfort myself that it was only a nightmare and I would soon wake up, and I found it very difficult until I wasn't sure anymore if it was a nightmare or real.

> I finally woke up from the dream so frightened that I wanted to wake my husband, but I decided to try to calm down. I fell asleep again and had a second dream. I dreamed I had stayed up all night writing a paper you asked me to do. I started to bring it into the room you told me to. It was locked. I decided to have some coffee and came back. I did. This time your wife was in the room. She told me who she was. I said I knew. Then she told me she was your daughter's mother as though this made her a figure of great importance and dignity. This made me feel guilty and gave me the feeling that I could not see you anymore. She didn't want me to and in respect to her sacredness as a mother I couldn't.

Had I not become alerted to the beginning transference, which certainly reflected an oedipal problem, I am convinced that my sinister qualities would have become so overwhelming in her unconscious mind that she would have discontinued therapy. As matters stood, we were able to engage in fruitful discussions to a satisfactory interpretation of her dream.

"The task of interpreting a dream" says M. Hollander (1965), "is somewhat like understanding a poem." The therapist sensitizes himself or herself to the *manner* in which the dream is presented and attempts to divine why the patient is bringing up the material at this time. The therapist relates the content to what is known about the patient's past and present interpersonal patterns as well as the character of the immediate relationship with the therapist. The therapist probes into provocative environmental happenings that may have brought out the conflicts symbolized in the dream. He or she searches for dream manifestations of transference and resistance. The therapist avoids employing universal symbolism, focusing rather on allusions and figurative references in the here-and-now, while mindful of the fact that the present rekindles the flames of the past. At the same time the therapist attempts not to overemphasize dreams, for by making too much of them the patient may utilize them to excess, even as vehicles of resistance. The artistry of dream interpretation is selecting out of the tremendous number of variables those that can satisfy the requirements of the immediate therapeutic situation.

42

Identifying Important Trends and Patterns: The Examination of Attitudes toward the Therapist, Including Transference

All people progress from childhood to adult life with attitudes, values, and behavior tendencies that are parcels of past experience. These persist in the form of fixed patterns that repeat themselves compulsively in certain interpersonal situations. Thus, a grown man, intimidated as a child by a punitive father, may respond to all authoritarian men with a cowering, ingratiating set of reactions, as if he virtually still were a little boy awaiting punishment for a misdeed. A grown woman who, as a child, was violently competitive with a younger sister for the attentions of her parents may carry on a campaign for absolute supremacy in important endeavors or situations, as if she repeatedly had to prove that she was "best" and hence worthy of praise and affection. Such patterns, given the proper stimulus, go on repetitively, forming the very fabric of the individual's way of life. They are stoutly defended, irrespective of how irrational they may be or how inherently contradictory they are in operation. The motivants for these drives, and the early experiences that engendered them, seem to exist in the unconscious of every individual. One is aware merely of an impelling urge that forces the adoption, in certain situations, of stereotyped ways of thinking, feeling, and behaving.

Obviously such tendencies, sooner or later, are potentially disruptive to the individual and, when they cannot be controlled, may create difficulties that disorganize adjustment. Normal people are capable of exercising some measure of control by virtue of wanting to avoid the unpleasantness that usually follows unrestrained responses. The defenses employed to curb such impulses may help one to adjust, but in no sense do they minimize the urgency of drives that periodically may express themselves in direct or highly symbolized form.

Fortunately, in addition to immature stereotyped patterns, all persons exhibit

reactions that are reality-determined. These make up many, perhaps most behavioral tendencies.

Thus, the man described above who behaves like a little boy may respond to certain males in an assertive manner once he has assured himself of their good will or has ascertained their incapacity to hurt him. Indeed, with selected men, under special conditions, he may even act the part of authority. Or the woman who competes blindly may be content with a secondary role whenever her security and self-esteem are assured.

Each individual will, therefore, play varying roles with different people, and, contingent on how secure one feels and the measure of one's self-esteem, one will react with either infantile past patterns or more mature patterns.

In Chapter 39 we have considered the examination, through focused interviewing, of the patient's current interpersonal involvements in order to identify disturbing patterns responsible for the emotional disorder. In the present chapter, we shall cover the process of investigating both stereotyped infantile and mature rational responses as they are expressed toward the therapist within the framework of the therapeutic situation.

Before taking up this process, it is necessary to emphasize that in supportive therapy, and in directive forms of reeducative therapy, it is often unwise to delve into the nature of the relationship with the therapist. Such a move tends to challenge the position of the therapist as a benevolent authority and the foundations of faith on which success in treatment may depend. Indeed, the attempt is made to perpetuate in the patient the illusion of the therapist's protective powers, no effort being extended coward examining the irrational sources of the patient's dependency need. The hope is to adjust the individual to less disturbing unconscious impulses, to increase repression of the more destructive ones, to expand existing assets, and to encourage compensations and sublimations so that patient can live as happy a life as is possible with his or her liabilities. Nevertheless should the patient's attitude toward the therapist become disturbing and interfere with the conduct of therapy, they are dealt with as manifestations of resistance to problem-solving and symptom relief.

In some forms of reeducative therapy, however, the more conscious manifestations of stereotyped patterns projected into the therapeutic relationship are explored and discussed in an attempt to modify or to control them. In reconstructive therapy, where an effort is always made to bring infantile patterns and their manifestations to full awareness and to determine their genetic origins, a thorough study of what goes on in the patient's relationship with the therapist is mandatory.

Insight into many of the patient's problems may be gained expediently through exposure of feelings and attitudes toward the therapist. The patient always projects into the relationship strivings that are both reality-determined and conditioned by habitual, unrealistic impulses toward people. The differentiation by the therapist of these two kinds of strivings helps the patient to understand the automatic, compulsive nature of some responses.

There is nothing so dramatic to a patient as to realize that he or she reacts to the therapist, not as a real personage, but as a virtual reincarnation of a parental or sibling figure (transference). The demonstration of how attitudinal and behavioral reactions are rooted in past relationships and how they distort the present reality situation is a living demonstration to the patient of the irrational way that he or she feels and behaves in everyday contacts with people. This realization may start a process of re-evaluation of the self.

One of the important effects of understanding the nature of impulses and attitudes toward the therapist is that it enables the patient to differentiate rational from irrational authority. Expectations of being treated by the therapist in a manner similar to the way that the patient was handled by previous authorities are not fulfilled. Avoiding a punitive, judgmental attitude, the therapist regards the patient's difficulties with sympathy and understanding. Expressions of hostility by the patient are accepted without indignation or retaliation. This allows the patient to display resentment more and more openly. It permits the patient to investigate its source as well as to understand reasons for its present existence.

Although every patient responds to the therapist with some patterns that are unrealistically determined, these may not be openly expressed. Subjected to reality testing, certain impulses are recognized by the patient as irrational. They may be considered threatening to an idealized relationship with the therapist. Accordingly, they are disassociated, suppressed, or repressed. Sometimes they impinge merely on the periphery of awareness, appearing in a symbolized form in dreams and fantasies or revealing themselves in slips of speech and random behavior, such as acting-out. Transference may manifest itself in relationships outside of therapy, the patient discharging toward a mate, relative, friend, or other personal feelings and attitudes that he or she dares not express toward the therapist.

Certain activities on the part of the therapist discourage or encourage the revivification in the therapeutic relationship of archaic patterns. Where the therapist considers that desired goals in therapy can be achieved without the stirring up of excess transference, the therapist may decide to deal with emerging irrational attitudes in as immediate and forthright a manner as possible. Thus, hostility, sexual impulses, and intense dependency are handled by discussion and clarification as soon as they become apparent, an effort being made to keep reality in the fore. The relationship is maintained constantly on a positive level. This is the stance utilized in many, perhaps most, forms of therapy.

Among the techniques utilized to reduce transference are these:

1. Focusing discussions on present relationships and the current life situation

2. Minimizing or avoiding the consideration of the past, including relationships with parents

3. Avoiding dreams, fantasies, and free associations.

4. Avoiding the couch position and employing face-to-face interviewing

5. Spacing interviews no more frequently than once or twice weekly

6. Dealing with any unrealistic attitudes or feelings toward the therapist as soon as

these are perceived

7. Playing a role opposite to that which the patient anticipated on the basis of past relationships with traumatizing authority

8. Exercising activity rather than passivity in the relationship

Through the use of these techniques it may be possible to withhold infantile urges from awareness, or to direct them away from the therapeutic relationship toward outside relationships, or to relegate them to a position where they may be held in check by rational controls.

In spite of these activities and precautions, transference may burst forth in full fury, interfering with the treatment plan. When this happens, it will have to be handled like any other kind of resistance, by such techniques as active interpretation.

Transference, may, however, be encouraged in certain patients whose problems are very deeply repressed and who are constantly being upset by unconscious conflicts. No movement may be possible except through the direct experiencing of their problems in the relationship with the therapist. Among syndromes in which obstinate repression may occur are anxiety reactions, phobic reactions, conversion reactions, dissociative reactions, stress reactions, and certain obsessive-compulsive reactions. Here mobilization of transference as a learning vehicle may be helpful.

Transference may become so intense that the patient will actually live through with the therapist some early developmental blocks and traumatic experiences that produced the original repressions and other mechanisms of defense. The development of exaggerated transference reactions (transference neurosis) enables the patient to reexperience early deprivations and intimidations and to master them in another, more favorable setting with a new, more accepting, more permissive, better disciplined authority.

During classical psychoanalysis the therapeutic situation is deliberately manipulated so as to induce regression. This is considered inevitable and important for the

revivification and working through of the most unconscious conflicts. The patient "will become a child again and be reborn, so to speak. Then he will grow up again, grow up better than he did before, guided by his now more mature intelligence and the warnings and lessons of his unhappy experiences now better understood" (Menninger, KA, 1961).

There is disagreement regarding the necessity for such regression, the neo-Freudians considering the here-and-now problems more important than those of the past, and believing that personality change can be achieved without the patient regressing to the infantile neurosis. Indeed, there are some analysts who, while analyzing positive and negative transference, consider the outbreak of a transference neurosis a sign of bad therapy.

Transference may operate both as stimulant toward and resistance against uncovering the unconscious; it may function, as Waelder (1936) has remarked "as the condition under which it is eminently possible to bring direct influence to bear on the patient." As a means toward understanding the most dynamic drives in the individual, transference has no parallel. The concerted analyses of both positive and negative transference are ways of bringing the patient to an understanding of the self in depth.

> I recall the first patient I had as a "control" when I was in analytic training, who taught me how persistent and irrational a transference reaction could be and how in its proper handling a profound understanding may evolve. The patient was an attractive young lady in her early 20s who had a slight stammer and whose complaint was that she was unable to "fall in love" or even to develop a warm relationship with a man. Yet she had intensely romantic and erotic fantasies about men, which made her actual detached experiences with them so much more disappointing. The technique that I was employing was patterned after the classical model. I judiciously maintained a passive, non-interfering manner under the weekly tutelage of my supervising "control analyst." Several months of free associations rolled by during which I judiciously took notes from behind the couch and waited hopefully for something interesting and dramatic to emerge from the depths of her unconscious. And one day to my consternation it did, with a violence that left me dismayed and somewhat frightened.

> The start of this episode was, to my surprise (since I could see no reason for it), sudden and complete silence on the part of the patient. Whereas she was customarily a spirited and garrulous analysand, a complete change had occurred in her since the session on the day before when she had rambled along enthusiastically, associating vigorously to events in her past. This day she walked into the room, cast a furtive glance at me, and retreated to the couch, where she stared fixedly at the

ceiling with face flushed, fists and jaw clenched. Sensing that something was happening. I waited expectantly in vain for her to reveal her thoughts. After 20 minutes had passed, my curiosity overwhelmed my studied noninterference, and I proceeded to interrogate her. But nothing seemed capable of penetrating her muteness.

Ten minutes prior to the end of the session she precipitously propelled herself from the couch and was about to bolt out of the room. I stopped her before she reached the door, and losing my therapeutic composure, I urgently insisted that she tell me what her reaction was all about. Her response was violent consisting of a torrent of abuse and invective. "You bastard," "You son of a bitch" were among the milder expletives. Shrieks mounted into an accusatory crescendo. "You know, you know what you did!" she repeated with no trace of a stammer.

It required almost a half hour of reassurance to induce her to tell me what had upset her. The pith of her agony, it turned out, was that after she had left my office following the last session, she noticed me dashing across the street against traffic. This was no illusion or hallucination. Opposite my office building there was an optical shop that filled prescriptions for eyeglasses. I had left a prescription there some days previously and, having a few minutes before my next patient arrived, I decided to rush out, get my eyeglasses, and return to my office as expeditiously as I could. I did not notice that my patient was waiting at the corner and that she observed me dodging a few cars in my haste. This, she protested, was exactly what her father would do. He took risky chances to the horror of her mother and the entire family, and he was involved in several serious accidents, finally being killed in a car crash. "You are like him," she remonstrated. "You did it to defy me." My explanation of what prompted my hasty journey fell on deaf ears. I was, she insisted, making up a story to appease her, following the style of her father. It was only after I showed her the receipt of payment for my prescription that she stopped her attack. But for months she was emotionally convinced that I had perpetrated a ruse.

The experience opened up a deep pocket of distrust that she had harbored for men since her childhood. With the help of my supervisor who guided my analytic work, I was finally able to win her trust. This was the start of a new era in her relationships with men. Had I not provided her with a precipitating incident, I am sure that she would perhaps later on have found another reason to justify her transference reaction.

As resistance, transference manifests itself in attempts to gratify childish impulses. Stubbornly refusing to acknowledge their unreality, the patient insists on living them through with the therapist. The analysis of the resistance aspects of the transference is an important aim in all psychotherapies.

Employing positive aspects of the transference relationship to promote supportive

and reeducative measures is common in non-analytic psychotherapy. Positive transference, accordingly, in many forms of therapy is left unanalyzed; it is even encouraged to expedite the therapeutic process. On the other hand, negative transference is always considered an impediment in treatment; it is analyzed and worked through exhaustively as soon as it is perceived.

When one wishes to effect a transference interpretation, rather than dissipating it by some active gesture, one should permit it to build up to a peak without defending oneself. Once the top of the reaction has been reached, one should wait until it has receded somewhat before interpreting it. In the height of emotion the patient will tend to deny the validity of the therapist's remarks or look upon them as evasions of blame. This is in contrast to what is done in classical analysis when interpretations are often made at the peak of the emotion purposefully to foster frustration and in order to put the patient into contact with repudiated parts of the self.

On the other hand, the therapist may seek to prevent the full transference reaction by interpreting it at its start, when it is at the fringe of awareness, from evidences of transference in silences, peculiarities in behavior, dreams, or acting-out. Here the need for stirring up a past emotional reaction in its *full* intensity may either be contraindicated or deemed unnecessary.

The way of making a transference interpretation may be important because the patient needs to be prepared for it. The patient's most natural reaction would be to deny its validity since its roots are unconscious. The therapist first points to the manifestations of the reaction and asks if this may not be more extreme or more unusual than the reality situation demands. Should the patient deny this, the decision may be to wait until the reaction reappears, when again it is brought to the patient's attention. Once the patient acknowledges that perhaps his or her reaction is unusual, the therapist may then suggest its origin in past relationships and perhaps, if there is sufficient evidence, speculate on the person or persons with whom the therapist is being identified. Finally, the therapist should study the patient's response to these interpretations.

The techniques that may be used to accentuate transference are:

1. Employing passivity and anonymity in the relationship.

2. Focusing discussions away from the present life situation.

3. Encouraging consideration of the past, including relationships with parents.

4. Using free association and the couch position. Removing of oneself from the direct gaze of the patient.

5. Concentrating on dreams and fantasies.

6. Increasing the frequency of sessions to 4 or 5 times weekly in order to break down repression.

7. Avoiding answering questions and restricting interpretations.

8. Avoiding dealing with unrealistic attitudes or feelings toward the therapist until these have built up to overwhelming proportions.

9. Acting in a role that coordinates with that assumed by the patient's traumatizing parent.

Patients will respond variably to these techniques, from failure to mobilize transference in certain rigid and detached persons, to explosive reactions that prove traumatic to the individual in borderline conditions. Indeed, in some patients intense transference may promote too great a shattering of repression which, not being reestablished, may eventuate in a psychosis. Syndromes such as borderline conditions, psychotic states, and certain personality disorders, psycho-physiologic reactions, and some obsessive-compulsive reactions do not respond favorably to the deliberate mobilization of transference. Even in cases where it is indicated, the fostering of transference is not to be encouraged by any therapist who has not had extensive analytic training and experience. (See also Chapter 49)

QUESTIONS ABOUT TRANSFERENCE

The following questions are frequently asked about transference to which are given

to accent what has been said above.

1. Aren't transference, relationship, and corrective emotional experience interchangeable terms?

Transference has become a watered-down expression that is sometimes confused with other forms of the patient-therapist relationship. At different times in this relationship the patient will play different roles, depending on the special needs that exist at the time. One of the roles is transference, whose meaning should be restricted to the feelings and reactions that the patient harbors toward significant persons in the past that are now being projected into the present. To a large extent such feelings are repressed and relegated to the oblivion of the unconscious. When they do surface during therapy they give us insight into infantile conflicts. They also tend to distort the immediate reality situation and divert the patient from engaging in goal-directed therapeutic tasks. Because transference can in this way act as a resistance to therapy, an attempt is often made to work it through or resolve it by interpretation whenever traces of archaic stereotyped negative or eroticized reactions manifest themselves. There are circumstances, however, when the allocation and deliberate buildup of transference is encouraged in order to examine its dimensions, origins, and effects, and especially how it engenders the present neurosis or character disturbance.

Analysis of transference is the major task in classical analysis and to elicit transference, techniques are utilized to encourage regression and the acting-out in the therapeutic relationship of repressed feelings and memories. When the buildup becomes so intense that the patient actually confuses the therapist with past important persons, the phenomenon is sometimes termed a *transference neurosis.* In certain patients, like borderline cases, the behavior may be explosive and psychotic-like (transference psychosis). Utilizing the leverage of the therapeutic alliance that has been built up, and appealing to the patient's "reasonable ego," the therapist actively interprets the patient's transferential responses, with the goals of bringing reality into the picture and of inculcating insight.

"Positive transference" is rooted in the patient's ever-present longing for an idealized parental figure who will love, protect, and lead the patient on to happy security and creative self-fulfillment. Positive transference thus is deliberately employed as a catalyzing force to promote supportive and reeducative therapy. It is only when it becomes unreasonable, the patient reaching out for magic in the hope of fulfilling infantile dreams and archaic sexual needs, that the transference must be neutralized by interpretation since its indulgence will interfere with or destroy therapeutic progress.

Positive transference should be distinguished from the working alliance in which the patient cooperatively relates to the therapist with expected trust. Experiencing understanding and empathy, the patient is encouraged to distinguish between punitive and non-punitive authority, and to dissociate the therapist from the judgmental, punitive agencies in his or her past as well as from their precipitates in the superego. It is this unique kind of relationship that facilitates restoration of morale, alleviation of tension, the ability to divulge and face repudiated impulses and hurtful past experiences, tolerance of confrontations, absorption of constructive suggestions, identification with the value system of the therapist, utilization of reinforcements toward more adaptive modes of coping, and acceptance of clarification and interpretations that will lead to better understanding and a working through of one's basic problems. The relationship itself then acts as a "corrective emotional experience."

These varying dimensions of the relationship do not operate exclusive of each other, but may shift from one to the other at different phases of the therapeutic process. It is important for the therapist to recognize what is happening to the relationship to avoid a bad impasse, which, should it happen, will eliminate perhaps the most potent corrective force in treatment.

2. We know that the patient's reactions to the therapist are important. How do you present this to gain the patient's cooperation in reporting his or her feelings about the therapist, which in my experience is too often concealed out of embarrassment, anxiety, and so on?

One can say to the patient: "I am constantly going to look for the manner in which you react to me and how you feel about me. The reason for this is that in these reactions we can learn about how you have reacted to your parents and other people better than in wringing it out of your memories, many of which have been forgotten. So no matter how embarrassing it may seem, or how anxious you get, tell me about your feelings and ideas about me so we can both learn about you."

3. It is paradoxical to me that transference, which is the central issue in psychoanalysis, is not considered to be of importance in many other forms of therapy like behavior modification. How would you account for this?

I believe that this dilemma can be explained. In classical analysis there is a deliberate creation of transference through frequent visits (four to five sessions weekly), studied anonymity, free association, and other devices for the purpose of activating unconscious and repudiated aspects of early experience. The surfacing of this material is often in the form of projection onto the therapist of the incorporated parental introjects. The working through of unresolved past needs and conflicts in the more congenial atmosphere of the therapeutic alliance is for the purpose of resolving unconscious conflict, which is what analysts believe to be the pathogenic core of the neurosis.

In other less intensive forms of therapy no attempt is made to liberate unconscious ideation, the focus of therapy being on the more conscious and here-and-now aspects of experience. Repressive defenses are either unaltered or are approached obliquely, with the consequence that transferential projections do not occur with the intensity that they manifest in classical analysis, where they may take the form of a stormy transference neurosis or frenzied transference psychosis.

This does not mean that transference is absent in symptom-oriented or problem-solving types of therapy like behavior modification. Transference may appear in attenuated forms as in dreams, in restrained acting-out, or in other highly disguised kinds of behavior. Under such circumstances therapy may still not be interfered with and may proceed satisfactorily with achievement of sought-for goals of problem-solving and

symptom alleviation. Sometimes, however, especially where defenses are not too strong, transference may break through in force and act as resistance, under which circumstance its resolution may be required to expedite therapeutic progress.

4. Cannot reconstructions of the past from the history of the patient, dreams, and recollections serve as well as activating the past through transference?

Not at all. Such reconstructions may have some effect, but only an attenuated one compared to the insight gained through living the past through in some dramatic situation in the present such as a transference neurosis.

5. What is the true value of transference in psychotherapy?

Transference reactions enable us to penetrate into the past of the patient and to see how early experiences with important persons, usually parents and siblings, have produced a paradigm around which the individual fashions many present reactions. This knowledge is especially important in patients whose symptoms and behavioral difficulties and problems in their relationships with others are repetitively sustained through the insidious operations of transference. More importantly, the therapist often becomes the target of transference projections and, when this happens, the therapeutic process may get derailed because of resistance to the therapist and to the treatment techniques. Resolution of this resistance (generally through interpretation of what is happening) puts the treatment process back on the rails, so to speak. At the same time, the patient's new insight is an opportunity to appraise one's behavior from a causative perspective, and, if motivated to do so, to correct unrealistic patterns and attitudes so that they are not contaminated by past experiences, traumas, and fantasies. In this way, the therapeutic relationship can act as a corrective emotional experience.

6. Are all positive reactions to the therapist manifestations of neurotic transference?

There are genuine positive feelings in human relationships that do not have to be

considered neurotic or transferential. These must be differentiated from distorted overvaluations and ideas of the therapist's magical powers, undaunted givingness and benevolence that are manifestations of neurotic transference. The former feelings are productive aids in the psychotherapeutic process; the latter are sooner or later destructive to the process.

7. When does transference especially act as resistance?

Transference acts as resistance when the patient tries to live through with the therapist early ungratified needs and impulses at the expense of getting involved with therapeutic work. For example, needs to gratify oedipal wishes through sexualizing the relationship with the therapist (by fantasies, overt behavior during the session, or acting-out away from the treatment) may become an obsession with the patient. Also, needs and impulses, or mere awareness of these, may create anxiety and mobilize resistance to the therapist and to his or her interventions. Another and not uncommon form of transference resistance involves fighting off the influence of the therapist the way the individual fought off an authoritarian and interfering parental figure during the developmental separation-individuation struggle.

8. Can transference occur toward persons other than the analyst?

Of course this can happen, but we must always alert ourselves to the possibility that such a reaction is a displacement from transference on the analyst, which is being repudiated and expressed through a surrogate. Thus, infantile sexual wishes which ordinarily would be projected onto the analyst may be denied and then expressed through the body of another person outside of therapy.

9. Should you try to regard a patient's unusual emotional reactions as manifestations in some way of the transference?

If possible, yes. Often what may be helpful is questioning whether in responding to certain happenings the patient had or now has thoughts, feelings, or fantasies about the

therapist. If the patient denies this, one may casually accept this but should search in the nonverbal behavior, slips of speech, etc., for evidences of transference and confront the patient with such evidences.

10. Can one take transference reactions at their face value?

It is always essential to search for latent content behind manifest behavior.

For example, one of my patients experienced anxiety in one session and hesitatingly revealed a rape dream in which she was the victim and I the rapist. Thoughts of my having sexual designs on her had occupied her for several days. I interpreted her reaction as concealing a desire to be seduced by me. This interpretation started a series of memories related to lascivious fantasies about her father that accompanied her early masturbatory activities. Our focus on her oedipal fears and feelings had a most constructive effect on her relationship with me and resulted in a good deal of progress in her treatment.

11. Are there different kinds of transference interpretations, and if so, which are most effective? Also, is it better to relate transference to the here-and-now or to the past?

Transference traditionally has connoted a concentration on the therapist of the patient's involvements with early objects. Accordingly, the therapist is conceived of as a resource for archaic needs and impulses, as well as a vehicle for defenses against them. This common concept of transference, namely that it acts like a bridge between the past and the present, has been expanded to include reactions related to here-and-now relationships between patients and therapists, as well as between patients and other authority figures. Defenses against such reactions have been also considered aspects of the transferential spectrum. The transference interpretation, while not neglecting exposure of origins in the past, may productively include how the past is influencing present reactions. Some analysts also search for manifestations of the self that are being expressed through transference.

Consequently, when we talk about transference interpretations, we are alluding to a range of activities, such as:

1. relating the patient's reactions to those he or she originally had toward parents or siblings;

2. differentiating the patient's distorted attitudes and feelings toward the therapist from the actual reality of what the analyst is like;

3. pointing out how the manifest behavior toward the therapist shrouds latent intentions;

4. indicating how the patient's feelings and behavior toward the therapist reflect important incidents that have happened in the past; and

5. depicting how drives embodied in character structure operate to create pathology.

Transference interpretations may also embrace displacements from the self onto the therapist.

12. Does interpretation of the transference always lead to insight?

No, the patient may not be ready for or may resist the interpretation. The best results in transference interpretation will be obtained where the patient is immersed in strong emotions and the interpretation links these emotions to the transference situation. Similarly, a current conflict that can be connected with transference may make the impact of the interpretation greater.

13. Some authorities contend that only transference interpretations are important. Do you agree?

There are many analysts who affirm C. Brenner's (1969) contention that "every interpretation must be a transference interpretation if it is to be effective." This implies that true insight can be achieved only through interpretation of the transference. Any analyst who has utilized and witnessed the effectiveness of interpreting the transference

once it has developed to full intensity cannot argue with the sentiment behind these statements, but the implication that other kinds of interpretations are ineffective may certainly be challenged.

When we observe the resistance encountered in analyzing neurotic symptoms and character traits directly, we must credit transference interpretation with making the greatest impact on the patient. But to restrict ourselves to this single activity limits the therapist's flexibility. Indeed, attempting to wedge all events and reactions into a transference formulation may do no more for the patient than to mobilize resistance. Nontransference interpretations can be extremely important in their own right, apart from reinforcing the impact of transference interpretations.

14. How does free association relate to transference?

Free association loosens past memories, which liberate emotions, which in turn tend to activate transference.

15. How truly essential is a transference neurosis for successful analysis?

Most analysts believe it to be indispensable. Some do not. Thus, Gill and Muslin (1976) have pointed to Glover's assertion that "there may be successful analysis … where no transference neurosis develops." Of course we are dealing here with the definition of a "successful analysis." If it means the surfacing and interpretation of the unconscious repressed aspects of childhood, a transference neurosis provides the patient with the best opportunity for the working through of these residues. If it means the achievement of reconstruction of the personality, there is no guarantee that a transference neurosis will accomplish this objective in every case. Nor is there validity in the idea that it is only through a transference neurosis that one can achieve personality reconstruction. Admitting these exceptions, the majority opinion still is heavily on the side of a working through of a transference neurosis as a most helpful vehicle for a successful analysis.

16. Is acting-out always a manifestation of transference?

Where a patient is in therapy, it should be regarded as such unless proven otherwise. But, factually, acting-out can occur exclusive of transference.

17. Why, if transference acts as a resistance to dynamic therapy, do dynamic therapists try deliberately to produce it in their patients?

Transference embodies some of the core infantile conflicts that operate unconsciously to produce neurotic illness. Its elicitation allows the therapist to confront, interpret, and clarify the meaning and purpose of the patient's illness. It may, however, create resistance as it develops; a chief therapeutic task is the resolution of this resistance, the working through of which becomes an important part of the cure. The purposeful encouragement of transference is an aspect of psychoanalytic treatment, particularly in its classical form. In other forms of dynamic therapy no effort is made to mobilize transference, but it still is dealt with by interpretation and clarification where it operates as resistance to therapy.

18. When would you consider it unwise to encourage transference as a therapeutic technique?

Transference should not be encouraged:

1. When the patient already has a problem in reality-testing (as in psychoses, unstable borderline cases, and paranoidal personalities);

2. when there is not enough time to work through transferential dependencies (as in short-term therapy);

3. when the therapeutic alliance has not been firmly established to sustain the rigors of transference;

4. when the defenses of the patient are so fragile that he or she cannot handle anxiety or tolerate frustration (which is inevitable in the transference experience);

5. when the objective in therapy is not deep conflict resolution but, rather, a more harmonious adjustment to the current reality situation.

From a practical standpoint this limits the number of candidates for transference mobilization to a highly selected group. It must be remembered, however, that, as sincere as our attempts may be to limit transference, it may still appear spontaneously, and it will then require careful resolution should it interfere with the therapeutic process.

19. Should positive transference be analyzed?

Positive transference should not be analyzed in short-term therapies, where it is utilized as a catalyzing force. It requires analysis in longer-term therapy where, because of the inherent magical expectations it invokes, the dependency it inspires, and the erotic interest stimulated, it can be a deterrent to progress. Incidentally, when a positive transference is resolved, a hidden negative transference may surface that will, of course, have to be worked through.

20. How soon will transference reactions begin?

They can occur in the first session and even before the first session with fantasies about the therapist and anticipation of what will happen in treatment. Manifestations of transference may be more easily controlled early in therapy than later on when intensity increases. Transference may exhibit itself only in dreams, slips of speech, and nonverbal behavior.

21. There is a form of transference during therapy that we call "falling in love" with one's therapist. Isn't this really a help in treatment?

On the contrary, I would consider it as a resistance. It often comes when the patient is working on especially difficult phases of a problem. This transference is usually not a mere verbalization to appease the therapist, but stems from archaic eroticized needs that have been deeply repressed and have little to do with the real person of the therapist. The patient will urgently and persistently demand gratification, if not in an actual sexual experience, then in intimacies that have symbolic sexual values. The therapist's refusal to abide by the patient's wishes is extremely frustrating to the patient and the patient may

seek external outlets for gratification in the form of acting-out with potentially disturbing and even dangerous consequences. So long as this transference need exists, the patient will resist the real aims of treatment. It is urgent, therefore, to resolve the transference. The best way to do this is to continue refusing to abide by the erotic transference need (gratification of which can be extremely destructive to the patient and the therapist) and to handle it through interpretation both as a form of resistance and as a means of understanding some of the deepest needs, conflicts, and defenses of the patient, certain manifestations of which are reflected in the symptoms for which therapy is now being sought. Interpretation of transference is an art and will call for astuteness and objectivity, as well as awareness and management of the therapist's own countertransference. Analysis of transference provides a way of metamorphosing archaic sexual fantasies and impulses into mature, fulfilling sexuality and constructive sublimations.

22. In dynamic psychotherapy how do you keep a balance of an empathic working relationship and the transferences that you want to come through to give you an idea of the patient's innermost conflicts?

While you are interested in finding out the nature of the patient's infantile conflicts, you try to keep the lid on transference material that will act as too great resistance to you and your techniques. You do not have to use special tricks to bring out these transference manifestations. They will come through, if not in direct behavior toward you then in acting-out away from therapy. You will generally get clues about transference from nonverbal behavior and especially from dreams. If there are evidences of hostility, fear, sexual interest, detachment, or paralyzing dependency, deal with these through open discussion before they germinate into full-blown patterns that may be more difficult to handle.

Even though these manifestations will give you inklings about some of the most urgent conflicts, your first task is to see to it that transference does not interfere with the working relationship, at the same time that you utilize it to give the patient some insight into the origin and nature of some of his or her conflicts. In psychoanalytically oriented

therapy one may want to encourage some transference, but, as I mentioned before, transferences will probably not need encouragement, emerging spontaneously in some form as defenses are challenged. Where controls are rigid, some therapists utilize techniques to encourage transference (more passivity on the part of the therapist, increasing the frequency of sessions, focusing on the past and on early relationships, encouraging dreams, etc.), although too great regression should be avoided. Where one wants to deal with present-day adaptations, transference is discouraged (by its early exposure and interpretation, by decreasing session frequency, by activity in the relationship, and by focusing on real events rather than the past and dreams).

23. How can you tell when a patient is in transference or is going into transference?

Generally, the therapist will be able to discern in the patient a manner that is different from the usual behavior. At the start of therapy the patient is generally highly defended and plays the conventional role of a patient with helping authority. After a while, and particularly where the patient's defenses are challenged, a change in demeanor becomes manifest. The patient may engage in periods of silence, or complain of having nothing in mind or having little to talk about, or cancel or break appointments, or come late, or keep looking at his or her watch if time is passing too slowly, or forget to pay the therapist's bills. On the other hand, the patient may verbally or nonverbally show an extraordinary interest in the therapist's private life, or become competitive with the therapist or with the therapist's other patients, or display dependency on the therapist, hanging onto every word, or openly or covertly make sexual advances toward the therapist. More difficult to detect are acting-out tendencies that the patient conceals from the therapist, in which feelings that are related to the therapist are projected to outside persons or situations. One way the patient has of concealing acting-out is by talking almost exclusively about the past, or speculating on dynamics, or bringing in involved dreams that are extremely difficult to decode.

Often the first intimations of transference are in dreams in which certain behaviors

are exhibited toward symbolized versions of the therapist. The way such intimations are handled will depend upon whether the therapist wants to let transference build up until it reaches a crescendo, as in psychoanalysis, or to dissipate it by exploration and interpretation before it acts as resistance, as in non-analytic treatment.

ILLUSTRATIVE CASES

Example 1

A beginning breakthrough of transference is indicated in the following excerpt.

> *Th.* You know sometimes I get the impression that you act with me as if you are walking on eggs. I wonder if you have any feelings toward me you are not talking about.

> *Pt.* I don't, I don't know. This is one of the disturbing things ... when I'm all tangled up inside and don't know *(weeps)*... I don't want to cry ... I'll wipe my nose ... I don't know why I'm so upset today, really I don't. I felt so much better yesterday.

> *Th.* Perhaps it's because I bring up the subject of your feelings toward me.

> *Pt. (cries)* I feel irritated, just a momentary anger. I haven't been particularly conscious of it. I don't dislike you, just irritated, *(pause)*

> *Th.* Do you want to tell me more about your feelings toward me?

> *Pt.* I don't want to have feelings for you.

> *Th.* You don't want to have feelings for me?

> *Pt.* No. I don't know why.

> *Th.* Perhaps you are afraid of showing emotion?

> *Pt.* I certainly would be afraid of feeling affectionate.

> *Th.* You would?

> *Pt.* I certainly would.

> *Th.* I wonder why?

> *Pt.* I was thinking of it, as a matter of fact, yesterday. I felt...well... if I behaved well ... perhaps you would be good to me ... fatherly like, I mean.

Th. If you behaved affectionately to me you mean?

Pt. Yes, but I'm afraid.

Th. Afraid? Of what?

Pt. That it would not be taken seriously. Would it?

Th. If you felt affectionate toward me, of course I would take your feelings seriously. Perhaps what you're saying is that I might reject you or hurt you in some way?

Pt. What I mean is that I'd be ashamed of my feelings, that this would be a one-sided relationship. I think I feel you'd ridicule me.

Th. Actually, you don't know how I'd act, and yet you behave as if I do ridicule you for your feelings.

Pt. If I had feelings would they be responded to ... would they?

Th. You mean would I reciprocate with the same kind of feeling?

Pt. That's it.

Th. If I did, this would not be a therapeutic situation for you.

Pt. I suppose not.

Th. But if you allowed yourself to talk about your feelings, I might be of considerable help to you in your problem.

Pt. (*giggles*) Now I feel very silly.

Th. Silly?

Pt. I do like you very much.

Th. (*smiling*) Mm hmm.

Pt. And I did feel about you ... that you were able to help me. I did feel you were protective, something like I wanted father to be.

Example 2

The following excerpt is from a session with a patient suffering with a severe anxiety reaction with psycho-physiologic components. During the session the patient brings up a transference reaction that she traces to its source and then recognizes the operation of

similar reactions in her relationships with people.

Th. I notice that you don't want to look at me today.

Pt. I don't want to like you. I'd rather not like you.

Th. I wonder why?

Pt. I feel I'll be hurt. Liking you will expose me to being hurt.

Th. But how *do* you feel about me?

Pt. I don't know. I have conflicting emotions about you. Sometimes I like you too much, and sometimes I get mad at you for no reason. I often can't think of you, even picture you.

Th. Do you feel that you stop yourself in your feelings toward me?

Pt. Yes, I don't want to like you. If I do, I won't be able to stop myself. I'll get hurt. But why do I feel or insist that I'm in love with you.

Th. Are you?

Pt. Yes. And I feel so guilty and upset about it. At night I think of you and get sexual feelings and it frightens me.

Th. Do I remind you of anyone?

Pt. Yes. *{pause}* There are things about you that remind me of my brother. (*laughs*) I realize this is silly.

Th. Mm hmm.

Pt. My brother Harry, the one I had these sex experiences with when I was little. He made me do things I didn't want to. I let him fool with me because he made me feel sorry for him.

Th. Do you have any of the same feelings toward me?

Pt. It's not that I expect that anything will really happen, but I just don't want to have feelings for you. I never liked doctors or dentists, especially dentists. The other day I had to go to a dentist. My mind was filled with crazy thoughts.

Th. Mm hmm.

Pt. These crazy things come into my mind that make no sense. I made this dental appointment, and I thought of the drill going into my tooth. Then I thought of the drill being an egg beater. Later I went to the movies, and in a cartoon I saw eggs. I then realized my attitude toward eggs has always been wrong. As a child my mother scolded me for frying eggs and burning them. Then the day before I went to the dentist, I got nervous. I then pictured eggs being

cooked, and then I had a picture of a raw egg and realized the white of the egg looked like seminal fluid and I got sick. It's like this fluid can kill me. I remember my brother wanted to have sex with me when I was a child. He said he had this fluid in him and it would poison him if he didn't get it out. I let him fool with me. Then he told me about people putting it in their mouth. It disgusted me, made me sick. I have dreams of my mouth being smashed and my teeth falling out. The whole thing seems to be connected with sex.

Th. But what about your feelings for me?

Pt. I know it's the same thing. I'm afraid of you taking advantage of me. If I tell you I like you that means you'll make me do what *you* want.

Th. Just like Harry made you do what he wanted.

Pt. Yes. I didn't want to let him do what he did, but I couldn't stop myself. I hated myself. That's why. I know it now because there is no reason why I should feel you are the same way. That's why I act that way with other people too. It's like what happened not long ago with my art lessons. I went to this art place where I study, and I got very nervous and I had to go home. *(pause)*

Th. Try to connect up what happened.

Pt. It irritates me that I can't paint as well as I should. This woman who runs the art place seems to like me. I don't like that. It's like I'd get too friendly with them. I don't like to have people get too close to me. I think wrong about that. When I was little my sister used to take advantage of me too. But the most of it was my brother. The whole thing is the same as happens with you. It's all so silly and wrong. You aren't my brother and the other people aren't my brother. I never saw the connection until now.

Example 3

A patient on the verge of experimenting with the expression of aggression brings out transference feelings that help her understand some reasons why she repressed aggression.

Pt. I want to talk about my feelings about you.

Th. Mm hmm.

Pt. You sit here, a permissive person who lets me go on. I want to do something now, but I'm afraid you will be disappointed in me if I upset the apple cart, if I explode. I think we are too nice to each other. I'm ready not to be nice. My greatest fear of you is that you are potentially going to be severe with me if I get loose. Also, I fear I will let you down by not performing well, by not being nice. I feel I will gain your disapproval. And yet I see you don't condemn and don't criticize. It is still important to me to gain a nod from you or a smile *(pause)*

Th. It sounds as if you would like to let loose with me, but you are afraid of what my response

would be. *[summarizing and restating]*

Pt. I get so excited by what is happening here. I feel I'm being held back by needing to be nice. I'd like to blast loose sometimes, but I don't dare.

Th. Because you fear my reaction?

Pt. The worst thing would be that you wouldn't like me. You wouldn't speak to me friendly; you wouldn't smile; you'd feel you can't treat me and discharge me from treatment. But I know this isn't so, I know it.

Th. Where do you think these attitudes come from?

Pt. When I was 9 years old, I read a lot about great men in history. I'd quote them and be dramatic. I'd want a sword at my side; I'd dress like an Indian. Mother would scold me. Don't frown, don't talk so much. Sit on your hands, over and over again. I did all kinds of things. I was a naughty child. She told me I'd be hurt. Then at 14 I fell off a horse and broke my back. I had to be in bed. Mother then told me on the day I went riding not to, that I'd get hurt because the ground was frozen. I was a stubborn, self-willed child. Then I went against her will and suffered an accident that changed my life, a fractured back. Her attitude was, "I told you so." I was put in a cast and kept in bed for months.

Th. You were punished, so to speak, by this accident.

Pt. But I gained attention and love from mother for the first time. I felt so good. I'm ashamed to tell you this. Before I healed, I opened the cast and tried to walk to make myself sick again so I could stay in bed longer.

Th. How does that connect up with your impulse to be sick now and stay in bed so much? *[The patient has these tendencies, of which she is ashamed.]*

Pt. Oh … *(pause)*

Th. What do you think?

Pt. Oh, my God, how infantile, how ungrown up. *(pause)* It must be so. I want people to love me and be sorry for me. Oh, my God. How completely childish. It is, *is* that. My mother must have ignored me when I was little, and I wanted so to be loved. *[This sounds like insight.]*

Th. So that it may have been threatening to go back to being self-willed and unloved after you got out of the cast, *[interpretation]*

Pt. It did. My life changed. I became meek and controlled. I couldn't get angry or stubborn afterward.

Th. Perhaps if you go back to being stubborn with *me,* you would be returning to how you were before, that is, active, stubborn but unloved?

Pt. *(excitedly)* And, therefore, losing your love. I need you, but after all you aren't going to reject me.

The pattern is so established now that the threat of the loss of love is too overwhelming with everybody, and I've got to keep myself from acting selfish or angry.

Example 4

A patient with a homosexual problem is brought to an awareness through transference of sexual feelings toward her father that incite anxiety and detachment from men.

Pt. Inwardly I feel like a wreck right now. And yet I just sit here very quietly and calmly as if nothing is wrong.

Th. In other words, you can put on a beautiful front.

Pt. Yeah, I'm doing it right now. You don't know what I look like from the other end. You don't know what I look like. I mean. I wondered what would happen if I came in here and said exactly what I feel. I'm sick of this faking, which I still do in here. But in what respect. I don't know. I'm so scared to tell you a lie; I live in a fear of it. And the other day when you asked me—this is an example of it. You were pointing out an example and asked me. did I see. what was it, "Born Yesterday?" I said, "Yes." But I saw the play, not the movie. Now what the heck difference it makes, I don't know, but it bothered me later. Don't you remember it. But a few sentences later I, I corrected myself and said "I saw the play." because it bothered me. The thought of telling you even that much of a lie is intolerable.

Th. Do you feel you've been lying to me in any other way?

Pt. I haven't lied to you about anything that I know of.

Th. Mm hmm.

Pt. But it's just that I feel I'm still not myself. I want to find somebody to give my whole self to.

Th. Mm hmm.

Pt. That's exactly what I want to do, and still I don't do it. *(pause)*

Th. Still you're holding back.

Pt. But, in what way I don't know.

Th. And you feel somehow that maybe I don't know the real you.

Pt. Yes. Like everything that happened to me all day long. I carry on long discussions with you in buses and trains *(laughs)* and, I say, "I must remember to tell him that tomorrow." And then I never bother to tell any of these things.

Th. Are they any specific kinds of things?

Pt. Yes, now I, I could just pick out one.

Th. Mm hmm.

Pt. Yesterday I went to buy some glasses, dark glasses, with the idea of getting some eccentric looking things—things must be eccentric looking with me.

Th. Mm hmm.

Pt. So I asked the saleslady what she would suggest. So she suggested black. So I said, "That's idiotic, but I'll get black glasses." And they are a bit eccentric looking, but silly, and, I wanted to go and read you something out of a book that I thought about today. But why? Because I wanted you to see those glasses. You see? And I would have gone right through with it, but I doubled back on myself in the train today and said it's silly to do that. And when I put them on on the train, I noticed somebody looking over at me. I'm aware of myself all the time, and of being a fake. I sit down with a book in front of me, one leg over the other. I'm doing it now, and I don't feel this way at all. I don't feel like a blah-blah woman of the world person at all.

Th. What *do* you feel?

Pt. I don't know. I don't know what it is that I feel. All I know is that what I look like— what I believe I look like anyway—I'm not. And I do a billion things during the day which, which are just crazy, which I carry on about.

Th. Do you feel that way right now?

Pt. All the time. And then before I came up here I got weak. By god, I didn't feel I had the strength to walk one block over to the Madison Avenue bus. I took a taxi. Absurd. And then I stopped to have this drink. It's ridiculous.

Th. Maybe you're afraid and tense about coming here.

Pt. No. It, it, it's the idea, it's always been, "If I could only have one person to tell the whole truth to, one person who could see me just nude, period. With nothing on." *(pause)*

Th. Mm hmm. And?

Pt. And that's exactly what I'm not doing. And I try so desperately.

Th. In other words, what you're saying to me is, "Look, I'm putting something over on you. I'm not letting myself be completely exposed to you."

Pt. But why I do it, I don't know, *(pause)* I'm putting up a front with you, or maybe I'm pulling the wool over your eyes, the way I'm pulling the wool over my father's eyes, and my mother's, and over at the school, and with everybody. And I feel maybe you're going to be sucker enough to fall for that.

Th. Perhaps I know you better than you think I know you.

Pt. I have the feeling as though you don't know a darn thing about me.

Th. Mm hmm.

Pt. I mean I've never talked about these things that have meant so much to me, like this morning.

Th. Mm hmm.

Pt. Uh, I go along wearing filthy clothes, underclothes. (*laughs*) I mean what people can't see, I don't care. Nobody sees it, it's so small it couldn't possibly smell, so I don't worry about it. (*laughs*)

Th. Mm hmm.

Pt. And so I didn't bother with it, and I thought about it, "Now here you sit down in the doctor's office, and he sees you look very decent in that. Does he know that you've got filthy underclothes on? There's no button here; there's no button there. Does he know that?"

Th. You feel very guilty about how you are inside, and the kind of person you are. *[interpreting]*

Pt. I want somebody to see it; that's the point of it.

Th. Do you think I'm not observant enough to see it?

Pt. No, but I feel as though I'm putting on an act for you. Oh, I know *(laughs)* it's your business after all, I mean …

Th. Maybe you feel I'm not smart enough to know you, all of you?

Pt. That's not it. I feel that I haven't given you a chance to see everything *(laughs)*

Th. (laughs) I see.

Pt. But I don't know why I'm so upset. It has something to do with you.

Th. What do you feel about me?

Pt. (pause) Number one. *(sigh)* the thing I felt very much about you. I mean, uh, uh, as a person I like you very much.

Th. Mm hmm.

Pt. But I have a tremendous curiosity about you.

Th. Have you?

Pt. Yeah.

Th. For instance?

Pt. Marriage, children, everything about you. I'm interested in knowing.

Th. What about your theories about that? What do you think?

Pt. Well, I, it's always my purpose. I'm concerned with that all the time. When I talk to your secretary, I walk out with a smile and joke about something, and I always think, "Oh, I bet she thinks I'm a really happy little kid running around. I bet she likes me. Or maybe she doesn't like me." Always concerned with what people think.

Th. Mm hmm.

Pt. And, and with you. For instance, there were two men I was putting on the young lady act with, always an act. I dressed up to kill every time I saw them, and all that kind of thing. And then, when I found out they had grown daughters, I felt like a fool. I said, "What are you trying to impress them with? They've got one of their own." And that's why I'm interested in you, too. I, I must impress you still.

Th. Mm hmm.

Pt. I want to know what you think of me. How do I strike you, and how I would strike you if you met me on the street.

Th. Do you have any theories about how I might feel about you?

Pt. Well, the only think you've ever said which stuck in my mind so hard was that you thought it was all right to say what I wanted. But I want to know more. I want to know what strikes you? Every analyst also is, is a casual observer, and I want to know what you think of me.

Th. It's more important for me to get an idea of what *you* think I think of you, than for you to find out what *I* actually think of you at this time. You're not quite sure of what I think of you.

Pt. No, not at all.

Th. You're not sure that I like you?

Pt. Yeah, I believe you like me. I believe you consider me rather intelligent.

Th. Well, how do you know?

Pt. Well, first of all you told my father so.

Th. Mm hmm. Did he tell you that?

Pt. Yeah. I had him repeat it thousands of times *(laughs)* just to make sure. It made me feel like a million dollars that day. In fact, I even celebrated. I went downtown.

Th. Is that so?

Pt. This is absurd, but that's, that's just the way I felt. So concerned over what you must think of me.

Th. Now if I told you I liked you and that sort of thing, it would not help you. In fact, it would prevent you from feeling spontaneously about me. It's important that you become aware of all of the feelings you have, some of which are justified and some of which have nothing to do with reality. We can get important clues about things that are happening to you from your feelings.

Pt. Yes.

Th. It may be a little hard on you if I don't come out and tell you exactly how I feel all the time.

Pt. Mm. Yeah.

Th. If I keep saying, "What do you think I feel about you?" …

Pt. Yeah.

Th. Or, "What are your theories about this or that?" it might be a little hard on you, but in the long run it will be most helpful to you.

Pt. Yes.

Th. But if you resent this kind of role that I'm playing with you, then tell me about it.

Pt. No, it, it's just pleasantly annoying, you know, that's all; it's tantalizing, so to speak. *(pause)* If you asked me to be truthful and tell you what I would most like to do right now, I'd have to say, "I want to sleep with a man, but I want him to have his pants on."

Th. Mm hmm.

Pt. "But no top. Big shoulders. And I would be nude. And I want to inspect his penis, and I want to play with it. And I want him, just, just to sort of annoy me, but I don't want to have to lie back and just take it. I want to be able to just squirm around and let myself go, just be a whole physical thing and no mind at all.

Th. Yes.

Pt. And then I come to think about what would this man have to look like. From his shoulders, right around about here—and that's you. It just came to me. The man is you. I have been thinking these thoughts since I started coming here, sex thoughts.

Th. The man is I?

Pt. Yeah.

Th. Mm hmm.

Pt. I got, I got those feelings of sex now that are driving me crazy. By god, I didn't know I could ever say that.

Th. You couldn't say that to me?

Pt. No, no. Well, but I did. But I thought. "Well, maybe it's not so. Maybe it's just nonsense." But the more I thought about it, the more it was you. I tried to push it out of my mind, but it's true.

Th. Maybe that's why you were upset.

Pt. It's possibly that. But it's a horrible thought that I can think that. I remember seeing daddy without his clothes. His penis seemed enormous. I get a funny feeling. It's repulsive and exciting too. Just like I feel about you. I try not to think about it. *[It is apparent that her feelings toward me are projections of her feelings toward her father.]*

Th. What about your sex feelings about men?

Pt. I just have no feeling about it. Maybe it's safer that way.

Th. Maybe it's safer to feel sexy toward women, because it's not safe to feel sexy with men? [*interpreting her homosexuality*]

Pt. Definitely.

Example 5

The following case illustrates the operation of a transference neurosis in facilitating insight. Sporadic backaches (lumbago) were among the patient's most disturbing symptoms. From time to time backaches became exaggerated during a treatment session. Observing the content of his conversations when this happened, it was determined that backaches developed whenever the patient bragged or boasted about himself, whenever he voiced comments that might be construed as criticisms of me, whenever he expressed demands that I might possible reject, or whenever he mentioned circumstances in which he had behaved in a selfish or intolerant manner. On one occasion, when these facts were brought to his attention, the patient stiffened with severe back pain, which became so intense that he winced. This was coupled with pain in his scrotum and drawing sensations in the perineum. Asked to tell me what was on his mind, he expostulated that he could never express himself frankly with his father. A stern puritanical man, his father had subjected him to severe discipline whenever the patient deviated in the least from the righteous path of moral, unpretentious living. Even childish pranks were forbidden. When

questioned about the form of punishment his father employed, the patient said, "He would beat me across the back with a stick." The area of attack coincided precisely with the zone of his present backaches.

At this point I mentioned that it was rather significant that in talking to me about certain topics, he had symptoms of backache. This sounded as if he were being punished for his thoughts. Seemingly, no impression was made on the patient by the interpretation. However, when he appeared for the next session, he was manifestly disturbed. Hitherto gentle and courteous, he stormed into my office and launched into a verbal attack on me. A fragment of this session follows:

> *Pt.* I haven't wanted to say this, but it's bothered me for some time. Your attitude, I mean. *[The patient is quite anxious as he talks.]*

> *Th.* My attitude?

> *Pt.* You remember when I first came to see you and told you about my flight instruction and taking my instructor's test?

> *Th.* Yes. *[This incident was a minor one that I almost had forgotten.]*

> *Pt.* Well, you acted very flippant and disinterested.

> *Th.* In what way?

> *Pt.* The way you talked and looked.

> *Th.* I wonder. Why didn't you mention this at the time?

> *Pt. (pause)* Well, I thought that I was wrong to boast about it. And I felt you resented my boasting, blowing my horn. I know I feel this, and you'll say it's my imagination, but I feel I'm right that you cut me off from talking. I felt you were contemptuous of me.

> *Th.* If this were true, I certainly wouldn't blame you for feeling the way you do. But searching into myself, and trying to recapitulate what happened, I don't remember wanting to cut you off, or feeling flippant, or deriding you in any way or acting contemptuous toward you. Is it possible that you see in what I did or said, something that wasn't there?

> *Pt. (angrily)* I don't believe you. I think you're saying that to be therapeutic. I feel that.

> *Th.* As if I'm saying this to reassure you?

> *Pt.* Yes, because I feel this is what you did.

Th. Cut you off and acted contemptuous on the basis that you were boasting?

Pt. Yes. It's confusing to me.

Th. Say, how come you bring that up now? This happened 5 months ago.

Pt. Something you said last time I was here made me mad. I don't know what it is now. *[Apparently my pointing out the possibilities of a transference reaction removed his repression and released hostility.]* I still feel you don't want to admit what you did.

Th. Well, I'll try to examine my feelings about you and see if I really did cut you off and deride you. As far as I know right now, this isn't how I felt. As far as I can see right now, I don't feel at all contemptuous toward you.

Pt. It's hard for me to believe that. I mean it's hard to see why you shouldn't be annoyed.

Th. Why should I be annoyed at you?

Pt. Look at the crazy things I did, I told you about. That episode with that woman and everything else that followed.

Th. Maybe you feel I ought to look down on you for what you've done?

At the next session the patient was again accusatory. He said that I acted detached and unfriendly. I did not give him an opportunity to attend my lectures or to socialize with me. He recalled that he had recently met me at a restaurant and that I had nodded but did not offer to share my table with him. Again I assured him that if it were true that I had willfully rejected him, he had a right to be angry. However, the nature of the therapeutic situation was such that any social contact might interfere with an opportunity to work out his problems.

For several sessions we talked back and forth in this manner. I was aware of the fact that the patient was trying to goad me into acting in an angry, recriminatory way, paralleling his father's reactions. Were I to have responded in this way, he probably would have left therapy, convinced that I was an arbitrary, hostile person. Or he would have submitted himself and then developed a dependent, compliant attitude with a continuance of his symptoms. The upshot of our talks was a recognition of his projection into our relationship of attitudes that he had about his father that had conditioned his general feeling toward authority. His ability to challenge my reaction, to vent his hostility, to

understand that his reactions were carryovers of earlier patterns, without encountering counterhostility enabled him successfully to work through his problem in therapy.

Were the patient in formal psychoanalysis, he would have been allowed to experience his feelings intensely without my interpreting and attempting to resolve them as soon as they developed. This would have dredged up from the deepest recesses of his unconscious early memories and feelings, and he would have lived through his infantile neurosis in the transference neurosis. Whether the outcome would have been more successful than that which I had been able to achieve through once-a-week dynamic psychotherapy is a matter of speculation.

43
Exploring Trends and Patterns

Once an important trend or pattern is identified, the therapist should attempt its exploration in as elaborate detail as possible. The relationship of the trend to other aspects of the psychic life, and a study of the conflicts it engenders, may be investigated by focusing the patient's attention on and eliciting detailed associations to every trend manifestation. While doing this, the therapist should attempt to circumscribe the subject coverage so as to prevent rambling. If permitted to bounce along from topic to topic, the patient will pursue a course of least opposition, veering away from pockets of anxiety. This, a manifestation of resistance, is partly without conscious design and must be combatted in the interest of making more rapid progress. A certain amount of rambling is, of course, inevitable, but where it goes too far afield from the subject under inquiry, the patient should be brought back to it.

The immediate preoccupation of the patient may cover such diverse areas as disagreeable symptoms, a general state of unhappiness or boredom, daily happenings and events, obligations, hopes, ambitions, important past incidents, experiences with parents and siblings, current interpersonal relationships, fantasies, dreams, attitudes toward therapy, and feelings about the therapist.

Eventually, these areas may be explored in detail; however, immediately, the learning process will be enhanced where every session is organized around an important theme. Thus, we may, during one session, work on the patient's sexual problems, since these seem all embracing. Or, if the patient is preoccupied with a fear of being exploited or hurt in an interpersonal relationship, this may constitute the area of investigation. Actually, all of the patient's difficulties are interrelated. Consideration of one element will, of necessity, eventually involve others. For instance, in dealing with sexual life our discovery of masochistic impulses will bring out attitudes toward males, females, authority figures, compeers, subordinate persons, parents, and children. Working through

the sexual problem will also involve a resolution of interpersonal distortions. Conversely, if we focus on problems with authority, with subordinates, with parents and other persons, the individual's sexual relationships will inevitably come up for inquiry.

Where a number of trends simultaneously occupy the mind of the patient, a more effective use of the session may often be accomplished by a selection of areas according to the priority rating indicated in Chapter 19. "The Conduct of the Psychotherapeutic Interview."

Generally, however, the matter of selection poses no problems for the therapist because important trends or patterns are usually sufficiently intense to announce themselves in no uncertain terms.

Experience will readily confirm the fact that any pattern under exploration has tendrils that permeate many facets of the patient's personality. Constant exploration eventually brings patients to an awareness of the implications and contradictions of their way of life and to a recognition of how they foster the very difficulties of which they are so intolerant. Insight into the fact that their responses to people are not justified by present-day reality is an important step in the process of getting well. As mechanisms of defense are exposed and resistances are resolved, patients may be increasingly motivated toward experimenting with life on new terms and more and more capable of mastering the anxieties that have conditioned their customary reactions. Life no longer is regarded as a mere arena of past happenings. Situations and relationships are better reevaluated in the light of existing reality.

> To illustrate, we may consider the case of a married woman of 32 years of age, with two children, 4 and 2 years of age. The reasons for her coming to therapy were spells of excessive tension, attacks of anxiety, obsessional fears of her children dying, and periodic bouts of violent scrubbing of her hands, which had become progressively worse during the past 2 years. During the first phase of therapy the patient readily established a working relationship and accepted without too great resistance the structuring of the therapeutic situation.

> A great deal of her concern during the ensuing treatment sessions was with her marriage. From its very onset she had become aware of great boredom in her role as housewife. A successful buyer in a large department store, she had given up her position as soon as she had become pregnant. Whereas previously she had

enjoyed considerable standing as a buyer, she now had very little status as a mother. In addition, her husband's salary did not permit liberties in spending. She was, in fact, forced to conserve in order to budget the family funds. This imposed a great strain on her. Since she had never experienced neurotic symptoms prior to her marriage, she assumed that they were caused by the responsibilities of being a mother, of having no distinction as a wife, and of needing to operate with restricted funds. My comment to these statements was that while hardships undoubtedly had existed, it was likely that she was responding to her situation with certain attitudes and feelings that might bear examination.

Enjoined to observed her reactions to various life happenings, the patient began to make certain connections as illustrated in the following fragment of an interview.

Pt. I had a bad few days last week. Everything got on my nerves. Betty (*the patient's older child*) came down with a bad cold, and I was tied down more than ever. The scrubbing returned, and I was more upset than ever.

Th. I see.

Pt. And on Wednesday I began thinking. (*laughs*) The funniest thing happened. I was working in the kitchen and suddenly I got that awful feeling. It came on me like a squirmy wave. I got scared and tense and the muscles back here *(strokes the muscles in the back of her neck)* got tight and my head filled up as if I had a tight bandage around, and queasy feelings in the pit of my stomach.

Th. Mm hmm.

Pt. And there was something else that happened. I knew something was bothering me and I just didn't know what.

Th. Mm hmm.

Pt. Something bothering me. It's like something I had to do, supposed to do. It was such a frustrating feeling, *(pause)*

Th. A frustrating feeling, as if you just couldn't grasp what was going on?

Pt. Yes, just like that. So out of desperation, I guess, I turned on the radio. The first thing was one of those breakfast Mr. and Mrs. programs. They were bantering back and forth, and I detected a snide attitude toward the woman. This made me boil. And all of a sudden the thing flashed in mind. It came to me that I promised my husband that I'd buy him several pairs of socks a week ago. I've been putting it off, and putting it off, and not thinking of it. When I'd go out, it wouldn't occur to me to get the socks until I'd remember when I got home. *(laughs)*

Th. (smiles) You suspected something was going on inside of you?

Pt. I knew it. As I was listening to the program, it came to me. I suddenly got mad, furious and said, "Darn him, why doesn't he buy socks for himself? Why should I do *his* dirty work?" *(laughs)*

Th. You resented his making this demand on you?

Pt. (laughs) No question about that. My next thought *(laughs)* ... it was, "Damn him, why doesn't he buy socks for *himself.* Why do I have to do *all* the dirty work around here. He wants and expects me to be a slave, just tidy up the place and get nowheres." I thought of him in his nice comfortable office. Then I thought of how wonderful I felt when I was working. At least I felt appreciated and didn't get the constant criticism I get now.

Th. This must re?lly burn you up.

Pt. I suppose marriage is a sacrifice. I do love the children. I don't know what they'd do if I went back to work. But it's the noise, noise, the howling of the kids and the criticism of my husband.

Th. When you were working, you felt you were doing something significant that gave you status.

Pt. You know, doctor, I sometimes feel as if I was absolutely crazy to give up my job. I don't know what I imagined marriage was going to be like.

Th. And it turned out to be something where you have to take care of howling kids and buy socks for your husband.

Pt. You know, as soon as I had these thoughts I got very mad. I screamed out loud, "Why doesn't he buy the socks himself." I had a picture of him *(laughs)* this is silly ... slipping on, *(laughs)* slipping on a banana peel and turning a half somersault in the air, I started laughing. Doctor, do I want him to break his neck? When this all happened I noticed that I felt better. My headache went away and the stiffness in the neck. [*Apparently, realization and acknowledgment of her hostility removed the necessity for its repression and its conversion into symptoms.*]

Th. Now what do you think this was all about? *[testing her insight]*

Pt. I know you have been hinting to me that there must be reasons for the state I'm in. I get very mad at things all the time. Most of the time I'm on fire in here, *(points to stomach)*

Th. But you haven't been too aware of how angry you've been.

Pt. I just began to realize it because after this happened and I still felt mad, I called my husband and asked him to pick the socks he wanted himself. I told him to get them himself. Just like that, I did.

Th. What did he say?

Pt. (laughs) He said O.K.

Th. O.K., nothing more?

Pt. No, he wasn't upset, or mean, or angry.

Th. Did you expect him to be angry?

Pt. Why, of course. You know, doctor, I must be scared to death of my husband to act the way I do.

Th. Maybe you're scared of your own anger too? *[a cautious interpretation]*

Pt. I don't know. I just feel as if this whole thing is mysterious—what happened to me. *[The patient rejects this interpretation temporarily. Later she advances it herself, having accepted its implications.]*

Observation of her responses to varied situations and interpersonal relationships brought the patient to an awareness of attitudes and impulses that mobilized anxiety and generated symptoms. Hostility toward her husband and children had been so repressed that she was only tangentially aware of its manifestations. The recited episode of the radio was an indication that she was attempting to understand and to come to grips with her basic problems. The quarrel between the radio breakfast couple had apparently exposed her own unexpressed feelings about her husband. Further exploration of her resentment at being asked to do a menial chore for her husband, opened up a channel to her feelings about the role she played as a woman, a wife, and a mother.

In later interviews the patient brought up more fantasies, which included the accidental crushing of her husband by a truck while crossing the street, the untimely death of both of her children with a virulent strain of pneumonia, the winning of a radio prize of $50,000 with which she purchased a prosperous business, and, upon the demise of her husband, marriage to a gallant, soft-spoken "sweet" man with qualities antithetical to those of her husband. Hitherto she had paid little attention to her fantasies, their connection with deeper conflictual sources being shadowy to her. But appreciating that there were reasons for her fantasies as well as symptoms, she alerted herself to possible meanings.

Although she had been, to some extent, aware of her unhappiness as a housewife, she was not cognizant of how deeply she resented this role. Exploring her resistances to the awareness of her hostility, however, enabled her to focus on her right to experience and to express spontaneous feelings. As expected, this constituted an assault on her repressions and mobilized guilt and some anxiety. The patient recited incidents when she

was unable to assert herself. However, she also described situations when she was capable of taking a forceful and even aggressive stand. It became apparent that under circumstances when she was in a subordinate position, she became submissive, passive, afraid, and unable to express aggression. Under other conditions, where she was dominant, "in charge of things," and "on top of the heap," she could be expressive and even cruel. As a buyer in a prominent store, she had enjoyed prestige, the respect of her associates, and a considerable amount of power. She had felt free and had been able to stand up for her rights whenever crossed. Indeed, she had gotten the reputation of being a "strong woman." The obvious delight in her voice as she recalled her exploits as a buyer was in contrast to the hopeless, apathetic manner with which she discussed her present life experiences. When this fact was brought out, she agreed that the discrepancy was indicative of what she secretly might be wishing—a return to the security she had had as a buyer.

The patient recalled her feelings of defeat in the past when, as a girl, she was barred from games by the boys in her neighborhood. She had always wanted to be a boy and she deeply resented being "hemmed in" as a girl. Toward a younger brother she evinced great envy, and she recalled with guilt having been envious of his possession of a penis. Shamefully, she admitted that she had anticipated as a child being changed into a boy, and in her dreams as an adult, she sometimes pictured herself as a man. While working as a buyer, she remarked, she donned attire of mannish style, which gave her " a wonderful sense of freedom."

An illustrative dream indicating some of these trends was the following:

> "I see myself on a veranda. Everything seems shoddy and strange. I am in the house with my mother. I see an animal like a rat in the kitchen on a mirror. It is small like an embryo. It makes me sick. Then I see a manly woman with a man on the veranda and am frightfully jealous."

Associations to the dream made it apparent that she conceived of her life with her mother (and perhaps on a transference level her relationship with me) as shoddy and weakening. The rat embryo was a reflection of her debased infantile feminine self. The

manly woman who could appropriate and manage a male was the other aspect of herself that she cherished.

Much of the material during this period of treatment concerned itself with her relationships with her parents and her younger brother. Her mother, she felt, was a cold, rejecting person who gave her little love and acceptance. Her father was a detached, harsh, puritanical individual who spent little time with her and with whom she never developed a feeling of closeness. Her brother remained, until recent years, a source of envy and concern. On the one hand, she felt resentment toward him; on the other hand, she felt strongly attracted to him physically. She never believed that she was respected as a person by any member of her family. For instance, she recalled with bitterness how all efforts to express aggression or to resist the demands of her parents were met with violence. During her entire childhood she was reminded of her stubborn, recalcitrant nature; she was told that she had uncontrollable rages that had to be dealt with severely.

This information was utilized during interviews to facilitate inquiry into the genetic origin of her resentment at being a woman and into the defenses she employed against expressing hostility. To show any hostility when she felt herself to be in a subordinate role threatened her with the same feeling of loss of love and punishment that she had experienced as a child in relation to her parents. To stand up for her rights, and to express aggression, meant that she was "bad," unloved, and unlovable. She equated this with being a woman. On the other hand, when she was in command of a situation, "on top of things," and dominant, she identified herself with males; she felt invulnerable and capable of expressing aggression.

Gradually, the patient could see how she extended these feelings into her environment and how she responded to every aspect of her life situation with attitudes rooted in past misinterpretations. For example, some of her dreams reflected a desire to be married to the husband of her best friend. Her associations revealed great envy of her friend for being wedded to a passive man who allowed himself to be domineered by a woman. In her relationship with me, too, she began to express basic patterns. Encouraged

to verbalize her feelings, she expostulated attitudes of envy and resentment. On one occasion she remarked angrily, "It makes me furious to come here and see you sit comfortably on your behind all day in a nice soft chair, and collect a nice fat fee. I've got to struggle in the kitchen all day and do scut work for nothing. I catch myself thinking, 'Who does he think he is, telling me, what to do?' But I know you don't order me around." Focusing on our relationship, the patient was able to appreciate her competitiveness with me, which was of a quality similar to that which she had sustained with her father and brother.

Her ability to express hostility toward me without encountering retaliatory punishment enabled her to bring up more and more undistorted manifestations of her conflict. Murder wishes toward her husband and children, homosexual impulses, desires to repudiate her femininity and to become masculine, prostitution wishes, compulsions to soil, and many other impulses were verbalized and explored.

ILLUSTRATIVE CASE

The process of exploring a trend may be illustrated by a fragment of a session with a patient suffering from a psychophysiologic bladder disorder, who, coming late for the session, exhibited strong tension and anxiety. The ramifications of a compulsive need to please others are investigated.

> *Th.* You appear to be greatly upset by coming late. I wonder why.
>
> *Pt.* It's that I don't like to come late. I have a feeling you will look down on me and find me out to be an unreliable person. As if you would be displeased with me for not coming on time. *[This suggests a trend related to feelings of being rejected by authority as well as doubts about his capacity to "please."]*
>
> *Th.* What might I do if I were displeased? *[exploring the trend by asking questions]*
>
> *Pt.* You could show your displeasure by acting, say cold, like father did. Even possibly you might not continue treating me. *[introducing one genetic determinant of his reaction and an association of the therapist with his father]*
>
> *Th.* I see. [*I could focus on his relationship with his father at this point, but I decide instead to let him associate at random.]*

Pt. And a feeling of good performance comes into it. I want to be an ideal patient *(laughs)* someone who is on time, someone who cooperates and becomes successfully analyzed. *[This may be another aspect of wanting to be a good boy.]*

Th. In other words, you have to please, *[interpreting]*

Pt. Yeah.

Th. Even if it means getting well to please?

Pt. That would be an interesting motive to get well—to please somebody. But I know what you're saying, that I might do it because I have a need to please everybody, *(pause)*

Th. Everybody?

Pt. Yes. You know, when I first started coming here, I didn't know what I was doing, like needing to please every woman that came along, to do things for *them.*

Th. Do you think you still do that?

Pt. (pause) Why … yes, I find myself doing that automatically, without thinking. It's still a very important thing with me. In that sense I'm getting a satisfaction out of pleasing them. But I find lately that it's more irksome than before. I'm getting a little more selfish than before. I suppose it's good, or isn't it?

Th. You don't sound convinced, *[challenging the patient's conviction that he is doing a good thing]*

Pt. (*laughs*) Well, you know I don't realize I'm doing something to please someone until I begin to think what I did. Then I get mad. *[The thought comes to me that hostility generated by his constant need to please may be responsible for his psychosomatic symptoms.]*

Th. There must be a reason why you need to please others, *[focusing the patient's attention on the purpose of his trend]*

Pt. I don't know why I have to do it.

Th. Well, suppose you start thinking about why anybody should want constantly to please and not to offend, *[more focusing]*

Pt. I can see that I feel I have no worth as a person, except in pleasing people. I mean that's what it seems to resolve itself down to. *[While this is probably correct, the patient is not yet aware of the implications of what he is saying and of the connections of the trend to please with other important aspects of his personality.]*

Th. And if you have no worth as a person unless you please somebody, what do you think happens when you please somebody?

Pt. I achieve, I get some worth.

Th. And if you do please someone, how would you feel about that person after you please?

Pt. Resentment, I suppose.

Th. Well, how *do* you feel, I mean what *has* your experience been?

Pt. I've noticed that often I kick myself afterward, feel I'm a "heeler" and have to toe the mark. Then I start not wanting to see the person. This holds true with my wife too. A wall falls in between the two of us. I just feel nothing toward her for days afterward. *[The patient is aware of his detachment, which, an important part of his character structure, seems to be a defense against further encroachment as well as a manifestation of hostility.]*

Th. Mm hmm.

Pt. It's a very complex problem because, after all, people do like you for your qualities. They can't just like you really for nothing, and they can't like you for being a bastard unless they're sadistic, I mean masochistic, really. If these women, for example, like me the way I am, they must like me because I am the way I am. People have liked me. I would say that with most of the people I come in contact with, I'm fairly well-liked. It must be because of the way I am. *[The patient seems to be defending his character traits.]*

Th. Which is what?

Pt. Which is a pleasant guy.

Th. You mean they like you because you please? That you go out of your way to please?

Pt. I guess so.

Th. You mentioned that if you don't please, then you might be a bastard. People couldn't like a bastard. Does it follow that, if you don't supposedly please people, you have to be a bastard? Or that you just reject, repudiate, and act sadistic toward people if you don't please?

Pt. No, except that that's easier to do than to reach the happy medium. I suppose.

Th. Do you feel that you might have impulses to be a bastard and not to please and just be sadistic toward people? *[exploring possible sadistic traits]*

Pt. I don't consciously, but Jesus, I must be trying to cover up something. I'll show my resentments in disguised ways. I can be very brusque in the office. If people come in to see me when I'm busy, and I don't want to see them, instead of saying—being pleasant about it—sorry, but I'm busy today, come back another time, I convey a feeling to them, I know it, that I don't want to see them. And I wish to hell they'd get out of there. But it's not done in an open way, it's a compromise, I suppose. I can honestly say that consciously I have no destructive feelings at all, to speak of, unless something occurs and my temper might flare up, I used to have ... when I was a kid I threw a hammer at my cousin. But I must have had some display of temper at one time, but it's gone. I actually don't like other people trying to please me. If someone wants to do something for me, a favor of some kind, I don't like it, I don't want them to. Now *why,* I don't know. I never examined why. *[The patient is aware of contradictions in his trends.]*

Th. There must be a reason why you don't want people to do favors for you or to do things for you.

Pt. May be it implies that I, I'm not worthy of being done a favor, and that there are strings attached to favors.

Th. What may happen if you accept a favor from a person?

Pt. I feel that I'm putting them out in some way, and I don't want to put them out. "Why are you doing this for me?" I say.

Th. You distrust their motives?

Pt. Well, I know that I never liked to take anything from my father. He used to be pretty generous in a material way, always used to bring me toys when I was young and presents, usually the best that he could get. Then there was money. From the time I was in high school and college I remember feeling uncomfortable when he gave me the money. So I'm not sure whether it's a feeling that I was unworthy of getting the money. Maybe unconsciously my feelings were so destructive that by taking anything from him I compromised, I don't know.

Th. All right, what might other reasons be for not wanting to accept things from people? For example, have instances occurred where you felt uncomfortable or turned down offers of a person wanting to please you or to do things for you?

Pt. Well, for example, my girl wanted to see me yesterday, and I wanted to see her, but it involved her coming in, making a special trip. And there was a chance that I couldn't see her. I felt that it wasn't fair of me to ask her to come in and she didn't insist on it. I felt under those circumstances it would be unfair and hurtful to her.

Th. That you might hurt her? You didn't want to be hurtful to her. You felt it would be ungracious and aggressive of you?

Pt. It would be an unpleasant experience for her, and she would do all this for me and get nothing out of it. I don't like people to take trouble from me.

Th. Have people taken trouble from you at any time in the past?

Pt. I guess when they took trouble, they let me know that they took trouble, *(pause)*

Th. Who?

Pt. My mother, *(pause)*

Th. What did she do?

Pt. Well, she always would say, for example: "Now be a good boy, oecause you have such a good father. Your father is so good to you, he gets you all these things."

Th. He pleases you; therefore you have to be good to him?

Pt. Yeah.

Th. And under what circumstances would you be angry at father? [*I decide to explore his relationships with his parents to see if the trend we are working on goes back to his childhood.*]

Pt. They'd be damned scarce.

Th. In other words, did she convey to you the idea that because your father did things for you, you'd better not be mad at him? There was no reason why you should be angry at him?

Pt. Well, I don't know if she particularly conveyed to me that there was no reason, but she implied that even if I had a reason, I wasn't justified. He was my father, and he did all these things for me. In fact, she conveyed that *she* did things for me too, and it was trouble for her that she did them for me. She gave the impression that she loved me, but she let me know that she went through a lot of trouble for me. She happens to be a very selfish person, but that was the impression that I had when I was young. So maybe I'm afraid that I don't really want to do anything for anybody, that if they do a favor for me, then I have to do something for them. You have a payment, almost, to make. And paying would be much against what I really feel. And all these years I've been going on pleasing people with, I guess, a very strong resentment against it. But the other extreme of not ever pleasing anybody is just as bad.

Th. Isn't it possible that the problem in your not being able to accept things from people is that there might be strings tied to the acceptance? They'd be pleasing you. but you would also have to please them back. You wouldn't be able to stand up for your rights; you wouldn't be able to fight with them if necessary or feel resentment toward them, if it was justified. It's as if they tried to buy you off and you couldn't maintain your independence. *[This is a tentative interpretation.]*

Pt. If I take a favor, yes. And I don't like to ask people to do anything for me.

Th. Is it also possible then, that your not being able to take things from people means to you the ability to maintain your freedom and to express your feelings of resentment? If that's so, you might also try to keep their resentment at bay by doing things for them. Then they won't be angry at you. Is that possible? *[more interpretation]*

Pt. That's very true. Yeah. Particularly exemplified in these women. I don't like scenes. I don't like resentment shown. I don't like anger shown at me, and if I see them, I see them often so that they won't get nasty and they won't say anything. So it becomes a double-faceted thing, doesn't it. To gain acceptance and also to do away with any resentment or aggressions that they might have. *[The patient shows here a good capacity to make a connection between several important tendencies.]*

Th. What happens when you *are* exposed to aggression or resentment? How do you react then?

Pt. I don't like it at all. It's a feeling that there is no strength inside of me to withstand it. I must be wrong. I guess that's another part of the problem- And, of course, the more significant the people are, the more important it would be to me. I guess with my girl, for example, I don't like it; but I don't get any anxiety feelings. I guess I throw a kind of shield up around myself, separate myself from her when she does get to show resentment. And maybe I feel a little

stronger inside, a little more worthwhile now. I feel that she's wrong in many cases. I never felt really, that *anyone* was wrong, as far as I was concerned. I could always see their side of the picture very clearly. One time, just before I went to California, I'd been working for my uncle. Some people in his business quit and he wanted me to come back, and I didn't want to come back. To me the work had ceased to be important, and we had quite a to-do. He was very angry with me and caused me a lot of anxiety. I wanted to go back, but my girl was on the other side. "Don't do it," she said. "Take your vacation." That sort of thing. But I disliked intensely the fact that he was angry at me. I couldn't feel that he was right. I think that I might feel a different way today in such a situation. I'm sure I wouldn't have the reaction I had then, but the reaction I had then was a very, very anxious one. I couldn't be right; I should go back to work; he's mad at me, my uncle, and that sort of thing.

Concomitant with the exploration of his personality patterns the bladder symptoms improved, and, as his adaptations became more assertive, they eventually disappeared.

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The Uncovering of Unconscious Material

Where our goal in therapy is purely symptom relief or problem-solving there is no need, as a general rule, to delve into the depths of the unconscious. Treatment planning is focused on biochemical, neurophysiological, conditioning, manifest interpersonal, and social-environmental issues. The use of pharmacological, behavioral, persuasive and other supportive and reeducative interventions usually will suffice to achieve our objectives. It is only where symptoms and behavioral abnormalities are generated by intrapsychic pathology, or where such pathology acts as resistance to our effective employment of symptom-oriented and problem-solving methods that we may have to focus our sights on some areas beyond the zone of awareness. Our hope here is that the mobilization of sufficient insight into unconscious saboteurs will liberate the individual from their obstructive influence.

Illuminating certain aspects of unconscious conflict, however, is an integral part of our therapy where our goal is personality reconstruction. The roots of the disturbance that we seek to eliminate are buried so deeply that the employment of an uncovering process is desirable if not mandatory. This process, oriented around development of insight, is depreciated by many non-analysts who regard it as an unnecessary and even obstructive formality. More rapid and effective relearning can be achieved, they claim, through other cognitive and conditioning procedures. While insight in itself has been grossly exaggerated as a curative force ["as every experienced therapist knows some patients change in therapy without achieving insight and some patients achieve insight without ever changing"(Fierman, 1965)], it is the *sine qua non* to self-understanding. Cognitive restructuring, however, does not follow in the wake of insight; rather it is a consequence of the working through of this knowledge toward an acquisition of new modes of thinking, feeling, and behaving.

The "depth" of exploration of repressed conflictual foci will vary according to the

needs of the patient. It is doubtful that a total divulgence of unconscious material is ever required. Nor is it possible, through the use of any of the techniques known today—focused interviewing, free association, dream and fantasy interpretation, exploration of transference, hypnoanalysis, narcoanalysis, art therapy, play therapy, etc.—to uncover the unconscious completely. There are some repressions that seem to remain insoluble in the face of the most skilled therapeutic handling. Fortunately, however, most people may be helped sufficiently through the gaining of insight into merely some of their unconscious conflicts.

Among repressed and repudiated aspects of psychic activity are fears and fantasies associated with the various bodily functions, particularly eating, excretion, and sexuality. There are hostile and destructive impulses directed toward other persons and toward the self. There are traumatic memories and experiences too painful to be recalled in consciousness. There are incestuous desires and other unresolved sexualized elements. There are impulses toward sadism, masochism, voyeurism, exhibitionism, and repudiated homosexuality. There are such normal strivings as desires for love, companionship, recognition, self-esteem, independence, and creative self-fulfillment, which have developed incompletely or, for anxiety reasons, been abandoned. There are, in addition, rejected neurotic drives for affection, dependence, superiority, dominance, ambition, power and detachment as well as the conflicts that these drives initiate.

Efforts to banish from mind certain painful needs and conflicts may temporarily mask the merciless hold they have on the individual. There may be awareness of some character drives, for example how dependent one is in a relationship. Dependency however, may not be recognized as a key motif in one's life that undermines self-esteem, nurtures helplessness, and kindles hostility and anxiety.

The specific psychic elements that are repressed are a product of the unique experiences of the individual. Any aspect of feeling or thinking or behaving may be subject to repression if it conflicts with social standards, as transmitted to the patient by the parent through disciplines. These injunctions, incorporated into the superego, continue to

exert pressure on the person. In our culture such impulses as sexuality, hostility, and assertiveness are particularly subject to repression. Also commonly repudiated are impulses toward dependency and passivity as well as compulsive drives for power and independence.

In spite of deflection from the mainstream of the individual's thinking, repressed material may gain access to awareness in the form of highly symbolized and distorted derivatives. It is through detection and translation of such derivatives that awareness of the deeper content becomes possible.

THE SYMBOLISM OF THE UNCONSCIOUS

Thus, the patient's dreams, fantasies, free associations, symptoms, and behavioral tendencies may reflect unbelievably primitive or childish symbols. Often, expression is couched in terms of various organ functions. Simple activities, such as sucking, eating, excreting, and sexual functioning, may represent a host of attitudes and strivings. *The form of expression may seem bizarre, senseless, and without rational design.* A need for security and dependency may thus appear as a desire to suck the breast, penis, or nipple. All parts of the body, including the genital organs, may be implemented in this sucking process. Dependency may also be expressed by fantasies of cannibalistic incorporation of a real or nonexistent person. The amalgamation may be achieved by other means, as by entering the body of the person through any of the various orifices, by sexual intercourse, or by changing into a phallus and being sucked up into the vagina and womb. There may be a peculiar extension in which the person on whom the subject wishes to depend is identified with the fecal mass, with resultant overevaluation of excretory products and activities.

Hostile attitudes toward women may be represented by the biting and destroying of a female figure, or of a woman's body contents, breast, or nipple, or of a fantasied penis within her abdomen. This attack may be attempted with the mouth, anus, or penis or with excretory products. Destructive feelings toward males may be symbolized by impulses to castrate, or to devour or incorporate the penis or the body conceived as a penis. Fantasies

of eating or expelling loved or hated persons in the form of feces may occur.

Guilt feelings and fears of retaliation may be symbolized by fantasies of being eaten or castrated by devouring animals, ghouls, monsters, or witches, of being absorbed into a vagina for purposes of destruction, of being attacked by a male sexual organ, a female organ, or an imagined intravaginal penis. There may be fears of being penetrated anally by the penis of a strong man or of being injured and killed by feces. A loss of aggressiveness and intactness may be designated by a fear of castration; this may be accompanied in males by reparative attempts and in females by a denial of the fact that there is no penis or by frenzied attempts to secure one in fantasy from a paternal, fraternal, or maternal person in whose body a penis may be imagined to exist.

Phallic symbolism is extraordinarily common in unconscious ideation. Some persons are more prone than others to use it to express basic needs and attitudes. Sexuality here becomes a magical shortcut to close relationships with people and the nucleus around which the individual's thoughts and symptoms are oriented.

The clinical importance of sexual symbolism lies in its projection and displacement onto seemingly unrelated objects, the complete dynamics of which cannot be understood until the sources in the unconscious are divulged. Possession of an intact male organ is frequently utilized to represent a sense of aggressiveness and power. Strivings for strength, activity, and dominance may thus be symbolized unconsciously by a desire for a penis in a female, who may believe that possession of a penis is a magical solution for all of her problems, including the fear of functioning as a female. Compulsive vomiting may have its origin in need to disgorge a fantasied devoured penis, or it may represent a denial of the desire to incorporate the penis through swallowing. Anorexia nervosa may connote a persistence of the childish fantasy that pregnancy comes about through eating. Phallic overvaluation may also bring about a wish for a larger and more powerful penis in a male. Submission, passivity, and subordination may be signified in a woman by the lack of a penis and in a man by desires for breast, castration, and homosexuality. Where security is sought through dependency and subordination, castration may also be a goal that is

usually countered by a desire for activity and a fear of castration.

Unconscious symbolism is so incompatible with rational thinking that its very existence may be denied, even by professionals who are dealing with some of its manifestations. Rarely do unconscious symbols break through directly, except perhaps in dreams or under the influence of psychotomimetic drugs like LSD. During psychotic breaks also, symbolisms of nuclear conflicts may appear in more or less direct form.

NUCLEAR CONFLICTS

There is imbedded in the psyche of each person products of the inevitable clash of maturing needs and reality restrictions, the mastery of which constitutes one of the primary tasks of psychosocial development. It must be emphasized that these conflicts are universal qualitatively, though quantitatively differing in all persons as a result of constitutional and conditioning variations and the integrity of the existing defenses.

The earliest nuclear conflicts are organized in relationship to the parents. For instance, the infant's association of the presence of mother with satisfaction of his or her needs (hunger, thirst, freedom from discomfort and pain, demand for stimulation) results in her becoming affiliated with gratification of these needs, with pleasure and the relief of tension. At the same time the absence of mother becomes linked to discomfort, distress, and pain. During the last part of the first year the child reacts with what is probably a primordial type of anxiety to separation from the mother, and with rage at her turning away from him or her toward anybody else, child or adult. This blended gratification-deprivation image of mother is probably the precursor of later ambivalencies, powering sibling rivalry and the rivalries during the oedipal period. It also gives rise to motivations to control, appease, and win favors from mother and mother figures, to vanquish, eliminate, or destroy competitors for her interest and attention, and to punish mother and mother figures for actual or fancied deprivations. The mother symbol becomes symbolically linked to later sources of gratification or deprivation. Moreover, if a disruption of homeostatic equilibrium occurs at any time later on in life or if for any reason anxiety erupts with a shattering of the sense of mastery, the primordial anxiety

imprints may be revived, activating separation fears and mother-invoking tendencies along lines pursued by the individual as an infant.

The gratification-deprivation, separation-anxiety constellations, laid down during phases of development early in the period of personality growth will tend to operate outside the zone of conscious awareness. Whenever habitual coping mechanisms fail the individual and anxiety is experienced, the individual may feel the helplessness and manifest the behavior of an infant, and may seek out, against all logic, a mother figure or her symbolic substitute (such as food in compulsive eating activities). It is little wonder that mothers, and their later representatives (protectors, authorities), come to possess symbolic reward (pleasure) values along with symbolic abandonment (pain, anxiety) potentials. This conflict, deeply imbedded in the unconscious, acts as compost for the fertilization of a host of derivative attitudes, impulses, and drives that remain with the individual throughout life. Other conflicts develop in the child's relationships with the world that are superimposed on the conflicts associated with the demand for magic and for the constant presence of the mother figure.

The actual experiences of infants during the first years of life, the degree of need gratifications they achieve, the relative freedom from deprivaton, their learning to tolerate some frustration and to accept temporary separation from their mothers provide them with coping devices to control their nuclear conflicts, which, nonetheless, irrespective of how satisfying and wholesome their upbringing may have been, are still operative (albeit successfully repressed), waiting to break out in later life should the psychological homeostasis collapse.

Nuclear conflicts, to repeat, are inherent in the growing-up process irrespective of the character of the environment. This is not to say that a depriving or destructive environment will not exaggerate the effect of conflict or keep it alive beyond the time when it should have subsided; a wholesome environment will tend to keep in check operations of conflict, helping to resolve it satisfactorily. *Nuclear conflicts are in part ordained by biological elements and in part are aspects of the culture. We should expect their*

appearance in minor or major degree in all persons. Their importance is contained in the fact that they give rise to reaction tendencies that, welded into the personality structure, may later interfere with a proper adaptation. Of clinical consequence, too, is their tendency to stir from dormancy into open expression when anxiety breaks down the ramparts of the existent defensive fortifications.

The exposure of repressed nuclear conflicts *that are creating problems* constitutes a task of dynamically oriented therapy, the object being to determine the distortions they produce in the character structure, their affiliation with current conflicts, and the subversive role they play in symptom formation. It may be possible even in short-term therapy—especially in dreams, transference, acting-out behavior, and certain symptoms —to observe how an important nuclear conflict is continuing to disturb the present adjustment of the patient.

DERIVATIVE CONFLICTS AND THEIR MANAGEMENT

In contrast to nuclear conflicts that are relegated to unconscious oblivion, many derivative conflicts issue from these conflicts and become part of the character structure.[6] A remarkably uniform arrangement of traits occurs in all people, distinguishing features being fashioned by the unique developmental experiences and by the subculture. These traits are not necessarily handicapping except when they become exaggerated and interfere with relationships with people and when they contribute to a defective self-image.

At the core of many problems are *excessive dependency needs* that had not been adequately resolved in childhood. A healthy balance between dependency and independence is essential for emotional well-being. Where it does not exist, problems ensue. Most likely the average person's childhood yearnings for nurture and affection were not optimally met, leaving a residue of unmet needs that tend to express themselves intensely when the pressures of life mount. Or dependency was pathologically encouraged by a mother who utilized the child as a vehicle for her own unfulfilled demands, hampering the child's growth and strivings for independence. *Unresolved dependency is a*

ubiquitous fountainhead of troubles. It stems from what is perhaps the most common conflict burdening human kind—inadequate separation-individuation. And people are apt to blame their troubles on the world: the revolt of youth, governmental corruption, inflation, communism, capitalism, or the atom bomb. Most people, however, somehow muddle through, working out their troubles in one way or another. It is only where separation-individuation is too incomplete and dependency needs too intense that solutions will not be found.

People with powerful dependency needs will often cast about for individuals who demonstrate stronger qualities than they themselves possess. When a swimmer tires, he or she looks about for something or someone on whom to lean or with which to grapple. A dependent person can be likened to a tired swimmer, who wants to find someone or something who can do for one what one feels cannot be done for oneself. What the person generally looks for is a *perfect* parent, an ideal that exists only in a personal fancy. Actually, there are no perfect parental figures who are able or willing to mother or father another adult. So our dependent person is continually being frustrated because his or her hopes and expectations are not met by someone else. A man who weds expecting an all-giving mother figure for a wife is bound to be disappointed. Further, if he does find a person who fits in with his design and who treats him like a helpless individual, he will begin to feel that he is being swallowed up, that he is losing his individuality, that he is trapped. Consequently, he will want to escape from the relationship. Also, as he senses his dependency, he will feel that he is being passive like a child. And this is frightening because he knows that he is not being manly; he may actually have homosexual doubts and fears since masculinity is associated with activity and independence. Women are no less victimized by dependency than are men. And their reactions are quite similar in that they are apt to regard both males and females on whom they get dependent as potential nurturing mother figures.

A second consequence that inevitably accompanies the first is *resentment* (hostility). Resentment invariably fires off because either one must find a perfect parent who will take care of everything or feel trapped when someone does take care of matters thus

prompting feelings of passivity and helplessness. Resentment breeds guilt because people just are not supposed to be hateful. Even guilt does not always keep the hostility hidden. Sometimes when a man has had too much to drink or when he is very frustrated about something, his hate feelings leak or pour out. That in itself can be terribly upsetting because he may fear he is getting out of control; or the mere awareness of his inner angry condition can make him despise himself. *Sadism* and sadistic behavior may be directed at the object of his dependency, who he believes is trapping him or who fails to live up to expectations. It may be drained off on scapegoats: blacks, Chicanos, Jews, communists, capitalists, and so on. Self-hate complicates his existence because it sponsors tension and depression. Hatred directed outward and then turned in results in *masochism,* in the form of major and minor self-punishments. These may range from fouling up a business deal to inability to accept success, to dangerous accident proneness, to physical illness, to foolish, outrageous, or embarrassing behavior.

Dependency and resentment are two sides of the same coin. The picture is not complete, however, without a third consequence, *low independence,* which is an invariable counterpart of high dependence. Low independence is a feeling that one cannot gain, by one's own reason or strength, the desirable prizes of our culture—whether they be love and justice or wine, women, and song. A spin-off of low independence is a *feeling of inferiority,* a lack of proficiency on achieving desirable goals. Part and parcel of inferiority feelings is the uncertainty about being manly and masculine. Self-doubts about one's sexual integrity are torturous; the usual sequel is to try to compensate by being the quintessence of everything powerful: overly aggressive, overly competitive, and overly dominating. Proving himself with women may lead to satyriasis and Don Juanism. Our man may have fantasies and images in his mind of strong men (often symbolized by their possessing large penises) and may be particularly attracted to them because of their strength. But his awareness of how much he thinks about men may cause him to wonder if he is homosexual and to fear the very things that he admires. He may actually on occasion be sexually attracted to idealized male figures, and he may fantasize incorporating their penises into himself. This may produce consternation and guilt feelings.

Interestingly, low independence feelings in women lead to the same self-doubt and compensations as in men. Some women will try to repair the fancied damage to themselves by trying to acquire the characteristics of men (penis envy) through the outer trappings of masculinity (e.g., acting aggressively, swaggering, and wearing male apparel, etc.) that in our culture are symbolically equated with independence. They will compete with and try to vanquish and even figuratively castrate males. In its exaggerated and pathological form, they will act toward other females as if they themselves are males, dominating and homosexually seducing them.

The constant reverberating of these three traits will leave our man feeling spiteful toward himself in the form of a devaluated self-image. He feels he is miserably incompetent, undesirable, and unworthy. Everywhere he sees evidence of his insignificance: he is not tall enough, he has developed a paunch, women do not seem to pay attention to him, his hair is thinning, his job is not outstanding; his car, his house, his wife—nothing is perfect. He may even think his penis is of inadequate proportions. He feels like a damaged person. These feelings torment him, and he vows to prove that he is not as devalued as he feels. He commits himself to the task of being all-powerful, ambitious, perfect so as to repair his devalued self-image. Then he imagines he can surely respect himself. If he can live without a single misstep, all will be well. He tries to boost himself on his own to the point where others will have to approve of him. He may only daydream all this, or he may, if events are fortuitous, accomplish many of his overcompensatory goals.

If he climbs high, he will most likely resent those below who now lean on him and make demands on him. To those who exhibit weakness, he will show his anger. While he may be able to be giving on his own terms, an unexpected appeal from someone else will be regarded as a vulgar imposition. He actually wants for himself someone on whom to lean and be dependent. However, giving in to such a desire speeds up his doubts and makes him feel even worse. He may pursue just the reverse course from his original dependency drive by competing with any strong figure on whom he might want to lean. He shows the pseudo-independence reminiscent of the adolescent who disagrees on

principle with whatever the parents say. And he may compensate for his devalued self-image by exploiting all the cultural symbols of being a worthy person, such as being perfectionistic, compulsively ambitious, and power driven. These compensatory drives may preoccupy him mercilessly, and he may organize his life around them. One failure means more to him than twenty successes, since it is an affirmation of his lowly status.

These difficulties are compounded by the way they interact with our man's sexual needs. When one's dependency needs are being gratified, there is often a pervasive feeling of well-being that floods one's whole body. Upon awakening following surgery, for example, the confident, smiling face of a nurse can suffuse a man with grateful, loving feelings, at least part of which may be sexual. The sexual feeling is not that of adult male to adult female but rather that of a helpless child toward a warm mother. Such a feeling is tantamount to an incestuous surge and may bring with it great conflict and guilt. Should this dependency be the nature of a husband's continuing relationship to his wife, he may be unable to function sexually with her since he is virtually involved in a mother-son relationship. On the other hand, if the nurturing figure is a man, homosexual fears and feelings may arise with equating of the host's penis with a nipple. For women the dependency situation does just the reverse. A nurturing mother figure calls up in her fears and feelings of homosexuality which may or may not be acted out in passive homosexuality with yearnings for the breast. Moreover, low feelings of independence may, as has been indicated, inspire ideas of defective masculinity in males with impulses to identify with muscle men. Fantasies of homosexuality or direct acting-out of homosexual impulses may follow. In women, feelings of defective independence may inspire a rejection of the feminine role and fantasies of possessing a penis, the symbol in our culture of power and independence. Sadism and masochism may also be acted out in sexual activities in both men and women.

The reverberation of all these traits calls for strenuous efforts on the part of our subject. Dependency, activated resentment, together with its components of aggression, guilt, and masochism threw into gear low feelings of independence, which in turn fueled self-devaluation with its many defenses and overcompensations.

Where can a man turn next to gain some sense of composure? He often turns to a fifth characteristic, *detachment*. Detachment is an attempt at escaping from life's messy problems. Our man by now is fed up with the rat race and wants to get out. He says, "No more committees, no more parties, no more responsibilities, no more extras of any kind, no more involvement with people" He wants an island fortress, or at least a castle with a moat around it, and he would pull up the drawbridge and say no to everything and everyone. He is sure that this is the solution; he decides not to become rich and famous.

But it does not work. People need people. Life is not satisfying alone. Our man finds loneliness to be a worse state than what he was enduring before. He realizes that people constitute one of life's richest gratifications. So, he plunges in again. By now his dependency is really driving him. And if he is desperate enough, he may attach himself all over again to a figure who holds out some promise of being the perfect parent. Then the neurotic cycle is on its way again: power, hostility, low feeling of independence, devalued self-esteem, and detachment.

These drives are never entirely quiescent. In the average person outlets are invariably present to keep them going. There is no one whose dependency needs were perfectly met early in life. This hunger lives on, and with this hunger, the mechanism of dependency is continually operative. In our culture, in this generation, the unmet dependency needs set in motion the successive traits just described. As long as outlets of expression are controlled, the individual may manage to keep going, switching from one or the other and turning them off if they threaten to carry one away. To some extent all people are victims of these derivative conflicts—to a minor degree at least.

Dependency inevitably breeds resentment in our culture. If outlets for the resentment are not available and if compensations for a devalued self-image cannot be pursued-in other words, if the individual cannot readily switch from one satisfaction to another—then conflict and stress reach proportions where one feels catastrophically overwhelmed. When tension mounts excessively and there seems to be no way of escape, anxiety strikes with frightening fears of helplessness and dissolution. Operations to

defend against anxiety may then be instituted, but the defense is often ineffective or more burdensome than the condition it was designated to combat.

Sometimes I draw a sketch on a blank paper showing high dependence, low dependence, devalued self-image, resentment-guilt-masochism, and detachment, and repeat the story of their interrelationship. I then ask the patient to figure out and study aspects that apply. If a general description of dynamics is given the patient, along the lines indicated above, a little insight may be inculcated that can serve as a fulcrum for greater self-understanding. The insight may be temporarily reassuring at first; then it seemingly is forgotten with a resurgence of symptoms. A review of what has occurred to stimulate the upset may consolidate the insight and solidify better control. This will have to be done over and over again. An important tool here is self-observation, which the therapist should try to encourage and which will help the working through process, without which insight can have little effect.

> I once treated a patient whom we shall call Roger.[7] At the initial interview a well-groomed gentleman presented himself with an expression of depression and bewilderment. The problem, he said, started while discussing seemingly casual matters with his best friend and partner during a lunch hour. He was overwhelmed with a feeling of panic, with violent heart palpitations and choking sensations, which forced him to excuse himself on the basis of a sudden indisposition. Back at work, he recovered partly, but a sensation of danger enveloped him—a confounding agonizing sensation, the source of which eluded all attempts at understanding. Upon returning home, he poured himself two extra jiggers of whiskey. His fear slowly vanished so that at dinner time he had almost completely recovered his composure. The next morning, however, he approached his work with a sense of foreboding, a feeling that became stronger and stronger as the days and weeks passed.

Roger had obviously experienced an anxiety attack the source of which became somewhat clearer as he continued his story.

> The most upsetting thing to Roger was the discovery that his symptoms became most violent while at work. He found himself constantly obsessed at the office with ways of returning home to his wife. Weekends brought temporary surcease; but even anticipating returning to his desk on Monday was enough to fill him with foreboding. He was unable to avoid coming late mornings, and, more and more often he excused himself from appearing at work on the basis of a current physical illness. Because he realized fully how his work was deteriorating, he was not surprised when his friend took him to task for his deficiency. Forcing himself to go to work became easier after Roger had consumed several drinks, but he found that he required more and more alcohol during the day to subdue his tension. At

night he needed barbituate sedation to insure even minimal sleep.

The surmise that I made at this point was that something in the work situation was triggering off his anxiety. I felt that Roger had attempted to gain surcease from anxiety by implementing mechanisms of control (first-line defenses, see p. 518) such as trying to avoid the stress situations of work and deadening his feelings with alcohol and sedatives. These gestures seemed not too successful since he was obliged to remain in the work situation no matter how much he wanted to avoid it.

> Continuing his story, Roger said that wild, unprovoked feelings of panic were not confined to his work. Even at home, his habitual haven of comfort and safety, he experienced bouts of anxiety, which burst forth at irregular intervals. His sleep, too, was interrupted by nightmarish fears, which forced him to seek refuge in his wife's bed. A pervasive sense of helplessness soon complicated Roger's life. Fear of being alone and fear of the dark developed. Other fears then occurred, such as fear of heights, of open windows, of crowds, and of subways and buses. In the presence of his wife, however, these fears subsided or disappeared. Roger consequently arranged matters so that his wife was available as often as possible. For a while she seemed to relish this new closeness, for she had resented what she had complained about for a long time—his coldness and detachment from her.

What apparently had happened was that not being able to escape from the anxiety-provoking situation at work, and being unable to develop adequate first-line defenses to control or neutralize his anxiety, Roger was retreating to and sought safety in a dependent relationship with his wife (second-line defenses) that paralleled that of a small child with a mother. Various fears of the dark and of being alone were indicative of his childlike helplessness. This kind of adaptation obviously had to fail.

> Not long after this, Roger continued, he developed fantasies of getting into accidents and having his body cut up and mutilated. When Roger confided to his wife that he was greatly upset by these occurring fantasies, she enjoined him to consult a doctor. He rejected this advice, contending that he was merely overworked, and he promised to take a winter vacation, which he was sure would restore his mental calm. Fearful thoughts continued to plague Roger. He became frightened whenever he heard stories of violence, and he avoided reading new accounts of suicides or murders. Soon he was obsessed with thoughts of pointed objects. Knives terrified him so that he insisted that his wife conceal them from him.

The return to a childish dependent position apparently mobilized fears that in too close association with a mother figure he would be subjected to smothering and destruction. Sexual feelings toward his wife were equated with forbidden incestuous

feelings for which the penalty was fierce and bloody. Fantasies of accidents and bloodshed could be reflections of Roger's mutilation fears. The repetition of the oedipal drama thus could follow a shattering of Roger's repressive system. Attempting to reinforce repression by repressive measures (third-level defenses, see [Fig. 37-1](#)), Roger employed phobia formation striving to remove himself from symbols of mutilation such as knives and other cutting instruments.

> When asked if he had other symptoms or fantasies, Roger, in an embarrassed way, confided that in the presence of forceful or strong men, he experienced a peculiar fear, which he tried to conceal. Sometimes he was aware of a desire to throw his arms around men and to kiss them in a filial way. This impulse disturbed Roger greatly, as did fantasies of nude men with huge genital organs. His sexual life continued to deteriorate. While he had never been an ardent lover, he had prided himself on his potency. His sexual powers now seemed to be disappearing; when he approached his wife, he was impotent or had premature ejaculations. This upset Roger and created fears that he never again would function well sexually. To disprove this, he forced himself compulsively to attempt intercourse, only to be rewarded by further failures. Anticipatory anxiety soon made sexual relations a source of pain, and when his wife suggested that they abstain, he agreed, but he was frightened that she would leave him for another man.

The fear Roger manifested of strong males, the desire to act in an affectionate way with them, the terror of homosexual assaults by nude men with huge genital organs were, if we follow our previous line of reasoning, the products of his fear of attack by father figures irate at his appropriation of the maternal object. A disintegration of Roger's sexual life was inevitable because he was relating to his wife not as a husband but as a child. Abandonment of a male role with his wife was, therefore, necessary to avoid anxiety. While serving as a spurious protective device, his sexual inhibition obviously further undermined his self-esteem.

In attempting to make a tentative diagnosis of Roger's condition at this point, I was confronted with the contemporary contradictions that plague our attempts at classification. All emotional difficulties spread themselves over a wide pathological area, involving every aspect of the person's functioning—intellectual, emotional, physical, and behavioral. Based as they are on presenting complaints and symptoms, systems of nosology often lose sight of the fact that the entire human being is embraced in any emotional upheaval. The particular classification into which a patient fits then may

depend merely upon the relative emphasis the diagnostic agent (i.e., the therapist) or the patient puts upon selected symptoms.

This may be illustrated in the case of Roger. His complaints were those of tension, irritability, explosiveness, anxiety, depression, psychosomatic symptoms, phobias, and obsessive thoughts. In addition, he exhibited a character disturbance in such manifestations as excessive submissiveness and dependency. Were Roger chiefly concerned with his physical ailments—his headaches, dyspepsia, listlessness, fatigue, failing health, or impotence— we would be inclined to regard him as a person suffering from physical disorders of psychological origin, that is, a type of somatoform reaction. Should his anxiety attacks have caused him greatest concern and were he to have focused his attention on his anxiety, we might classify him as "anxiety disorder." In the event his depression was of prime interest, a diagnosis of "dysthymia" (psychoneurotic or reactive depression) might be entertained. If emphasis had been put on his obsessive concern with bloody amputations, death, and pointed objects, this might be called "obsessive disorder." His fear of heights, subways, buses, crowds, and of solitude and the dark are those often found in "phobic disorders." Finally, had his submissiveness, passivity, and other character defects been considered his most significant problem, he might be labeled as a "personality disorder." The matter of diagnosis, then, would be essentially a matter of what seemed immediately important. Actually, we might say that Roger suffered from a mixed psychoneurotic disorder with anxiety, depressive, psycho-physiologic, obsessive, phobic, and distorted personality manifestations. This diagnostic potpourri is not surprising when we consider that every individual whose homeostasis has broken down exploits dynamisms characteristics of all levels of defense in addition to displaying manifestations, psychological and physiological, of homeostatic imbalance and adaptational collapse.

> When Roger was asked what he believed had precipitated his anxiety originally, he was unsure, but he hazarded that it might have been related to a change in his position at work. Not long after his tenth wedding anniversary, at age 33, Roger was promoted to senior member of the firm. His elation at this was short-lived as he became conscious of a sudden depressed feeling, which progressively deepened. Inertia, boredom, and withdrawal from his ordinary sources of pleasure followed. Even his work, to which he had felt himself devoted, became a chore.

> Always eager to cooperate, he experienced, during work hours, a vague dread of something about to happen which he could not define. He could not understand why he would react to a promotion that he wanted by getting upset.

Should a therapist not be interested in pursuing the patient's symptoms further to determine their origin in early past experience or in unconscious conflict, in other words, avoiding a dynamic approach, an abbreviated approach aimed at symptom reduction might now be selected without further probing into history.

First, an effort may be made to treat the symptoms through medicaments, like sedatives or tranquilizers for anxiety, and energizers for depression. Roger may be enjoined to slow down in his activities and to detach himself as much as possible. He might be requested to take a vacation, engage in hobbies and recreations in order to divert his mind off his difficulties.

Another way of handling the problem might be to assume the source of the difficulty to be Roger's work situation and to get him to change his job to one that did not impose too great a responsibility on him. He would be encouraged to try to detach himself more from his wife and slowly to begin functioning again on the basis of the customary distances that he once put between himself and others. Active guidance and reassurance may make it possible for Roger to return to his own bedroom and to assume indifference to his wife that might enable him to function without anxiety.

On another level, the therapist might utilize behavior modification methods to desensitize the patient to his anxieties as well as to institute assertive training to promote greater self-sufficiency and independence. Approaches such as these understandably would not correct any basic character problems that lay at the heart of Roger's distress. Yet they might make it possible for him to get along perhaps as well as he had ever done prior to the outbreak of his neurosis.

Since my approach was a dynamic form of short-term therapy aimed at some personality rectification, I proceeded to explore as completely as I could his past life through interviewing and to probe for more unconscious motivational elements through

exploration of dreams and fantasies and through observation of the transference.

> Roger was the younger of two brothers. He was reared by a domineering mother who was resentful of her role as housewife, which had halted a successful career as a fashion designer. Unhappy in her love life with her husband, she transferred her affection to her younger son, ministering to his every whim and smothering him with cloying adulation. Roger's brother, George, bitterly contested this situation, but getting nowhere, he subjected his sibling to cruel reprisal. Roger's father, recoiling from the not too well concealed hostility of his wife, removed himself from the family as much as he could manage and had very little contact with his sons.

The dynamics in Roger's case became apparent during therapy. Basic to his problem was a disturbed relationship with his parents, particularly his mother. The yielding of her unmarried professional status to assume the role of housewife apparently had created in the mother resentment toward her husband and rejection of her children. This inspired a "reaction formation" in the form of overprotection, particularly toward her younger child, Roger. Frustrated and unfulfilled, she used Roger as a target for her own needs and ambitions with the following effects: (1) in Roger, encouragement of overdependence and passivity, strangling of assertiveness and independence, and stimulation of excessive sexual feelings toward the mother, and (2) in George, hostility displayed directly toward Roger as aggression, and (3) in her husband, detachment.

> Overprotected by his maternal parent, neglected by his father, and abused by his brother, Roger took refuge in the relationship offered him by his mother. His dependency on her nurtured submissiveness and passivity, with alternative strivings of rebelliousness and fierce resentment which he repressed because they threatened the security he managed to derive through compliant behavior. Roger both cherished and loathed the crushing attentiveness of his mother. Toward his father and brother he felt a smothering fear, which he masked under a cloak of admiration and compliance.

The withdrawal of his father made it difficult for Roger to achieve the identification with a masculine object necessary for a virile conception of himself. Roger turned to his mother for protection. He revolted, however, against too great dependency on her, fearing that excessive closeness would rob him of assertiveness and that his aroused sexual feelings would bring on him disapproval from his mother as well as punishment from his father and brother. Repudiating competitiveness with the other male members of the family, he attempted to win their approval by a submissive, ingratiating attitude.

> During adolescence Roger emerged as a quiet, detached lad, never permitting himself to be drawn into very intimate relationships. He was an excellent and conscientious student, and he was well-liked for his fairness and amiability. At college he was retiring, but he had a number of friends who sought his companionship because he was so easy to get along with. His romantic attachments were superficial, and the young women he squired to parties admitted that he was attractive but complained that it was difficult to get to know him.

Adopting detachment as a defense against a dependent involvement, and compliance as a means of avoiding physical hurt, Roger evolved a character structure that enabled him to function at home and at school, although at the expense of completely gratifying relationships with people.

> Upon leaving college, he entered a business firm, arrangements for this having been made by his father. He resisted for two years the exhortations of his mother to marry the daughter of one of her best friends; but finally he succumbed, and he seemed satisfied and happy in his choice. The yo ng couple lived in harmony, and he was considered by his group to be an ideal example of an attentive husband and, after his son was born, of a devoted father. His steadfast application to his work soon elevated his position, until he became a junior member of the firm. His best friend and confidant was one of the senior members, toward whom Roger bore the greatest respect and admiration.

His work and marital life, which were more or less arranged for him by his parents, turned out to be successful since he was able to employ in them his compliance and detachment mechanisms. Toward his best friend and other senior firm members, Roger related passively as he had related previously toward his father and brother. Toward his wife he expressed conventional devotion, keeping himself sufficiently distant to avoid the trap of a tempting dependent relationship that would threaten the independent assertive role he was struggling to maintain.

> The only distressing element in Roger's life was his failing health. Constantly fatigued, he evidenced a pallor and listlessness that inspired many solicitous inquiries. Dyspeptic attacks and severe migrainous headaches incapacitated him from time to time. In addition to his physical symptoms was a pervasive tension, which could be relieved only by recreational and social distractions.

Inner conflict between dependency, submissiveness, compliance, detachment, and aggression, however, constantly compromised Roger's adjustment, producing a disruption of homeostasis with tension and psychosomatic symptoms. His failing health, fatigue, pallor, listlessness, dyspeptic attacks, and migrainous headaches were evidences of

adaptive imbalance. What inspired this imbalance was an invasion of his capacity to detach, produced by the demands made on him by his wife and associates. In addition, his submissive and compliant behavior, while protecting him from imagined hurt, engendered in him overpowering hostility, which probably drained itself off through his automatic nervous system producing physical symptoms.

> As might be expected, Roger's affability and needs to please won for him the praise of his superiors at work, and he was advanced and finally offered a senior position.

Had Roger at this point refused to accept senior membership in the firm, he might have escaped the catastrophe that finally struck him. His legitimate desires for advancement, however, enjoined him to accept. His conflict became more and more accentuated until finally he no longer was able to marshal further defenses. Collapse in adaptation with helplessness and expectations of injury announced themselves in an anxiety attack during luncheon with his friend.

As long as he had been able to satisfy to a reasonable degree his needs for security, assertion, satisfaction in work and play, and creative self-fulfillment, Roger was able to make a tolerable adjustment even with his psychosomatic symptoms. The precipitating factor that had brought about the undermining of Roger's capacities for adaptation was his promotion to senior membership in the firm. While Roger had ardently desired this promotion, for reasons of both status and economics, actually being put in a position of parity with his friend violated his defense of passivity, compliance, and subordination and threatened him with the very hurt he had anticipated as a child in relationship to his father and brother. To accept the promotion meant that he would be challenging of and perhaps triumphant over father and brother figures. This touched off fears of injury and destruction at the hands of a powerful and punitive force he could neither control nor vanquish. Yet Roger's desire for advancement, inspired by realistic concerns, made it impossible for him to give up that which he considered his due. Since he was aware neither of how fearfully he regarded authority nor of how he was operating with childish attitudes, he was nonplussed by his reactions.

A dream revealed during one psychotherapy session will illustrate some of our patient's maneuvers that became operative and apparent in therapy (see <u>Fig. 44-1</u>).

Pt. I had a dream last night that upset me. I am in bed with this big woman, big wonderful breasts. She's my wife, but she changes into a negress. She strokes and touches me all over, and I feel completely loved and accepted. I awoke from the dream with a strong homosexual feeling that upset me. [*Here Roger symbolizes in dream structure his dependency impulses, his repulsion against his dependency, his incestuous desire, and the resultant homosexual residue and defense.]*

Th. Yes, what do you make of this?

Pt. I don't know. The woman was comforting and seductive. I always like big-breasted women. Exciting. But my wife isn't as stacked as I'd like her, or as she was in the dream. *(pause)*

Th. How about the negress?

Pt. I never liked the idea of sleeping with a colored woman. Makes me feel creepy. Colored people make me feel creepy. I know I shouldn't feel that way. Last time I was here I noticed you had a tan like you had been in the sun. I said, "Maybe he's got negro blood." I know I shouldn't care if you did or not, but the idea scared me for some reason.

Th. Sounds like the woman in your dream was partly me. *[This interpretation was proffered in the hope of stirring up some tension to facilitate associations.]*

Pt. (pause) The idea scares me. Why should I want you to make love to me? *(pause)* By God. maybe I want you to mother me, be giving, kind.

Th. How *do* you feel about me?

Pt. I want you to be perfect like a God; to be accepting and loving; to be wise and strong. I realize I'm dependent *[motor one],* I resent my need to be dependent on you *[motor two].* When you show any weakness, I am furious. I feel guilty and upset about my feelings. I feel like killing anybody who controls me. I know I must face responsibility, but I feel too weak and unmasculine *[motor three],* I feel like a shit *[motor four]* and hate myself. I am a nothing and I'd like to be a somebody, but I can't.

Th. Apparently it scares you to be a somebody. When you were promoted, you started getting upset.

Pt. Why should 1? I suppose I feel like I'm stepping out of my depth. Like I'm not man enough. The whole thing puzzles and frightens me.

Th. So what do you do?

Pt. I am constantly running away *[motor five],* I get so angry at people. I don't want to see anybody. I'm so upset about myself. I try not to feel. But I can't seem to make it on my own. *[The reinstituting of motor one]*

FORGOTTEN MEMORIES AND EXPERIENCES

In the course of exploring the unconscious, experiences in the past that have been traumatic are apt to be revived by the patient. Forgotten memories may be remembered of which the patient may have been relatively or completely unaware. The importance of this material constantly comes up for appraisal.

There are those who believe that the recall of forgotten traumatic incidents in the developmental history is essential for cure in reconstructive therapy, since repressed memories are fountainheads of conflict. A criterion of cure set by Freud was a removal of the amnesia of the third and fourth years and a recovery of memories during this period that are associated with the patient's neurosis. There are other authorities who tend to disagree with this standard, believing that therapy, focused on immediate interpersonal relationships, can change personality without the need for probing into the past. This, it is avowed, is because the past is always repeating itself in the present and can be better managed when it becomes freshly apparent in contemporary behavior. Actually we are more concerned with a patient's *ideas* about his past rather than what actually happened in the past. The patient's *interpretations* about parental attitudes and behavior can be more important than the actual reality. One may observe this within some families when a parent behaves toward a child in what seems on the surface to be loving and giving, yet the child reacts as if being maltreated and tortured. A prejudiced child advocate might say that the child penetrates the facade of lovingness and recognizes that the parent is merely concealing maliciousness and rejection. But the advocate could be wrong in that it is the child who anticipates and even desires malicious treatment. Parents can communicate destructive designs to their children, wishfully anticipating that their offspring will act out fantasies that they themselves cannot openly express. Children are not entirely helpless pawns, however, and they do act out their own selfish promptings. Do we have to expose all past happenings before a person can get well? It is credibly established clinically that an individual in many ways relives the past in present behaviors, thoughts and feelings, and it is usually through working with present-day distortions that we can rectify the effect of past troubles rather than the other way around.

The mechanism associated with the repression of early experiences is organized around the need to avoid anxiety. In early childhood, inimical happenings are extremely traumatic. One reason for this is that the child feels relatively helpless in a world, the manifestations of which are a constant source of mystery. Relations between cause and effect are indeterminate, and in this world there are many inscrutable menacing events over which the child has no control. One way of coping with childhood anxieties is to project them in the form of phobias. Another way of dealing with anxiety that threatens to overwhelm the immature ego is through processes of repression and dissociation. These phobic and repressive defenses continue to function far beyond the period of childhood, and the ego reacts to the original traumatic events as if it still were too weak and too vulnerable to deal with them. This is possibly the reason why many adults feel that there is something buried deep within themselves so terrifying that they cannot bear to bring it up.

An important question is whether early traumatic experiences are universally damaging. It is difficult to provide a complete answer to this question. All children undergo traumatic experiences of one sort or another during the period of socialization. A cataclysmic happening, however, can bring the effects of minor experiences to a head and can embody the accumulated emotions of all past inimical events.

Traumatic experiences in early childhood thus act upon a sensitized soil at a time when ego resources are relatively limited. Often these experiences, when uncovered, appear so insignificant that one might doubt their potency in evoking such disproportionate emotional responses. Yet, if one considers that the traumatic experience is a condensation of a series of damaging events and that it comes to stand symbolically for all of them, one may appreciate that it can be greatly overvalued.

As a general rule, early traumatic experiences are of two types. In one type the events are so devastating or destructive that no child could be expected to cope with them. This occurs where the child is severely injured physically or witnesses an incident so horrible that the experience takes away security. The other type of traumatic experience

can in no way be considered extraordinary since it is a part of the normal growth process. Growing up involves the capacity to abandon narcissistic and omnipotent strivings, to tolerate frustration, to channelize aggression into socially accepted outlets, to control sexual impulses, and to develop independence and self-assertiveness. In the course of development, the child is subjected to many frustrations that involve abandonment of selfish strivings in favor of those that will bring cooperative relationships with others. Most children are capable of handling such frustrations without too great difficulty. However, an insecure child, and particularly one who has been rejected and denied legitimate demands for love and support, will be so overwhelmed by feelings of helplessness that the child will be unable to tolerate frustration and to withstand traumatic experiences that are a usual component of growing up. Such an individual is likely to react catastrophically to relatively normal hardships such as are imposed on every child. Certain events, like the birth of a sibling, the discovery of the genital difference between the sexes, the witnessing of parental intercourse ("primal scene"), or exposure to any bloodshed and cruelty, may mobilize inordinate anxiety.

The insecure child may feel so threatened by rejection or punishment that the child will find it necessary to repress such impulses as hostility toward parents and siblings, masturbatory desires, sexual curiosities, and strivings for mastery, independence, and self-assertion. The repression of these impulses involves much experiment. The child for a long time defies the parents, even at the risk of incurring retaliatory punishment. Gradually, however, the child may yield to parental discipline. Frequently repression occurs dramatically following a particularly traumatic incident that convinces the child that danger can be real. For instance, an insecure child who retains certain rebellious tendencies may witness the flogging of a dog that has done something to offend its master. The child may be frightened by this brutal treatment and may unconsciously identify with the animal, fearing injury in the same way if he or she persists in defying the parents. The result may be a phobia in regard to dogs, the dynamic purpose of which is to be insulated against fear of aggressive impulses. The event comes to constitute a traumatic experience that may be repressed in an effort to avoid any reminder of pain. The dog phobia will, nevertheless, persist, aiding the repressive process.

During later life, too, even in adulthood, intensely traumatic experiences may shock the organism into a revival of the mechanism of repression. This move is motivated by a need to ward off a threat to the self. There are no better examples of this than those seen in the neuroses of war in which traumatic incidents may be blotted from the mind.

In the course of therapy the recovery of repressed traumatic experiences may ameliorate or dissipate certain symptoms, especially those that serve the function of keeping these memories repressed. Many compulsions, obsessions, and conversion symptoms fall into this category. The most dramatic results occur in simple conditioned fears and in amnesias of recent origin, such as hysterical amnesias, trauma of the skull, and exposure to unbearable stresses like those during disasters and war. Where the personality is relatively intact and the individual has, prior to the traumatic event, functioned satisfactorily in interpersonal relationships, the recall of forgotten events may restore the previous status.

Theoretically, all symptoms have an historical origin. It may be argued that were we capable of probing deeply enough into the past, of penetrating the myriad conditionings, of reviewing every stimulus that ever invaded the senses and every idea that entered the mind, of peering into all influences, pleasurable and inimical that have impinged on patients, we might be able to demonstrate to them how each of their symptoms came into being. This task, however, is impossible, for many vital early experiences that have molded the personality are not accessible to recall, having occurred prior to the phase of mnemonic accessibility, or having been subjected to a practically impenetrable sealing-off process of repression. In spite of a most extensive analysis one is able to recapture only a fragment of the total of life experiences. Even where we have not laid out for ourselves so ambitious a task and are satisfied with reviewing the most important experiences in the patient's development, we find these so numerous as to defy recapitulation.

However, to indulge our imagination, we may conjure up a situation in which we track down the origin of each of the patient's symptoms. Having done this, we should probably find, in most cases, that the symptoms themselves would not vanish. The

expectation that recovery of traumatic experiences will invariably produce an amelioration or cure of the patient's neurosis is founded on a faulty theoretic premise. Even though the individual's character structure is in a large measure developed from the bedrock of past experiences and conditionings, and even though damage of personality has resulted from untoward happenings in early interpersonal relationships, it does not follow that a recall of these experiences will correct the existing condition.

As an analogy, we may consider a focus of infection that operates insidiously over a period of years. The original source of the individual's physical disability is this infective focus, but by the time it is discovered, it has already influenced other bodily structures. It may have produced kidney damage or acted as a stimulus of secondary foci of infection. The removal of the primary focus will leave the body still suffering from the effects of the original infection, and it will be essential to cure these secondary effects before the patient can be pronounced cured. A single catastrophic experience or a series of harmful experiences can likewise act as a focus, engendering in an insecure person the conviction that the world is menacing and that the people in it are not to be trusted. The experience may influence the individual in forming decisive attitudes and reaction patterns. By the time of adulthood, however, the manner of dealing with the conflicts will have been structuralized into behavior so ingrained that the recall of the original trauma will have little effect upon habitual responses. Therapy will involve tedious reeducation and reconditioning long after the recall of the initial traumatic memories.

Often during therapy a patient may recover the memory of a forgotten traumatic happening and through this recall may experience considerable abreaction. The patient may even be liberated from certain associated symptoms. However, the essential difficulty will probably remain. The patient will still be insecure. The circumstances that sensitized the patient to the original traumatic scene will continue to plague him or her in daily interpersonal relationships. The essential task in therapy, therefore, would seem to lie not only in recovery of early traumatic experiences, but also in ascertaining the reasons why the experiences became so catastrophic as to necessitate repression. Ultimately, a remodeling of behavior will be mandatory before we can pronounce our objective as

successful.

It must always be remembered that a neurosis is not a fortuitous happening, dependent exclusively upon early traumatic events. It is rather a form of adaptation to, and defense against, a world that is regarded by the child and later by the adult as potentially hostile and menacing. Current reaction patterns and attitudes, while derived from past experiences, are not an automatic repetition of infantile modes in an adult setting. They are forms of behavior motivated by a desire to escape helplessness, to gratify vital needs, and to allay tension, anxiety, and hostility. The individual reacts to the present with characterologic machinery that is rooted in past experiences; but present-day problems are the immediate results of conflicts deriving from demands, fears, and resentments that arise also from current interpersonal relationships.

Overemphasis on the part played by the past may produce certain unfortunate effects during therapy. The patient may utilize inimical childhood experiences as a justification for neurosis and for resistance to change. Therapy may bog down in a compulsive historical review of the patient's past, a definite cleavage developing to isolate it from the present. Some patients who have familiarized themselves with early theories of psychoanalysis are led to believe that awareness of their past conditionings will magically dissolve their problems and reintegrate them in their dealings with the world. Consequently, the analysis becomes a stereotyped search for an illusory pot of gold at the end of a mnemonic rainbow.

While an exclusive preoccupation with the past imposes definite limitations in therapy, one must not be won over to the fallacious notion that the historical experience can be entirely meaningless. Tendencies in this direction are apparent in certain current insight therapies, and they foster a concentration on relatively recent material. There is in this approach a dichotomization of the personality, as though the individual had two parts —an important present and a past that has little bearing upon prevailing attitudes, values, and goals.

Knowledge of the historical roots of a disorder is in itself not sufficient to produce

cure, but it is of tremendous value in establishing continuity in the individual's life, from infancy to adulthood. It points to weakness and sensitivity of the ego at the time of a particularly traumatic experience. It shows how some repetitive happenings in the present are a reflection of the same problems that existed in childhood. Of particular therapeutic benefit is the ability of the ego to withstand the emotions liberated by the recall of early traumatic incidents. The neurotic individual often has little self-respect because of the constant necessity of yielding to the fear of the past. To be able to master this fear, and to tolerate the anxiety that previously caused the individual to cringe, has an enhancing effect on ego strength.

The relationship with the therapist acts as an important tool in the recall of buried memories. In the transference the patient will be stirred up emotionally and will experience attitudes and impulses that have a potent effect in reviving mnemonic prototypes of what he or she is undergoing in the present. The transference will frequently touch off patterns that cannot be uprooted by any other method.

During therapy, however, some patients may be incapable of remembering any traumatic experiences. This failure need not necessarily block the therapeutic process, and important changes in the dynamic structure of the personality can occur with little recall of the past. Interpretation of the transference and the establishing of an unambivalent relationship with the therapist may enable the individual to function on better terms with himself or herself and with others. It is possible also that the individual may give up infantile defenses without recalling the specific traumatic memories or experiences that inspired them.

On the other hand, analysis of the transference and interpretation of dreams, free associations, and material elicited through interviewing may, in themselves, fail to beget memories. The patient seems to be stymied by a stubborn amnesia relating to vast segments of childhood or later life. The inability to recall vital situations of the past may represent resistance to accepting the implications of certain drives and defenses as they reveal themselves in the relationship with the therapist.

Obdurate resistance to recall frequently constitutes a means of avoiding anxiety of a sort that initially fostered the repression. In some patients it serves to retain the secondary gain inherent in their neurosis. The amnesia affecting recall may be so stubborn that even the most concerted effort will fail to bring the repressed material to the surface. Where, with extensive probing the patient is unable to recover damaging traumatic experiences—although one is reasonably certain that such experiences have occurred—it is probable that the amnesia protects the ego from anxiety that it would be unable to handle if the experiences were recalled. Here the reasonable ego is still too weak to absorb anxiety and to reconsider the experience in a factual light. The ability to recall early traumatic experiences, and to reevaluate them, requires considerable ego strength. In a number of conditions—for example, conversion reactions—sufficient ego intactness exists so as to make possible the handling of fears and conflicts associated with an inimical past. In these ailments the recovery of repressed experiences may suffice to produce a cure of specific symptoms.

In other conditions, however, such as certain personality disorders and psychoses, the ego is so vulnerable and weak that it cannot tolerate either the repressed memories or their implications. Therapy may fail to break down the resistances to recall, or the traumatic experience may be remembered with a peculiar dissociation of its emotional content. The forgotten event may be remembered as a vague experience without emotional implications, what is recalled being enough to satisfy the rational demands of the individual. The damaging emotions and the significance of the experience itself are, however, repressed. The individual reacts to devastating childhood incidents or fantasies in an apathetic manner, as if they were somehow detached. There is no abreactive process. It is almost as though the patient, by recall, seeks to fulfill a dual purpose: first, to retain the good will of the therapist by remembering things and, second, to hold on to his or her resistance by repressing the emotional meaning of the traumatic event.

Failure to uncover buried memories may be due to the fact that therapy has not bolstered the ego to a point where it can absorb the anxiety liberated by the recall of early experiences.

HYPNOTIC RECALL OF FORGOTTEN MEMORIES

In some cases hypnosis may uproot unconscious memories. One may question the efficacy of such a process, for it is axiomatic that a premature confrontation of the ego with unconscious material merely serves to create anxiety and to enhance resistance. Yet hypnosis need not have this effect, providing the recall is adroitly handled. Instead of battering down resistances by forcing memory of things, it is best to give full freedom to recall when the patient feels capable of dealing with such memories. During hypnosis the patient may be told that there are certain experiences and memories that are quite important and that, because of their painful nature, they have been forgotten. Assurance may be given that it is not necessary to remember all details of such memories at once, but that the patient will be able to reveal and to tolerate isolated fragments of these memories and experiences as time goes on. Under the influence of such suggestions the patient will bring out those elements of a forgotten memory or experience that can be tolerated, and as the patient becomes stronger and realizes that he or she is not injured by the recall, more and more material will be available, until finally the fragments can be reconstructed into a consistent whole.

Piecemeal recovery of a forgotten memory or conflict may be furthered by employing such techniques as dream induction, automatic writing, regression and revivification, drawing, and mirror gazing (Wolberg, LR, 1964a). The evidence elicited by all these procedures may make the meaning of the experience increasingly clear to the patient. As a general rule, the implications of the memory will not be accepted until the patient realizes its importance and presents a recapitulation as a product of personal efforts and conviction. Reconstructing the patient's memory in the waking state, from material uncovered during hypnosis, may rob the recall of its therapeutic effect.

One of the best methods of handling material that is recalled in hypnosis is to instruct the patient to forget a revived memory until he or she feels convinced of the truth of the memory and understands it thoroughly. It may be weeks before the patient is capable of bringing up portions of the material spontaneously, with corresponding insight. Even where the patient recalls in the waking state memories recovered in a recent

hypnotic session, the patient will usually be unable to integrate their meaning until the ego has had time to prepare itself. The authenticity of the memory may, of course, be in question since fantasies are common in the process of recall. But fantasies are creative constructs and dealing with them may also have a therapeutic effect. Indeed, sometimes fantasies are more potent sources of conflict than actual past traumatic happening.

THE HANDLING OF UNCONSCIOUS MATERIAL

The actual handling of derivatives of the unconscious depends on the projected goals in treatment. In supportive therapy one may totally disregard unconscious outpourings. In reeducative therapy the most manifest eruptions are selected for exploration. Thus, immediate character distortions and the surface conflicts these initiate may be a chief focus. The less manifest, more repressed aspects of the unconscious are usually deliberately avoided. In reconstructive therapy various strata may be explored, from topical spontaneous unconscious manifestations to those that are so deeply repressed that they require mobilization through the dissolution of repressive barriers.

Among the techniques in reconstructive therapy exploited to stir up unconscious activity and to remove repression are employing a passive role in the therapeutic relationship; focusing on dreams, fantasies, past experiences, and early relationships with parents; increasing the frequency of sessions; and using the couch position and free association. These activities may lead to a transference neurosis. Sometimes narcoanalysis, hypnoanalysis, art analysis, and play analysis are utilized as adjuncts for the probing of unconscious material. Of all measures, the provocation of a transference neurosis is perhaps most effective.

Unless the therapist is trained to do reconstructive psychotherapy, it is unwise and even dangerous to stir up unconscious material. Explosive forces may be liberated by a lifting of repressions with which the untrained therapist may be incapable of coping. Where, in the course of supportive or reeducative therapy, disturbing unconscious material spontaneously appears, the therapist may strive to help repression by avoiding discussion of the material, by dealing with it reassuringly, by focusing the interview on

reality matters, and by the use of greater activity in the relationship.

There are a number of ways in which unconscious feelings and attitudes can be expediently brought to the patient's attention. Some activities employed during interviewing are restating, reflecting, and interpreting whenever the therapist recognizes an unconscious trend in the patient's verbalizations, dreams, fantasies, slips of speech, free associations, or transference reactions. These activities at first register themselves only minimally on the patient's mind since acknowledgment of unconscious trends is laden with much anxiety. Incredulity or polite acceptance without conviction may mark the first reactions of the patient to the disclosures.

As has been indicated, a patient may be helped to accept repudiated aspects of the psyche by the recollection of early traumatic experiences and memories. The realization that traumatic memories were being repressed, and the understanding of their symbolic significance may provide the patient with a wedge with which he or she can penetrate into unconscious conflicts and gain insight into their significance.

When interpretations are presented to the patient, it may be important to recast the wording of early memories or experiences in the very terms utilized by the patient, even though these parallel the expressions used as a child.

ILLUSTRATIVE CASES

Example 1

The following excerpt illustrates the verbalization in transference of unconscious sexual impulses on the part of a male patient toward his father. The material was expressed explosively with great anxiety, following a prolonged period of silence. This is from a session in which free association was employed.

> *Pt.* My God. I feel I'm in love with you. I can't break away from you, but I want to come. I want to come here every day.
>
> *Th.* Every day?

Pt. I'm afraid of you. You are so high and I am so low. I'm afraid of my feelings for you. Oh, God, as I talk I think of your penis. It's in my mouth. Oh, oh …it makes me afraid. It makes me so afraid … oh, oh. *[The patient seems to be in a transference upheaval.]*

Th. Why?

Pt. You're so big and I'm so little. I'm down on the floor. Oh God, I'm frightened … oh, oh. I'm afraid you'll stick it up. This is awful. Please don't. I have to do what you want me to do. I want you to put me down on the floor. I want you to be powerful like my father. I want you to tell me what to do. I want to love you, and I want you to love me. I don't want you to hurt me or kill me.

Th. You feel I may hurt you?

Pt. I know this isn't real, but I have a feeling you are my father. I want to reach out and grab my father. He is sitting there, gentle and strong. I want to scream and cry. I want you to come to me. Father, come to me! Please come to me! I want you to kiss me and hold me close. Everything is whirling around. I can't stand it. I see myself nude. You are standing over me. Oh, God, please give it to me.

Th. What is it that you want?

Pt. Don't get near. Oh God, don't kill me. I'll do anything you say. I feel so little when I talk. I'm afraid to be big. I can't be the same as you. I don't want to, I don't want to. *(cries)* I don't want to … no, no, no. *(cries)*

Th. Why don't you want to?

Pt. I don't want to grow up. I can't fight like the other boys. I never could. I love you. I want to wear your suit, but I can't wear it. I can't touch it, anything you wear, *(continues crying and then begins to act more cheerful)*

Th. Well, how do you feel now?

Pt. God, that was a horrible experience. It was like I was a little boy again. I can't understand why I said the things I said. I remember father. He never let me do anything. I always thought I hated him and was afraid to do anything, not even shovel the snow. He acted like he always had to be the boss. Kind of hard on me, I can see it now. I always felt that I never wanted to grow up; I wanted to be a little boy. Maybe I wanted to be punished because I felt guilty about not liking my father. Even now, when I am near him. I am afraid he will hit me. He goes into such a rage. I wonder what would happen if I hit him back. I felt the same way about you, but I never realized these sexual feelings. It scares me to think about that, *(pause)*

Th. It scares you?

Pt. It's funny I never wanted you to touch me. It scares me. It scared me suddenly to realize I want you to treat me like a woman. On the other hand, I want you to touch me. I was afraid for father to touch me. Maybe I felt the same way toward him as toward you. This whole thing must be some way connected with my fear of homosexuality.

Th. And with fantasies about your father.

Pt. I just remembered a dream I had last night. I'm at home, the house we had when I was little. There is a bed against the wall. Father is there in the room. He is undressing. I wonder if he is approaching me. I'm in bed. There is a funny excitement, repulsion, and fear. His body is big. It has a nauseating smell. His penis is enormous, enormous, big and red, fearful. I feel repelled by his body. I know he wants to stick his penis up my rectum. This I realize will kill me. I grab a gun and shoot at him, but it doesn't go off. I keep firing, but the bullets shoot out a couple of inches and fall on the floor. Father comes closer. I want to scream and can't. I then woke up screaming and found I had an ejaculation.

Th. What do you think this means?

Pt. It must be connected with what we've been talking about—my fear of women, my fear that they'll reject me. I must be scared of being rejected or even killed for my interest.

Example 2

The following interview illustrates the use of hypnosis in recovering the memory of a traumatic incident, in the form of a "primal scene," which engendered an hysterical conversion symptom.

The patient, a woman of 28, came to therapy because of anxiety that was so severe that it absorbed all of her attention and energy. It had its inception in a particularly violent quarrel with her boyfriend, with whom she had expressed growing dissatisfaction. The imminence of a rupture in her relationship with her friend caused the patient to respond with panic, since she was devoted to the man and marriage had been contemplated in the near future. She was aware of the fact that she was repeating a pattern, because all of her relationships with men had terminated in the same kind of violent disagreement. During one interview, while working on her sexual attitudes, the patient complained of a blurring of vision. She confided that this symptom had appeared on certain occasions when she looked into a mirror. She then searched the room intently with her eyes, and asked if a mirror were present.

The following is an excerpt of the recorded interview, during which the meaning of her eye symptom becomes apparent. The patient is in a waking state at the start of the session.

Pt. (panic in voice) I have that funny feeling again about a mirror—looking at it, *(pause)* and everything is blurred.

Th. You act somewhat upset by this.

Pt. Everything is upside down.

Th. Upside down?

Pt. Not really, but it seems like it. *(pause)* Do you have a mirror here? I don't see one, but it feels like it.

Th. What does it feel like?

Pt. I … don't … know … An upside down feeling … I'm doing something with a mirror reflection … a reflection.

Th. Tell me about it.

Pt. It's like last night. The same thing happened. I was at a friend's house, thinking of coming here. There was a mirror table in front of the sofa, when I was sitting there … I looked in the mirror, and everything I saw in the mirror began to look more real than the women in the room. And I thought, that's strange, and it looked like I could walk right into the room … the mirror room.

Th. Almost as if it were a different world?

Pt. Well … well, it didn't seem to be upsetting anyhow, *(pause)* It looked very inviting.

Th. You were not afraid to walk into that mirror room?

Pt. Now, it looks very frightening, but I have been dreaming about a mirror, *(pause)*

Th. Tell me more.

Pt. Upside down, backward, and all the letters and all … *(pause)* everything you say— everything has to be read backward. I used to do mirror writing when I was little.

Th. What about your writing; you say it was mirror writing?

Pt. Oh! I wrote quite a lot.

Th. What did you write?

Pt. Oh, just the way I felt and whatever I did when I was a child. I sometimes would doodle something about a mirror. A mirror of some kind seemed to be on my mind.

Th. You did write about a mirror?

Pt. Well, sometimes.

Th. Do you remember seeing anything unusual in a mirror?

Pt. I can't think ... I can't remember.

Th. Maybe I will put a pen in your hand, and we'll see. Let your hand just do what it wants. [*I try to induce automatic writing in the waking state, which may be possible in patients suffering from hysterical reactions. This may reveal repressed material.]*

Pt. I use the typewriter.

Th. You can write freehand pretty well, can't you?

Pt. I guess so.

Th. Just let your hand move along as it wishes. Just let it do as it wishes, and pay no attention to what it writes. Just put the pen right down, and don't look at it as you talk to me; just let your hand travel along as it wishes. You will notice that it will be almost as if an outside force pushes your hand along without paying any attention to what your hand writes. Just talk to me. You acted a little bit nervous when you walked in here today.

Pt. Yes.

Th. Are you any less panicky than you were?

Pt. Well ... it isn't panic exactly.

Th. What is it then?

Pt. I don't know.

Th. Like something deep down underneath that bothers you?

Pt. Uh huh.

Th. Are you now aware of what that something is?

Pt. Oh! It's disgusting—something I saw, I guess.

Th. Something you saw?

Pt. Uh huh.

Th. What?

Pt. I don't know.

Th. There was something you saw?

Pt. Uh huh.

Th. Put your pen down, and maybe your hand will tell us more about what you saw— what it actually was that you saw. *(The patient's hand scribbles a few words.)* Can I see that? I mean the sheet you wrote on. Your hand seemed to scribble something while we talked. Now let's see what your hand wrote. *[The patient responded to the suggestion to write automatically.]*

Pt. It says, "You used to have a mirror to write in when you were a girl."

Th. You used to write in a mirror?

Pt. Yes, it was a mirror with a barricade in front of it, and when you put the paper down, you couldn't see what you were writing, but you had to look in the mirror and then you could see. That was the mirror writing.

Th. I see. How old were you then?

Pt. I guess around 8, 7 or 8.

Th. Around 7 or 8?

Pt. Uh huh.

Th. It would seem that perhaps around that period of your life something quite significant happened to you.

Pt. Yes, I guess so.

Th. Do you know what that was?

Pt. (pause) I can't remember.

Th. Now I would like to have you sit just exactly as you are. *[Hypnosis is induced at this point.]* And I want you today to bring your hands up, this way—clasp them together closely. I want you to watch them—watch your hands. I am going to count from one to five. You are going to notice when I count from one to five that your hands will become pressed together, the muscles will stiffen, you hands will get tighter, tighter, and tighter, so that at the count of five it will be difficult or impossible for you to open them. Keep gazing at them. One. tight; two, tight, tight; three, tighter and tighter; four, as tight as a vise; five, so tight now that when you try to separate them, you cannot. *(pause)*

You notice now that your eyelids will get very heavy, that they close, they shut, they feel as if little steel bands are pulling them together. Your breathing gets deep and automatic, and you go into a deep, deep sleep. You are very, very drowsy; you are very tired—very, very sleepy; you are going to get drowsier, drowsier, and drowsier. You are going to fall asleep now, and you will stay asleep until I give you the command to awaken. You'll stay asleep until I give you the command to awaken. You feel very relaxed. Let your breathing become regular and deep. You feel more comfortable and relaxed. You are very, very sleepy. I am going to unclasp your hands now—just like this. I am going to bring them right down to your sides.

I am going to take this arm and stretch it out in front of you now, and as I do this, the arm is going to get very stiff and rigid. The arm will get stiff and heavy and rigid, heavy and stiff like a board. I am going to count from one to five. At the count of five, the arm will have got so firm, stiff and heavy and rigid, that it will be difficult or impossible to bend it. One, firm; two, heavy; three, firmer and firmer; four, just as firm and stiff and rigid as a board; five, just as firm and stiff and rigid as a board. Notice how stiff it is. The harder you try to bend it, the heavier and stiffer it becomes, until I push it back the other way, and then it loosens up. Bring it down, bring your head down this way. Relax yourself and go to sleep. Go to sleep, deeply asleep, very deeply asleep. Just relax all over, *(pause)*

Now I am going to give you a suggestion that you begin to enter into a deep sleep, so deep that you don't keep anything back from me. I am going to help you to a point where you will be able to see what it is that is behind the mirror. *(pause)* I want you to start getting very, very little. I want you to start feeling very, very little.

Your head is getting smaller; your arms and legs are getting smaller. You are going back, back, back to the time when you had that mirror. You are going right back to the time of the mirror. Your feet are getting tiny, you are shrinking, you are getting little, you are getting very small, you are shrinking, you are getting very, very small, you are getting very tiny. You are very, very small and tiny as if you are little again, just the way you were then. You are little, you are tiny. How old are you? How old are you? [This is a technique aimed at regression and revivification.]

Pt. Eight.

Th. You are 8 years old. (*Patient appears to be trembling with fear.)* Are you afraid? You look afraid. Tell me what you are afraid of. What are you afraid of? Tell me.

Pt. (panicky) Of myself.

Th. Anything else?

Pt. I don't know. It's a secret.

Th. You are afraid of yourself, afraid of yourself. Now listen carefully to me. I am going to ask you now to make your mind a blank; I am going to ask you now to make your mind a mirror. You are a little girl, and you are looking in a mirror. In your mind you will see a letter that will appear in the mirror. Every time when I clap my hands together, you will see a letter. It will appear in the mirror. The letters all put together, in whatever order they may come, will spell a word. That word holds the secret of what frightens you. One, two, three, four, five—watch the mirror, *(clap)* [This is a technique of circumventing repression.]

Pt. K.

Th. K—one, two, three, four, five—watch the mirror, *(clap)*

Pt. F.

Th. F—one, two, three, four, five—watch the mirror, *(clap)*

Pt. U.

Th. Now, when I clap my hands together, see the entire word.

Pt. F-U-C-K.

Th. F-U-C-K. Now watch that mirror again—watch that mirror, and when I clap my hands together, you will see that secret, you will see that secret. Don't be afraid now … One. two. three, four, five, *(clap) (pause)* Tell me about it.

Pt. Woman up on top of a man. *(Patient is panicky as she talks.)*

Th. Who? *(Patient moans in a distressed manner.)* You see a woman on top of a man. All right now, watch that mirror. Watch that mirror.

I am going to clap my hands together, and then, all of a sudden, the face of the woman in the mirror becomes clear. As soon as I clap my hands together, it will be as if you see the face, you see the features. Watch carefully, *(clap)*

Pt. Mother.

Th. Your mother! Now watch carefully. I am going to clap my hands together. The minute I do, you will be drawn right into the mirror, and the man's face will become clear.

Pt. (with fright) My father.

Th. Your father. Are you afraid? What do you think is happening?

Pt. I am afraid.

Th. Now listen carefully. If this is an actual scene—an actual memory—you finally will be able to understand it. Your fear is getting less now; you are beginning to get less and less fearful. Don't be afraid; don't be afraid. Good I want you to sit here for a while, then I'm going to help you start growing up to your present adult age. If you like, you can remember what you saw, remember everything that happened, when you awaken. After that you can talk to me; we can talk this thing out. You would like to be well, completely well and unafraid, wouldn't you?

Pt. Uh huh. (The patient is breathing heavily, sweating, and is obviously shaken.)

Th. Good. In a moment I am going to wake you up. *(pause)* Now listen carefully to me. When you awaken, I want you to begin talking. Try not to be afraid even if you remember an actual memory. If you remember all the details, I want you to remember also the reasons you became afraid and had to forget them. I want you, if you can, to remember your fears, whatever they were. When you talk to me, the thing may come back as it happened, just exactly as it happened with all details. If you remember, tell me exactly how it happened. You have spent your life running away—hiding. You may not want to hide now. I am going to count from one to five, and on the count of five open your eyes suddenly and talk to me rapidly. One, two, three, four, five, *(patient awakens)* How do you feel?

Pt. (mumbles)

Th. I can't hear you.

Pt. Very funny.

Th. Tell me all about it.

Pt. I don't know. What shall I do now?

Th. Do you remember what happened here?

Pt. Yes.

Th. What happened?

Pt. (somewhat fearful) The mirror writing happened … and then mother and father vanished.

Th. Did you ever see your mother and father together—intimately?

Pt. I know I did. It's all been in the mirror writing.

Th. Do you recall the incident when you saw your mother and father together?

Pt. Yes.

Th. Are you afraid now?

Pt. My father's dresser with the mirror was next to the door, and that was reflected then. I was outside and I saw it all. [*It would seem that the image inspired such anxiety in the patient that she attempted to repress it. Yet the mirror image also caused great excitement. The consequence of this conflict was mirror writing and blurring of* vision.]

Th. I see. So you stood outside there, and you saw the mirror reflection?

Pt. I saw mother on top of father.

Th. So you saw your mother on top of your father?

Pt. I think so.

Th. A child, when she perceives these things, thinks of them in different terms than an adult. What might you have thought as a child, what could have been going through your mind? What do you think was happening? You must have thought something, *(pause)*

Pt. They keep turning around.

Th. Do you see the two of them now?

Pt. Yes, when I close my eyes.

Th. Do they keep turning around:

Pt. Yes.

Th. Describe to me what they do.

Pt. First father is on top, and then mother is on top now. First mother is on top, and then father is on top. *(There is fear and excitement in the patient's voice.)*

Th. Now what's happening?

Pt. Upside down.

Th. Do you remember the first few weeks when you came to see me? You were so upset, you said everything was upside down.

Pt. Uh huh … upside down.

Th. Perhaps you were excited by what you saw?

Pt. Yes, yes.

Th. Do you have any thoughts of upside down?

Pt. I don't like it upside down, *(pause)*

Th. Why?

Pt. I feel as if it's been killing me.

Th. You feel what?

Pt. As if it's been killing me.

Th. What's been killing you?

Pt. It isn't real, like in the mirror.

Th. Now keep your eyes closed, and when I count from one to five, you will be asleep. *[Hypnosis is reintroduced here.]* One, go to sleep; two, sleepier and sleepier; three, go to sleep, deeply; four, deeply asleep; five, deeply asleep. *(pause)* How did you feel about your mother when you saw that thing? What did you think about your father when you saw a thing like that?

Pt. I don't know. [*It is possible that the patient has repressed some of her feelings in relation to this memory.]*

Th. Now listen carefully. I want you to sit there. I am going to count from one to five, and then clap

my hands together. When I do, you are going to have the same emotion that you had when you looked into that mirror, if you actually did look into that mirror. You won't be able to keep it back. Just let it come out spontaneously. As soon as I clap my hands together, tell me the emotions that you feel. One, two, three, four, five, as soon as I clap my hands together, tell me the emotion, *(clap)*

Pt. Anger. (Patient speaks in a drawl with her fists clenched.)

Th. You feel anger? Listen to me now. When I count from one to five and clap my hands together, you will see who it is that you are angry at. One, two, three, four, five, *(clap)*

Pt. (pause) Mother.

Th. Mother. You were angry at mother; at what you saw?

Pt. Yes, but I always try to see backward.

Th. Why?

Pt. I was angry at father, too. She didn't really want him.

Th. She didn't want him?

Pt. No.

Th. Why?

Pt. Mother didn't seem to want to bother with him, I guess.

Th. Did you love your father?

Pt. Yes.

Th. You did love him?

Pt. Uh huh, very much, but I stopped loving him.

Th. What made you stop loving him? How old were you when you stopped loving him?

Pt. I don't know. Maybe I didn't love father because of mother.

Th. Did you feel that you would eventually like to find a man like your father?

Pt. Oh, I did in my teen age, yes. Father is quick—he used to be very clever and funny. Once he got angry with mother, and he didn't speak to her for a long time. He was very jealous. He was very cross with me.

Th. He was very cross with you?

Pt. Yes, father was when I started going out with boys.

Th. He did not like to have you go out with boys?

Pt. He was always … *(pause)* jealous.

Th. He was jealous.

Pt. Yes, he was.

Th. What was his name?

Pt. Lewis *(laughs)*

Th. Why did you laugh when you said Lewis?

Pt. 'Cause your name is Lewis.

Th. 'Cause my name is Lewis?

Pt. Uh huh.

Th. Do I in some way resemble your father?

Pt. Not very much. I got awfully upset when I saw that mirror thing.

Th. What sort of person was your father?

Pt. He was very determined.

Th. Determined?

Pt. Uh huh. Maybe I liked him too much.

Th. Most little girls love their father. Little girls often get infuriated with their mother for having father, but they finally decide that they will find a man of their own, that they don't have to have father.

Pt. Mother was always like that, telling me that too.

Th. Did she want you to go out with men?

Pt. Yes, she did *(pause),* oh, yes; but I think she turned me against them.

Th. What did she do to turn you against them?

Pt. Oh, always blazed at me; she's always blazed at me. I think she really hated men.

Th. She really hated men?

Pt. Uh huh.

Th. How did you learn that?

Pt. I ... I ...I just felt it.

Th. Now I am going to wake you up. When you feel you understand the meaning of what we have been discussing, you will remember what is necessary. I will count from one to five. At the count of five, open your eyes and wake up. One, two, three, start waking up, four, five.

This excerpt has illustrated the use of hypnosis for the recovering of a traumatic memory or fantasy by hypnoanalytic techniques of regression and revivification, along with a counting procedure. These adjuncts are of aid in circumventing repression. Because repression is sponsored by anxiety that the patient is yet unable to control in the waking state, she is given a suggestion at the end of the session to remember the incident only when she has worked through its implications. In this particular case she was able to understand in a short while the significance of her mirror fixation and eye symptom and she was then able to integrate her reaction to the traumatic scene of childhood. She was also able with further therapy, to resolve her difficulty in her relationships with men.

In Chapter 19, "The Conduct of the Psychotherapeutic Interview," a number of techniques have been described by means of which insight may be propagated. Among these are (1) *accenting* certain verbalizations, (2) *summarizing* what the patient has said in order to coordinate and emphasize specific aspects, (3) *restating* the remarks of the patient to elucidate on situations that the patient has overlooked, (4) *reflecting* back to the patient the emotional forces behind his or her utterances, (5) *establishing connections* between symptoms, feelings, and inner conflicts, (6) *maintaining tension* in the interview to stimulate a thinking through of a problem, (7) *extending measured support* when tension threatens to shatter the cognitive functions, and (8) *making interpretations* by which the more unconscious elements of the psyche are brought to the patient's awareness.

Interpretation as a vehicle for insight is particularly valuable in reconstructive psychotherapy since there is, in this form of treatment, an emphasis on unconscious aspects of mental activity. In the present chapter we shall deal with the dynamics and methods of interpretation.

VARIETIES OF INTERPRETATION

Interpretation consists of seeing beyond the facade of manifest thinking, feeling, and behavior into less obvious meanings and motivations. Involved in interpretative activities are different degrees of directiveness. The lowest degree consists of waiting for the patient to interpret things, giving as few cues as possible. Next, the patient is enjoined to attempt the interpretation of representative experiences. Of greater degree is a piecing together of items of information, and of seemingly unrelated bits, so that certain conclusions become apparent to the patient. Leading questions are asked to guide the patient to meaningful answers. More directive is the making of interpretations in a

tentative way so that the patient feels privileged to accept or reject them as he or she chooses. Finally, the therapist may deliver very strong authoritative interpretations, couched in challenging, positive terms.

Helping the Patient to Make Interpretations

The insights that patients achieve through their own reasoning powers have certain advantages over those that are defined by the therapist. Accordingly, wherever possible, the therapist works toward stimulating the thinking through of problems by restating the material that a patient has verbalized, by summarizing, by emphasizing important connections, by focusing on pertinent data, by asking specific questions, and by arranging cues in such a way that inferences will be more easily forthcoming from the patient. Understandably, patients, bewildered by their neurosis, will want the therapist to provide answers to their questions. They resent the responsibilities that the therapist imposes on them. Particularly, they are dismayed at the therapist's refusal to make absolute pronouncements. They may, therefore, require a reason why the therapist does not act as a detective who uncovers dramatic facts, but rather assumes the role of an objective helper who merely aids the patient to arrive at his or her own discoveries. As a general rule, self-interpretations are possible only where the patient has become sophisticated in the understanding of dynamics and where significant material is not too deeply repressed. Interpretations, when they are presented by the therapist, are made to dispel resistances to self-understanding and to remove blocks to learning rather than to apprise the patient of the content of the repressed. However, once the patient has made what seems to be a valid interpretation, the therapist may elaborate on this.

In the following excerpt, a patient is helped to an awareness of the projection into his present relationships with women of attitudes that he had toward his mother.

> *Pt.* In the presence of women I find myself wanting to please them. I don't know why that is. It doesn't occur with all women. Where a woman has no physical attraction to me, it makes no difference; but even there, I try to please them to some extent. Physically attractive women I must please. Then I pick up weaknesses in them and then feel contemptuous of them. I look for perfectionism in women. But then I try to please them. I realize that there is something funny about trying to please someone you also have contempt for, but I want them to think

I'm a certain kind of person.

Th. A certain *kind* of person?

Pt. Yes, I want them to think of me as attractive. Maybe that's why I have to please them.

Th. How do you feel when women make all the effort in wooing and pleasing you?

Pt. Wonderful, I like that. I get very happy and relaxed.

Th. But when they aren't forward?

Pt. I've got to make the passes.

Th. To get from them something?

Pt. Yes, to get praise and love from them.

Th. But when you have to make the effort to get that, you start finding fault with them. I wonder why?

Pt. I want it to be spontaneous. My mother used to do things for me until my younger brother was born. Then I felt out of things. But I remember the tantrums I had. When I raised hell, I got attention. *[He seems to be aware of the fact that his tantrums were attention getting devices.]*

Th. You had to make an effort there to get praise and love from her. *[emphasizing the association]*

Pt. Yes, yes, yes, just like the feelings I get now when I have to force myself on someone to get praise from them. *[The patient makes a connection with the present.]*

Th. How did you feel when you did this with your mother?

Pt. Angry, disgusted, bitter toward her.

Th. And with these women you try to please? *[presenting cues to the patient so he can come to certain conclusions]*

Pt. Exactly the same.

Th. So the conclusion is what?

Pt. That I'm treating other women as if they are my mother or I want them to be my mother. But that's nuts. But it must be so that I act that way. *[This seems to be an important insight.]*

Making Tentative Interpretations

The presentation to the patient of the therapist's observations, hunches, and

conclusions, prefaced by such phrases as "Perhaps," "It may be," "Possibly," and "Do you think it's possible," is an excellent way of making interpretations. This allows the therapist to confront the patient with facts in a non-authoritarian manner, permitting the patient freedom to accept or to reject the interpretation on the basis of personal judgment and without the feeling of having offended or contradicted the therapist. This makes for a relationship of cooperation, in which the patient feels that he or she is an active participant and that his or her voice carries at least as much weight as that of the therapist.

A patient comes in to a session with a headache. Through tentative interpretations, she arrives at its source and dynamics.

> *Pt.* I really feel I'm an ungrateful person. In many ways people have done things for me, and I do little in return. At the office, for instance, my boss told me I could have an extra week off for vacation this year, with pay. It made me feel good, but I was left dissatisfied and I've had this headache since. *[The patient recognizes the irrationality of her having responded with a headache to a thoughtful gesture by her employer.]*

> *Th.* What about your feelings about your boss?

> *Pt.* He's a wonderful man, energetic, and he knows what he wants. He's really gotten places.

> *Th.* Mm hmm. How do you get along with him?

> *Pt.* Oh, fine. We get along well. Of course he irritates me sometimes. He acts as if he knows everything. But he's an all right guy.

> *Th.* But it's funny you had this headache after the boss gave you an extra week off. *[exploring the situation that led to her feeling of dissatisfaction]*

> *Pt.* Yes, I did.

> *Th.* Do you have any idea why?

> *Pt.* No.

> *Th.* What does his giving you a week off mean to you?

> *Pt.* Well, I appreciate it, but I shouldn't be like that. I always was independent and liked to be on my own. My father wanted me to go into medicine, but when he died, all those plans went out of the window. But I've tried to be on my own. *[This sounds as if the patient interprets her boss's gesture as threatening her independence. If she takes something from him, she may put herself in his power.]*

Th. Is it possible that you resented your boss's gesture because it put you more under his power, and threatened your independence? *[tentatively interpreting this hunch]*

Pt. (laughs) It's more than possible. I don't like to have people do things for me. It makes me feel helpless. I don't want to owe anybody anything. *[She responds favorably to the interpretation.]*

Th. So that you might possibly feel that this gesture by your boss took away from you an important thing—your independence, *[a further tentative interpretation]*

Pt. Well it does, doesn't it? *[This indicates that my hunch was correct, since she seems to equate the two.]*

Th. You think it does.

Pt. Don't you?

Th. There may be other ways of looking at this thing. Because you may need to maintain a sense of independence for special reasons, any relationship or situation that does anything for you may destroy this security mechanism and arouse resentment.

Pt. But isn't it silly for me to feel that, because I know Mr. Meyers *(her boss)* doesn't want to take me over. [*She recognizes the irrationality of her feelings.]*

Th. Is it possible that *you* might be afraid that you, deep down, want him to take you over, to become dependent on him? *[tentative interpretation of her resistance to possible dependence on anyone on the basis of a deep desire to be dependent]*

Pt. No, I don't. I mean I don't really want to be dependent, *(pauses and laughs)* or maybe I do. (*laughs*) You know my headache is lifting now and is practically gone. *[We seem to have hit an important conflict.]*

Th. Do you see the connection between your impulse toward independence, your possible striving for dependence, your reaction to your boss, and your headache?

Pt. Yes, I believe I do. *[The patient continues to explore the interrelationship.]*

Making Authoritative Interpretations

Sometimes the repressions of the patient are so intense that they impair the capacity for critical thinking. Here the patient may be unable to make connections or to arrive at insights through his or her own efforts, no matter how adroitly the clues are presented. Even tentative interpretations may have little impact on the patient. During reconstructive therapy, especially, it is sometimes desirable to employ a bold and even confrontational authoritative approach in offering interpretations. This is a deliberate step, calculated to

upset the balance between the repressed and the repressing forces. The released tensions and anxieties mobilize defensive reactions that can then be observed and explored. One of the defensive devices is a denial of the validity of the interpretation. Eventually, however, the patient may work through resistances to its acceptance. Acceptance of an interpretation does not always mean that it is valid. It may be that the patient is so intent on pleasing the therapist or fearful of contradicting the therapist that he or she will incorporate a false explanation. If the patient is suggestible, he or she will grapple also onto a spurious commentary with the eagerness of a religious convert.

Because of the anxiety that is apt to be stimulated, authoritative interpretations should be made only where there is sufficient frequency of visits to handle any disturbed reactions that may occur. As a rule, interpretations of this type are made only when there is some preconscious awareness of a pattern. The stronger the ego of the patient and the better the working relationship between patient and therapist, the more unconscious may the material be with which one deals.

A patient remarked during a session that a peculiar uneasiness came over her recently while in the presence of her husband. This feeling had started 2 weeks previously and had become increasingly intense since then. Through an authoritative interpretation she was helped to realize that the basis for her reaction was transference toward the therapist, which she had repressed.

> *Pt.* I have this dead feeling toward Tom. *(her husband)* I have a feeling he will hurt me and beat me. I remember his slapping me when he was drunk a time ago. I was badly frightened but furious. I feel I'm wasting my life with him. The whole relationship sounds impossible.
>
> *Th.* Do you have any positive feelings about Tom?
>
> *Pt.* Yes, I'm terribly attracted to him sexually. This type of man is charming but kicks your teeth in.
>
> *Th.* Under what conditions does he do this?
>
> *Pt.* Whenever I am in any way critical of him. I feel like half a person. I'm afraid to say anything critical. *[She will feel critical toward her husband and expect counterhostility.]*
>
> *Th.* Does this fear of being critical relate to other people? *[exploring for a neurotic pattern]*

Pt. Not everybody.

Th. How about me? *[This is a confrontational attempt to see if her critical feeling applies to me.]*

Pt. (*pause, patient's eyes tear*) This is silly. I'm afraid you'll think me silly, *(cries) [The fact that this emotional reaction is evoked shows that transference may be operating.]*

Th. You are afraid to be critical of me. *[authoritative interpretation of her reaction to the expression of criticism toward me]*

Pt. (*continues crying*) There have been several things you said that hurt my feelings, *(cries)*

Th. Like what?

Pt. A long time ago, *(cries)* when I first came here, I told you I felt I hadn't grown up. You said I'd have to grow up to be well. You said it as if you were blaming me. I can't help it if I'm this way. I wouldn't be here if I was well. *[The patient has taken something I said out of context, distorted it, and is using it to justify her feeling toward me.]*

Th. Did I give you the impression I was critical of you?

Pt. You sounded like you were. You gave yourself away. I've been afraid to say everything that came to my mind since then. Afraid to stir up your anger, *(cries) [This is good evidence that transference is operating.*]

Th. Perhaps I gave you that impression, but I'm not aware of wanting to criticize you in any way.

Pt. But you did.

Th. You *felt* I did.

Pt. Yes, and this is how everybody has been with me. *[Fear of criticism seems to be a basic pattern.]*

Th. All your life?

Pt. Yes, as far back as I can remember. I was never allowed to tell my parents what I felt, my disappointments. They hushed me up when I cried for anything. It happened with my teachers, and it happened with my husband. It's still going on.

Th. And it happened with me.

Pt. (*smiles*) I'm being awful, I know, feeling like this. I know you don't intend to be like that, but I can't get confidence to be myself. And if I can't, I'll never get well.

Th. It is important for you to be yourself and tell me everything you think. Actually, I don't feel critical toward you, but I may give you that impression. As a matter of fact, you are injecting feelings in your relations with me that are the same as those you had toward your parents. Suppose you think about that. [*authoritative interpretation*]

Pt. (smiles) I feel better talking about it. I expected you to reprimand me. I remember when I was 8 and played hooky with a girl. *[The patient goes on to relate an incident for which she was criticized.]*

CONTENT OF INTERPRETATIONS

Interpretation choices are usually in the following order:

1. Resistances of any nature, particularly to a working relationship with the therapist, to insight, and to the translation of insight into action

2. Defense mechanisms of various types—their nature, purpose, manifestations, and origin

3. Indications of transference, especially those aspects that serve as resistance

4. Personality traits and patterns—their form, expression, purpose, genetic origin, and contradictions

5. Conflicts, impulses, feelings, attitudes, and other repressed aspects of the psyche of which the patient is at least partially aware

6. Current sources of stress and their interaction with personality needs and defenses

7. Early experiences as revealed by the patient in relation to conflicts, defense mechanisms, transference, and personality patterns

INTERPRETIVE ACTIVITIES

The manner of presentation of interpretations is as important as the content. The following points may prove helpful:

1. The language in which interpretation is couched should be as simple as possible, employing terms familiar to the patient.

2. Most patients integrate short, pointed interpretations rather than an elaborate exegesis. Certain patients, however, seem to require long, intellectual explanations. Sometimes the use of metaphors, analogies, and illustrations from the problems of other people are helpful. Interpretations should, if possible, be related to a basic theme.

3. Too many interpretations or scattered interpretations should be avoided, for the patient can learn only a little at a time.

4. Tentative and even authoritative interpretations should be tactfully presented in such a way that the patient has a right to reject or accept them without feeling that the therapist is being offended. Under no circumstances should the therapist argue with the patient or act chagrined if the interpretations are not accepted.

5. Before making an interpretation, the therapist must be reasonably convinced of the verity of the assumptions. To advance an opinion in a hit or miss manner, hoping that it will touch something off in the patient, is worse than useless.

6. The timing of interpretation is important. The patient must be prepared sufficiently for an interpretation so that it does not take him or her too much by surprise. One index of preparation is preconscious awareness of a trend or pattern. The dynamics of the patient's problem may soon become known to the therapist. It may require an enormous amount of restraint to withhold interpretations until the patient displays a modicum of awareness thus indicating a degree of ego strength favorable to understanding. Interpretations prematurely presented to the patient will create resistance since they act as a warning to the ego that its defenses have been penetrated and that a further attack is impending. A barrier of resistance may unnecessarily be created.

7. Attitudes and beliefs of the patient should never be ridiculed, nor should interpretations be made in such a manner that the patient assumes them to be accusations. Where attitudes and patterns are to be undermined because they wield a pernicious influence on the patient, the patient may be shown that he or she has been forced to employ these devices as defenses. For instance, a woman complains that she is never able to keep the interest of men because she is much too eager to make an impression on them. She relates an incident in which she forcefully attempts to establish a relationship with a new male acquaintance. An incorrect interpretation would be, "See what you are doing; you are throwing yourself at the man." This interpretation involves an accusation and a moral judgment. A better interpretation would be, "Perhaps you are acting too anxious here about setting up a relationship." This poses a problem that the patient must ponder.

8. Interpretation is most effective where there is good rapport between patient and therapist. Where a patient feels negatively toward the therapist, the patient will usually be unable to accept interpretations.

9. Some therapists believe that a "terminal interpretation" is useful at the end of each session, summarizing the important material of the session. Other therapists find no need to employ this procedure.

In reconstructive therapy, where interpretation of very deep unconscious needs and defenses is deemed necessary, special handling will be required. Neurotic defenses are elaborated in early life by a weak ego threatened with overwhelming anxiety. The mature accretions that later invest the ego may not destroy the core of helplessness laid down in childhood. The patient, afraid of being overwhelmed by feelings of catastrophic helplessness that once threatened to destroy, will, when an anxiety experience is imminent, attempt to overcome the threat by employing the same original protective defenses. Logic plays no part in this process.

The rational approach in dealing with an ego that has swathed itself in impenetrable defenses is through an analysis of resistance. Interpretation of the resistance accomplishes the purpose of confronting the patient with what is being defended against. This leads to an uncovering of unconscious impulses, fears, and conflicts, and it opens the way of access to deeper and deeper material. The dangerous nature of the material again stimulates anxiety and mobilizes further resistances, usually of an unconscious nature. It is essential to demonstrate to the individual the manifold disguises that resistances may assume, for unconscious resistances can crumble only when their conscious derivatives are repeatedly presented to the patient. The interpretation of layers of resistance progressively exposes the deepest drives and impulses and ultimately leads to the original nucleus. Only through such work is the patient able to appreciate the purpose of resistance, its historical origin, his or her active participation in maintaining it, and, finally, the unconscious impulses the resistance is opposing. This permits the patient to tolerate more and more undisguised derivatives of impulses and eventuates in a gradual recovery of repressed elements of the self.

How aggressive the attack on the resistances should be depends upon the quantity of anxiety that is present and upon the ability of the ego to withstand the attack. Interpretation of resistances will often produce tension, anxiety, and hostility. If the patient is already suffering from as much anxiety as can be handled, the additional emotional burden may be too difficult to bear, and the patient may react with an increase of resistance. In such cases it is essential to proceed more cautiously. On the other hand, if the patient manages to repress anxiety through the operation of continuing avoidance, a more aggressive attack on the resistance will be necessary. This may be undertaken as early as possible in order to mobilize anxiety for the purpose of increasing self-observation.

The technique by which interpretations are presented is also of vital importance in determining the acceptance of components that the ego is warding off. The patient may present evidences of hostility, erotic strivings, castration fears, and penis envy. To interpret these as such to the patient may accomplish little or nothing. As a general rule an interpretation is futile if the patient does not have an idea of what is going on. Interpretation will produce no real change until the unconscious is represented by preconscious material familiar to the patient. Consequently, when an unconscious derivative makes its appearance in the field of awareness, the patient's attention may be directed to considering what may be behind the derivative. For instance, one patient, while discussing his relationship to me in glowing terms, became aware, through my calling his attention to it, of the clenching of his fists and the tension of his muscles. At first he denied these facts, but as I repeatedly called his attention to his mannerisms and as I presented him with the possibility that there might be a reason why he became tense and clenched his fists, he thereupon became aware of hostile feelings.

It is essential to demonstrate the connection between symptoms, feelings, and attitudes in order to show patients how a purposeful trend runs through their lives. In this way they may learn that their behavior is not a series of random events, but that it has continuity and meaning. They also must realize that their symptoms are not fortuitous, that they themselves are bringing about what they believe they are experiencing

passively. They must become aware of the purpose of evasions, of how they fallaciously draw the past into the present, of what compromises they make with life, and of the consequences of these compromises on their functioning. It is also often essential to trace symptoms back to their historical origins. Here the manner in which interpretations are made is also of the greatest importance. It matters little how accurate interpretations may be if patients are unable to understand their meaning, and it is important to integrate the meaning within themselves in the form of insight.

In tracing genetic origins of drives, defenses, and conflicts there is often a tendency to interpret present behavior as if it were a mere stereotyped repetition of earlier patterns in the relationship with the parents. As a practical matter, this type of explanation usually has little effect on the patient. It is true that everyone carries over in one's character structure attitudes and patterns molded out of specific conditionings in early interpersonal relationships. It is true also that one reacts to people as if they were virtually reincarnations of one's parents, with attitudes, fears, and demands such as are expressed in early relationships. Such a repetitive process, however, does not occur automatically. It is dynamically motivated by needs in the individual that are so intense that no amount of logic can swerve one from one's purpose. To say to patients that they have hostilities or erotic wishes directed toward the therapist because the latter is a symbol of their mothers toward whom they once had an erotic urge that was repressed is not really a helpful interpretation. What is essential is that the patient understands what motivations underlie the present emergence of hostile or erotic feelings toward the therapist. Ultimately, of course, we are concerned with why and under what circumstances the patient developed certain attitudes toward parents that have functioned as nuclei of later interpersonal strivings. Explaining to the patient that unresolved strivings in relation to parents must be present, because the therapist is a parental surrogate toward whom there are irrational feelings, arouses merely an intellectual acknowledgment without any deeper understanding.

Once we concede that all behavior serves a dynamic purpose, we must attempt to define the purpose behind the patient's present behavior. For instance, we must discern

the reasons why the patient feels erotic in the therapeutic situation. In analyzing the motives behind the erotism, we may find that the patient is becoming more and more anxious about the therapist and that the erotic feelings constitute a wish to absorb the latter within oneself in order to gain exclusive love and support. Or the patient may have become more and more fearful of the therapist and may wish to disarm the therapist by expressing extreme devotion and sexual love.

If patients act in a hostile manner toward the therapist, it is rot sufficient to show them that they are using the therapist as a father substitute, creating a new childhood situation in the present. It would be more meaningful to discover the immediate circumstances associated with the hostility. Thus, a patient may feel frustrated by the therapist, for no apparent reason. Upon investigation the therapist may discover that the reason behind the frustrated feeling is a secret desire to engage in an extramarital affair, along with a fear that the therapist will frown on such a venture.

To interpret the patient's strivings as related to something that is happening in the present helps to provide the patient a picture of interpersonal attitudes in operation. It permits the patient to see how drives relate to feelings that actually have no source in present-day reality. The patient comes to realize that feelings do not arise out of nowhere and that one is not working with intangibles. Eventually, the patient may be able to appreciate how similar impulses operated also in relationships with important persons in the past and that there, too, they served a vital purpose, of a sort similar to the purpose they serve now. Considerable activity on the part of the therapist may be necessary since the patient usually has a tremendous amount of resistance to divulging the motives behind feelings. The patient's drives, neurotic as they are, constitute a way of life that is not easily relinquished.

One of the tasks of reconstructive psychotherapy can be the recovery of important unconscious memories and experiences (see Chapter 44). The mere revival of forgotten traumatic events will not in itself correct the damage that has been done to the ego. While it is true that the ego has been rendered weak by inimical childhood happenings, other

defensive attitudes have also been elaborated on the basis of experiences relating to persons and circumstances in the patient's later life. Interpersonal reactions are composed of a chain of patterns that show a continuity, each link predisposing the individual to later reactions. If the patient is to understand how early inimical experiences relate themselves to present behavior, it is necessary to analyze and to interpret the intermediate links. This does not mean a discarding of important deep material that is brought up during therapy. It means that the patient must be given the task of working back from immediate character patterns and interpersonal attitudes to disclose the connection with the deeper experiences and impulses.

The proper interpretation of the transference makes it possible to establish the connections with these deeper impulses. It must be emphasized again that in interpreting the transference, it is not enough to tell the patient that he or she is acting out an irrational striving that has its origin in what happened in early relationships with the father, mother, or siblings. Such an explanation is interesting and possibly true, but, practically judged, it is without therapeutic value. What is important is to demonstrate to the patient the reason why such infantile reactions persist and what purpose they serve in the present.

In a certain number of patients the therapist will be overwhelmed with unconscious material while no effort is made by the patient to relate this material to the present malfunctioning. In such persons there is probably a dissociation of the past from the present. There may be a minimization of current feelings in the desire to conserve the secondary gain derived from the neurosis. The outpouring of unconscious material here is somewhat in the nature of a confessional. The patient may seek to relieve the sense of guilt and to avoid responsibility for the symptoms through the absolution obtained in divulging the past. It is always essential to get the patient to realize that current problems cannot be solved merely by revealing unconscious material. The material must be related to what is happening in the present. Hidden wishes, conflicts, fears, and early traumatic experiences certainly condition habitual behavior patterns, but it is essential to work out with the patient an understanding of how they manifest themselves in every act and thought in daily life.

The exploratory process is likely to bring out an enormous amount of sexual material, and one may get the impression that the only existing difficulties are of a sexual nature. The therapist will certainly be led into a blind alley if unconscious symbolisms are taken at their face value. Presentation of raw oral, anal, and phallic material may be very confusing to the patient, not only because of a need to repress the implications of this material, but also because the language of the unconscious is inscrutable to the conscious mind. Emerging from unconscious strata, it is like foreign speech. The material is, possibly valid, but it must always be translated into constructions that are meaningful to the patient in terms of one's relationship to others.

It is not enough to demonstrate to a female patient beyond any vestige of doubt that unconsciously she desires to possess a penis. It is essential to correlate this wish with her envy of men and with her rivalry and destructiveness in relation to them. It is particularly important to understand what the desire for a penis signifies in terms of the current needs of the patient. It may, for example, be a means of refuting a fantasy of being irreparably injured, or it may constitute a striving for superiority that is rooted in a sense of helplessness.

Desire for, or fear of, castration must also be explored from the standpoint of what purpose these strivings serve in the psychic economy. It is not sufficient to assume that preoccupation with castration is the mere continuance of an infantile fear or wish that has never been completely resolved. The persistence of such an impulse indicates that it serves some purpose in the present. For example, a castration fear may originate in a current feeling of loss of self, a solution for which is sought in strivings for passivity and dependency, which are equated with femininity and castration. Again it must be emphasized that all conscious and unconscious behavior is dynamically motivated and has a definite meaning and function.

RESPONSES TO INTERPRETATION

Inexperienced therapists, impressed by readings in dynamic psychology, often operate under the illusion that they need merely to bring the patient to an awareness of

the problems for these to come to some kind of dramatic halt. In practice this does not happen. Indeed, the effect may be, not an amelioration of distress, but its exaggeration.

The individual's reaction patterns have already been set up in an almost reflex way. Many values accrue to a habitual manner of life, no matter how disturbed this may be. Knowing that the individual reacts with certain patterns and appreciating why they exist does not eliminate the need for such patterns. A confronting of the patient with interpretations may do nothing more than to create a sense of hopelessness because the patient feels powerless to inhibit customary responses.

The patient's reactions to interpretations will depend on a number of factors, including intelligence and the capacity to understand the interpretive meanings. They are conditioned by how basic the patient's neurotic patterns are to security and self-esteem. The manner in which interpretations are presented and the quality of the existing relationship with the therapist are other important items. Any interpretation may seriously unbalance the equilibrium between the patient's defenses and the repressed conflicts. The responses to interpretation may, therefore, reflect an upset in homeostasis and contain customary defensive efforts to restore homeostasis as well as experimentation with new and better defensive devices.

Acceptance of Interpretations

Possible signs of acceptance of an interpretation are expressions of surprise, enthusiasm, relief, excitement, increased flow of associations, and confirmation of the validity of the interpretation. The accuracy of an interpretation is often registered by acknowledgment that it "rings a bell" or "clicks." An immediate acceptance does not necessarily mean that the patient will continue to subscribe to the accuracy of the interpretation or to put it into operation. Indeed, untoward later responses may be the consequence of interpretation due to resistances that are set into motion by the challenging of primary and secondary neurotic gains and the mobilization of anxiety. This is why such phenomena as apathy, depression, or defiance may follow a successful session during which the patient accepts and responds well to interpretations. On the other hand,

the acceptance of interpretations may sponsor a start toward working through of the particular pattern under exploration, in the course of which new trends are uncovered, requiring further interpretation and working through.

The ability of a patient to accept an unpalatable interpretation will be proportionate to positive response to the therapist. If the patient trusts the latter, or is convinced of the therapist's good will, or realizes that one has the right to reject the interpretive offerings, the patient usually will be able to tolerate the interpretation more readily and without undue transference reactions. Resistance to interpretation is most common in the absence of a good working relationship. It is often caused by a fear of succumbing to the therapist, of being overwhelmed and dominated, and of losing one's independence.

Stimulation of Tension and Anxiety

Since interpretation upsets the balance between the repressed and the repressing forces, it is bound to mobilize anxiety that may express itself in nascent form or may release depression, hostility, aggression, or psychosomatic symptoms. This effect may be desirable where there is little activity in the therapeutic process. Here, interpretation may provoke anxiety, which, in turn, will stimulate movement. The arousal of anxiety, however, may not be intended, or, if calculated, the quantity of anxiety may be so great that it threatens the working relationship. Here, the therapist will have to stop the investigative process temporarily and attempt to stabilize the patient, perhaps using supportive measures if the integrative capacities of the patient show signs of shattering. Such undue anxiety may be the product of the improper timing of interpretations, of the inaccuracy of the interpretive effort, or of the presentation of the interpretation in an accusatory, belittling, or derisive manner.

Rejection of the Validity of the Interpretation

The immediate rejection of an interpretation may mean that the patient's capacities for insight are not yet sufficiently developed, that resistance is being mobilized to protect the status quo, or that the interpretation is incorrect. Forms of rejection are many, such as

outright denial, shifts in the content of verbalizations, inability to think, evasions, anger, or detachment. More deceptive is a surface intellectual acknowledgement of the possible accuracy of the interpretation with no real emotional conviction. The rejection of an interpretation does not preclude its therapeutic effect. There may be an uncalculated absorption of the interpretation and an activation of conflicts with a marshalling of defensive forces. A delayed reaction occurs here, the working-through process operating on an unconscious level, resistance being resolved slowly with an eventual restructuring of patterns.

Handling Untoward Effects of Interpretation

If the patient responds to interpretation with anxiety, rage, or other disturbing reactions, the therapist may have to reassure the patient to offset a deterioration of the working relationship. The following excerpts from treatment sessions are suggestive of how this may be done.

Interpretation to a patient of a pattern of destructive aggression toward persons with whom the patient became friendly brought this response and reply:

> *Pt.* I feel ashamed and hopeless when I realize what I've been doing to people. I can hardly face myself, but I can't stop myself. *(cries) [The patient may be utilizing a masochistic defense here to support survival of his pattern.]*
>
> *Th.* The fact that you see the problem doesn't make you bad or any worse than you were before. But in seeing your problem more clearly, your guilt is being aroused and you may want to torment yourself. Actually you *can* do something about your problem if you do have a desire to get well. But it will take a little time, and you must try not to be impatient.

This reassurance brought out more constructive responses from the patient and helped the working-through process of his aggressive pattern.

Another patient presented the following dream:

> My wife left me, I cried uncontrollably, and my mother came in to console me and pet me. I wanted consolation and somebody's sympathy. Then my mother's face changed to that of my wife, but her face had a Roman nose. She wanted sex. She wanted to go down on me. I said no, but she insisted and I succumbed. The room was filled with people, and as I looked at her she seemed taller. She said, "Don't forget to get in touch with me. My name is Janet

James, and I am at the Edison Hotel." Then I overheard a conversation about my wife, Flossie. I heard she was pregnant. I was astonished. I felt it was impossible unless she was unfaithful.

In his associations the patient interpreted the dream as a need for a mother figure in his wife. He expressed disappointment with the mothering his wife had given him. When asked to associate to "Janet James," he remarked that James was the name of a boyhood friend with whom there had been mutual masturbation. This friend, who had a Roman nose, had written to the patient last week saying that he planned to visit New York in the fall and requested that the patient make arrangements to meet him. At this point I made a tentative interpretation that disappointment with his wife might cause the patient to think about the sexual earlier childhood relationship with a boy friend. In response to this interpretation the patient blanched and complained of panicky feelings. An excerpt of the interview follows:

> *Pt.* Does this mean I want to be homosexual? My God, if that's true! (*Patient is obviously upset.*)

> *Th.* Of course not. You know the mind thinks in symbols. When a person is disappointed in his wife, the mind may say, "Oh, the hell with women; maybe a man would be better." (*I laugh, and the patient rapidly overcomes his panic and laughs with me.) [Months later the patient began working on his homosexual impulses.]*

ILLUSTRATIVE CASES

Example 1

The following session illustrates the technique of helping a patient make her own interpretations. The patient, a young newspaper woman concerned with a sexual problem, with symptoms of frigidity and vaginospasm whenever she attempted sexual relations with men, translates the meaning of her symptoms from her dream symbols.

> *Pt.* I had a complicated dream last week. The first part concerned a ship in drydock. It was surrounded on either side by land but was pointed toward the sea. it was being repaired to go out to sea.

> *Th.* Mm hmm.

> *Pt.* And the rear end of the ship was like one of the landing ships that were used for tanks or something like that. It had sort of a drawbridge drawn down to the drydock.

Th. Mm hmm.

Pt. And it opened from the bottom of the ship, not from the deck. It opened actually into a dry river bed. it had a lot of pebbles and stones, and there's no vegetation around any place. *(pause)*

Th. Rather stark and drab.

Pt. Yeah, and the problem was to get this ship repaired before this enemy army arrived and …

Th. There was a war going on?

Pt. There was a war of some kind going on. And, they were approaching from the other side of the river. When it became apparent that we wouldn't have time to finish getting the ship ready to go to sea, we decided something had better be done for defense against the enemy. *(pause)*

Th. Mm hmm.

Pt. And I was more or less in charge of the project and decided that the thing to do was to build up the hill on the other side of the dry river.

Th. As a defense?

Pt. As a defense and disguise so that the enemy might be confused. And I was in the process of doing it when a man came along, an unidentified person, and said, "Well, I think I can do a better job. I have some bulldozers that can build the thing up." So I said, "Fine," and I didn't actually see the bulldozers in operation, but the hill began to build up. and it had a, a series of sort of turrets on it, made out of earth, probably phallic symbols.

Th. Phallic symbols?

Pt. Yeah.

Th. Why do you say that?

Pt. Well, because of the way they just sort of rose out of the ground.

Th. I see. You mean their shape?

Pt. Yeah. And when he got that built up, I saw it was a magnificent job. And then I realized that there was danger of a flood and asked him what should be done in those circumstances about the ship. And he said, "Well, we could close all the doors and windows on the ship and tie it down to the drydock and just let the water flow over it."

Th. You mean a flood was about to happen?

Pt. It was about to happen.

Th. In addition to the invasion.

Pt. Yeah, and I asked him about water on the deck, and he said, "Well, that happens all the time, and there wouldn't be any damage there. So we'd be quite secure staying on the inside of the ship." The character of the flood was sort of a flash flood that would be over in a very short time. We knew that the waters were backed up.

Th. Mm hmm.

Pt. And we didn't know whether, whether the flood would hit, but we had to be prepared in case it did. Then we went back to the ship, and I couldn't get the door at the rear end to work properly. It wasn't opened quite far enough. Either someone had, had knocked a lever and it had closed a little bit, or a spring had slipped. But it wasn't wide opened, and there were several levers, and I was confused as to which one to use. I asked the man which one to use, and he told me, and I tried it, and the door began to close more, and I said, "Here, I want it opened." And he said that you have to push another lever as well.

Th. Mm hmm.

Pt. So I did and the door came on opened. And in that circumstance I felt a little helpless, as if I didn't quite know what it was that I needed to do.

Th. And this man came along to help you. *[The thought occurs to me that the man may represent the therapist.*]

Pt. Yeah. And it was the same one who helped build the hill.

Th. Oh, yes.

Pt. Then the next dream had to do with a big courtyard, cobblestone courtyard with stone buildings around it. European style, completely deserted. And, again, an army was going to make an invasion. And this dream also was very stark. It was like a drawing rather than like an actual scene. And a woman came into the courtyard, and she was sort of an animated cartoon and not a real person. And it could be seen that she'd been drawn with charcoal, actually. She came into the courtyard, obviously fleeing the armies. I knew that she was hunting a place to hide, and I knew that there was no place really to hide. Well, she went into the ladies room. The door for it was on a flat stone wall and shaped like a Gothic window with the point at the top, very narrow, so narrow that you had to turn sideways to get into it. And I knew that she was going to be found anyhow and that when she was found, that all kinds of horrible things would happen. Because it was the Communist army that was coming in, and she was known as a very active anti-Communist.

Th. Mm hmm.

Pt. And it was more as if I were watching a movie that was going on. *(pause)*

Th. Mm hmm. Any other elements to the dreams?

Pt. I think that's all.

Th. Well, now, what associations do you have to those dreams?

Pt. Well, the first one in the ship, my parents are at sea on a, on a ship now. i don't know whether it has anything to do with them or not. But certainly the ship lying in a drydock, again it's sort of like a vaginal canal, *(pause)* And it needed repair and wasn't ready to go to sea. perhaps going to sea, is sallying forth in a, a sexual light.

Th. Mm hmm.

Pt. And, who the enemy was I don't know. But it was very stark and very cold and, no vegetation of any kind, no real warmth.

Th. It sounds very bleak.

Pt. And, the bleak feelings, I think, are the same bleak feelings that I have about my sexual life.

Th. Uh, huh.

Pt. And about relationships with men. *(pause)*

Th. All right, now, what about the bleak feelings that you have about your sexual life and relationships with men? And what is there that may have inspired the bleak feelings? Do you have any idea?

Pt. It might have been our discussion the other day about Howard. *[Howard is a married man with whom the patient started having a sexual affair.]*

Th. Mm hmm.

Pt. I have feelings of not quite knowing where I stand in the relationship.

Th. Not knowing where you stand in the relationship with him.

Pt. No.

Th. How could that have stirred up the feeling that you were about to be attacked?

Pt. Gee, I don't know.

Th. What else did we talk about the other day?

Pt. We talked about the, the seduction scene in the "Ways of Love,' which I feel is, is a matter of an attack. In fact, it probably means that to me very much. I know whenever a pass is made at me, I feel as if it's, it's kind of an assault.

Th. Mm hmm.

Pt. And, less a compliment than the reverse. And I feel that there's an aggression against me rather than, than for me.

Th. Mm hmm.

Pt. And that it's something I have to fight.

Th. You're conscious of a feeling of danger when anybody makes a pass at you?

Pt. Yeah, very much.

Th. Well, now specifically in terms of what we have been talking about in the past couple of weeks, what danger might there be related to facing something you perhaps want to face?

Pt. Yeah. (*laughs*) The going out and making an acquaintance with a man that would come to a satisfactory relationship. *[There was evidence that the patient conceived of a relationship with a married man as safe. Unmarried men frightened her since she feared being trapped by them in marriage.]*

Th. Do you think that that could have stirred up the dream?

Pt. I think it very probably could. I know it could.

Th. So that in the face of our talking about the necessity of not marking time with a safe situation, Howard, and experimenting with unmarried men, there may have been anxiety.

Pt. Yeah.

Th. Now, what could those anxieties be in terms of the dream?

Pt. Well, I felt that the ship which is, I think, obviously *me* had to be repaired.

Th. The ship had to be repaired. It wasn't yet completely repaired

Pt. Yeah.

Th. And?

Pt. And the door at the rear end of the, of the ship, I think is certainly a symbol of the genital area.

Th. Mm hmm.

Pt. And that was where the entrance and exit from the ship were made. It's obvious that it's in a sexual sense the repairs have to be made and a feeling that the enemy is going to arrive before the repairs are made.

Th. Mm hmm.

Pt. Before the ship is really secure, and ready to sail, on the sea itself.

Th. The enemy being symbolized by the war?

Pt. Yeah.

Th. And the actual invading enemy was what?

Pt. The flood.

Th. The flood, and in previous dreams water had meant what?

Pt. It's a sexual symbol.

Th. The flood is a sexual symbol. Now here you were then in charge of yourself and your own sexual functions, and the feeling was that repairs had not been completely made and, as such, you would be vulnerable to attack?

Pt. Yeah.

Th. Or to drowning. And you go off on to the shore and procure the help of a man. Now what does that bring to your mind?

Pt. Well, he came up to me and volunteered to help. And my feeling about it was one of, uh, I was very happy that he had because I felt that I needed help. I welcomed it. And then when he built up the defenses against the flood and against the enemy, I felt that he'd done a very adequate job.

Th. Mm hmm.

Pt. And it had given me time, and it had helped to know what to do. You see, the flood came along, but still I felt secure.

Th. But what kind of defenses were they that he had built up?

Pt. The phallic.

Th. Phallic? Now what would that mean in terms of you • own defenses?

Pt. Homosexuality.

Th. Homosexuality and also masculinity? *[The patient had assumed masculine attitudes, dress, and mannerisms.]*

Pt. Yeah.

Th. So that in the masculine facade that you might have displayed, there was a defensive attitude, wasn't there?

Pt. Yes.

Th. Which might explain perhaps the wearing of the masculine-cut clothes, the assumption of a kind of masculine role in life.

Pt. Yeah.

Th. As a defense against what?

Pt. Against a pass. (*laughter*)

Th. Against a sexual approach by men, against war, against invasion. It seems that your mind conceived of masculinity as something behind which you could hide.

Pt. Yeah.

Th. All right. Now in the dream the man assures you that you could seal up.

Pt. Mm hmm

Th. What does that remind you of?

Pt. Mm, of the conversion hysteria, the tightening of the vaginal canal, the spasm, and pain.

Th. The lightening of the vaginal canal. The vaginal spasm. The sealing up, and also other elements of detachment from men.

Pt. Yeah, keeping a distance from men.

Th. That is, keeping a distance, keeping a cloak around yourself, making yourself invincible, a fortified city that no man can approach. Not making dates with men, keeping away from men, all that as a defense against invasion. All right, now let us examine the next part of the dream, that is, the second dream. This involves also a war, and you're in an open court and there are many buildings around. There is this woman who's playing some kind of a role; she's drawn into this thing.

Pt. Mm hmm.

Th. What is going to happen to her?

Pt. She's about to be captured.

Th. Captured, and what are the horrible things that might happen to her if she is captured?

Pt. Probably death.

Th. Death?

Pt. But torture before.

Th. Torture and death. Now, in terms of the previous dream, what is the torture and death equated with?

Pt. With sex.

Th. With sex.

Pt. Yeah.

Th. If there is an emotional attitude toward sexuality that equates it with torture and death, understandably it would have very little pleasure value for you.

Pt. Yeah, that's right, and that's how it's been.

Th. And if your feeling toward sex was that emotionally it was like torture and death, well, nobody could blame you for wanting to run away from it. All right, now, what did this woman in the dream do to escape?

Pt. She went into the ladies room.

Th. The ladies room. She goes into the ladies room thinking this would be her sanctuary?

Pt. That maybe it would be, but knowing that she probably would be caught anyway.

Th. That was escape into femininity? It was like a church, a Gothic structure?

Pt. The door was, but yet I think the door was nearer a phallic symbol than a church.

Th. Like a phallic symbol?

Pt. Yeah, uh huh. it was, it was narrow, she had to go into it sideways, and it was twice as high as she was tall.

Th. I see. What type of symbol would that be?

Pt. I think a male phallic symbol.

Th. Male phallic symbol? So that no matter what escape she tried, the outcome was inevitable, wasn't it?

Pt. Yes. Well, in this dream, I was. I was sort of a spectator and didn't really take part in it. I just watched these things going on. I'd had some fear for my own safety. But I seemed to be separated from the dream. I wasn't really taking part in it. *[Detachment is one of the patient's characterologic defenses.]*

Th. Yes.

Pt. And my concern was for this woman who had really stood up and asserted the things she believed in.

Th. Mm hmm.

Pt. And I felt that she was unjustly going to be caught and tortured.

Th. Yes. Well, now in terms of your own feelings, how did you feel in the dream? Was there anxiety?

Pt. Um, not so much anxiety as a sort of detached feeling, a feeling that the whole thing was going on sort of coldly and relentlessly.

Th. And you had no way of controlling it?

Pt. In the, in the first dream I felt that there were some means of control, and in the second one I really didn't have anything to do with the dream, with what went on in it.

Th. Do you think I'm pushing you too hard in therapy? [*I ask this question to see if the patient feels threatened by what is happening in treatment and to probe for transference.*]

Pt. Uh, I don't feel I'm being pushed too hard.

Th. Because in the dream the inevitability that you feel about what is going to happen and the fact that you're helpless in the situation would seem to indicate that maybe if you did get yourself involved with an unmarried man, it would be to please me. That old pattern of compliance?

Pt. Mm hmm.

Th. The old pattern of not being able to resist. I'm just throwing this out to you because it may complicate your feelings for me if you feel yourself pushed into a relationship without your wanting it.

Pt. No, I don't feel pushed. I think I see the inevitability of it from my own standpoint.

Th. How?

Pt. Well, it comes down to a choice between I guess the boat being overcome by the flood and closing itself off and going forth and maybe facing it. A choice between having no relationship with a man and having one.

Th. Mm hmm.

Pt. Dissociating myself from what's going on or getting into the swing of it.

Th. In other words, either detaching yourself the way you have previously or facing the dangers you've invested in sex.

Pt. Yeah.

Th. And in running away from men you would be letting all your sexual emotions drain off in a relationship with a woman.

Pt. Yeah.

Th. Well, how do you feel about that? I mean, which of these choices do you feel you want?

Pt. Well, I want to make the heterosexual choice.

Th. You do?

Pt. Yeah.

Th. But it may be awfully hard, *[anticipating resistance]*

Pt. Yeah, and I, I, I feel that it will be. I feel that I'm going into, I think like that second dream, that I'm going into a world that I don't really have any feelings in.

Th. Mm hmm.

Pt. Um, except maybe feelings of torture and fear of death. Um. *(pause)* I feel reluctant to do it. *[The patient has good insight into her resistance.]*

Th. Mm hmm.

Pt. But I feel that, that it has to be done.

Th. Why do you feel it has to be done? [In treatment of patients with a homosexual life style any desired change should always be the complete choice of the patient.]

Pt. Well, I don't think I can mature as a person unless I do it.

Th. Yes. And you really feel that you want to make a try at it?

Pt. Yeah.

Th. It may be hard. You may feel as if you're being invaded and may want to run away. The emotions certainly are powerful, as the dreams would seem to indicate. They might impel you to just break off the relationship, break off therapy, return to the old status quo of homosexuality, and all that sort of thing. *[Mention of possible setbacks helps forestall disappointment if setbacks occur.]*

Pt. No, I don't think so. *(laughs)*

Th. Well, what do you think?

Pt. I don't know. I know that I'll, I'll resist making the relationships.

Th. Mm hmm.

Pt. And I anticipate going through anxiety states.

Th. Mm hmm.

Pt. As I try to make the relationships.

Th. Mm hmm.

Pt. I think that I've got enough of a one track mind that I'll stick to it, *(laughs)* until I get it done, by golly. And, I, I feel like I've started something, and I feel the need to finish it.

Th. Wanting to get it done is nine-tenths of the battle. The fears and the panicky feelings which are so vivid inside, and which you've undoubtedly experienced or have prevented yourself from experiencing by detaching yourself, the hysterical defenses of spasm and frigidity, and all that sort of thing, you feel you can begin to handle?

Pt. Yeah.

Th. Now, the intensity of your feeling will probably still be there. You can anticipate that you're going to get scared because, after all, this is an emotional thing. You may not even know where the feelings come from. All you'll feel is a vague kind of panicky feeling or a cold feeling that there's nothing in sexuality. Or another feeling may be that in some inscrutable way you may be damaged or hurt in a sexual role.

Pt. Yeah.

Th. This isn't absolutely definite. You may now have the strength and the motivation to experiment with men and see just what actually does happen, always anticipating the old defenses, which are what? What are your old defenses against heterosexuality?

Pt. Well, homosexuality mainly.

Th. Homosexuality. That's one defense, certainly, because it keeps your sexual energies drained off and it keeps you in a dependent relationship, as we've seen.

Pt. Yes, and the other defenses are there too, the sealing off, vaginal spasm, the running away, and acting masculine.

Th. And the whole assumption of a masculine role. Now all these things you may find operating insidiously as you begin to function in a heterosexual role.

Pt. Mm hmm.

Th. And it may be awfully hard. The temptation to go back to homosexuality may be terribly great because the starker the fields on this side, the more green the fields seem across the river.

Pt. (laughs) Well, I've had sort of flash backs insofar as dreams are concerned, and once in a while in terms of conscious feelings, toward homosexuality. I've always known that, that it was in relationship with Howard, if I felt helpless, or felt that I was being aggressed against, then immediately the homosexual thing would happen. It would just sort of be like pushing a button, *(laughs)* Not only that, but almost as if, whenever there was any kind of heterosexual involvement of any kind, that it was just like pushing a little button and a picture would come on the screen.

Th. And the fields may possibly begin to grow and get greener and even abundant with vegetation, as experimentation proceeds. With Howard, which was really a break in this homosexual pattern, you experienced, at first, pain, and then no pain, but no feeling.

Pt. With Howard I was able to make that break because I felt safe in that relationship. I felt very safe in it.

Th. In what way?

Pt. Well, a lot because of his attitude. I didn't feel that he was overly aggressive. I didn't feel that he was possessive.

Th. Mm hmm.

Pt. And I didn't feel that he'd force himself on me when I didn't want him to.

Th. Mm hmm.

Pt. And often when he would come to see me, he would ask me, "Are you busy?" or "Do you expect someone else?" or "Is there something else that you had planned that I'd be interfering with?" And I always knew that if I said, "Yes, I am busy," or "Yes, I am expecting someone," he'd go away.

Th. I see. So he was not a formidable enemy.

Pt. No. (*laughs*) I felt that he was rather cooperative.

Th. Mm hmm. And that gave you an opportunity to begin to handle some of your anxieties about men. But you may have doubts about other men. You have doubts that they can be as gentle, or could be handled as easily, or that you'd have as many escape routes as with Howard.

Pt. Yeah, well, the escape routes were always there with Howard, and I was always conscious that they were there.

Th. Mm hmm.

Pt. In fact I pretty well had to be conscious that they were there in order to be able to make a relationship with him.

Th. Yes, after all, he was tied down to a wife, if you ever wanted an escape route.

Pt. (*laughs*) Yes, that was true.

Th. Envisaging a relationship with another person, however, who was not tied down, and who would not perhaps be as diffident, and, as he fell in love with you, would be more insistent about seeing you when *he* wanted to see you, this might produce a little more anxiety, mightn't it? [preparing her for an eventuality]

Pt. I imagine it would.

Th. Yes. On the other hand, a relationship need not be entirely made up of anxiety. There may be some positive values there for you as you begin to work this thing out.

Pt. I find that in my general relationships with, with men that their personalities come through. Which didn't happen at all before. Before it was sort of like dealing with someone in an animated cartoon. It was a person without personality or life.

Th. Almost as in the last dream, this woman sort of going through motions like an animated cartoon.

Pt. Yeah.

Th. Going through a sexual attack perhaps. It'll be very interesting, when you get a man who's worthwhile, to begin experimenting to see just whether the feelings still duplicate the feelings in the dream. It will be rather interesting to see that.

Pt. Well, I felt in the dream that this woman was an admirable person because she had stood up for her rights.

Th. Mm hmm.

Pt. And my sympathies were with her.

Th. Yes.

Pt. She was very aggressed against and helpless in the situation. And the things she really stood for were going to be killed, which I think is myself in a heterosexual relationship.

Th. And the things she stood for that were likely to be killed in a heterosexual relationship were what?

Pt. Yeah, my own aggressiveness, my own creativeness, and my own plans toward my personal life.

Th. Your creativeness, your aggressiveness, your plans, which are symbolized by what?

Pt. By masculinity.

Th. By masculinity. And in a feminine role your masculinity is likely to be taken from you?

Pt. Yeah.

Th. And that which you have cherished so ardently may possibly just be smashed to smithereens if you get into a female role. Now that's a rather dismal concept.

Pt. I should say it is.

Th. That creativeness, aggressiveness, productivity, being worthwhile are so equated with masculinity is interesting. It is something we may have to work out very, very carefully, in order to permit you to go on. Because, if it is really true that your creativeness and aggressiveness and productivity will be crushed in a female role, there is no reason why you should want a female role. But this is a misconception and a challenge. Why there has been this equation, what the meaning of it is are interesting things we may begin to explore.

Example 2

A man, with a reputable position in the community, allowed himself to be picked up by a prostitute. Falling in love violently with this woman, the man abandoned his wife and his three children and, to the horror of his friends, took up residence with the prostitute. Of all persons, only his minister was able to make enough of an impression on the patient to get him to seek psychotherapy. After 3 months of treatment the patient, realizing how destructive his behavior was to himself and his family, left the prostitute and returned home. This was accomplished without pressure from me. I had the feeling, however, that the patient felt resentful that therapy had deprived him of a source of intense sexual excitement. This anger was not openly expressed, but I intuitively sensed it. In the following fragment of a session, the patient presents enough material for me to make both tentative and authoritative interpretations of his resentment.

> *Pt.* I know I shouldn't want Marie (*the prostitute*) as bad as she is. The whole thing is silly, the kind of person she is, I mean.

> *Th.* But you do seem to want her in spite of her faults, *[reflecting underlying attitudes]*

> *Pt.* I know she is bad for me, Rita (*his wife*) is so much more of a real person. But I can't get Marie off my mind. I don't want to go back to her though because that same mess will happen all over again. I would like to be able to think about Rita all the time, to be thrilled by her. But I can work better now and would like to help Rita get the art training she wants. (*long pause*)

> *Th.* I see. *(pause)* What are you thinking about?

> *Pt.* A flash came to me, a fantasy of my standing on the subway platform. A person in front of me. As the subway approaches, I imagined myself pushing this man off.

> *Th.* What kind of a person is this?

> *Pt.* Unidentified. I couldn't identify the man. I seem to see him with a blue suit. He seems sinister for some reason. Sometimes when I stand on the platform of a subway, I have a fear I may jump off or that someone may push me off.

> *Th.* But in your fantasy you push this man off. You're angry with him?

> *Pt.* Oh, no, I don't feel ... I didn't feel anything. Just like pushing him off. *(yawns)* I'm kind of tired today. I had a hard day at the office, all kinds of pressures. I thought of canceling my appointment today because my secretary had forgotten to mark it and I forgot it, and I was supposed to talk to one of the out-of-town advertising people. *[This sounds like resistance.]*

Th. How do you feel about coming here? Do you feel it's an inconvenience to you? *[handling his mention of wanting to cancel his appointment]*

Pt. (*laughs*) It is. I come because I think it's necessary, not because I want it. There isn't anything enjoyable in it.

Th. So maybe you resent coming here, [*a tentative interpretation*]

Pt. No, I don't think I resent it because I know I *should* come. *[He rejects the interpretation.]*

Th. Mm hmm.

Pt. But it is a lot of work to get here; it does take time. It isn't anything I would do for fun. And then I feel that I have the responsibility to my family to get this thing straightened out.

Th. But how do you feel about doing it for yourself?

Pt. Frankly, I'm doing it for my family. Indirectly, I suppose, I benefit from it.

Th. You know, I get the feeling that you really resent coming here, *[an authoritative interpretation]* Let's take that fantasy. Here in fantasy you do an aggressive thing to someone in a blue suit.

Pt. Yes.

Th. What kind of suit do I have on?

Pt. (startled) Why *your* suit is blue! *[The patient seems astonished.]*

Th. Maybe I'm the man in the fantasy and you want to get *me* out of the way. If so, you do seem to resent me. *[tentative interpretation]*

Pt. Oh. I almost forgot. *[He reaches in his pocket and pulls out a check.]* I've been carrying this around for 2 weeks and always forget to give it to you when I'm here.

Th. There must be a reason for that.

Pt. (blushes) You mean I might not have wanted to pay you?

Th. That's possible, *(pause)*

Pt. But I did have the intention to pay you. I just forgot.

Th. People forget for definite reasons very often. Could you possibly not have given me the check because you felt critical of me? *[a tentative interpretation]* If that's the case, then your giving me the check now is making up with me for being critical.

Pt. (laughs) Well, I'll tell you, I have been annoyed having to come here. I've even resented your good intentions. Not that you've ever told me to stay away from Marie, but I've been ashamed to go on the way I did. I've even wanted you to tell me Rita was better than Marie

for me. But, damn it, the pull is there, the excitement. I can't go back, but I can't seem to push myself forward either.

Th. You see, there is a contradiction in some of your strivings. Your present stalemate is a result of being wedged in between your desire for Marie and your guilt and sense of responsibility to the family. You want me to make the choice for you and you are angry if I don't. *[authoritative interpretations]*

Pt. Yes, I can see that, and I know that attractive as Marie is, life with her would be poison for me. I don't need you to build up Rita because she's a person with quality.

Th. Now, were I to make the choice for you, you'd have trouble. For instance, if I told you to give up Marie, I'd become the repressing authority you've been fighting all your life. As a matter of fact, you may find Marie attractive and want to kick over the traces to defy this authority and to do as you please. Then our relationship would get bad because you'd probably want to defy me. On the other hand, if I encouraged you to give up Rita and to yield to your desires, you would be contemptuous of me. And if you went back to Marie, you'd blame me for exposing you to something from which you got pleasure, but which was very destructive to you. *[more interpretations]*

An accident-prone patient with an obsessive-compulsive personality sought therapy for anxiety and depression. From early childhood on he had been fearful of harboring a dreadful disease, the present form of which is cancer. At the fifth session when it became apparent that reassurance had failed to allay his fear of succumbing to a cancerous process of the brain akin to that of a colleague in his profession, the therapist confronts him with his masochistic need through authoritative confrontation.

Th. I realize that, as you have told me, doctors make mistakes. But I get the impression that in your case, with so many medical and neurological checks, there is little chance that you have cancer of the brain. More important than this is why you have to torture yourself with this idea or with other fears. Like all the other cancers you thought you would develop in the past and didn't.

Pt. Doctor, I tell you, I get so upset. I can't eat or rest. I get up in the middle of the night with a cold sweat.

Th. {firmly}) Now listen to me. You are giving yourself a hard time. Now why in the devil do you *have* to wear a hair shirt all the time. One torturous idea after another. You've always had it. I really feel you've always had it. I really feel you've got a stake in punishing yourself. All the guilt feelings you have about your parents. You must feel that you are a terrible person for feeling the way you do. *[authoritative interpretation]*

Pt. I can't get the thoughts out of my mind about what will happen to me when they die.

Th. Like what?

Pt. {pause) I don't know. I'm afraid I can't get along without them. And yet I have these awful thoughts that something terrible will happen to them. *[Obviously the patient is caught in a conflict of dependently needing his parents, feeling trapped, resenting his helpless dependency, fearing that his anger will somehow bring about their death and turning this resentment back on himself. His guilt feeling enjoins him to punish and torture himself. This will probably prevent him from benefitting from therapy. To try to take away his masochistic need for self-punishment without dealing with the basis for his guilt would prove either futile or would only be temporarily successful.]*

Th. Now look. You have this need to punish yourself and all the torture you're putting yourself through, and all your symptoms and the messes you get into, accidents and all, are, I feel, directly related to this need for self-punishment. The reason I bring this up is that as long as you have this need, you will block yourself from getting well in our treatment. What we are going to do is plan how you can break this vicious cycle.

A treatment plan then was evolved to help him break his dependency ties by getting him to take vacations away from home and then to find an apartment for himself away from his family. Having been enjoined to vent his anger, the patient became increasingly able to tolerate his hostility and to accept his parents for what they were. With support he was able to resist their insinuations that he was a disloyal son for leaving them and for living his own life. A dramatic change occurred in his symptoms, and a 2-year follow-up showed continued improvement and maturation.

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The Handling of Resistances to Cure

Despite our best intentions and the most heroic efforts, even where patients express hope and determination to conquer their problems, they may sometimes be unwilling to relinquish them. Personality change is painful as progress takes hold. Anachronistic patterns regressively pull the individual back to the dreams and demands of the past. Temporary secondary gains and the desire to avoid anxiety at all costs hold patients in a grip from which they may be unable to release themselves.

Interpretations of these defensive operations help patients gradually to an understanding of their unhealthy patterns and to a discovery of what, if any, vicarious satisfactions they gain from them. In this way the patients learn to master some of the anxiety that made the defenses necessary. However, because certain drives serve a protective function and yield intense gratifications, the individual is apt to fight treatment desperately. Under these circumstances, therapy is interpreted as an assault on secret wishes and expectations.

FORMS OF RESISTANCE

In his book, *Inhibitions, Symptoms and Anxiety,* Freud (1966) emphasizes five types of resistance: (1) "repression resistance," which is motivated to protect the ego from anxiety; (2) "transference resistance," inspired by a refusal to give up hopes for regressive gratifications from the analyst, along with a desire to frustrate him or her; (3) "episonic gain resistance," which follows upon a need to indulge secondary gains and the advantages of symptoms; (4) "repetition compulsion resistance," motivated by a drive to repeat neurotic impulses under the lash of a self-destructive principle; and (5) the need for punishment to appease guilt. Psychoanalysis is a "never ending duel between the analyst and the patient's resistance" (Menninger, KA, 1961).

Resistance operates not only in psychoanalysis but in all forms of psychotherapy. This is not remarkable because therapy threatens to upset the delicate balance between various elements of the personality. To give up defenses, however, maladaptive as they may be, expose patients to dangers or deprivations that they consider more upsetting than the inconveniences already suffered as a result of the symptoms.

Resistance may take myriad forms, limited only by the repertory of the individual's defenses. Patients may spend time on evasive and aggressive tactics: fighting the therapist; or proving the therapist is wrong; or winning the therapist over with gestures of helplessness, praise, or devotion; or seeking vicarious means of escaping; or evading treatment. Fatigue, listlessness, inhibitions in thinking, lapses in memory, prolonged silences, intensification of complaints, pervasive self-devaluation, resentment, suspiciousness, aggression, forced flight into health, spurious insight, indulgence in superficial talk, engagement in irrational acts and behavior (acting-out), and expressed contempt for normality may occupy patients to the detriment of their progress.

Resistances may consume the total energy of the patient, leaving little zeal for positive therapeutic work. Sometimes a skilled therapist may bypass resistance by prodding reality into the face of the patient. Sometimes it may be handled by interpretations. Often it operates in spite of attempts to dissipate it, bringing the best efforts of the therapist to a halt. Because resistance is so often concealed and rationalized, it may be difficult to expose. Even an experienced therapist may be deceived by its subtleties.

In supportive therapy resistance may be manifested in a refusal to acknowledge environmental disturbance or in a defensiveness about one's life situation. There may be a greater desire to cope with present known vexations than to chance unknown and perhaps grievous perils. There may be a reluctance to yield inimical conditions that gratify needs for self-punishment and justify one's recriminations against the world. In reeducative therapy, resistance to the changing of modes of relating to people cannot be avoided. New interpersonal relations are, in the mind of patients, fraught with danger.

They can be approached only tentatively and with great hesitation. The patients may accordingly remain oblivious to their interpersonal distortions, no matter how frequently they are brought to their attention and how thoroughly they are interpreted. They will repeat the same patterns, with continuous bouts of suffering, and seemingly little insight into what is going on. In cognitive therapy, attempts to alter values or modify belief systems are often met with a confounding reluctance to yield anachronistic and debilitating self-statements. In reconstructive therapy impediments are even more manifest. A most complex array of resistances may materialize. This is especially the case where a weak ego creates an inability to face and to master anxiety related to unconscious conflicts.

Suppression and Repression

Any material that is emotionally disturbing will be suppressed or repressed by the patient until enough strength is gained to handle the anxieties evoked by its verbalization. This material may seem, and actually may be, insignificant or innocuous. It is essential to remember, however, that it is not so much the events or ideas that are disturbing, but rather the meanings given to them and the feelings they inspire.

> Thus, a female patient suffering from feelings of hopelessness and depression, relieved through excessive alcoholic indulgence, could talk freely about her bouts of antisocial behavior that bordered on the criminal, with little disturbance; yet she required one year of therapy before she could relate an experience of removing the clothing of her younger brother and observing and handling his penis. The excitement of this experience and the guilt engendered by it were so intense that she had isolated the memory in her mind.

Only when I had proved myself to be a non-condemning person, who would not punish or reject her for the desires that produced this incident, was she able to bring it up and to reevaluate it in the light of her present-day understanding.

Intensification of Symptoms

One of the earliest symptoms of resistance to cure is a reinforcement of those neurotic devices that had previously kept the individual free from anxiety. Something to anticipate, consequently, during therapy is an acute exacerbation of neurotic symptoms.

An explanation that the patient may possibly get worse before getting better is often a safeguard against interruption of therapy.

Self-devaluation

An insidious type of resistance is that of self-devaluation. Here patients refuse to concede that there is anything about them of an estimable nature or that they have any chance whatsoever of achieving worthwhile status. To every interpretation, they respond with the allegation that they are lost, that there is no need for them to continue, that they are hopeless, that it is too late in life to expect a change for the better. The inner image of themselves is often that of a hideous, contemptible person, and any attempt to explain to them that this is a distorted picture usually falls on deaf ears; their self-contempt is used as a bulwark to progress in therapy. There may be, in addition, a deep wish to be cared for like a child by rendering themselves helpless (parental invocation). The desire to depreciate themselves may be in the nature of escaping criticism by anticipatory self-punishment. A masochistic indulgence is also a cover for a fear that if one acknowledges oneself to be an able person, active and independent efforts will be expected of one. Patients with this misconception will hang on to their self-contempt with a determination that is astonishing, and only painstaking analysis of this resistance can lead them out of their morass. Sometimes self-devaluation is masked by surface narcissism and grandiosity.

Forced Flight into Health

Another form of resistance is "forced flight into health." Here individuals try to convince themselves and the therapist that they are well and that they no longer need treatment. Any implication that they are not making a good adjustment is resisted with vigor. Actually, patients may conduct their affairs with a semblance of normality in that they appear to be confident, self-reliant, and normally assertive. Yet the trained observer may detect a false note and often can perceive the tremendous effort that is needed to maintain the illusion of health. This form of resistance is usually associated with the need to maintain a rigid watch over everything one says for fear one will lose control. From a

pragmatic point of view, it makes little difference if a patient flies, swims, walks, or crawls to health, as long as one gets there. However, assumed health, fashioned by resistance, is generally short-lived.

Intellectual Inhibitions

The urge to ward off the therapist may result in a reluctance to think, to talk, or to feel. The patient, yielding to this urge, will insist that there is nothing pressing to talk about. Thus a singular sterility in the associations develops with an inability to think constructively about pressing problems.

The patient may break appointments, come late, forget to mention significant aspects of the day, block off memory of the dreams and fantasies, manifest inattention, show an inability to concentrate or to remember what has gone on before, relapse into silence during the interview, or display a mental fogging that persists both inside and outside of therapy.

The following excerpt from a session illustrates this phenomenon.

The patient, a divorcee of 32 years of age, with an hysterical, infantile personality, involved sexually with 2 men who were supporting her, came to therapy after making a suicidal attempt. After one year of treatment, her recognition of her dependency caused her to decide to get rid of her lovers and to get a productive job. The patient came a half hour late for the session that follows:

> *Pt.* (*apologetically*) I've been forgetting things lately. Absent-mindedness for about 6 months. Last week I forgot to go to an important meeting. I will make appointments and completely forget them. I forget things to do.

> *Th.* Let's explore that and see if we can learn something about it.

> *Pt.* I keep forgetting names and telephone numbers. I don't know why. Maybe I'm so preoccupied with what's to become of me.

> *Th.* Are you preoccupied?

> *Pt.* I am. I can't remember anything.

Th. What *is* on your mind?

Pt. I have the constant worry that I better hurry and do what I have to do. I am concerned with dying. I keep thinking I may not be here long. I noticed yesterday that my shoes on the floor were empty. I then said, "What will people do with my shoes when I die? I wonder who'll go over my papers."

Th. What's this all about? Do you feel the life you are now living is not worth living?

Pt. I feel threatened by giving up these people who are supporting me. I wonder if I can live and get along. What will become of me?

Th. Maybe you resent giving up these dependent patterns?

Pt. I must resent it; yet even though I do, I can't tolerate them any longer. I've gotten to the point where I can be casual with my supporters and tell them exactly what I feel. I told Max that I can't go to bed with him; he's too old for me. This is terribly threatening for me because the instant I do that my income is cut off.

Th. Mm hmm.

Pt. And Max told me he would give me money without strings tied to it.

Th. This must be a great temptation.

Pt. It is, and I see myself not wanting to give it up. I've accepted it in my mind to try it out.

Th. You may be in a great conflict between being dependent and being active and independent.

Pt. Yes, I don't know which to do.

Th. That's something that you yourself will have to work through.

Pt. I suppose my mind is in a fog because I don't know what to do, but somehow I feel I'm getting stronger. *[The mental fog and her coming late for the session are apparently signs of resistance.]*

Very frequently, negativistic resistant states develop several weeks or several months after the patient appears to have entered into the spirit of treatment, spontaneously analyzing difficulties and making what appears to be good progress. Suddenly, without warning, a blocked, inhibited pattern develops.

Acting-out

Along with unwillingness to verbalize ideas and impulses, the patient may indulge in

irrational acts and behavior in everyday life. This "acting out" appears to be a way of supporting the inability to talk during treatment. The acts serve to drain off anxiety and leave little energy available for work during the treatment hour.

Superficial Talk

Another form of resistance is a veering around one's problems in superficial talk. Here verbal comments are used as a defense to ward off basic issues. The patient may spend the entire time of treatment in talk that embraces topics of the day, current events, or past experiences portraying personal tragedy and martyrdom. There is little of deep significance in the conversation, and, if allowed to do, the patient may continue for years to discuss material that is interesting enough but that actually has little to do with significant problems. Often the patient will want to monopolize the interview and will resent the therapist getting a comment or an interpretation in edgewise. Rarely will the patient talk about attitudes toward the therapist, who may begin to feel merely like a sounding board for the patient's boasts and diatribes. It is almost as if in superfluous conversation the patient defies the world to make him or her talk about innermost problems. Associated with this, there may be an attempt to intellectualize, to figure out convoluted connections, and to present a rigid and logical system of what must have happened to one.

Insight as Resistance

A device that is apt to be confusing to the therapist is the use of insight as a form of resistance. Here patients routinely will go through a detailed accounting of how well they understand themselves, using the best accepted terminology, presenting the dynamics and mechanisms of their disorders in approved textbook style. To all appearances they have gained complete insight into the origin of their problems, into their compulsive trends and distorted relationships, and into the consequences and destructive influences of their neuroses. Yet in their daily experiences they go right on with their usual neurotic modes of adjustment, manifesting the same symptoms that originally brought them to treatment. It is probable in such cases that the patient's insight is a highly intellectualized

affair that is employed to confuse himself or herself and the therapist.

There are many reasons why a person utilizes insight as a smoke screen behind which to indulge customary neurotic trends. One of the most common reasons is the desire to escape criticism and detection. Here, a dissociation exists between how the patient thinks and feels. It is often easy for the therapist to minimize the seriousness of the patient's disorder when confronted during treatment with a beautiful recitation of psychopathology. Behind the camouflage of insight it is apparent that the patient uses knowledge of mechanisms as an instrument to allay guilt and to forestall criticism in regard to daily actions.

This mechanism is often found in extremely dependent patients who have magical expectations of what therapy will do for them. The chief motivation for entering treatment is the feeling that the therapist will bring about those neurotic objectives that they, themselves, have failed to obtain through their own efforts. Compliance here is the keynote, and the patients, by reciting their spurious insights, will feel that the therapist must reward their aptitudes in learning with anticipated bounties. The facade is at least partially unconscious, and the patients may really believe that they understand themselves thoroughly. The clue to what is going on is usually furnished by the outbursts of hostility and criticism that eventually are pointed toward the therapist when, after months of precise and punctilious performance, the patients do not magically get from therapy what they originally set out to achieve.

Dissociating the Treatment Hour from Life

Sometimes resistance takes the form of the patient's utilizing the treatment hour as a special event dissociated from life. Regarding it as such, the patient will go into the mechanisms of interpersonal relationships with complete freedom, displaying insight that seems to end after he or she exits from the therapist's office. It is obvious that with the therapist, the patient is operating under a set of standards entirely different from those used with other people in general. There seems to be something recondite about the treatment hour, for it is set apart from all other experiences. The special resistance here is

that of not seeing how the material that is uncovered in the treatment hour relates to everyday situations. This isolation of treatment from life is often rationalized by the patient on the basis that the therapist is a scientist, who does not condemn one for acts for which one would be punished by others. In this way the patient will lead a dual existence and seemingly be unable to fill the chasm between what happens in treatment and experiences outside of treatment.

Contempt for Normality

An insidious kind of resistance expresses itself in a fear of, or a contempt for, normality. Associated is a refusal to assume responsibility or to make an effort on one's own. By substituting new patterns for old, patients believe that they are yielding up something valuable, something they may never be able to replace, that they will become a prosaic bore, or that they may be exposing themselves to dangers with which they will be unable to cope. This type of resistance appears most intensely in reconstructive therapy after the patients have gained insight and are ready to execute it into action.

A patient with a phobic reaction extended to subway travel made a trip to my office by subway for the first time since treatment had started. She entered the room sullenly and remarked fretfully that she was furious with me. Her anger had started when she discovered that she had no great anxiety riding on the train. A fragment of the session follows:

> *Pt.* I am so angry and resentful toward you. *(pause)*
>
> *Th.* I wonder why.
>
> *Pt.* I feel you are gloating over my taking a subway. I feel mother is gloating too. *[Originally accompanied to my office by her mother with whom she had been living since her divorce, the patient with therapy gradually overcame her agoraphobia except for riding on the subway.*] I resent her too. I felt she was pushing me, trying to force me to break away from her. She gloats if I do something that makes me independent. I feel that when I go ahead you gloat too. *[The patient had become so pathologically dependent on her mother that she was scarcely able to let mother out of her sight. Mastering some dependency and walking alone was achieved previously in therapy, although the patient was very reluctant to give up this aspect of her dependent relationship.]*

Th. It sounds as if you are angry about being able to travel on the subway.

Pt. Mother seems to be anxious to give up her responsibility for me. I resent that. But I also don't like the idea of my being so close to mother too.

Th. I see, as if you want to continue being dependent and yet resenting it.

Pt. When I get sick at night, I ask her to make me some tea; and then I resent her patrician attitude when she does this.

Th. But what about your feeling about me?

Pt. It's like giving in to you. But yesterday I felt liberated by the idea that I'm in the middle of a conflict and that coming here offers me hope. I realize that my neurosis is threatened by my getting well. (*laughs*)

Th. What part of your neurosis do you want to hold onto?

Pt. (laughs) None. But I have a feeling that I don't want to be normal, that in giving in to you I'll be like anybody else. Also that you'll expect more things of me. And (*laughs*) that if I get too well you'll kick me out. *[Here the patient verbalizes a variety of resistances: namely, a desire for uniqueness, a contempt for normality, a fear she will be expected to face more anxiety-provoking situations, a reluctance to give up her dependence on me, a punishing of her mother and of me by refusing to acknowledge improvement, and an unwillingness to yield her masochism and the various secondary gain elements accruing to her neurosis.]*

Occasionally a psychosomatic complaint may be a manifestation of resistance, as illustrated in the following fragment from a session with a male patient:

Pt. Everything was going well until this morning when I got stomach cramps. They have been with me all day.

Th. Mm hmm.

Pt. I find it hard to concentrate because my stomach bothers me so much. Mondays I always have a hard time for some reason. It's happened the last few Mondays.

Th. Seems like an unlucky day for you. *(pause)*

Pt. I was thinking about how long it takes to get well, and I was wondering if others did any better than I do. Of course, things are a lot better now, and I was thinking of taking a course in journalism up at the New School. The only thing is that it comes on Mondays, and that's hard. I … uh … uh … *(Patient brings hand to his abdomen.)* I had something I wanted to say … but I can't think of anything but these cramps. *(He takes a cigarette from a pack, reaches into his pocket for matches but cannot find them.)* Do you have a match?

Th. I believe so. Here's one. *(pause)*

Pt. Well … *(coughs)*

Th. You were saying that Mondays are pretty tough on you? Perhaps something happens to you on Mondays that upsets you.

Pt. I … I … I don't know.

Th. You do come *here* on Mondays.

Pt. Why … yes … yes … I mean I do.

Th. Maybe something is upsetting you in coming here?

Pt. I don't know what it might be. *(pause)* Maybe I'm upset that you feel I'm not doing well. *[We discuss his feelings that he is not living up to expectations. This is what has been giving him anxiety. His cramps are manifestations of internalized resentment and act in the service of resistance. [The symptoms soon vanished completely when he could see their connection with his faulty assumptions.]*

Reluctance to Yield the Pleasure Values of the Treatment Hour

A form of resistance that is frequently overlooked is one that involves reluctance to yield the positive pleasures that the patient gets out of the treatment itself. The patient may derive such comfort from the therapeutic hour that other gratifications seem dubious, and may refuse to give up the neurosis because of a desire to continue therapy indefinitely. This is frequently the case in a very dependent patient, who looks forward to the hour to get a "fix," who perhaps pays lip homage to all the dynamic principles uncovered during treatment, but whose chief motive for therapy is to get suggestions and courage to carry on with daily routines. Unless one watches oneself carefully, the therapist will fall into a trap laid out by the patient and may, by the patient's helplessness and apparent inability to do things voluntarily, feel forced to feed the patient with doses of advice and admonishments, which the patient absorbs as if these were pronouncements from the Deity.

Transference Resistances

Perhaps the most common and disturbing of resistances are those that are produced in response to the relationship with the therapist or that take the form of transference.

Contact with the therapist is understandably disturbing when it mobilizes attitudes, impulses, and feelings that threaten the repressive forces. Patients will, in the attempt to escape from the associated anxiety, exhibit their usual characterologic defenses to detach themselves, make themselves helpless, control and overwhelm the therapist, or render themselves invincible by pseudo-aggressiveness. In supportive and some types of reeducative psychotherapy the patients will manage to restore their equilibrium through the medium of such defenses, and they will, more or less successfully, repress disturbing irrational, unconscious drives. In reconstructive therapy, on the other hand, the therapist constantly interprets the nature and purpose of the various defenses as they arise. This constitutes an assault on the integrity of the repressive system and will precipitate much tension. Eventually the patient cannot help coming to grips with the emotions and drives that hitherto have been successfully avoided. The patient will then mobilize further protective devices to reinforce the crumbling repressions.

One of the earliest manifestations of this struggle is an intensification of symptoms, which seems to serve the desperate function of restoring psychic equilibrium. Soon the struggle becomes more personalized as the patient realizes that relationship with the therapist is the womb of the distress. Resistance once exerted against awareness of the original unconscious material is now shown toward projected and animated representations in the transference.

The patient may exhibit a disarming dependent attitude toward the therapist, who is regarded as the embodiment of all that is good and strong and noble in the universe. This kind of resistance is often found in individuals who are characterologically submissive, subordinate, and ingratiating and who strive to adjust to life by clinging parasitically to a more powerful person. It is as if the individual had an amputated self that could be restored only by symbiosis with a stronger individual. There is even an associated tendency to overvalue the characteristics and qualities of the therapist. This type of relationship is extremely shaky because the patient regards therapy as a magical means to security and power. Consequently, the therapist must always live up to inordinate expectations that are sheerly in the realm of fantasy, beyond possibility of fulfillment. The

patient will make unreasonable demands on the therapist, and, failing to get what he or she secretly wants, be filled with outrage.

Another form of relationship resistance is based on an intense fear of the therapist as one who is potentially capable of injuring or enslaving the patient. This attitude stems from a hostile image of the parent that usually is applied to selected authoritative individuals. Treatment in such cases proceeds only when the patient realizes that the therapist does not desire to punish or condemn for the impulses or fantasies, but instead is benevolently neutral toward them. Little progress is possible until the patient accepts the therapist as a friend, not foe.

Sometimes patients display a disturbing need to be victimized and unfairly treated. They will maneuver themselves into a situation with the therapist in which they feel they are being taken advantage of. They may even exhibit various symptoms that they attribute to the harmful effects of therapy. In order to reinforce their waning repressive system, they thus seek to transform the therapist into a stem authority who commands and punishes them. Where this happens, they will experience severe anxiety if the therapist is tolerant and condones their inner impulses.

When resistance is displayed in the form of hostility, the resulting reaction patterns will depend on the extent to which the patients are able to express aggression. Where the character structure makes it mandatory to inhibit rage, the patients may respond with depression and discouragement. They may then want to terminate therapy on the grounds that they have no chance of getting well. They may mask their aggression with slavish conformity and perhaps evince an interest in the therapist's personal life, assuming an attitude of camaraderie and good fellowship. There is in such efforts a desire to ally themselves with the enemy in order to lessen the danger to themselves.

On the other hand, where the patients are able to express hostility, they may exhibit it in many ways especially where the transference becomes intense. They may become critical, then defiant, challenging the therapist to make them well. Irritability is often transmuted into contempt, and the patients may accuse the therapist of having

exploitative or evil designs on them. Feeling misunderstood and humiliated, they will manufacture, out of insignificant happenings in their contact with the therapist, sufficient grounds to justify their notion of being mistreated. They will become suspicious about the therapist's training, experience, political convictions, and social and marital adjustment. They may enter actively into competition with the therapist by reading books on psychoanalysis to enable them to point out the therapist's shortcomings. They may become uncooperative and negativistic.

Sometimes hostility is handled by attempts at detachment. The need to keep the therapist from getting too close may burn up a great deal of the patients' energy. They may refuse to listen to what the therapist says. They may ridicule in their minds proffered interpretations. They may forget their appointments or seek to discontinue therapy, inventing many rationalizations for this. They may strive to ward the therapist off by discussing irrelevant subjects or by presenting a detailed inventory of their symptoms. In their effort to keep aloof they may attempt to take over therapy, interpreting in advance their unconscious conflicts, the existence of which they suspect or fabricate. An insidious type of defense is a preoccupation with childhood experiences. Here the patients will overwhelm the therapist with the most minute details of what must have happened to them during childhood, presenting a fairly consistent and logical survey of how previous inimical experiences must have produced all of their present difficulties.

Occasionally the impulse toward detachment is bolstered by contempt for the therapist's values; the patients will feel that their own standards are what really count. Because of this they will be convinced that the therapist cannot like them and will "let them down." They will rationalize these feelings and say to themselves that the therapist is no good, or incompetent, or of no importance, or that psychotherapy is nothing but nonsense.

The desire to control the situation may reflect itself in many ways. Some patients may seek to shower the therapist with gifts and favors, or they may develop a sentimental attachment that assumes a sexual form. Therapy may be regarded as a seduction, the

patient experiencing in it intense erotic feelings. One of the motives involved in falling in love with the therapist is to put the latter in a position where there will not be too close probing into the patient's deepest secrets. The incentive may be to devalue, test, influence, get the whip hand, or fuse with the therapist; in this way taking a shortcut to cure.

Many patients come to treatment not because they desire to function more adequately in their interpersonal relationships, but rather because they seek to obtain from treatment the fulfillment of neurotic demands that they have been unable to gratify through their own efforts. In such cases resentment and resistance develop when the patient does not receive from the therapist the specific type of help that was expected.

Upon analyzing what the patient wants from the therapist, it turns out that what is sought is not a cure for the neurosis, but an infallible method of making it work. Many patients desire to achieve neurotic expectations without having to pay the penalty of suffering. The individual with a power drive may thus insist on a formula whereby one can function invincibly in all activities. The perfectionist will want to find a way to do things flawlessly, with as little effort as possible. The dependent individual will expect to amalgamate with the therapist and to have all whims gratified without reciprocating. The detached soul will seek the fruits of social intercourse, while maintaining distance from people. When these drives are not gratified in therapy, when patients sense that these are instead being challenged, they will become tremendously resistive.

In sicker patients, resistance is sometimes exerted against accepting the idea that it is possible to function adequately without repairing a fantasied injury to the genital organs. In the female this may be expressed in the expressed refusal of continuing life without the possibility of ever procuring for herself a penis, which she regards as the bridge to activity and self-fulfillment. In males, the assumption of a passive role is often interpreted as equivalent to being castrated, and resistance may be directed against assuming any role that does not involve aggressive "masculine" fighting or "machoism." Even accepting help from the therapist may symbolize passivity.

Psychotherapy may produce other unfavorable resistance reactions in patients with immature ego structures. The transference can become so dramatic and disturbing to these patients that they respond to it in an essentially psychotic manner. They will accuse the therapist of being hostile, destructive, and rejecting, and they will refuse to acknowledge that their attitudes may be the product of their own feelings. The reasonable ego here is very diminutive and cannot tolerate the implications of some surfacing of unconscious drives and conflicts. The patient acts out inner problems and constantly avoids subjecting them to reason. The acting-out tendency permits the neurosis to remain intact. Where the therapist is seen as a cruel or lecherous or destructive being who threatens the patient with injury or abandonment, any action or interpretation is twisted in the light of this delusional system. Fear and anxiety issuing from the patient's irrational strivings lie like boulders in the path, barring the way to a more congenial therapeutic relationship. In such cases therapy will be prolonged, and the relationship must be worked on actively so as to constitute for the patient a gratifying rather than threatening human experience. (See also Chapter 42)

METHODS OF HANDLING RESISTANCE

Little has been written on how definitely to solve the paradox of the patients who seek help yet resist any external control or guidance toward change. What would seem to be indicated is a participant model for therapy in which the patients take responsibility in treatment, monitoring their own behavior and determining the nature of their interactions, environment, and their future plans.

In psychoanalysis, early in treatment the patients gather from the passivity of the analyst that they have to make their own decisions and work through their blocks toward utilizing insight in the direction of change. Interpretation of resistances is the prime modality used and the analyst hopes that the patients will in the resolution of these obstructions generalize their learnings in therapy toward making new constructive adaptations.

In psychoanalytically oriented therapy, the therapist is more active and employs

techniques in addition to interpretation to help the patients effectuate change. These techniques often draw from many schools and are more or less eclectic in nature.

In behavior therapy, the therapist is highly active, utilizing when necessary a rich assortment of devises, including systematic desensitization, operant conditioning, modeling of preferred behaviors, role playing, work assignments, and cognitive therapy. These treatments are sometimes blended with counseling.

At the outset it often becomes apparent that what some patients want from therapy is to overcome suffering without giving up attitudes and behaviors that are responsible for their suffering. What is required before any progress can be made is to work toward motivating the patient to change and to formulate worthwhile objectives in treatment. In behavior therapy these are delineated and persistently pursued.

In his chapter on self-management methods, Kanfer (1980) describes a behavioral model drawn from Skinnerian methods and research findings in social and cognitive psychology as well as current clinical practices. Through various techniques, the patient acquires skills for use in problem-solving. The patient is also trained in altering noxious elements of the environment. Development of constructive repertoires is conducted through negotiations with the patient. Past experiences are reviewed only to provide information during behavioral analysis on the circumstances surrounding the original conditions when the maladaptive behavior was developed, and to point out the present inappropriateness of this behavior.

In controlled environments like a hospital or in military organizations, reinforcement contingencies may be relatively easily applied. But in one's ordinary living environment these are not so readily arranged, and it is for this reason that manipulation of cognitive variables through cognitive behavior therapy can be valuable in order to help evolve constructive self-reinforcing attitudes. A good deal of support will be required from the therapist at the start of treatment, but this will diminish as the patient becomes more skilled in self-management. A contract is usually negotiated, details of which spell out the required behavior, the time goal, the reinforcements for fulfillment of obligations, some

aversive consequences of nonfulfillment of the contract, and the way reviews and evaluations will be conducted. Where required behaviors occur outside the range of observation of the therapist, self-monitoring is mandatory and here the patient will benefit from keeping a careful record of his or her behaviors. Assignment of tasks expedites self-observation and hastens the development of new behavioral repertoires. Techniques are employed to set up environmental conditions unfavorable to the undesired behavior, and to establish contingencies for self-reinforcement. Discussions cover the patient's experiences in self-management with the object of helping to transfer learnings and skills to situations that may develop in the future. There are other models one may follow if one is pursuing a behavioral program, but the one I have outlined seems to cover the essential points.

As soon as the therapist realizes that resistance is interfering with therapy, it is necessary to concentrate on the resistance to the exclusion of all other tasks. This may be done in a number of ways. In supportive and reeducative approaches, this is done by reassurance, persuasion, and various manipulative and strategic maneuvers. In reconstructive approaches a cognitive attach or the resistance itself is instituted.

Identifying the Resistance and Exploring Its Manifestations

Calling the patient's attention to the resistance itself and exploring its manifestations are essential procedures.

For example, a patient has for the past few sessions arrived 5 to 10 minutes late. The sessions are spent in a discursive account of family events, including the impending marriage of his son, the forthcoming graduation of his daughter, and the attacks of "gall-bladder trouble" suffered by his wife for which she may need an operation. The responsibilities imposed on him by his business and social position also occupy his attention. He mentions having suggested a 2-week vacation in Florida, but his wife promptly vetoed the idea. He pauses in his conversation and then remarks that there is nothing on his mind.

Sensing resistance, I direct the interview along the following lines:

Th. I wonder if there is something on your mind that bothers you that you are not talking about.

Pt. Why, no, not that I'm aware of.

Th. The reason I bring this up is that you have been coming late to your sessions, and during your sessions you have kind of rambled along, not talking about things that bothered you too much. At least I have that impression. *[pointing out possible resistances]*

Pt. Why no, I mean you want me to talk about anything on my mind. I'm supposed to do that, am I not?

Th. Yes.

Pt. Well, I haven't had anything else bothering me.

Th. Perhaps not, but have you had any symptoms that upset you?

Pt. No. I've noticed though that my jaws tighten up sometimes. And my wife tells me I'm grinding my teeth in my sleep.

Th. Mm hmm. That sounds like tension of some kind.

Pt. I know I feel a little tense.

Th. A little tense?

Pt. I've been upset that I have to do, do, do for other people, give, give, give, and get little in return.

Th. As if people expect things from you and do not want to give anything?

Pt. Yes, I'm getting fed up with my life, the way it's been going.

Th. I see. This could be upsetting.

Pt. I suppose you'd say I feel frustrated.

Th. Well, what do *you* say?

Pt. (laughs) It's hard to admit it, but I am. Sometimes I'd like to chuck up the whole thing, and be single again, without responsibilities, to do what I want to do.

Th. I should think you would feel frustrated that you can't. If this is what you really feel this is what you want.

Pt. Lately I've been getting this way. *[The patient discusses his secret ambition of wanting to be a writer and admits that he was embarrassed to talk about this. He also was, he remarks, afraid*

to admit that he resents being tied down to a routine family life and has fantasized divorce. His resistance to talk about these things along with his internalized rage at his life situation seem responsible for his muscular symptoms.]

Pointing Out Possible Reasons for the Resistance

Where patients are cognizant of their resistance but do not recognize its purpose, the therapist should point out various possibilities for the resistance. The defensive object of the resistance may be interpreted along with the facades; the patients may be shown that their resistance protects them against the threat of change. Thus, a patient hesitates repeatedly during a session; the periods of silence are not broken by the usual interview techniques.

> *Th.* I wonder what the long silences mean.
>
> *Pt.* Nothing comes to my mind, that's all. I kind of wish the time was up.
>
> *Th.* Perhaps you are afraid to bring up certain things today. [*suggesting that her silence is a resistance to prevent her from bringing up painful material.*
>
> *Pt.* Like what?
>
> *Th.* Well, is there any event that happened since I saw you that you have not mentioned to me?
>
> *Pt.* (*silence*) Yes. there was. I met a man last Wednesday who sent me. I made a big play for him and am going to see him Sunday. *[The patient's infidelity to her husband is one of her symptoms, of which she is ashamed.]*
>
> *Th.* I see.
>
> *Pt.* I have wondered why I did this. I realized you wouldn't tell me not to, but I feel guilty about it.
>
> *Th.* Was that the reason why you were silent?
>
> *Pt.* (*laughing*) Honestly, I thought there wasn't much to talk about. I minimized the importance of this thing. But I realize now that I didn't want to tell you about it.
>
> *Th.* What did you think my reaction would be?
>
> *Pt.* (*laughs*) I guess I thought you'd think I was hopeless or that you'd scold me.

Reassuring Tactics

Reassuring the patient in a tangential way about that which is being resisted necessitates an understanding by the therapist of the warded-off aspects.

For instance, a woman with an obsessional neurosis comes into a session with symptoms of exacerbated anxiety. She has no desire to talk about anything but her suffering. This seems to me a sign of resistance. When I inquired about dreams that she may have had, the patient reveals one that, in a disguised way, indicates murderous attitudes toward her offspring. The idea occurs to me that she is attempting to suppress and repress thoughts about her children.

A significant portion of the session follows:

Th. I wonder if you haven't been overly concerned about thoughts of your children.

Pt. I'm frightened about them, the thoughts.

Th. You know, every mother kind of resents being forced into playing the role of housewife. This is a cramped life to many persons. Most women may resent their children and from time to time wish they weren't around. It's natural for them to feel that, *[reassuring the patient about possible hostility]*

Pt. (rapidly) That's how I feel.

Th. They may even get a feeling sometime that if the children pass away, that will liberate them. Not that they really want that, but they look at it as an escape, *[more reassurance]*

Pt. That's what I didn't want to say. I've felt that it was horrible to be like that.

Focusing on Material Being Resisted

Bringing the patient's attention to the material against which the resistance is being directed must be done in a very diplomatic way, preferably by helping the patients to make their own interpretation or by a tentative interpretation.

A patient with a problem of dependency complained of an intense headache and a general feeling of disinterest in life.

The interview was rather barren, but enough material was available to bring the

patient to an understanding of what he was trying to repudiate.

> *Pt.* My wife has been telling me that I just am not like the other husbands. I come home and read the newspaper and don't go grubbing around in the garden.

> *Th.* What does that make you feel like?

> *Pt.* I guess she's right. But as hard as I try, I know I'm being a hypocrite. I just gave that up.

> *Th.* But your wife keeps pounding away at you.

> *Pt.* Well, what are you going to do. I don't help her around the place. She resents my being as I am.

> *Th.* But what do you feel your reaction is to her pounding away at you?

> *Pt. (fists clench)* It drives me nuts. I'd like to tell her to stop, but I know she's right.

> *Th.* Is it possible that you resent her attitude, nevertheless, and would prefer her laying off you when you don't do the chores? [*a tentative interpretation of the material against which there is resistance]*

> *Pt.* God damn it. I think she is being unreasonable when she sails into me. *[The patient takes courage from my interpretation and expresses resentment.]*

> *Th.* Mm hmm.

> *Pt.* After all, I come home tired and I find no interest in planting cucumbers. Besides, it's crazy. My neighbors plant dollar tomatoes. Each tomato costs them a dollar. It's no economy. The whole thing is silly. *[The patient continues in a diatribe, venting his resentment about his wife's attitude. At the end of the session his headache had disappeared.]*

Handling Acting-out

Acting-out is a common manifestation that has been given various interpretations (Abt, 1965). Fenichel (1945) defines acting-out as "an acting which unconsciously relieves inner tension and brings a partial discharge to warded-off impulses (no matter whether these impulses express directly instinctual demands, or are reactions to original instinctual demands, i.e., guilt feelings); (the present situation, somehow associatively connected with the repressed content, is used as the occasion for the discharge of repressed energies, the cathexis is displaced from the repressed memories to the present, 'derivative,' and this displacement makes the discharge possible.") Aronson (1964a) considers the essential features of any acting-out sequence to be a reenactment of a

childish ("pregenital") memory or fantasy, of which there is no conscious recollection, precipitated by transference or resistance during psychotherapy, displacing itself to some organized "ego-syntonic" action, thus permitting a partial discharge of inner tension. At the same time there is no awareness of any relationship of the old memory or fantasy with the current action.

Prior to coming to therapy the patient, having indulged in acting-out tendencies as a way of expressing unconscious impulses and feelings, may have gotten into certain scrapes. During psychotherapy acting-out may occur even in patients who have, before treatment, shown no evidence of it in their behavior.

There are some psychotherapists who take the view that acting-out can serve a useful purpose in some patients, that it may be growth inducing and, particularly where basic problems originated in the preverbal state, they constitute a means toward assertiveness and a preliminary step toward gaining insight. Consequently, they tend to encourage and even to stimulate acting-out. Other therapists, however, regard acting-out as always detrimental to therapeutic progress since it drains off the tension that should be employed for a requisite understanding and working through of conflicts. Between these two extremes an intermediate viewpoint may be taken, acting-out being managed in accordance with whether it serves as an obstruction to or as an intermediate stage toward learning.

Some patients who were overindulged and poorly disciplined as children will engage in untoward acting-out behavior to goad the therapist into a setting of limits such as they had never experienced with their own parents. On the other hand, where parents have been too authoritarian and have cowed the patient to a point where the slightest emergence of defiant or antisocial conduct inspires fear of a counterattack, acting-out may constitute a breaking out of restraints. The handling of acting-out in these two instances will be different.

Where acting-out occurs as a resistance to therapy, it is usually inspired by the transference situation. Because patients refuse to verbalize prior to acting-out and

because they may conceal and rationalize their behavior, it may be difficult to deal with it therapeutically. For instance, a prudish female patient, shortly after starting therapy, confessed having involved herself in extramarital love affairs with several men. It was only through a dream that I was able to get a glimpse of her guilt feelings at sexual actions that were totally foreign to her personality. Confronting her with the existence of sexual guilt brought forth divulgence of the information that she had, during the past month, become so sexually aroused that she felt forced to seek satisfaction in outside affairs. Focusing on her feelings about me, the patient was soon brought to an awareness of how closely she had identified me with her father, and of how her incestuous impulses were being displaced. The establishment of the connections of her current behavior with its infantile roots enabled her to control her acting-out and to work through her fantasies within the therapeutic situation.

The therapist should consequently be alert to extraordinary behavior patterns that occur in the patient. Thus, a man who is ordinarily restrained may engage in random, multiple sexual affairs to the point of satyriasis, or involve himself in dangerous but exciting aggression-releasing situations that are potentially disastrous to him. One patient, for instance, whenever provoked by hostility toward her therapist, would get into her car and drive speedily and recklessly. Only when she narrowly escaped an accident would she slow down.

When acting-out is recognized, it is necessary to bring this to the attention of the patient. The therapist may suggest that there are reasons why the patient feels forced to engage in certain behaviors. Talking about feelings *prior* to putting them into action will help the therapeutic process. Acting compulsively the way that the patient does tends to interfere with therapy. Should the patient accept these statements and verbalize, enough energy may be drained off in the interview to forestall acting-out. Interpretation may also help to dissipate the need for unrestrained behavior. Interpretive activities will require a repeated pointing out to the patient of manifestations of acting-out conduct. At the same time attempts are made to link actions to fantasies or impulses that are preconsciously perceived. Material from free associations and dreams may be valuable here. What helps

in most instances is bringing the patient to an awareness of evidences of transference. Should any of the acting-out manifestations contain healthy elements, the therapist should attempt to reinforce these. The strategic timing of interpretations is important. Where acting-out occurs during a session as a manifestation of transference and resistance, interpretations will be particularly effective; nevertheless, a prolonged period of working through may still be required.

Should acting-out persist and should this be potentially dangerous to the patient, the therapist may direct the patient to desist from the acts on the basis of their destructive nature, while encouraging talking about impulses. Of course, in some instances, it may be impossible for the patient voluntarily to stop acting-out. Exhibitionism, voyeurism, transvestism, and masochistic sexual activities are examples. However, with persistence it may be possible to get patients to talk freely about their temptations and to help them, to an extent at least, to gain some voluntary control. Increasing the frequency of sessions and giving patients the privilege of telephoning the therapist whenever the impulse to act-out occurs are often helpful. As a last resort, if patients continue dangerous acting-out, the therapist may threaten to withdraw from the therapeutic situation unless control over impulses is exercised. Behavioral aversive conditioning techniques are sometimes employed as a means toward checking acting-out that cannot be controlled in any other way. Cooperation of the patient will, of course, be necessary. The patient may also be told, "If you want to continue in this self-destructive behavior, you can do it by yourself; you don't need me. If you want to change, I can help you."

It goes without saying that acting-out within the therapeutic session, like physical attacks on the therapist and lovemaking gestures, are to be discouraged or prohibited. Patients may be told that they can talk about anything they please, but that unrestrained actions are not permitted by rules of therapy. Experience has shown that these interfere with the therapeutic process.

Handling Transference Resistances

Where transference has developed to the point where it constitutes resistance to

treatment, it will have to be resolved. If it is not dissipated, it will seriously interfere with the working relationship. Treatment may become interminable, the patient utilizing the therapeutic relationship solely as a means of gratifying neurotic impulses at the expense of getting well. Frustrated by the absence of what the patient considers to be the proper response to reasonable demands, the patient may terminate treatment with feelings of contempt for or antagonism toward the therapist.

Superficial manifestations of transference may often be adequately handled by maintaining a steadfast attitude and manner, constantly bringing the patient back to reality. Sometimes a studied avoidance of the role that the patient wants the therapist to play, or acting in an opposite role, minimizes transference. For instance, if the patient expects the therapist to be directive and controlling, on the basis of a conviction that all authority is this way, the therapist deliberately acts permissive, tolerant, and encouraging of those activities toward assertiveness and freedom that the patient cherishes but which he or she believes the parents had prohibited. Such role playing rarely is successful because the patient will usually see it as a ruse. It is better to interpret to the patient what the therapist believes is behind the patient's reactions.

A female patient, conditioned to expect punishment for infractions by a punitive parent, appears for a session depressed and guilt-ridden. She seems to demand that the therapist scold and punish her for having drunk to excess the evening before and for having acted sexually promiscuous. Not being able to stimulate this reaction in the therapist, the patient launches into an attack, upbraiding the therapist for passivity. The therapist continues to react in a tolerant and nonjudgmental manner, but interprets the responses of the patient in terms of her desires for punishment and forgiveness to propitiate aroused guilt feelings.

Severe manifestations of transference being rooted in infantile conditionings will usually require prolonged "working through." Strategically timed interpretations of the sources of transference in childhood experiences and fantasies, and of its present functions, will be required.

Among the most disturbing of transference resistances is that of the sexual transference, which takes the form of insistence that one can be cured only in a sexual relationship. While therapy may set off a temporary sexual attraction toward the therapist, this fascination usually disappears as therapy progresses or upon the simple structuring of the therapeutic situation. However, in some patients the sexual preoccupation becomes intense and persistent. A male patient, for example, will pick out from the behavior of a female therapist minor evidences that he will enlarge to justify his belief that the therapist must be in love with him. The protestations of the patient may greatly flatter the therapist, and the urgency of the expressed demands may tempt her to respond partially by touching or holding the patient. These advances are most provoking to the patient and incite greater sexual feeling. Should the therapist engage in any kind of sex play with the patient, this can have only the most destructive effect on both participants. Once the patient has even partially seduced the therapist, he may develop contempt for her weakness and for her abandonment of ethical principles. The therapeutic situation will obviously terminate with any expressed intimacy.

It is important in handling sexual transference not to make the patient feel guilty about sexual feeling. Rather, the feeling should be accepted and an attempt made to find out what it means in terms of the patient's past sexual attitudes and behavior. For instance, sex may indicate being accepted or preferred by someone. It may perhaps have the connotation of vanquishing or humiliating others. Sometimes reassuring comments are helpful in abating the patient's reactions. Thus the patient may be told, "It is usual for persons to develop such feelings for their therapist," or "It is good that you have these feelings because they will enable you to work out important attitudes and relationships," or "The *feeling* you have toward me is a step in your ability to feel and to relate to other people," or "This will serve as a means toward better relations with others." Where the patient brings in dreams and fantasies, it may be possible to interpret, with all the precautions already mentioned, the sources of the patient's transference reactions.

Another disturbing resistance is that of the hostile transference. Here the patient will react to the therapist as if convinced of the reality of the therapist's unfriendliness,

destructiveness, ineptness, seductiveness, and maliciousness. The patient will be importunate, irrascible, and insistent that it is the therapist who misinterprets and not he or she. The patient may become retaliatory or destructive in response to the therapist's fancied hostility, or may experience panic, depression, or psychosomatic symptoms. A resolution of hostility by the introduction of reality and by interpretation is indicated, following some of the suggestions given for the management of the sexual transference.

Where transference cannot be handled in any other way, active steps will have to be taken to minimize it. Such measures include a focusing in the interview on the current life situation rather than on early childhood experiences, avoidance of dreams and fantasies, discouraging discussion of the patient's relationship to the therapist, abandonment of the couch position and free association if these have been employed, decreasing the frequency of the interviews, presenting interpretations in terms of the character structure and current life situation rather than in terms of genetic determinants, and greater activity in the interview.

THE NEED FOR WORKING THROUGH RESISTANCE

Resistance may burn up the entire energy of the patient, who may self-defensively concentrate on fighting the therapist, or proving the therapist to be wrong, or winning the therapist over with gestures of helplessness, praise, or love, or seeking various means to escape or to evade treatment. The struggle is an intense one and usually goes on below the level of awareness.

When one appreciates the purpose of resistance, one realizes that patience is a great virtue. The therapist must bear with the neurotic individual as he or she progresses and takes refuge over and over again in customary defenses. Resistance is yielded only after a great struggle, for change is a painful affair.

Since resistance has a dynamic function, an effort is made to help the patient to relinquish it slowly. Too sudden removal may produce severe anxiety and may provoke a reinforcement of the neurotic defenses intended to protect the individual. Relinquishment

of resistance will thus be blocked by a threat of repetition of the anxiety experience.

Resistance is best managed by demonstrating its presence, its purpose, its ramifications, its historical origin, and the manner of its operation in the patient's present relationships with the therapist and with people in general. As resistances are gradually analyzed and resolved, repressed material appears in consciousness in a less and less disguised form. Resistances require a constant working through. A single interpretation of a resistance is hardly effective.

The therapist should allow resistance to evolve fully before taking it back to its origins. If a second resistance develops, the therapist must handle it by returning to the first one and demonstrating to the patient the interrelationship of the two. Tackling the patient's defensive reactions inevitably causes the patient to feel threatened and to dispute interpretations of his or her resistance. This reaction is opposed by a contrary motive, that of retaining the good will of the therapist. Often the patient will attempt to satisfy both of these motivations at the same time by abandoning his or her defense in the forms recognized by the therapist and changing it to a less obvious type. The understanding of these elaborations and their continued exposure forces the patient to take a real stand against them and, finally, to abandon them entirely.

It is always essential to remember that resistance has a strong protective value. Patients will usually reject any insight that is too traumatic, perhaps toying with it for a while, then forgetting it. However, through careful handling, insight into how and why the resistance is operating may be gained. First, the patient must be made aware of the resistance. Merely calling attention to it alerts attention to a specific task. It prevents burning up energy in pursuit of maintaining the resistance, constructively diverting it toward tracing down its meaning.

Once a resistance develops, it is essential to abandon other tasks until it is resolved, because the patient will not be productive while battling the therapist. It is best at first not to probe too deeply for unconscious material, but rather to work intensively upon the immediate interpersonal relationship. To aid in the process, the patient must be

impressed with the fact that there is nothing morally bad about showing certain defensive attitudes in the form of resistance.

The dealing with transference resistances may be a prolonged affair in the personality disorders. Here the ego seems blocked in absorbing the full meaning of the oppositional behavior as it becomes apparent. The patient may acknowledge the presence of certain drives. The patient may even understand their irrational nature and historical origin, but this pseudo-insight provokes little change in the customary life adjustment. The entire therapeutic process is intellectualized, the patient perhaps using insight to fortify himself or herself against anxiety. The patient's relationship with the therapist never proceeds to a level of good feeling that is shorn of hostility and inordinate expectations.

In infantile, narcissistic character structures particularly, intellectuality serves as a defense against unconscious impulses. Habitually there is a repression of the feeling aspects of the patient's personality, and mastery is sought through intellectual control. Any experience of feeling is regarded as catastrophic. By a curious transformation the defense itself may become a vicarious means of gratifying non-permissible drives as represented in hostile and sexual impulses.

Patients, who have a tendency to isolate emotional components from emerging unconscious material, may make the latter acceptable to themselves by repressing the affective content. Frequently they strive to neutralize their panic by means of attempted foresight and reason. During therapy they give the impression of being very active and at first seem to work extraordinarily well. Even though they make a brilliant feat of minutely analyzing their inner mental processes, little change occurs. Such patients may involve the therapist in long dialectic arguments that take on the nature of debates. Words replace action and constitute a defense against feelings.

Interpretation of this type of defense is bound to create great turmoil in the patient. The patient is prone to feel attacked and criticized by the therapist. "Negative therapeutic reactions" are common, the patient responding to important interpretations not with insight or relief, but with depression and discouragement. Hostility may be directed at the

therapist in an effort to annihilate the therapeutic work.

It is essential to remind every patient not to get too distressed if cure is not immediate. Some patients are confounded and depressed when they find, in spite of therapy, that they go on reacting in their usual ways. It may be necessary to explain that reaction patterns that have become established over a long period cannot be removed in a few sessions. They are habits that call for extended working through and reeducation.

In the event the patients insist they cannot get well because they are hopeless, the therapist may say, "You can express your hopelessness, but I will not go along with it. You can spend your energies feeling hopeless, and you don't need me for this; or you can spend your energies doing something about getting well in which case I can help you."

ILLUSTRATIVE CASE MATERIAL

Example 1

In this session, a female homosexual patient with a problem of dysphoria introduces a number of different resistances that block her progress.

> *Pt.* I keep losing my keys constantly. My mind can't seem to concentrate lately. I notice that the only time I want to think about my problem is when I come here. The minute I get out I feel relieved. When I leave here I notice my hands as very cold. *[This sounds like resistance in the form of intellectual inhibition.]*

> *Th.* I see. Can you tell me more about this?

> *Pt.* When I get out of the office, in waiting for the elevator, I push myself up against the wall pretending the wall to be Helen *(the patient's homosexual love object)*. I actually kiss that wall and I say, "Who does he think *he* is, trying to pull me away from my darling Helen. I won't have it, I just won't have it." *[This device seems to be a magical way of neutralizing therapy, which she interprets as a threat to her homosexuality.]*

> *Th.* What does it remind you of when you do that?

> *Pt.* Like being united with my mother. Everything seems to be O.K. again, and I can go on living. *[Having lost her mother in childhood, the patient's homosexuality, in part, is a neurotic attempt to reunite herself with her mother.]*

> *Th.* Mm hmm.

Pt. You see. I do that.

Th. But why do you think I want to take you away from your mother?

Pt. I see that. You see, the information I get here, I feel, is going to get rid of the old regime and bring on a new regime.

Th. And the old regime is what?

Pt. Homosexuality. That's strong. It's easier to live in than the new regime.

Th. And the new regime?

Pt. Is getting rid of the mother fantasy and working it out.

Th. So that you would consider any insights that you get here in a certain way.

Pt. As dangerous to my ability to function *(pause)* for the moment.

Th. So when you come here, I upset the balance and you may want to go to the opposite extreme.

Pt. I shift to the opposite extreme so I can function.

Th. You must perhaps think of me as a terrible person to do this to you. *[probing our relationship]*

Pt. You are a horror, *(said facetiously)* I adore you, you know.

Th. You do? Why?

Pt. You know I do. *[Our relationship, though ambivalent, seems good.]*

Th. In spite of what I do?

Pt. In spite of it. (*coughs*)

Th. Maybe I better stop doing this to you. *[challenging her desire for health]*

Pt. Hell, no. I don't go wild. There is a certain amount of control.

Th. The fact that you know all the reasons that exist for your problem . . .

Pt. (*interrupting defiantly*) Doesn't do me any good.

Th. You are still the arbiter of whether you'll do anything about the situation or not. But at least you have the right to know all the facts. There is no magic about this. The whole thing is your choice. Nobody is going to take anything away from you, you don't want to let go of.

Pt. But I don't have the ability to make a choice rationally, *(yawns)*

Th. Right now your choice would be irrational?

Pt. Yes, I'd choose homosexuality. But, not really. You know, my mind is wandering. I'm trying not to listen to you. You know what I'm doing now? I'm trying to figure out my school homework. *[Patient is aware of her resistance.]*

Th. Not paying attention to what I'm saying.

Pt. Isn't that awful. First I yawn and then my mind wanders. And I wasn't even aware of what I was doing. *[Again she recognizes her resistance.]*

Th. But now you've caught yourself.

Pt. I caught myself.

Th. There must be a reason why it's dangerous for you to integrate what we talk about. *[pointing out possible reasons for her resistance]*

Pt. I just won't listen to you. *(coughs)* I'll bet this throat business has something to do with it. Obviously.

Th. You sense your own resistance. Do you want me to leave you alone?

Pt. No, no. But I do want to get well.

Th. It may take time for you to overcome this problem. It started far back in your childhood. And you have been reacting automatically since.

Pt. You know, I didn't hear a word you said. My mind keeps wandering, *[more resistance]*

Th. Do you remember anything we talked about the last session?

Pt. Nothing. My mind's a complete blank. I can't pull myself together at all. (*coughs*) And you know why I can't do this?

Th. Why?

Pt. Because you are sitting back and judging me on my little speeches.

Th. I'm judging you?

Pt. It's not true, but that's how I feel. I sort of feel I'm on trial and that I'm likely to do things wrong. The same thing happens when I get up and speak in class. It's funny that I don't remember a damn word of what you said today.

Th. How about what I said to you last time?

Pt. Oh, I remember that, but I can't put it together.

Th. Suppose you try.

Pt. It's like the only thing that can give me pleasure is my homosexuality and my torture fantasies with masturbation. I feel that you will take these from me. I say to myself that if I let you take these things away, the time will come when I'll need them and I'll be without them. Take life's last spark away.

Th. No wonder you can't concentrate here, if you think this is what really is going to happen. As if there can't be a good substitute for your present pleasures.

Pt. But it's not entirely what I feel because I do want to get well. But I can't seem to do it today. When I leave here, I suppose I'll kiss that wall to get my equilibrium back. Or I will get a hopeless desire and sexual attraction for you. I don't want to listen to what you have to say. I just want to be close to you. *[transference resistance]*

Th. In a way that's the same thing as clinging to and kissing the wall? (I am not trying to discourage her transference, but merely to control its intensity.)

Pt. It is exactly the same thing. It's the same thing I have about Helen. Intellectually I'm not interested. I want to get into bed with her. So stop talking and let's have sex. That's how I feel about you. Same kind of feeling.

Th. Sex appeases your tension? Is that what you really want exclusively?

Pt. Obviously not, but I can see how this operates. And another crazy thing I do. When I leave here and get onto the street, I imagine you are watching me from the window. I get into my car and roar off.

Th. What does that mean to you?

Pt. It's like I get my masculinity back again.

Th. Which means you feel you lose it when you come here?

Pt. (laughs) Yes, I really do. I know that's silly. I say, "I'll show him. I'll roar off. I'll show him he can't make me into a woman." I try to get my feeling of power. (*laughs*) How silly can you get?

Example 2

A patient comes in with a hoarseness so severe that she can hardly talk. This symptom came on her several hours prior to her session and was not accompanied by any other signs of a head cold. Exploration reveals the symptom to be a manifestation of various resistances.

Th. I wonder if you have been at all emotionally upset prior to this hoarseness, *[focusing on possible emotional sources of the symptom*]

Pt. I don't know what you mean.

Th. Are you aware of anything emotional that is happening right now? (*long pause*) What about your feeling about therapy?

Pt. The only thing I can say now, which is nuts, is that I'm scared to death of you. *(pause)*

Th. The way you look at me is suggestive that you are afraid of me. (*The patient has a frightened expression on her face.*)

Pt. I was always aware that I had a tenseness before, but it never was like this. (*The patient is so hoarse it is difficult to make out what she is saying.*)

Th. What do you think this is all about?

Pt. I don't know, *(pause)*

Th. Have you had any dreams?

Pt. Yes, I had one dream I can hardly remember. It's scrambled, *(pause)* I dreamed I was in some sort of clinic. It was your clinic. *(pause)* And there was a young chap there who was very attracted to me. He was there for treatment too. I liked him, and he liked me. But I was a patient at the clinic and I was working there, both. I talked to a group of people on the stairs. You were there as an onlooker in a benevolent way. And I was kidding. I said I want to go to Paris and live a couple of years. But this guy I liked and I decided we would have to take you with us. We have to take Dr. Wolberg with us because we have to finish this treatment. I looked at you and said, "That's involved for you, isn't it?" You laughed. It was all said in fun. Then this young chap and I decided to go home, and we walked and walked. And all of a sudden it occurred to me that I was walking without any trouble at all. *(Among the patient's problems are muscular pains and arthritis complaints in both legs which make it hard for her to walk.)*

Th. Mm hmm.

Pt. (pause) And then I was back in the clinic, and this young chap said he wanted me to do his analysis. I said that's impossible. And he sort of grinned at me and disappeared out of the door. That's all I can remember. *[The thoughts that come to my mind are that the patient may represent herself in the dream as her feminine component and the young man as her masculine component. She wants to return to narcissism (loving the man) and feels she can function this way (being able to walk). However, she is unwilling to give up her dependency on me (returns to the clinic) and she relinquishes her masculine component (the man disappears out of the door). Another possibility is that the young man is a disguised symbol for me toward whom the patient feels she can express an erotic feeling. In this way she can dissociate her sexual feeling for me from her therapy. Working further on the dream may disclose its meaning.]*

Th. When did this dream occur?

Pt. Last night.

Th. What are your associations to it?

Pt. (pause) I'm blocked off on associations, *(pause)* I'm blocked off on thinking. I'm in a complete state of suspension, *[intellectual resistance]*

Th. What in the dream might give you clues about your fear of me? What might you be planning or thinking of that would make you afraid of me?

Pt. Well, when I said I want to go to Paris, I might want to run away.

Th. What does Paris mean?

Pt. If I could do what I want to do, I'd go to Paris for a couple of years. I love it, just adore it. I love the French people, their relaxation and acceptance. It was wonderful.

Th. What does Paris symbolize to you?

Pt. Fun and sex. It's a sexy place.

Th. And here you wanted to go with this young man.

Pt. Yes, he was cute. (*laughs*)

Th. Was there a sexual feeling about that dream?

Pt. Oh, yes, sure. I was all for this guy. I'll tell you who he was. I never thought of it until now. He was a guy I met at Bob's party last Wednesday night. He turned out to be a young psychiatrist, and he knew you. Which is connected with you. So there you are.

Th. So you really felt attracted to him.

Pt. Yes, but had to take you along.

Th. Why do you think you had to?

Pt. Obviously you two are the same.

Th. So that you may have sexual feelings for me and project them onto another person, or you have a fear of sex and also fear disappointment. [*tentative interpretation*]

Pt. {sighs) Couldn't that be the same thing?

Th. It might. There may also be a desire to leave your therapy and run off and have fun, and wonder about my disapproval of that. There may be many things. What do you think? *[tentative interpretations]*

Pt. Consciously I'm not aware of wanting to run away from therapy. It's very painful to me as you can see. I wouldn't be happy getting out of it; I'd only be happy getting through with it. But the sexual thing troubles me.

Th. What about any sexual feelings toward me?

Pt. I think I've always had that. I block off though and can't talk about it. It's almost impossible. [*She recognizes her resistance.*]

Th. What does talking about the feelings do?

Pt. Make me scared of you. I don't want to talk about it. I'm sure that's what's happening to me now, *(pause)* I'm just preventing talking, that's all. *(pause)* And I feel silly. [*This indicates an awareness that her hoarseness may be a form of resistance against verbalizing sexual feelings toward me.*]

Th. Silly about your feelings?

Pt. Mm hmm. *I* think it does. All my life I've covered up important things, so to let it out is an almost impossible thing. I talk about sex often in a pseudosophisticated way. I can make smart cracks faster than anybody I know, but it has nothing to do with me. To talk about my sexual feelings—no, no. The minute it touches me, I clam up.

Th. Yet you haven't been too inhibited in your sex life.

Pt. I think I was a great deal, even though I didn't act it. *(pause)* I just thought of a dream I had in which you kissed me. I told you about it two months ago. From that time on I haven't been able to talk about my sexual feelings for you.

Th. Mm hmm.

Pt. When I'm lonesome I say you are very attractive to me sexually, *(pause)* I feel sexual contact with you is forbidden, like it would be with a father. *(The patient's voice is much clearer now, as if her hoarseness is vanishing.)*

Th. If it's true that you feel extremely guilty about having sexual thoughts about me, that would cause you not to want to tell me your thoughts, [*interpreting her resistance*]

Pt. That comes close to it, I think. It's silly. *(laughs)* I'm beginning to see through you. *(The patient's voice is very clear at this point, her hoarseness having subsided considerably.)*

Th. What do you mean?

Pt. You're trying to make me talk about you. All right, *(laughs)* I have varying emotions about you. First, I say, "To hell with that bastard, I won't go back to see him." Then I say, "That's what he expects me to do, so I shall go back to see him." And then I say you are trying to be my friend, trying to do something decent. Then I get contrite about having had bad thoughts. All of which is a bunch of crap. I know it as well as you know it.

Th. So you must feel resentful toward me sometime.

Pt. I feel, *(long pause)* I feel now, and I have for the last few times I've seen you, that all of the threads that have bothered me have all come together in one knot, which knot has become

you. If I can get that knot untied, then I'll be free. All the other things that bothered me are minor. I'm pulling out everything I have to resist you.

Th. Resist me in what reference?

Pt. Horribly enough I'm afraid it's a resistance to getting cured, *[recognition of resistance of normality]*

Th. You sound disgusted with yourself.

Pt. I am.

Th. What might cure do to you?

Pt. Well, it could put me back to work. It could eliminate all my excuses for not doing things. It could make me take an aggressive and active role. It could make me stop drinking and take that fun away from me. It could make me take a decisive action about George *(her husband).* I've come through the labyrinth and I'm up to the door, and I'm just resisting like hell. *[The patient elaborates her many resistances against normality.]*

Th. You must be frightened. Because that door is the door people want to reach.

Pt. That's what I've been coming here to reach.

Th. And now that you're approaching it, you are a little afraid of it.

Pt. I'm scared as hell, but I'm beginning a little to understand it.

The following is an excerpt of the very next session that brings out some interesting points:

Pt. I had a very peculiar reaction. Of course, it is almost impossible for me to say it. a very peculiar reaction last time. And I don't know what it was that was said, whether it was something I said or something you said, I don't know. But it was something in connection with our conversation, our relationship. Then all of a sudden I got a "cat-and-canary" deal, which you knew perfectly well, because you couldn't help but see it on my face. I don't see how you couldn't, and then just as I left, I said, "I feel like you're laughing at me." I knew that you weren't laughing at me in the sense of being nasty, but you knew damned well I wouldn't tell you what was on my mind. And, of course, that's the hell of the "cat-and-mouse" thing, because I'm perfectly aware that you know what's on my mind. Or at least you know very well whether I'm holding something back and won't say it or not. And I know that you know; so, therefore, I get into one of these, as I say, "cat-and-mouse" deals.

Th. What makes you feel that I can read your mind, that I know what you're holding back?

Pt. I'll bet 99 times out of 100 you do. It's very difficult, and I feel very silly. Whatever it was, whether that was a part of it or something else, I got a reaction of being very silly and ingenue, and very ridiculous, and I couldn't get over that feeling. Now what tossed me into that?

Th. When did you get this feeling?

Pt. Sometime during the last part of our conversation last time. I don't remember very much what we said, only that I think you asked me how I feel about you.

Th. How *do* you feel?

Pt. Giddy.

Th. Giddy?

Pt. Yeah. I think when I use the word "silly" I probably mean that, *(pause)*

Th. How did you feel *I* must have viewed you? Was it that you thought *I* thought you were silly?

Pt. Yeah. I imagine that's it.

Th. Well, why?

Pt. *(pause)* My reaction when I left was that I wanted to put my arms around you and kiss you. Now whether that is a little-girl reaction or not, I don't know. But that was the feeling I had.

Th. You felt affectionate?

Pt. Yeah. And then I think that's probably why I felt embarrassed. I felt I *(laughs)* wanted to go over and sit on your lap, like a little girl, and I'm probably older than you are.

Th. You think I think you're silly if you want to do that?

Pt. Probably because I had the idea that you've been trying to make me grow up. And goddamn it, I don't want to grow up.

Th. If this is what you feel, this is what you feel. Let's try to understand it. Suppose you do feel like putting your arms around me or sitting on my lap. Do you think there is something wrong with that?

Pt. Apparently I do. I don't think so, but I *feel* there is. I must or I wouldn't react that way. And when I get the "cat-and-canary," as they say, the "cat-that's-robbed-the-canary-look" on my face, I usually have something in my head, which I entertain, which I think is not in order. *(pause)*

Th. You know it is rather interesting that you find it so hard to mention to me what had happened, *[focusing on resistance]*

Pt. Sometimes I'll go for months and won't mention some things to you. And it isn't because I want to hide something. That's the goddamned mechanism of this thing. I blurted out and told you the last time, but, of course, by the time I get to talking about things, it's just when I'm putting on my coat. Like last time I kicked myself around the block when I got outside. I thought, why that's perfectly silly, why shouldn't I have said that; I've said every other

goddamned thing. It's a wonder I came back today and said it. Because sometimes I might go for months and I might talk about every subject in the world. But some little thing like that which apparently has significance for me, I can't talk about.

Th. Perhaps it had such deep significance to you for a special reason?

Pt. Well, I find you attractive, *(laughs)* It's silly, but I have a thought it would be nice ... last time what I failed to say was that I thought it would be nice to go to bed with you. But it kills me to tell you that. [*sexual transference*]

Th. Perhaps you wonder what my reaction would be.

Pt. I can remember one instance now. I don't suppose it was the type of person. It was probably the way I was feeling at the time. But usually men have approached me and I pretty much took what I wanted and left what I didn't want alone. That's always the case. A few times I thought someone was awfully cute, and I have deliberately gone after it, trying to look undeliberate. The exception was this once, and I can't remember who this man was. I think I'd read it in a novel, and I decided to try to ask a man to sleep with me, and did. And the result was disastrous. He ran like he was hit by a poisoned arrow.

Th. I see.

Pt. This guy ran. I don't think I ever did see him again. I remember now. Yeah. To show you that I'm embarrassed about it, I can't remember his name. Anyway, he was a guy that I went to Viriginia with. I was going on my business. He was going on his business. He was trying to make a business deal with me. He was very good looking, and he was my type. He was dark and not too damned tall and big, and I thought he was very attractive. I had lunch with him several times. And so I was going to Richmond. And I said at lunch one day that I was going to go to Richmond on such and such a day. And he said, "What are you taking?" And I told him the train number. And I got on the train, and he had the compartment right next to me. That I've never figured out. Maybe it was just luck. So anyway, he started making love to me. He came in to my compartment, and we were having a couple of drinks, and we were talking. And he started making love to me and all in a roundabout way, an inch at a time, an inch at a time. He put his arms around me first, and all the powwow they go through. So I thought this is going to be silly. I'd been thinking about it for weeks. That looks good. I'd like to have that when I can get a hold of it. So I just turned and looked at him. I said, "You don't have to go through all this, because I *want* to sleep with you." And it scared the hell out of him.

Th. Do you feel that maybe you're afraid of being outspoken with me too?

Pt. Goddamn it, yes. (*laughs*) I see it now. I must be afraid. You will run off and leave me if I'm too outspoken. My parents never let me speak my mind. Everything I learned I got out of being on the go with the other kids on the street. *[We continue to explore her sexual feelings toward me.]*

The Management of Untoward Attitudes in the Therapist, Including Countertransference

Two people locked up in the same room are, sooner or later, bound to find their difficulties rubbing off on each other, each personality influencing the other. The patient will regard the therapist in many ways, such as (1) an idealized parental figure, (2) a symbol of the parents and of authority, and (3) a model after whom one seeks to pattern oneself. A therapist too responds to a patient in various ways. There is a tendency to project onto the patient one's own prejudices and values as well as to identify the patient with individuals from one's own past. The therapist's reactions are bound to influence those of the patient. In recognition of the fact that a therapist cannot truly act as a blank screen, no matter how thoroughly adjusted one is, many therapists have devoted themselves to a delineation of the clinical effects of what they have called *countertransference* (Balint & Balint, 1939; Berman, L, 1949; Bonime, 1957; Cohen, M, 1952; Gitelson, 1952; Heiman, P, 1950; Little, M, 1951; Orr, 1954; Rioch, 1943; Salzman, 1962; Tauber, 1964; Winnicott, 1949; Wolstein, 1959). The importance of countertransference is that it influences all forms of psychotherapy—supportive, reeducative, or reconstructive—sometimes to their detriment, sometimes to their benefit.

The idea that countertransference is always bad has in recent years been revised (see Chapter 5, 57). Countertransference may be used in a therapeutic way. Therapists, recognizing that their own neurotic feelings are being activated, may look not only into themselves, but also into what neurotic needs and drives in their patients are activating in their personal reactions. They may then bring up these provocations as foci for exploration. They may ask, "Is the patient aware of aberrant impulses and behaviors? What does the patient want to accomplish by them?" Confronting the patient with the behavior may have a therapeutic impact.

Accepting the benefits of some countertransference reactions, we shall in the

remainder of this chapter concern ourselves with its negative effects that account for a great many failures in psychotherapy.

Conceptions about countertransference are multifaceted. These range from the traditional idea that it is exclusively confined to feelings derived from repressed unresolved parental attachments (Winnicott, 1949) to strivings provoked by anxiety (Cohen, M, 1952) to the total range of attitudes of the therapist toward the patient (Alexander F, 1948). The tendency to dilute countertransference with reactions emerging from the habitual character structure has created some confusion. Befuddement also comes from the tendency to identify all positive or negative feelings toward the patient as forms of countertransference. The therapist as a functioning human being will have a warmth toward, a liking for, and empathy with patients—more with some than with others for realistic reasons. The therapist will also be candidly angry with certain actions of patients, the display of which toward the patient may not at all be destructive. Indeed, the patient may be traumatized by the therapist's failure to respond to provocations with justified indignation or rage. However, the reactions we are concerned with most in psychotherapy are responses of the therapist not justified by reality but which issue either out of the therapist's own transference or that emerge as expressions of the neurotic character structure. Therapeutic manipulations fostered by the therapist's needs, rather than by those of the patient, are bound to create rather than to solve problems (Lorand, 1963a).

Where disciplined in self-observation, the therapist may become cognizant of troublesome attitudes and feelings toward patients before expressing them in behavior. The more insight one has into one's interpersonal operations, the more capable one is of exercising any necessary control. Where there is little understanding of one's unconscious dynamisms, the therapist is most apt to respond with unmanageable negative countertransference.

An illustration of how countertransference may act to the detriment of therapeutic competence may be cited by the case of a male therapist who, well trained and endowed

with more than the usual warmth toward people, was able to achieve good results in psychotherapy with most patients. Notably defective, however, were his results with male patients who had serious difficulties with women. The therapist himself was involved in conflict with his wife, the details of which he was not at all loath to verbalize. This was undoubtedly a manifestation of his unresolved problems with women. Whenever his male patients divulged their difficulties with their wives, the therapist would immediately respond with rancor and vehemently denounce the chicanery of scheming females. This attitude, while temporarily comforting to some patients, ultimately resulted in their distrust of the therapist, engendered by a realization that they could never work through with him some of their basic life problems.

It is rare indeed that a therapist, irrespective of how free one is from personality blemish, can respond with completely therapeutic attitudes toward all patients. With some patients one may display an adequate degree of sensitivity, flexibility, objectivity, and empathy, so helpful to good psychotherapy. With other patients one may manifest a lack of these qualities and an inability to perceive what is happening in the treatment process. There will be a failure to recognize neurotic projections in the relationship, and to remain tolerant in the face of the patient's irrational and provocative behavior. Thus, infantile requests by the patient for exclusive preference, or sexual responsiveness, or expressions of resentment and hostility, or unfounded complaints of being exploited, may bring out in the therapist attitudes that interfere with a working relationship.

> If the analyst cannot identify with the patient, he will encounter difficulties, but identification in turn leads to other difficulties ... the analyst then experiences the patients' intense anxieties fears, rages, lusts and conflicts as his own, and unless he faces these problems and deals with them directly, he may resort to controlling devices to allay the patient's anxiety and his own—such as excessive tenderness or other devices similar to those employed by the patient's parents, or he may resort to primitive defenses similar to those used by the patient, especially paranoid defenses. (Savage, 1961).

Character distortions in the therapist will inevitably have an effect on the patient. Thus, a need in the therapist to be directive and authoritarian, while advantageous in supportive approaches, tends, in insight therapy, to interfere with the individual's growing sense of self, expanding assertiveness, and independence. Authoritarian attitudes also

pander to dependency strivings in the patient and coordinately nurture rebellious tendencies. Some therapists are driven by pompousness to make too early and too deep interpretations, which they hope will impress the patient with their erudition and perceptiveness. They may also attempt to force the patient into actions before the latter is ready for them. However, this playing of a directive role with the patient to satisfy certain emotional needs in the therapist must not be confused with a deliberate extension to the patient of emotional support when this is therapeutically indicated. The former is usually based on the motivation to parade one's power and omniscience; the latter is a studied, measured giving of help that is inspired by the needs of the patient.

Tendencies toward passivity and submissiveness in the therapist may also have a detrimental effect on treatment since it is sometimes necessary to be firm with the patients, as in helping them to avoid retreat, to execute insight into action, and in offering them essential guidance and reassurance. Submissive traits in the therapist, furthermore, operate to bring out sadistic, hostile attitudes in the patients.

Impulses toward detachment may develop in the therapist as a defense against entering into close contact with some patients. This trait is particularly destructive to the therapeutic relationship. The patient may be able to establish some sort of relatedness with a domineering or a passive therapist, but is totally unable to relate to one who is detached.

A therapist who, because of personal anxiety or a depriving life situation, is thwarted in the expression of certain basic drives may attempt to live through them vicariously in the experiences of the patient. The therapist may, therefore, tend to overemphasize certain aspects of the patient's behavior. Thus, if the patient is in a position of fame, or is financially successful, or is expressing sexual or hostile impulses, the therapist, if there is the unconscious need to satisfy such strivings, will focus unduly on these perhaps to the exclusion of other vital psychic aspects. This loss of perspective is particularly pronounced where there is any overidentification with the patient.

Neurotic ambitiousness may cause the therapist to glory in the patient's

accomplishments and to push the patient inexorably into areas that are calculated to lead to success and renown. Overambitiousness may also be extended toward seeking rapid results in treatment. Here the therapist will be unable to wait for the gradual resolution of resistance. Accordingly, the exploratory process will be promoted too hurriedly at the beginning of therapy. Perturbed by the slowness with which the patient acquires insight, the therapist may interpret prematurely, and then respond with resentment at the oppositional tendencies of the patient. The therapist may also propel the patient too vigorously toward normal objectives and then become frustrated at the patient's refusal to utilize insight in the direction of change.

Due to anxiety or guilt, it may be difficult for the therapist to countenance certain needs within himself or herself. When such needs appear in the patient, the therapist may exercise attempts to inhibit their expression. Difficulties here especially relate to impulses toward sexuality, hostility, and assertiveness. Should the patient introduce these topics, the therapist may act disinterested or may focus deliberately on another area. The therapist may be unaware of these personal psychic blind spots that prevent exploring anxiety-inspiring conflicts in the patient. Thus, a therapist who has problems in dealing with hostility, may, upon encountering hostile expressions, reassure the patient compulsively or channelize verbalizations toward a less threatening topic. Fear of hostility may also cause the therapist to tarry, to lose initiative, and to evidence confusion on occasions when the patient attempts to act in an aggressive or assertive way. Fear of special aspects of the patient's unconscious may cause the therapist to circumvent the discussion of pertinent material to the detriment of reconstructive therapeutic goals.

Other limiting personality manifestations may reflect themselves in neurotic attitudes toward money with an overemphasis of fees and payments, in an inability to tolerate acting-out tendencies in the patient, and in a tremendous desire for admiration and homage. Perfectionistic impulses may cause the therapist to drive the patient compulsively toward goals in treatment that are beyond the patient's capacities. At times some therapists, under pressure of their own neurotic drives, may set up a situation in treatment that parallels closely the traumatizing environment of the patient's childhood.

When this happens, the patient's transference may become extreme and perhaps insoluble. Certain patients may mobilize in the therapist strong feelings of rejection and intolerance, which will destroy the emotional climate that is so important for personality development. Other therapists, burdened with narcissism, and needing to impress the patient constantly with their brilliance, may utilize interpretation too freely and water down the therapeutic process with intellectualizations.

It must not be assumed that all neurotic displays on the part of the therapist will have a bad effect. If they play into the patient's immediate needs, they may bring the patient to a rapid homeostasis. Thus, a sadistic therapist may be eagerly responded to by a masochistic patient. An authoritarian, domineering therapist may satisfy the dependent impulses of a depressed person. Restoration of equilibrium will not, of course, alter the basic personality structure. Important to consider also is that growth in a psychotherapeutic relationship with a neurotic therapist may occur in patients with essentially good resources. Such patients will select out of positive aspects of the therapeutic situation elements that they can utilize constructively. They may rationalize the therapist's neurotic weaknesses, or not pay attention to them, or simply blot them out of their cognitive field. It is to be expected that perceptive patients will eventually discover some neurotic patterns or traits in their therapists. This may at first result in disillusionment, anxiety, resentment, or insecurity. If the relationship is a good one, however, there need be no interference with the therapeutic process, the patients ultimately adjusting themselves to the reality of a less-than-ideal therapist image. It may actually be helpful to discard the mantle of perfection with which the therapist has been draped in the early part of therapy. The degree and kind of neurotic disturbance in the therapist is what is important.

At certain phases in treatment therapist improprieties may become more pronounced than at others. For instance, during periods of resistance the therapist may respond with aggressive or rejecting behavior. Some actions of the patient may also stimulate countertransference. A patient who is frankly seductive may stimulate sexual feelings in the therapist; one who is openly antagonistic may precipitate counterhostile

attitudes. The patient may be sensitive to the moods of the therapist and work on these for specific gains, the most insidious effect of which is a sabotaging of the treatment effort.

Because countertransference may result in therapeutic failure, it must be handled as soon as possible. Where recognized, the therapist may be able to exercise some control over it. There are therapists, who, though unanalyzed themselves, have an excellent capacity for self-analysis and an ability to restrain annoying expressions of countertransference. This permits the therapeutic process to advance unimpeded. A therapist who has undergone successful personal psychotherapy or psychoanalysis will still be subject to countertransference from time to time. Nevertheless, one should, by virtue of one's training, be capable of detecting and of managing troublesome reactions as soon as they develop.

Instead of denying a neurotic response to the patient, which is so common, some therapists, detecting their own untoward responses, admit them openly and even analyze them with the help of the patient. Alger (1964) suggests that the therapist should "deal with these feelings in no way different than he deals with any other of his reactions. By this is meant that he be willing to include all the reactions he has while he is with his patient as part of the analytic data of that particular situation. ... In this view, the analysis then becomes a joint activity in which two participants attempt by mutual effort to assemble and openly share with each other their perceptions, their concepts, and most importantly their own feelings." Such therapeutic license will call for great skill on the part of therapist, to say nothing of personal courage.

One way of acquiring this skill is to examine oneself honestly rather than defensively when attacked or criticized by a patient. To be sure, it is impossible for a therapist to maintain a consistent attitude toward or interest in patients at all times. Names and events may be forgotten, indicating to the patient lack of rapport; appointments may be broken or confused, connoting unconcern; irrelevant comments may be made, pointing to "noncaring-ness"; tension and anxiety may be expressed, suggesting instability. Irrespective of the reasons for the therapist's reactions, awareness of what one is doing

and willingness to admit one's failings when they are discerned by the patient is of paramount importance. There is nothing so undermining to a patient as to have an observation, predicated on fact, dismissed as fanciful, or to have an obvious error on the part of the therapist converted into a gesture for which the patient is held responsible. Where the therapist is capable of admitting a blunder and of conveying to the patient that this does not vitiate respect and interest, the liability may actually be converted into an asset.

Certain therapists have taken this as license to articulate every aberrant thought and impulse to the patient, and even to act out with the patient. While this may be accepted by some patients as indications of the therapist's genuineness, it is destructive for most patients who expect the therapist to function as a rational authority. Therapists who are basically detached, and who are obsessively preoccupied with neurotic impulses, may, nevertheless, come through to the patient more sincerely as people when they engage in such random and undisciplined behavior than when they assume the straitjacket of a "therapeutic" attitude. From this experience of unrestraint, however, they may devise a theory and formulate methodologies, predicated on being free and abandoned in the therapeutic relationship, a stance that for most professionals will prove to be antitherapeutic.

Detection of countertransference and character distortions may not be possible where deep unconscious needs are pressing. It is this unawareness of their inner drives that so frequently causes therapists to rationalize them. Indeed, the very selection of certain methodologies and kinds of therapeutic practice are often determined by unconscious motivations. Thus, a therapist, basically passive, who fears human contacts and has evolved a detached manner as a defense, may be attuned to schools in which extreme passivity and nondirectiveness are the accepted modes. Or, if by personality domineering and aggressive, a therapist may be inclined toward endorsing the doctrines of those schools that advocate directive or coercive techniques.

MANAGEMENT OF COUNTERTRANSFERENCE

Those aspects of countertransference that reflect the projection of a patient's unconscious process may enable a sensitive therapist to detect unverbalized needs and conflicts. How to deal with countertransferential feelings constructively will depend on how skillful the therapist is in making interpretations and the readiness of the patient to accept such interpretations. It is essential that confirmation of the therapist's intuitive hunches be obtained from other sources of information such as the patient's nonverbal behavior, dreams, slips of speech, free associations, and acting out episodes. The therapist may have to delay interpretations until a strategic time presents itself. The manner in which interpretations are made will also determine how they will be accepted (see Chapter 45).

Some of the patient's actions may stir up realistic angry feelings in the patient that have nothing to do with countertransference. Here it is necessary to judge how propitious a disclosure of such feelings may be. It is sometimes important to verbalize one's angry feelings toward a patient who is behaving in a self-defeating and provocative manner, especially when there is no need to build up a transference neurosis. Such verbalization is not done in a punitive way, but rather as a means of bringing the patient to an awareness of how the patient comes through with people and why reactions toward him or her are less than congenial. Where the patient is in a negative transference toward the therapist or the transference is acting as resistance to therapy, the therapist must control angry feelings and work on the interpretation of the transference to get therapy "back on the tracks."

Since some negative countertransferential reactions are unavoidable, most likely breaking through when the therapist's emotional reserve is taxed or when the therapist is distraught and upset, the question arises as to what one can do to neutralize their antitherapeutic effect. Signs of countertransference include impatience with the length of a session or resentment at having to terminate it, doing special out-of-the-ordinary things for select patients, dreaming about a patient, making opportunities to socialize with the patient, sexual fantasies about the patient, unexplained anger at the patient, boredom with the patient, impulses to act out with the patient, and refusal to terminate when planned

goals have been achieved.

In order to become sensitized to one's own neurotic manifestations when they appear, all therapists should subject themselves to self-examination throughout the course of therapy. Such questions as the following are appropriate:

1. How do I feel about the patient?

2. Do I anticipate seeing the patient?

3. Do I overidentify with, or feel sorry for the patient?

4. Do I feel any resentment or jealousy toward the patient?

5. Do I get extreme pleasure out of seeing the patient?

6. Do I feel bored with the patient?

7. Am I fearful of the patient?

8. Do I want to protect, reject, or punish the patient?

9. Am I impressed by the patient?

Should answers to any of the above point to problems, the therapist may ask why such attitudes and feelings exist. Is the patient doing anything to stir up such feelings? Does the patient resemble anybody the therapist knows or has known, and, if so, are any attitudes being transferred to the patient that are related to another person? What other impulses are being mobilized in the therapist that account for these feelings? What role does the therapist want to play with the patient? Mere verbalization to oneself of answers to these queries, permits of a better control of unreasonable feelings. Cognizance of the fact that one feels angry, displeased, disgusted, irritated, provoked, uninterested, unduly attentive, upset, or overly attracted may suffice to bring these emotions under control. In the event untoward attitudes continue, more self-searching is indicated. Of course, it may be difficult to act accepting, non-critical, and nonjudgmental toward a patient who is provocatively hostile and destructive in attitudes toward people, and who possesses

disagreeable traits that the therapist in everyday life would criticize.

The ability to maintain an objective attitude toward the patient does not mean that the therapist will not, on occasion, temporarily dislike many of the things the patient does or says. Indeed, one may become somewhat irritated with any patient on certain occasions, especially when being subjected to a barrage of unjust accusations, criticisms, and demands. The stubborn resistances of the patient to acquiring insight and to translating insight into action, and the clinging of the patient to attitudes and action patterns that are maladaptive and destructive, will tax the endurance of any therapist, no matter how well integrated one's personality may be. But the capacity to understand one's own feelings will help the therapist better to tolerate the neurotic strivings of the patient and to maintain a working relationship.

To illustrate how a therapist may control countertransference, we may consider the case of a patient who is having an affair with the wife of his best friend and feels exultant about this situation. The therapist, repulsed by the enthusiasm and sexual abandon displayed by the patient, may, therefore, have a temptation to interpret the situation as a disgraceful one, with the object of putting pressure on the patient to give up his paramour. With this in mind, the therapist may enjoin, order, or suggest that the patient stop seeing the woman in question or desist from having sexual relations with her. Should the therapist step in boldly in this way, the interference will probably be resented by the patient. Indeed, transference may be mobilized, the patient regarding the therapist as a cruel, depriving, dangerous mother or father who prohibits sex or freedom. An artificial note will thus be injected into the relationship, the patient utilizing his affair as a means of defying the therapist. Not only will the patient continue in his infatuation, but the therapeutic situation may deteriorate. Or the patient may yield to the therapist's suggestion and give up the relationship with the woman and then become depressed and detached, as if he has been forced to relinquish something precious. He will feel that his independence has been violated.

In attempting to control one's responses, the therapist may indulge in self-searching.

Realizing moralistic attitudes, the therapist is better capable of keeping in the forefront the general principle that, right or wrong, the patient is the one who must make the decision about continuing in the affair or giving it up. Accordingly, instead of suggesting to the patient that he stop the illicit relationship, the therapist may say:

"Now here is a situation that seems to have a good deal of value for you. You get fun out of seeing your friend's wife, but you also see that there are difficulties in the situation. Now suppose we discuss the good and bad sides of your predicament." The patient then will verbalize his feelings about the virtues as opposed to the liabilities of his intrigue. Thereupon, the therapist may remark: "Here, you see, there are values as well as liabilities in the situation. It is important for you to consider all the facts and then decide the course of action you want to take." In this way the therapist strives to keep personal feelings from influencing the patient. The patient is then better equipped to evaluate what is happening and to plan his own course of action.

It is unnecessary for therapists to feel that they must strap themselves into an emotional straitjacket to avoid upsetting the patient. Nor is it essential that they be paragons of personality virtues to do good psychotherapy. As long as one is reasonably flexible, objective, and empathic, and provided that a working relationship exists, one may indulge a variety of spontaneous emotional responses, even some that are neurotically nurtured, without hurting the patient or the therapeutic situation. Actually, the patient will adjust to the therapist's specific personality, if it is sensed that the therapist is a capable, honest, non-hostile person who is interested in helping the patient get well.

For example, a therapist may be inclined to be active and somewhat domineering. The patient may then exhibit toward the therapist the usual attitudes toward domineering and authoritative people: the patient may become fearful, or hostile, or submissive, or detached. As the therapist interprets these reactions without rancor, the patient may challenge the therapist's overbearing manner. The therapist, if not threatened by this stand, will acknowledge the operation of some domineering tendencies. The very fact that the therapist admits responsibility, may give the patient a feeling that he or she is not

dealing with the image of imperious authority. The patient may then question the facades and defenses that automatically are employed with authority, and may countenance a new kind of relationship. In working out this aspect of the problem, the patient will undoubtedly see connections with other personality facets and begin working on these also.

If, on the other hand, the therapist acts in a passive, retiring way, basic attitudes toward passive people may emerge. Thus, the same patient may become disappointed, sadistic, or depressed. The therapist, observing such reactions, will be able to bring the patient to an awareness of why these tendencies are being manifested. The patient will learn by this that the therapist is really not an inconsequential person, in spite of a quiet manner. Indeed, the patient may discover personal qualities of need for a godlike authority as well as contempt for any lesser kind of human being. An important aspect of the problem will then be resolved. With this resolution other aspects will come up for consideration, such as the patient's attitudes toward domineering people. Thus, even though the patient deals with two entirely different reactions on the part of the therapist, basic difficulties will have been managed and hopefully worked out.

What is important, therefore, is not whether the therapist has an impeccable personality that admits no negative countertransference, but rather that prevailing distortions can be sufficiently reduced, controlled, or explicated to provide the patient with a suitable medium in which to work through neurotic patterns.

A basic assumption in insight approaches is one made originally by Freud that was to the effect that once the individual becomes aware of unconscious motivations, one can then alter one's behavior and get well. That this fortunate consequence does not always follow (a circumstance also recognized by Freud) is the disillusioning experience of many young therapists, who have predicated their futures on the premise that analysis of resistances will inevitably bring forth insight and cure like a sunbeam breaking through a cloud.

The fact that a patient acquires a basic understanding of the problems and delves into their origins as far back as childhood, does not in the least guarantee being able to do anything about them. Even if an incentive to change is present, there are some patterns that cling to a person obstinately as if they derive from a world beyond the reach of reason and common sense. The patient is somewhat in the position of the inveterate smoker who has been warned by the physician to give up tobacco at the risk of an early demise, or of the obese hypertensive who pursues gluttony with avidity while reviling his or her weakness and lamenting an inevitable doom. Chided by the physician to reduce weight to avert the threat of a coronary attack, the patient is unable to avoid overstuffing with the foods marked taboo on the reducing chart, irrespective of how thoroughly the patient appreciates the folly of intemperance. In the same way, repetitive compulsive patterns lead an existence of their own seemingly impervious to entreaty or logic.

Complicating this enigma further is the fact that the acquisition of even inaccurate insights may register themselves with beneficial effect, particularly if the therapist interprets with conviction and the patient accepts those pronouncements on faith. Marmor (1962) has implied that "insight" usually means the confirmation by the patient of the hypotheses of the therapist that have been communicated by various verbal and nonverbal cues. Having arrived at a presumably crucial understanding as indicated by

approving responses from the therapist, the patient experiences what is essentially a placebo effect. The restoration of the sense of mastery reinforces further belief in the validity of the supposition, and encourages the patient to search for further validations, which most certainly is bound to be found by the patient in the suggestive pronouncements of the therapist.

One of my patients reported to me what he considered a significant flashback that almost immediately resolved his anxiety: "This," he avowed, "was a cock-sucking experience I reconstructed from what must have happened to me in childhood. It involved an affair with a Chinaman. My father gave me shirts to take to the Chinaman who had a laundry nearby. I got the slip, but when I brought my father along to collect the laundry, I took him by mistake to another Chinese laundry. My father had a fight with the Chinaman over the slip. Then I remembered and brought my father to the right laundry. We lived in Cleveland at the time. That's why I know it happened before I was 6. Seems young to be running errands, but I had a dream that convinced me that the Chinaman sucked my cock. I remember he gave me lychee nuts."

This memory served to convince the patient that he now had the key to his fear of wandering away from home and his sexual problems. It required no extensive work to reveal this bit of insight as false, although it had a most astonishing effect on the patient.

This does not mean that some of the insights patients arrive at may not be correct. But not too much wisdom is needed to recognize that, with all of the doctrines of psychodynamics current among contemporary schools of psychotherapy, each one of which finds its theories confirmed in work with patients, factors other than their precepts, reflected as insights, must be responsible for at least some of the cure. The nonspecific windfalls of insight do not invalidate the specific profits that can accrue from a true understanding of the forces that are undermining security, vitiating self-esteem, and provoking actions inimical to the interests of the individual.

In opening up areas for exploration, a therapist should, in the effort to minimize false insight, confine oneself as closely as possible to observable facts, avoiding speculations as

to theory so as to reduce the suggestive component. The more experienced one is, the more capable one will be of collating pertinent material from the patient's verbal content and associations, gestures, facial expressions, hesitations, silences, emotional outbursts, dreams, and interpersonal reactions toward assumptions that, interpreted to the patient, permit the latter to acknowledge, deny, or resist these offerings. Dealing with the patient's resistances, the therapist studies the patient's behavior and continues to reexamine original assumptions and to revise them in terms of any new data that come forth.

The collaborative effort between patient and therapist made in quest of insight is in itself a learning experience that has an emotional impact on the patient that is at least as strong as any sudden cognitive illumination (Bonime, 1961). Malvina Kramer (1959) has pointed out that "what appears from the patient-analyst viewpoint to be a matter of insight and intrapsychic rearrangement turns out to be a far more complex process which depends on fields of multiple interaction on many levels."

Improvement or cure in psychotherapy may be posited on the following propositions:

1. The patient successfully acquires an understanding of the nature of the problem by developing the capacity to conceive of it in terms that are meaningful.

2. On the basis of this understanding, the patient begins to organize a campaign of positive action, acquiring symbolic controls, replacing destructive with adaptive goals, and pursuing these in a productive way.

True insight is helpful in this process. It acts as a liberating and an enabling force; it upsets the balance between the repressed and repressing psychic elements; it creates motivations to test the reality of one's attitudes and values; it gives the person an opportunity to challenge the very philosophies with which one's life is governed. But insight is not equivalent to cure; by itself it is insufficient to arrest the neurotic process and to promote new and constructive patterns.

Indeed, the development of insight may surprisingly produce not relief from distress, but an accentuation of anxiety. The ensuing challenge to change one's modus

operandi, and the sloughing off of neurotic protective devices make the possibility of exposure to hurt all the more real. No longer is one capable of hiding behind one's defense mechanisms. One must tear down one's facades and proceed to tackle life on assertive terms. Prior to acquiring insight, one may have envisaged "normality" in fantasy as a desirable quality, but the approaching new way of life fills the individual with a sense of foreboding.

Thus a man with an impotency problem may learn in therapy that his impotence is a defense against a fear of being mutilated by destructive, castrating women. Realizing that his defense is realistically unfounded, he must still expose himself to intercourse. This will continue to be extremely frightening to him until he convinces himself,. through action, that the imagined dangers will not come to pass. A woman, working in an advertising agency, may discover that a fear of competition with men is associated with her repudiation, on the basis of anxiety, of a desire for masculinity. Her knowledge then opens up the possibility of her being able to stand up to men. Specifically, she may practice her new insight on a man in her office who has advanced himself professionally over her, because she had assumed a retiring and passive attitude. The understanding that she is playing a role with men akin to the subordinate role she had assumed as a child with her brother does not ameliorate the anxiety that she feels at having to compete with her office associate.

To protect themselves from facing the threatened perils of action, patients may throw up a smokescreen of resistance. They may reinforce old and employ new defensive mechanisms. They may devaluate strivings for health even though these had constituted strong incentives for starting therapy. The original motivations may be submerged under the anxiety of impending fulfillment and the patients may then interrupt treatment.

It is an unfortunate fact that only too often does therapy grind to a halt at a point where insight must be converted into action. The impediment encountered by the patient is complicated by resistance against releasing intolerable unconscious fantasies associated with action. In psychoanalysis action inhibition may symbolically be repeated in

transference, and analysis of the resistance may liberate the patient. The therapist, while permitting the verbal expression of the unconscious fantasy in the relationship, does not participate in it; nor does the therapist encourage its sexual or hostile acting-out. Any interventions are predicated on the patient's need, not the countertransferential demands of the therapist. But even under those circumstances translation of insight into action may fail.

MODERN LEARNING THEORY AND PSYCHOTHERAPY

The difficulties that invest the resolution of old patterns and the elaboration of new ones make it necessary for therapists to use every stratagem at their disposal. Since psychotherapy involves a learning process in which the patient acquires abilities to abandon neurotic adjustment in favor of an adaptation consonant with reality, it may be interesting to consider the therapeutic situation in the light of a theory of learning. A number of attempts have been made to coordinate psychotherapy with the principles of modern learning theory. None of these has proven successful since the various propounded theories—including the stimulus-response and cognitive theories—are unable to account for the complexities of ego functioning, both normal and pathological. The ego seems to operate under laws of its own that have scarcely been embraced by any of the learning theories. Furthermore, there are various kinds of learning to which different postulates may be applied. The unsolved problems of learning would seem too diffuse to permit of any real application of learning theory to the phenomena of psychotherapy.

It may be helpful, nevertheless, to consider a number of well-known learning principles and to attempt to apply them to psychotherapeutic situations.

Learning is most effective where the individual participates directly in the learning experience. For this reason, the greatest impact on a patient is registered by patterns that come out during the encounter with the therapist—patterns that are a product of the collaborative relationship. Such a learning experience gives the patient a basis on which to reconstitute ideas of reality. It permits the patient to experiment with

the therapist as a new kind of authority in association with whom the patient can evolve a more wholesome image of the self.

This eventuality, however, does not always develop in therapy, and when it happens, it does not guarantee an integration of understanding toward productive behavioral change. First, the patient may have an investment in the maladaptive patterns that subserve spurious security needs. To give them up exposes the individual to fantasied dangers or to deprivations. For example, a homosexual man may learn that he seeks in the homosexual relationship a virile image to repair his own damaged genitalia. He learns also that avoidance of women is both a safety measure to withdraw him from competition with other men and a way of preventing his being overwhelmed and infantilized by a mother figure. These insights do not subdue his intense sexual interest in males nor stop him from seeking men as a source of gratification. They do not lessen his disgust toward women, with whom he continues to maintain a casual, detached, demanding, or hostile relationship.

A second factor that may hinder the occurrence of a meaningful learning experience in therapy is the fact that a patient's reactions may have become so automatic and conditioned that knowledge of their unreasonableness does not suffice to inhibit them; they continue in an almost reflex way. One patient as a boy was constantly being taken to physicians by a hypochondriacal mother. Threats of operations were used as measures to exact the cooperation of the boy for various injections and diagnostic procedures. In later life, the patient developed a profound fear of doctors to a point where he refused to expose himself to essential medical contacts. An understanding of the sources of these fears, and an attempt to control them, did not inhibit explosive physiological reactions at the sight of a physician.

A third instance in which the learning experience in therapy may not be effective occurs when the attitudes and behavior of the therapist do not provide the conditions most conducive to change; because patterns, perhaps inspired by countertransference, may reinforce the patient's neurotic expectations. A woman patient, burdened in her work

by damaging competitiveness with other women and constantly involved in winning the attentions of her male associates through her seductive manner, realizes during therapy the origin of these drives in her competitiveness with her mother for her father's favors. Yet she may cleverly maneuver the therapist into acting overprotective and reassuring toward her by playing on the therapist's personal interest in attractive women.

Repeated attempts to execute healthy responses may lead to their reinforcement. Nevertheless, repeated practice of rational reactions does not necessarily inhibit neurotic responses. The power of the repetition compulsion often neutralizes effective learning. Thus, a man who compulsively fails as soon as success becomes imminent may, on the basis of insight into this distortion, force himself diligently to take advantage of any emoluments his life situation yields. Yet the impulse to fail will become so overbearing that he may yield to failure even while trying to succeed. Learning, nevertheless, goes on in the medium of neurotic relapse, provided that the individual is aware of what is happening and has ideas of why he needs to foster his failure. This working through is helped by the therapist who is in a position to be objective. It may be achieved by the person alone if he has the motivation to examine and to correct his behavior.

Learning is facilitated through satisfaction of important needs, such as gaining of rewards and an avoidance of punishment. However, in the light of our experiences in psychotherapy, we have to recast our ideas about rewards and punishments due to the disordered values of the patient. Rewards to a neurotic person may most keenly be the expressed residues of surviving infantile needs, such as dependency or defiance, which are more or less unconscious. They may be organized around maintenance of various neurotic mechanisms of defense that reduce anxiety. In the latter case the individual will develop not health-oriented behavior but more sophisticated methods of supporting defenses. Thus, a married man, pursuing at the sacrifice of his safety and economic security, a disturbed young woman, who constitutes for him a maternal symbol, is suffused with pleasure whenever the woman favors him with her attention. Due to her narcissism, immaturity, and fears of men, she rejects his advances, yet she demands that he protect

and support her. Fearful that he will lose her affection, the man yields to the unsatisfactory arrangement of financing the irresponsible expenditures of the young woman in the hope that she will eventually bestow her favors on him. His hostility and anxiety mount as he becomes more and more trapped by his dependence. In therapy what the man seeks is freedom from his symptoms and, covertly, expert stratagems of breaking down the young woman's resistance to loving him unstintingly. After a period in treatment, he learns the meaning of his involvement. The rewards that he obtains in integrating this learning is the immediate approval of the therapist and the promised reward that his symptoms will be relieved if he extricates himself from his untenable situation. These satisfactions threaten the rewards he really seeks in terms of overcoming the young woman's rejection of him and of establishing himself as her favorite "son" and lover. What he does then is to utilize his psychological insights to understand the reactions of his desired mistress in order to outmaneuver her. Momentary sexual yieldings are followed by her executing violent scenes and threats of separation, which, precipitating anxiety in the man, binds him more firmly in his enslavement. The punishment that he receives is really no deterrent to his continued acting-out of this drama. Indeed, it fulfills an insidious need to appease his guilt feeling. Thus, as in many psychological problems, punishment becomes a masochistic reward.

We cannot, therefore, apply the same criteria of rewards and punishments to the complex problems of learning in psychotherapy as we do to some other forms of learning. This is why conditioning techniques that are utilized in behavior therapy fail to influence certain kinds of neurotic disturbance. As the working-through process continues in treatment, the patient may, however, eventually rearrange his value systems. He may then approximate healthy goals as rewards and conventional pain and suffering as punishments. Conditioning under these circumstances may then prove successful.

Rational understanding is a *sine qua non* of learning. Rational understanding in itself, as has repeatedly been emphasized, does not seem to help many emotional problems. This is because behavioral change is predicated on complex rearrangements of thinking, feeling, and acting that are bound together in tangled disorder. We attempt a

disentwining of this complex yarn by plucking away at the surface strands. There may be no other way of getting at the disorganized psychosociophysiological structure. Hopefully, our efforts will be rewarded. Even from superficial intellectual unravelings behavioral, and even physiological, readjustments may ensue. As S. Freud (1928) once said, "The voice of the intellect is a soft one, but it does not rest until it has gained a hearing." Ultimately our therapeutic operations may overcome the tumultuous emotions of the psychologically ill individual. Unfortunately, patterns and values acquired early in life may obstruct meaningful adult learning. The most obstructive interferences are systems that have been repressed and yet obtrude themselves in devious ways. For example, sexual education as it is now being taught in high schools and colleges may have little impact on a young woman who has developed, as a result of childhood anxieties, the practice of shunting sexual material out of her mind. Defiance of authority, developed to preserve autonomy and to neutralize overprotective and interfering parental figures, may subtly block the incorporation of factual data. Perfectionistic tendencies and fear of failure, residues of a damaged self-image, may interfere with effective recall in situations where performance is a measure of self-worth. The powerful imprint of early impressions and experiences on the total behavior of the individual cannot be overemphasized, and learning may be blocked until some resolution of inner conflict has been instituted.

Is it completely hopeless, then, to try to take advantage of any basic learning propositions in order to expedite psychotherapy? Let us attempt to answer this question by considering some of the positive learning factors that Hilgard (1956) has described so well.

Motivation is important in learning. Individuals who are motivated to learn will apply themselves to the learning task and more readily overcome their resistances. Rewards are much more effective learning stimulants than are punishments. In psychotherapy, rewards may be offered to patients in the form of encouragement and approval when they have come to important understandings or have engaged in constructive actions. The benefits of their activities may be pointed out in terms of what progress will do for them.

When learning failures occur, the person may be helped to tolerate them by pointing out previous successes. In psychotherapy failures are inevitable, partly due to resistance and partly to the repetitive nature of neurotic drives. Reassurance of the patients when they become discouraged by failure and helping them to see why the failure occurred may encourage them to try again. The therapist may accent the patient's constructive activities that were initiated in the past.

Setting realistic goals during learning is an important step. Individuals may be unable to achieve success where their objectives are beyond their capacities or opportunities. Where their goals are too modest, also, they will not make the effort that would be most rewarding. In psychotherapy, where the therapist senses that the patient is overly ambitious and that his or her plans are unrealistic, it is essential that the therapist bring the patient back to earth. There are some memories the patient may be unable to recover, some patterns so imbedded in the past that they cannot be overcome. Pointing some of these facts out may prevent the individual from engaging in frustrating efforts that discourage productive learning. On the other hand, when the individual's targets are too limited, for instance, where one insists that one is so seriously and irretrievably ill that one cannot achieve certain gains or execute essential actions, the therapist has a responsibility in stimulating the patient toward more ambitious aims.

Learning is most effective where there is a good relationship with the teaching authority and where mutual respect prevails. This is, of course, the essence of good psychotherapy. Where habitual contacts with authority are predicated on fear, hostility, or excessive dependence, the patient will probably display these patterns, which will then inhibit learning. The patient may be diverted from the task of learning toward fulfillment of regressive needs in the association with the therapist. The therapist must be alert to these maneuvers and must constantly keep the working relationship at the proper pitch, devoting efforts to this above all other tasks.

Active participation by individuals in the learning process is more effective than a passive feeding of materials to them. If the learner is able to figure out facts and to apply

these to a variety of situations, he or she will learn most readily. In therapy problem-solving tasks are given to the patients; questions are directed at them; a thinking through of solutions is encouraged. The motto is "Let's figure this thing out together" rather than "Here are the answers." The patients are constantly encouraged to enter into new situations and to observe their reactions to these challenges.

Where learning materials and tasks are understood by individuals, they will integrate knowledge better than where these are meaningless. Knowledge of how to perform well in the learning task, recognition of errors in operation, and the understanding of what constitutes effective performance are most helpful. In therapy the treatment situation is structured for the patient; the purpose of different techniques is presented to the patient in terms that can be understood. There are a number of routines that may seem mysterious to the patient, for instance, the refraining from advice given and the employment of dreams. A careful explanation of their rationale is conducive to greater cooperation.

Repetition makes for the greatest success in learning. Where recall can be spaced over an expanded span, material will be better retained. In psychotherapy the patient is continuously engaged in examining neurotic behavior; the patient acquires an increasing understanding of why one acts in certain ways. Repetition of successful behavioral responses is encouraged. The working-through process constitutes a continuous learning experience.

BUILDING MOTIVATION FOR ACTIVITY

If empirically we are to pay credence to these concepts of learning, we have to abide by the rule that the first step in helping patients to translate insight into action is to build adequate incentives toward the abandoning of old patterns of living. A constant analysis of the significance of the individual's habitual drives—their purpose, origins, contradictions, and resultant conflicts—casts doubt on the value of such drives. Gradually patients realize that their strivings do them more harm than they do them good, that they are responsible for much of their maladjustment, and that they promote many of their own symptoms.

Eventually they understand that the pleasures that they derive from the fulfillment of their patterns are minute, indeed, compared to the devastation that are created in their lives. They then become willing to challenge the validity of their customary modes of adjustment. Whether they will change their behavior is a choice they themselves have to make.

For example, a woman with a strong dependency drive discovers that her need for dependence dominates every aspect of her thinking and feeling. Finding an omnipotent person on whom to lean fills her with a sense of goodness and security. Life than becomes a bountiful place; she is suffused with vitality, imagination, and creativeness. But not long after this metamorphosis a curious change takes place in the way that she feels. Fear and panic begin to overwhelm her; she becomes sleepless and she feels depressed; headaches, dyspepsia, and muscle tension develop. To her consternation she seems to invite suffering, masochistically assuming the manner of a martyr, and then undermining the person who acts as her host. She appears also to want to capitalize on her plight, by holding forth physical weakness and infirmity as reasons for her avoidance of responsibility.

These patterns become apparent to her during psychotherapy in relation to her husband who she variantly adores, fears, and despises, making for a tumultuous marriage. She learns that while she is driven to submit herself to him as a powerful parental agency, this crushes her assertiveness and fosters feelings of helplessness. Exploration of the genesis of her patterns may show her how her dependency resulted from subjugation by an overprotecting mother, who stifled her independent emotional growth. This knowledge gives impetus to her desires for freedom. She sees how continued pursuit of dependency since childhood causes reflex helplessness and crushing of independence. Such insights are fostered in a nonjudgmental and tolerant treatment atmosphere, the therapist never is represented as an authority who orders the patient to change her way of life.

On the basis of her new understanding much dissatisfaction may be created in the patient with her present life situation. She will also be motivated to experiment with different modes of adjustment. The desire to give up dependency as a primary adaptive

technique may, however, be blocked by a fear of, and a contempt for, normal life goals. Anxiety here may mask itself as anhedonia—an indifference to or boredom with pleasures and impulses accepted as valuable by the average person—for, compared with the ecstatic, albeit spurious, joys of neurotic fulfillment, customary routines seem uninspiring indeed. The therapist accordingly engages in a constant analysis of misconceptions about normality in terms of their anxiety-avoidance components.

When our patient, for instance, manifests disinterest in certain people, it may be possible to show her that she harbors contempt for any individual who does not possess glamorous strength and omniscience. She may actually classify people into two categories: those who are superior and who potentially can serve as parental substitutes and those who are inferior and, therefore, are utter bores. The immense narcissism and grandiosity inherent in her attitudes about herself may become apparent to the patient as she realizes how she strives to gain omnipotence through passive identification with a godlike figure. At this point the patient may become aware of why she refuses to have children. She realizes that she does not want to be replaced as the favorite child of her husband. She does not want to "give" and be a parent to a child, since she herself wants to be that child. She conceives it her right to take from others.

This analysis of anxieties and expectations, and the continued verbalization by the patient of fears and anticipated pleasures, provides increased motivation to attempt a different life expression. But no new patterns can be learned unless the motivation to acquire them is greater than the motivation that promotes the survival of the existing neurotic habits. Therapist activities, therefore, must embrace encouragement of any desires that the patient voices for mental health, emotional growth, and freedom from suffering. The therapist must attempt to undermine the pleasure and security values that the patient seeks from the prosecution of her neurosis. Thus, the therapist may show the patient that the rationale of her dependency need is inescapable if one accepts the premise that she is incorrigibly helpless. While it is true that conditions in her childhood made dependency and related patterns necessary, she now continues to operate under assumptions that are no longer true. Her expectations of injury approximate those of a

child. If she analyzes her situation today, she will see that conditions no longer necessitate anachronistic reactions that are so destructive to her adjustment. She is challenged to revise her assumption of life as a repetitive phenomenon that is blackened by shadows of her need for parenting.

PROVIDING A FAVORABLE ENVIRONMENT FOR ACTION

With expanding insights the patient tends to affiliate neurotic strivings with suffering and maladjustment. Their operation and even their appearance begin to evoke discomfort. This provides motivation for their inhibition. Involved in the inhibitory response are incidental stimuli or cues that are associated with the neurotic patterns and that once could initiate them. More and more the patient becomes capable of controlling reactions and of engaging in productive responses.

It may be necessary for the therapist to prepare the patient in advance for any foreseen disappointments that may occur in the course of executing a new response. Thus, if our dependent patient decides that she must assert herself with her husband, she may resolve to do this by asking him for a regular allowance weekly, from which she can budget her household expenses, purchase her clothing, and provide for certain luxuries. Hitherto her husband has doled out funds whenever she needed to make a purchase, requesting an itemized accounting in order to check on her spending. He has considered his wife irresponsible—an attitude the patient has sponsored, partly out of need to avoid responsibility and partly out of hostility—because she has made many unnecessary purchases. He has for this reason restricted her spending. We may, therefore, anticipate that he will react negatively to her suggestion that he provide her with a weekly sum and that she be entrusted with the family purchasing. Because she has chosen this area as a test for her assertiveness, a negative or violent reception of her assertive gesture will probably mobilize anxiety and result in defeat. She may then suffer a decisive setback in her therapy and perhaps never again dare to approach her husband assertively.

To forestall this contingency, the therapist may ask her to anticipate her husband's reaction when the patient presents her plan. The patient may be fully expectant that her

husband's response will be negative. She may then be asked to anticipate her own reaction should he refuse to cooperate. The therapist may even predict for the patient a violent response on the part of her husband and get her to verbalize how she would feel if he became recalcitrant and punitive. Once the patient accepts the possibility that her request may bring forth hostility and once she recognizes that her husband may, on the basis of her past performance, perhaps be justified in his refusal to trust her management, the therapist may encourage her to approach her husband on a different basis. Discussing with him the need for practice in making herself more independent, she may suggest that he allow her to assume greater responsibility in the handling of finances. However, since even this prudent method of presentation may be rejected, the patient should be prepared for a disappointment. What is accomplished by this tactic is that the patient is desensitized to failure and musters the strength to cope with an absence of rewards for her new responses.

In many patients insight is translated into action without too great activity on the part of the therapist. In some patients, however, considerable activity may be required before therapeutic movement becomes perceptible. Although the therapist may have been more or less passive during the first two phases of therapy, this phase necessitates more energetic measures, and greater pressure and confrontation because of the patient's reluctance to face anxiety.

PSYCHODRAMATIC TECHNIQUES

In occasional instances role playing may be efficacious, the therapist taking the role of the individual with whom the patient seeks to relate on different terms. Or the therapist may suggest that the patient assume the role of that individual, while the therapist takes the part of the patient. The patient, in addition to building up immunity to rebuffs, enjoys in this technique an opportunity for emotional catharsis. The therapist is, in turn, possessed of a means of making the patient aware of one's undercurrent feelings and responses. If the therapist does group psychodrama, the patient may be introduced into the group while continuing to be seen on an individual basis too.

Conferences with Family Members

An element often overlooked in the resistance to getting well is the impact of the reactions on the patient of significant other persons. The patient's interpersonal relationships are bound to change as the shackles of the neurosis are broken by the patient. The threat to the existing family balance will mobilize defensive attack and withdrawal maneuvers on the part of those with whom the patient is in close bond and who are threatened by change. Often this creates such turmoil that the patient will block off progress and perhaps retreat to former patterns of interaction, only to be rewarded by a return of symptoms. The therapist may imagine that it is the therapy that is ineffective, an unhappy thought that the patient may well instigate and sustain. By being constantly on the lookout for possibilities of retrenchment into former behavioral patterns, the therapist will best be able to explain failure of progress as a form of resistance. This phenomenon is most clearly apparent in children, adolescents, and young people who live closely with their families, particularly those who are withdrawn and schizoid. Therapy in releasing independent or rebellious activities in the identified patient may create a crisis in the family homeostasis.

Family therapy with the significant others present may be very successful where the related persons are not too emotionally disturbed. Where an adult patient lives in a close relationship with another person, like a spouse, the person is bound to react with anxiety when the patient threatens to upset present routines. Thus, the mate of our female patient with the dependency problem will probably regard any change in the patient in her striving for freedom as an assault on his own rights. He may then attempt to undermine the patient's treatment.

Surmising such a contingency, we might find it expedient to arrange for a talk with the spouse. The consultation will have to be secured with the knowledge and even cooperation of the patient. One or several conferences with the spouse can often make the difference between success or failure in the patient's initial effort at a new response. Once the spouse sees the rationale of the new plan of action (and senses that he is not being blamed by the therapist), and he realizes that his own problems and needs are being taken

into account, he may voluntarily cooperate. Even hostile reactions of the patient may be tolerated by him, if he is alerted to the possibilities of such reactions. In our dependent patient, for example, an interview may be geared around the discussion with the husband of what he has noticed about his wife. Any troublesome attitudes and behavior mentioned may then be pointed out as manifestations of her problem of lack of assertiveness. In order for her to overcome this problem, which is so crippling to her adjustment, including her marital adjustment, it will be necessary to give her an opportunity to grow. Even though she may make mistakes, the husband is enjoined to exercise tolerance, since this is how people learn and grow. It would be better for her to make a few mistakes, for instance, in the way that she budgets her allowance, and to help her to learn through her mistakes, than to let her continue in her present state of turmoil.

Obviously, in order for the husband to adjust to the patient's assertiveness, it will be necessary for him to master some of his own needs that are being satisfied by the patient's passivity and dependence. A fear for his own masculinity, and/or a compulsive striving for superiority and power may demand that his wife relate to him as a subordinate. Consequently, the husband may have to experience a therapeutic change himself in order to allow his wife to exercise assertiveness in the relationship. He may go through an emotional crisis before this happens, even though he appreciates the purpose behind the plan as explained to him by the therapist. Naturally the husband's dynamics would not be thrown at him during an interview because he would most certainly reject the interpretations. Rather he may be told: "I know this is asking a good deal from you to let your wife experiment. You may not be able to do it, many people can't." This challenge may be enough to get his cooperation.

The following excerpt from a session with a woman whose dependency problem resembled that of the hypothetic patient we are considering as an example illustrates this point:

> *Pt.* And Sunday morning I was in church and I got a little nervous. Then when I came home, my husband started acting funny, wanting to go here, wanting to go there. I told him I thought he didn't really want to go anywhere. He brought up a lot of things. All of a sudden I looked at him and saw hatred on his face, and my mind stopped working. He said, "You care more

about the doctor than you do me." He acted very jealous, and I got upset.

Th. I see.

Pt. And in the last few months we had been getting along so well. You know I just am never going to go back again to what I was. I got upset at his attitude and wanted to throw something at him, but instead I turned it on me. I cried and tore my hair. He got me so angry, I lost control. I don't want to live with a man I have to appease. I told him he is a mean man and that I would leave him.

Th. And then what happened?

Pt. He got upset and cried. He told me it was his fault. He said he always was this way and that he could see he was wrong. Then I started feeling sorry for him. Then I got mad at him. I don't think I can stand him. He's brutal and mean. He isn't happy until he sees me groveling on my knees. Then he's happy. Maybe I'm not the woman for him. *(pause)*

Th. But you *could* assert your rights. You *could* define what you feel your rights to be.

Pt. But I have. I don't see what I did to aggravate him. I know he has a problem in wanting to treat me like a slave. Maybe someone else could stand it, but I can't. And I told him and threatened to walk out. *(pause)*

Th. So what happened then?

Pt. Surprising. He broke down and cried. Then he said it was all his fault. He said he could see how he treated me, that it was all his fault. He said he didn't know how I could stand it so long. He said he would try to treat me more like an equal.

There are many instances in which improvement in therapy of one marital partner results in increasing emotional disturbance of the mate. Indeed, a disturbed adaptation of the patient may be a condition necessary for the equilibrium of the mate. Thus, a husband, domineered by a power-driven wife, may satisfy masochistic needs under a domain of tyranny. He may be unwilling to give up his masochistic indulgences and adjust to an atmosphere of cooperative equality brought about by the wife's improvement through psychotherapy. Or a frigid woman, receiving treatment, may make sexual demands on her impotent husband who will then develop strong anxiety. Where the mate of the patient has good ego strength, he or she may possibly be able to adapt spontaneously adjusting to the new demands presented by the patient toward a healthier adjustment. The outcome of psychotherapy in one partner then will be emotional improvement in both members. However, it may be necessary for the mate of the patient to receive psychotherapy also

where spontaneous improvement does not occur. Conjoint marital therapy and even family therapy, including as many involved members of the family as possible, may be in order.

Adjusting the Patient's Environment

Where the patient's environment is disturbed, it may have to be altered before insight can adequately be translated into action. Thus, if there is undernourishment, shabby physical attire, bad housing, and other consequences of a subminimal budget standard, which are outside of the patient's control, a community or private agency may have to render assistance. An individual who is living with a brutal or neurotic parent or marital partner may be unable to achieve adequate mental health until an actual separation from the home is brought about. Domineering parents who resent their offspring's self-sufficiency may cause a patient to feel hopeless since compliance seems to be a condition for security.

The majority of patients are capable of modifying their environment through their own actions, once the disturbance is clearly identified and the proper resources are made available to them. Occasionally the adjunctive series of a trained social worker may be required, especially with children and patients with weak ego structures. The therapist, with the help of a social worker, may materially alleviate certain problems by simple environmental manipulation. This is particularly the case where the people with whom the patient lives are capable of gaining insight into existing defects in the family relationship. Such factors as favoritism displayed toward another sibling, lack of appropriate disciplines and proper habit routines, the competitive pitting of a child against older siblings, overprotective and domineering influences of the patient's parents or mate my sometimes be eliminated by proper psychoeducation. Correction of sources of discord and tension frequently is rewarded by alleviation or disappearance of symptoms.

Such situational treatment, while admittedly superficial, can have definite therapeutic value and may permit an individual to proceed to more favorable development. Often family members become so subjectively involved with the problems

of the patient, so defensive and indignant about them that they are unable to see many destructive influences that exist in the household. An honest and frank presentation of the facts may permit intelligent people to alter the situation sufficiently to take the strain off the patient.

It must not be assumed, however, that all situational therapy will be successful, even when gross disturbances exist in the household. Frequently the family is unable or unwilling to alter inimical conditions because of severe neurotic problems in members other than the patient or because of physical factors in the home over which they have no control. Here the social worker, through repeated home visits, may start interpersonal therapy that may bring the family around toward accepting the recommendations of the therapist. The worker may, in specific instances, render material aid to the family, or may assist in the planning of a budget or a home routine. Direct contact of the social worker with the family may reveal that others need attention or therapy.

Another function that the social worker can fulfill is to make available to the individual the various church, school, and neighborhood recreational facilities. Persons with emotional problems frequently become so rooted to their homes, out of a sense of insecurity, that they fear outside contacts. Establishing a relationship with and introducing the patient to groups outside the home may start a social experience that becomes increasingly meaningful for helping to release forces that make for self-development. A day hospital, day-care center, or rehabilitation unit are often of great value.

In cases where the destructive elements within the family are irremediable or where the individual is rejected with little chance of eventual acceptance, it may be necessary to encourage the individual to take up residence elsewhere. Temporary or permanent placement in a foster family or rest home may be essential. Although there is evidence that such change of environment rarely has an effect on deeper problems, residence in a home with kindly and sympathetic adults may serve to stabilize and to give the individual an opportunity to execute in action the insight learned. The most significant factor in changes

of residence is the meaning that it has to the patient. If the patient regards it as another evidence of rejection, it can have an undermining rather than a constructive influence. Instead of getting better, the patient may regress to more immature patterns of behavior. Above all, the patient must be adequately prepared for residence change or placement and should look forward to it as a therapeutic experience rather than as a form of punishment.

Caution must, however, be exercised in effecting drastic and permanent changes in the work or home situation, and thorough study of the patient is essential before one is justified in advising anything that may recast the patient's entire life. This applies particularly to problems of divorce and separation.

Many married patients seek therapeutic help while on the crest of a wave of resentment that compels them to desire separation or divorce. Mere encouragement on the part of the therapist serves to translate these desires into action. The therapist should, therefore, always be chary of giving advice that will break up a marriage unless completely convinced that there is nothing in the marital situation that is worthy of saving or until certain that the relationship is dangerously destructive to the patient and that there is no hope of abatement. This precaution is essential because the patient may completely bury, under the tide of anger, positive qualities of the mate to win sympathy from the therapist or to justify the resentment felt toward the mate.

When the therapist is swept away by the patient's emotion and encourages a breakup of the home, many patients will be plunged into despair and anxiety. They will blame the therapist for having taken them so seriously as to destroy their hopes for a reconciliation. It is advisable in all cases, even when the marital situation appears hopeless, to enjoin the patient to attempt the working through of problems in the present setting, pointing out that the spouse may also suffer from emotional difficulties for which treatment will be required. The patient will, in this way, not only be helped, but also the spouse, and constructive features of the relationship will be preserved. It is wise to get the patient to talk about positive qualities possessed by the spouse instead of completely being absorbed by the latter's negative characteristics.

On the other hand, it is undesirable, indeed manifestly impossible, to restrict every patient from making fundamental changes during therapy. Conversion of understanding into action presupposes that the life situation must be altered. The rule that no changes be made during the period of therapy is more honored in its breach than its observance. The important thing is that the patient discuss with the therapist plans to effectuate change *before* making them in order to lessen the possibilities of a neurotic decision, for instance one that may be in service of masochistic self-defeating impulses.

Learning New Patterns within the Therapeutic Relationship

The reexperiencing by the patient, within the therapeutic situation, of early unresolved fears, attitudes, and needs and the proper management by the therapist of these strivings are important means of learning. The patient has an opportunity to work out, in a more favorable setting, problems that could not be resolved in relationships with early authorities. The new patterns resulting are gradually absorbed and become a part of the patient's personality.

For this to happen, the therapeutic situation must serve as a corrective experience and must not repeat early disappointments and mishandlings. The patient while motivated to grow and to develop within the relationship, is hampered by anxiety, residual in expectations of hurt from domineering, rejecting, overprotecting, and punitive authority. This is why the therapist must not be tempted by the patient's unprovoked attitudes and behavior to repeat the prohibitions, penalties, and retribution of authoritative figures in the patient's past. Should the therapist respond in this way, the patient's convictions that authority is not to be trusted will be reinforced. No modifications of attitudes can occur under these circumstances.

Realizing that the patient must verbalize or act out unreasonable strivings in order to get well, the therapist will have an opportunity to react to these in an entirely different way from that anticipated by the patient. The therapist acts in a warm, accepting, and nonjudgmental manner. These attitudes inspire the patient to retest the original traumatic situation. The patient does this anticipating hurt. If the therapist, by virtue of

understanding and the ability to remain objective, can avoid repeating the punitive and rejecting threats, the patient may be helped to live through in a new setting crucial experiences that should have been resolved as a child. The therapist will constantly have to interpret to the patient the latter's expectation of hurt, and to help the patient to realize that the circumstances under which one failed to develop security and self-esteem were peculiar to a disturbed childhood.

This will call for a high degree of mental health on the part of the therapist, whose own value system is bound to incorporate many of the judgments and arbitrary attitudes residual in the culture, which, incorporated in the parent's attitudes, have crushed the patient's growth.

Within the therapeutic relationship itself, therefore, the patient is helped to find a new and healthier means of adjustment. A virtue of the working alliance is that it acts as a prototype of better interpersonal relationships. It fosters the patient's faith in other people and ultimately in the self.

One way that the working relationship is utilized is to battle resistances to action. It is sometimes necessary to encourage patients to face certain situations that have paralyzed them with fear. Utilizing the relationship as a fulcrum, the patients may be urged to experiment with new patterns while observing their responses. A program sometimes may be planned cooperatively with the patients, the therapist occasionally making positive suggestions. While advice giving is best eschewed, the advantages and disadvantages of alternative courses of action may be presented, the patients being encouraged to make a final choice for themselves. Thus, if a patient wants the therapist to make the decision on an issue, the therapist may ask, "What do *you* feel about this?" Possibilities of failure, as well as anticipated reactions to entering into new situations may be explored. The patient may be cautioned- by such statements as, "It isn't easy to do this" or "This may be hard for you." A method of stimulating action is to confront the patient with the question, "What are you doing about this situation?" whenever dissatisfaction is expressed by the patient on his or her progress.

Even with these promptings the patient may shy away from executing actions that threaten to promote old anxieties. If the initiative is put in the patient's hands, a stalemate may result. Although an analysis of resistances may encourage a cautious step into dangerous territory, the patient may need a gently firm push by the therapist before boldly approaching a new activity. In phobias, for instance, the patient may have to be strongly urged to face the phobic situation, on the basis that it is necessary to learn to master a certain amount of anxiety before one can get well. Where the relationship with the therapist is good, the patient will be motivated to approach the situation that seems dangerous with greater courage.

Success and pleasure in constructive action constitute the greatest possible rewards for the patient. Occasionally the therapist may indicate approval in nonverbal or in cautiously phrased verbal terms. Conversely, whenever the patient fails in an attempted action, sympathy, reassurance, encouragement, and active analysis of the reasons for the failure are indicated. The patient may be reminded that the difficulty has been present a long time and that one need not be discouraged if one does not conquer one's trouble abruptly. The patient may be given an explanation such as the following: "You know, an emotional problem is often like a hard rock. You can pound on it with a hammer one hundred times without making any visible impression. The hundred-and-first time, however, it may crumble to pieces. The same thing happens in therapy. For months no visible change is present, but the neurotic structure is constantly being altered under the surface. Eventually in therapy, and even after therapy, signs of crumbling of the neurosis occur."

Eventually the rewards of positive achievement and enjoyment issue out of the new and healthy patterns themselves. Surcease from suffering, reinforced by joys of productive interpersonal relationships, enable the patient to consolidate gains.

Adjunctive devices are often helpful during the action phase of therapy. These include the prescription of tranquilizing drugs, to help master anxiety associated with attempting new tasks, as well as hypnosis, self-hypnosis, and behavior therapy. (See

Chapters <u>56</u> and <u>51</u>.)

ILLUSTRATIVE CASE MATERIAL

The following is a portion of a session in which a man with a personality problem of dependency, submissiveness, passivity, and detachment indicates how he has put his insight into action and asserted himself.

Pt. There has been a great change in me. I haven't felt this way in my whole life. And it has been going on for weeks.

Th. Is that so?

Pt. Yes. Of course, I used to have spurts of good feeling for different reasons. Once I felt as happy as a lark when I was about 13. I had had eczema for years and x-ray treatments took it away. I felt grand for a short time. And then I felt wonderful when I met my wife, but it lasted only a short while. But all these things came from external causes. The way I feel now seems to be coming from inside of me. All my life I seem to have been a zombie, really dead, because I carried inside of me all sorts of standards of other people. I was like an automaton. If you would press a button, I would react in a certain way. I never had a sense of myself.

Th. Mm hmm.

Pt. Things have happened these weeks, which I think I handled well, and my reactions were good too. I have never had a prolonged period like this. Several times I'd say to myself, "I wonder if I can keep this up?" People mean different things to me now, you know. They are not powerful and threatening. My daughter was operated on at the hospital, for example. I regarded it in a sensible way. I said, "It's a minor operation. I'm concerned about her, but it's a simple thing and nothing to be upset about." I used to have a whole string of emotional responses that go along with illness. Now my wife has this worrying but that was instilled in her by her mother. So I had to go along handling various things with her feelings which used to suck me into a trap before and arouse guilt feelings in me.

Th. I see.

Pt. So she started to hammer at me a few days before the operation to see to it that the room in the hospital was a good one, that there was a television set there, and so on. Now this is a good hospital, I know, but their policy is annoying. I know they have a program, and you could stand on your ear and get nowhere by ordering them around. So I said to my wife, "I'm not going to follow out your directions and do this and do that because I don't think it's right. Everything will go smoothly." So I did it my way, and everything went smoothly.

Th. Previously how would you have done it?

Pt. To tell you this is a revolution is an understatement. I'd always appease my wife like I did my mother. I'd do what she said without questioning it. This time I did what *I* wanted, and I felt

no guilt. I had a sense of power. Everything went smoothly. When I got to the hospital, my wife was frantic because they gave my daughter a rectal sedative and she expelled it. The nurse was all confused and didn't know what to do. Then they called for her to go to the operation. I said, "I won't let her out of the room until she is properly sedated. I don't care if they get the whole hospital on my head; I'm just not going to do it." And I did this with ease. There was nothing to it. Before this I would say, "Look, I'm making these people wait, and so forth, and so forth." So the intern came up and gave her a sedative. They called the surgeon who agreed that the child shouldn't come down until she was sedated. (*laughs*) Everyone was chewing their nails, but I stuck to my guns. Not that I was unreasonable, but I did stick to what I felt was right.

Th. And things came out well?

Pt. Better than well. It's like a miracle. To think how fearful I was, before therapy, to take a stand with anybody. Especially, I wasn't able to be firm with my wife. When I got home, though, my wife started on me and said that I should have acted more cooperative. That burned me up because that questioned my stand. I told her calmly (*laughs*) that I had sized up the situation and felt this is what had to be done, and the proof was that things turned out well. Even if they didn't, I was sure I was doing the right thing.

Th. I see.

Pt. I then realized that my wife was under a strain, and I told her I was sorry if I talked rough to her. And then she said, "Yes, you're sorry," sarcastically. I said to her, "Look, I said I was sorry. I'm not going to crawl; I'm not going to stand on my head or any goddamn thing." And I didn't feel any anxiety or any guilt or anything. This morning my wife was as happy as a lark, as if nothing had happened.

Th. That made you feel you could take a stand and nothing bad would happen.

Pt. I just brought that up to show that I wasn't drawn in; I felt I was right and I wasn't going to try to dope out my wife's neurotic reactions to things and turn myself inside out trying to please her. I felt wonderful about this. So that was that.

Th. Yes.

Pt. I get a lot of resentment now at certain women mostly, and say, "Why did I have to knock myself out for years? What's so great about them? They are just people, and there are plenty of them around. Why were women so important to me?" I know what it springs from, and it seems so crazy to me now. (*laughs*)

Th. What *did* it spring from actually? *[testing his insight]*

Pt. Well, I would say that there were many factors involved and the picture becomes clearer; my whole life becomes clearer all the time. I would say it all started out, leaving psychologic terms out, with getting a terrible deal with my mother—she killed me. She must have acted in such a way that I was terribly uncertain of her love, and I must have gotten the feeling that if I didn't do exactly as she wanted me to do, she wouldn't love me anymore. And there was no approbation given to me as a person. I became a thing. I became something that was used as a ground for other people's neurotic problems. My mother, on the one hand, being

defeated in her life, used me to a point of smothering me with affection, which, I have a feeling now, covered a lot of repressed hostility and a lot of rebellion against being a mother. My father, on the other hand, showered on me his own lack of confidence as a man. He impressed me with what a man should be, that when he was with people, he wouldn't let them get away with anything. If a cab driver said anything to him, he'd beat him up. He had a tremendous temper. He'd say, "You got to fight; don't take anything from anybody." He never gave me any affection. He couldn't. I think he has a lot more qualities than my mother, but he is very compulsive in the matter, as shown by the fact that he couldn't be warm. He was compulsive about his own work and emphasized to me not to procrastinate or put off tomorrow what could be done today. The approbation came from getting good marks in school. That was the big thing.

Th. Yes.

Pt. So, I grew up with two big areas that were involved—the love area with my mother and the work area with my father. And then, in addition to that, my mother presenting the picture of what a bastard an aggressive man is. My father was a bastard, she said. "I love you," she said, "so don't be a bastard to me. If you do certain things that I don't like, then you are a bastard to me." So I grew up that way with no confidence in myself, no feeling about myself as having worth. The only worth I had was getting good marks to please my father and giving in to please my mother. So with one thing and another I started to crack up.

Th. What happened with your wife?

Pt. She became a mother, and the same thing would have happened with every woman. No matter what the woman was, she was irreplaceable because I had no confidence I could get another woman.

Th. How would you say your attitudes are now in that respect?

Pt. Well, I would say, number one, I know they are not irreplaceable. I think I use sex in an abnormal way. First, it was to prove being a man and to get this feeling of being approved and accepted by a woman like my wife, which after a while stopped working because it proved nothing. So I feel now they are not irreplaceable. I know they have problems, and I don't have to get involved in their problems. I don't have to be sucked in again into being an automaton who is prey to their whims. Pleasing a woman, no matter what her problems, is good as long as it is a reciprocal thing; but doing it just to please her becomes detrimental to the relationship. I suppose in our culture women are more insecure than men and have problems; but I don't have to get involved in their problems. I also have learned that making a woman insecure by making her feel uncertain about you is not the answer. Because, while it works temporarily to incite her interest, it breaks up the relationship after a while.

Th. So that you feel your attitudes are altogether more wholesome.

Pt. My, yes. I realized that my feelings and my needs are just as important as the woman's. All this time I've been making an intellectual exercise about resolving conflict. Instead, the drives I feel now are healthy and good. After all, if it's a fifty-fifty proposition; you can't be too submissive and you can't be too aggressive. I feel a lot more strength within myself. I feel more alive and more vital. The reactions of other people don't matter as much as my own, or I'd say better that my reactions are equally important as the opinions of other people.

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The "Working-through" Process

Mental health is won only after a long and painful fight. Even in supportive therapy, where goals are minimal, the person clings to symptoms with a surprising tenacity. In reeducative therapy the patient returns repetitively to old modes of living while making tentative thrusts in a new and more adaptive direction. In reconstructive therapy the struggle is even more intense, the patient shuttling back and forth, for what seems to be an interminable period, between sick and healthy strivings.

The initial chink in the patient's neurotic armor is made by penetrations of insight. The patient tries stubbornly to resist these onslaughts. The implementation of any acquired insight in the direction of change is resisted even more vigorously. Only gradually, as anxieties are mastered, does the patient begin to divest neurotic encumbrances.

Change is never in a consistently forward direction. Progress takes hold, and the patient improves. This improvement is momentary, and the patient goes backward with an intensified resistance, retrenching with all previous defenses as the problem is investigated more deeply. Anxiety forces a reverse swing toward familiar modes of coping with fear and danger. This is not a setback in the true sense because the individual integrates what has happened into the framework of rational understanding. With the gain achieved from this experience another step forward takes place. Again, anxiety forces a return to old methods of dealing with stress or resorting to disguised adaptations of one's defenses. In association with this there may be discouragement and a feeling of helplessness. But this time, the reintrenchment is more easily overcome. With the development of greater mastery there is further progress; and there may again be a regression to old defenses. The curve of improvement is jerky, but with each relapse the patient learns an important lesson. The neurotic way of adaptation is used less and less, and as patients gain strength through what is happening to them, they are rewarded with

greater and greater progress.

It is discouraging to some therapists to encounter such curious reluctances in their patients toward moving ahead in treatment. The therapist is bound to respond with discouragement or resentment when, after having made an estimable gain, the patient experiences a recrudescence of the symptoms. Should the therapist communicate dismay to the patient, the latter is apt to regard this as a sign of hopelessness or of having failed the therapist. Actually, there is no need for despondency or pessimism should the patient fumble along, repeat the same mistakes, or backslide when logic dictates that one forge ahead.

One way the therapist may maintain control of personal feelings is to anticipate setbacks in all patients. No patient will be able to acquire new patterns overnight. Each patient has a personal rate of learning, which may not be accelerated by any technical tricks.

Before structural psychic change can take place, it is necessary for patients to amalgamate changes that they have achieved in one area with other areas of their personalities. Analogically, it is as if in a business institution that is failing specific enlightenment comes to one department of the organization. After a new policy is accepted and incorporated by this department, it is presented to the other organizational divisions for consideration. Resistance against changing the status quo will inevitably be encountered, with eventual painful yielding by department heads, executives, and other administrative personnel. Many months may go by before the recommended reforms are generally accepted and put into practice. Not until then will the influence on the business be felt. In emotional illness, too, enlightenment produced by understanding of one facet of the individual's behavior will have little effect on the total behavior until it is reconciled with the various aspects of the patient's personality.

This process of *working through* is usually extremely slow, particularly where basic character patterns are being challenged. One may painstakingly work at a problem with little surface change. Then, after a number of months something seems to "give," and the

patients begin responding in a different way to their environment. Gaining satisfaction from the new response, they integrate it within their personalities. The old patterns continue to appear from time to time, but these become increasingly susceptible to influence and replacement with new more adaptive reactions. Having achieved a partial goal, one is motivated to tackle more ambitious aims. The investigative operation is extended toward these new objectives, and the working-through exercise then goes on with retreats and advances until constructive and established action eventuates.

Thus, a patient with a disturbing personality problem came to therapy because of the symptom of impotence. Understanding of his sexual misconception, with a working through of his fear of performance, opened up the possibility of more advanced objectives. A portion of an important session with this patient follows:

Pt. I saw Jane after I spoke to you. Sexually we got along better than we ever had. She had a good orgasm, and it was really the first time. We've been seeing each other for about 5 months, so it was sort of a milestone as far as I was concerned. And yet, I wasn't, I didn't feel as though I'd done a great thing, as though I'd "arrived" or anything like that.

Th. Previously you had felt—I can even recapture your own words—that if an occasion ever occurred with a person like Jane where you could really function to your own satisfaction and to hers, it would really mean you had achieved your goal. Now that it's come about, it hasn't proved to be anything like you anticipated.

Pt. I said to myself that something seems to be stopping me almost from thinking about it. I said, "Now, let's think about this thing because this is supposedly very important." And I just didn't grasp it, as though there's something you want so much, and you get it, and it doesn't mean anything. I said this ought to give you a wonderful feeling; this should be good for you, that this happened. It was good, but it didn't solve all my problems like I imagined it would. And I don't know whether it's because it's become less important to me. It continually demonstrates this business of I could do such-and-such, if only this were the case. How foolish that is because I thought to myself, "Well, really it's just once. Maybe it should be another time. Maybe I should prove myself again. Once really isn't enough." But I feel I could do it three or four times, or a hundred, and it still wouldn't be enough. *[The patient is apparently aware of the fact that sexual success will not solve all of his problems.]*

Th. As a matter of fact, it is possible that the reason you weren't functioning well sexually with her is that you weren't permitting yourself to enjoy sex for the pleasure value but rather for its value in building you up. *[interpreting his neurotic use of*

Pt. I would guess that I have certainly changed in that respect. It bothered me though that it didn't mean more to me than it did. I thought, "Well maybe that's why it happened," because it didn't mean so much to me. So that we're still really on the same basis, as far as this business is concerned.

Th. Mm hmm.

Pt. I say to myself, "Well, there's three women, Barbara, Martha, and Jane, that I'm sleeping with. I have now reached a point where I, they've all been able to have orgasms. It made me feel comfortable, but not. . . maybe I could be better off if I could think, 'Jesus, I'm terrific, or what a great man I am now'." But I don't feel that way.

Th. It would be a very neurotic thing to build up your self-esteem solely and completely, or largely, on the basis of how you function sexually. That's a facade that will cross you up.

Pt. It would be like evaluating a man on the basis of his appetite. If I would be with a woman and I could only have one orgasm, I would think to myself, "Well, you're not as much of a man as if you had two or three orgasms." And yet, it would be like saying, "If a man eats a plate of oysters, if he eats only one plate, he's not as much a man as if he'd eaten two or three plates." I realize my attitude is ridiculous.

Th. But still you seem to think one way and feel the other way.

Pt. It really is a tough situation. This sort of thing seems to be pretty much the kernel of my difficulty. It radiates in all actions and all spheres. I mean the sexual element now seems to, right now, this week anyhow, seems to be receding somewhat into the background and other aspects becoming important. I see where it's necessary to do more, to alter your personality and your attitudes. A whole new set of values have to be evolved, what's good and what's bad, what's right and what's wrong, the sort of life you want to live and what you want to do about it, which, I presume most people never really figure out. I have toyed with the idea before, but now I want to get into myself more.

Another patient with sexual fears and problems in his marital life was, with continued working through, able to make good progress. His relationship with his wife improved. Sexuality became less compulsive a function; he began to achieve greater assertiveness and a feeling of increased self-esteem. These changes are illustrated in the following fragment of the session that follows:

Pt. Tuesday night I decided to bring some flowers home. It was like a miracle, a tremendous response. In fact my wife's face was so overjoyed that I really felt a little sorry that—well, she'd been so miserable—it just required little things like that, not much to make her happy. I talked to her last night about my work, and she interpreted my actions as rejection. But it wasn't so, I told her. I said the things you really want are the important ones. She said that it's true. I explained to her about my work and eventually I thought I'd be able to spend more time with the children, and I was working toward that end. I feel much more comfortable in the situation. I was afraid that I'd have a compulsion to want to do as many things as possible along these lines, so that she'd know I was thinking of her. And the result would be that I'd have a conflict between wanting to do those things and other things like my work. But I find it's not so. I feel very comfortable, much more comfortable in the situation. I feel that I can do those things if I want to. If I think of something to make her know that I'm thinking of her, it's not an effort really on my part. I don't feel a compulsion to want to do them. In fact, when I got the flowers, I really enjoyed getting them. I would say

right now that my situation, therefore, on the whole is a little better. These other things aren't important to me. My wife is enjoyable. I'm more in control of the situation.

Th. You'll be able to make even further progress if you can think objectively about your situation and not act impulsively as you once did.

Pt. Yes, I guess so. I guess being tied up in a situation makes you lose your perspective, but I was so interested in the things that she was actually finding fault with me for, I felt that I concentrated on those, taking them as a personal affront, instead of realizing what they were. I suppose that the situation will change again in some way, but right now I guess things are fairly peaceful, considering everything. I have a great deal of work to do, but I think I'm less neurotic about it; for the first time, I would say, since I've been in business, I am willing and eager to strip myself of as much detail work as possible. Before I was just holding on to it. I made up my mind that this work has to be done and that until I do it, I won't be able to take it easy. The work has to be done before I can take it easy. So I said to myself, "Well, it's really awful because if I had three days like Saturday, where no one bothered me, in a row, I could do it all." So I told my wife that I'm going to have to work a few nights and she said O.K. In fact, last night, I did one of the things that she complained about, I came home late again. But it was wonderful; she didn't complain about it. She greeted me with a smile and said nothing about it. So I could see that that wasn't the important thing. I would say that I feel on the whole that I sort of climbed a little and reached a little plateau, if such a thing is possible.

Th. Well, let us examine that plateau, and see what incentives there are to move ahead. Because virtually, in terms of your goals that you came to see me for originally, you've pretty much achieved those, haven't you?

Pt. I suppose so. The physical symptoms that I had, I don't have them any more. I assume they'll just fade away, because I never think of them. Sexually, I'm functioning much better than I ever did before. So I guess on those two counts I've come a long way. That's true.

Th. In your assertiveness, in your capacity to stand up for your own rights, what about that?

Pt. Well, I'd say there is probably less progress made on that score. We haven't been working on it as much as the other thing.

Th. Well, do you feel that it's been a problem? Do you feel that that constitutes a problem for you?

Pt. Yes, definitely, but now I feel more like a person with rights and things like that, more of an individual than I felt before. But I think I still have a long way to go to feel really an assertive person, I would say. And this may be just a temporary peace that I've achieved. All the elements that caused me anxiety for the past few months have reached the point of equilibrium.

Therapeutic progress is gauged by the ability of the patient to apply what has been learned toward a more constructive life adaptation. The recognition of disturbing drives and the realization that they are operating compulsively do not guarantee that any

modification will occur. Nor do they mean that the patient has the capacity for change. The ability to progress depends upon many factors. Foremost is the desire for change. Among the motivating influences here are a sense of frustration induced by an inability to fulfill normal needs and growing awareness that neurotic strivings are associated with suffering far in excess of compensatory gratifications.

The detection of contradictions in the personality structure also acts as a powerful incentive to change. It is, however merely the first step in the reintegrative process. Thus, if a patient exhibits a pattern of compulsive dependency, the mere recognition of dependency and its consequences will not alter the need to cling tenaciously to others. While it may point the way to the more basic problem of inner helplessness and devaluated self-esteem, there is still a need to examine the meaning of the patient's impaired self-esteem as well as to determine its source. Furthermore, there is required an appreciation of the motivating factors in the individual's present life that perpetuate feelings of helplessness. Understanding the origins of one's dependency trend and tracing it to determining experiences with early authorities are important steps, but these too are usually insufficient for cure. As long as basic helplessness continues, dependency has subjective values the individual cannot and will not relinquish. While the irrationality of one's drives may be recognized as well as the unfortunate consequences, one will desperately cling to them, at the same time rationalizing prevailing motives. Partial insight regarding deep dependency promptings will not eradicate them nor dim their acceptance the remainder of one's life.

Working through, as has been previously indicated, is especially difficult in reconstructive therapy and a description of the process may at this point be helpful. The releasing of the self from the restraint and tyranny of an archaic conscience, freeing it from paralyzing threats of inner fears and conflicts, is an extremely slow process. Ego growth gradually emerges, with the development of self-respect, assertiveness, self-esteem, and self-confidence. It is associated with liberation of the individual from a sense of helplessness and from fears of imminent rejection and hurt from a hostile world.

The process of ego growth is complex and merits a more elaborate description. Fundamentally to encourage such growth it is necessary to cajole the ego into yielding some of its defenses. Within the self the individual feels to weak to do this and too terrified to face inner conflicts. Unconscious material is invested with such anxiety that its very acknowledgment is more than the patient can bear. Rooted in past conditionings, this anxiety possesses a fantastic quality, since it is usually unmodified by later experiences. It is as if the anxiety had been split off and were functioning outside the domain of the ego. In therapy it is essential to reunite the conscious ego with the repressed material and its attendant anxiety, but resistance constantly hampers this process. Promoting resistance is the hypertrophied set of standards and prohibitions that developed out of the individual's relationships with early authorities. These standards oppose not only the uncovering of unconscious material, but also the expression of the most legitimate personal needs.

Working through in reconstructive therapy must be accompanied by a strengthening of the ego to a point where it can recognize the disparity between what is felt and what is actually true, where it can divest the present of unconscious fears and injuries related to the past, where it can dissociate present relationships with people from attitudes rooted in early interpersonal experiences and conditionings. Ego growth is nurtured chiefly through a gratifying relationship with the therapist. The exact mechanism that produces change is not entirely clear. However, the therapist-patient relationship acts to upset the balance of power between the patient's ego, conscience, and repressed inner drives. The ultimate result is a liberation of the self and a replacement of the tyrannical conscience by a more tolerant conscience patterned around an identification with the therapist.

The relationship with the therapist may, however, light up the individual's fears of injury, as well as inordinate expectations, drives, and forbidden erotic and hostile desires. Despite the lenity of the therapist, the patient will keep subjecting the therapist to tests in order to justify a returning to the old way of life. If the therapist is too expressive in tolerance of the patient's deepest impulses, the patient will look upon treatment as a seduction for which one will pay grievous penalties later on. On the other hand, a repressive attitude expressed by the therapist will play in with the patient's residual

concept of authority as restrictive and, therefore, deserving of customary evasions and chicaneries. At all times the patient will exploit usual characterologic defenses to prevent relating the self too intimately to the therapist. The patient has been hurt so frequently in previous interpersonal relationships that there is the conviction that danger lurks in the present one. Under the latter circumstance the working-through experiences may take place within the transference relationship itself particularly when the patient is in long-term therapy and the therapist encourages the development of a transference neurosis. Obviously the therapist must have had psychoanalytic training to lead the patient through the rigors of the neurotic transference experience.

Many months may be spent in dealing with resistances that ward off the threat of a close relationship with, and the acknowledgment of certain irrational feelings toward, the therapist. The therapist acts to dissolve these facades by direct attack. Perhaps for the first time patients permit themselves to feel, to talk, and to act without restraint. This freedom is encouraged by the therapist's attitude, which neither condones nor condemns destructive impulses. The patients sense that the therapist is benevolently neutral toward their impulses and will not retaliate with counterhostility in response to aggression. Gradually the patients develop reactions to the therapist that are of a unique quality, drawing upon emotions and strivings that have hitherto been repressed. The release of these submerged drives may be extremely distressing to the patients. Because they conflict so outrageous with standards, bound to reject them as wholly fantastic or to justify them with rationalizations. There is an almost psychotic quality in projected inner feelings and attitudes, and the patients may fight desperately to vindicate themselves by presenting imagined or actual happenings that put the therapist in a bad light.

As the patients experience hostility toward the therapist and as they find that the dreaded counterhostility does not arise, they feel more and more capable of tolerating the anxiety inevitable to the release of their unconscious drives. They find that they can bear frustration and discomfort and that such tolerance is rewarded by many positive gains. Finally, they become sufficiently strong to unleash their deepest unconscious drives and feelings, which previously they had never dared to express. Projecting these onto the

person of the therapist, the patients may live through infantile traumatic emotional events with the therapist that duplicate the experiences initially responsible for their disorders. The latter phase occurs when the patients have developed sufficient trust and confidence in the therapist to feel that they are protected against the consequences of their inner destructive impulses.

Sexual wishes, hostile strivings, and other drives may also suddenly overwhelm the patients and cause them to react compulsively, against their better judgment. The patients almost always will exhibit behavior patterns, both inside and outside the therapeutic situation, that serve either to drain off their aroused emotions or to inhibit them. They may, for instance, in response to feelings of rage, have a desire to frustrate and hurt the therapist. Accordingly, they will probably have but tend to suppress imprecations and derisive feelings about the therapist, minimizing the latter's intelligence, or emphasizing any shortcomings. They may become sullen, or mute, or negativistic.

These reactions do not always appear openly and may be manifested only in dreams and fantasies. Sometimes hostility is expressed more surreptitiously in the form of a sexual impulse toward the therapist, which may have its basis in the desire to undermine or to depreciate. At the same time the patients realize that they need the love and help of the therapist, and they may feel that expression of hostility will eventuate in rejection. They may then try to solve their conflict by maintaining a detached attitude toward the therapist, by refusing to verbalize freely, by forgetting appointments, or by terminating treatment.

A danger during this working-through process is that the patients may act out inner impulses and feelings and fail to verbalize them. This is particularly the case where the patients are given no chance to express everything that comes to mind. Such acting-out has a temporary cathartic effect, but it is not conducive to change. If the patients do not know what they are reliving, they will think that their reactions are completely justified by reality. If acting-out goes on unchecked, it may halt the therapeutic process. The most important task of the therapist here is to demonstrate to the patients what in the

therapeutic relationship is being avoided by acting-out.

As the patients realize that their emotions and impulses are directly a product of their relationship with the therapist, they will attempt to justify themselves by searching for factors in the therapist's manner or approach that may explain the reactions. Inwardly they are in terror lest the therapist call a halt to therapy and thus bring to an end the possibility of ever establishing an unambivalent relationship with another human being. Yet they continue to respond with contradictory attitudes. On the one hand, they seek praise and love from the therapist, and, on the other, they try to repudiate and minimize the therapist. They resent the tender emotions that keep cropping up within themselves. The battle with the therapist rages back and forth, to the dismay of both participants.

One of the effects of this phase of the therapy is to mobilize ideas and fantasies related to past experiences and conditionings. The transference relationship is the most potent catalyst the therapist can employ to liberate repressed memories and experiences. As the patients express irrational impulses toward the therapist, they become tremendously productive, verbalizing fantasies and ideas of which they were only partially aware.

Sooner or later the patients discover that their attitudes and feelings toward the therapist are rooted in experiences and conditionings that date to the past; they realize that these have little to do with the therapist as a real person. This has a twofold effect: first, it shows them why exaggerated expectations and resentments develop automatically in their relationships with others; second, it permits them to see that they are able to approach people from a different point of view.

The transference is a dynamic, living experience that can be intensely meaningful to the patient. Recovery of repressed material is in itself insufficient. The material has to be understood, integrated, and accepted. During reconstructive therapy much material of an unconscious nature may come to the surface, but the patients will, at first, be unable to assimilate this material because it lies outside the scope of their understanding. In the transference relationship the patients are able to feel their unconscious impulses in actual

operation. They realize them not as cold intellectual facts but as real experiences. The learning process is accelerated under such circumstances.

The transference not only mobilizes the deepest trends and impulses, but also it teaches the patients that they can express these without incurring hurt. This is unlike the ordinary authority-subject relationship, in which the person feels obligated to hold back irrational feelings. Because of the therapist's tolerance, the patients become capable of countenancing certain attitudes consciously for the first time. They appreciate that when they express destructive attitudes toward the therapist, these do not call forth retaliatory rejection, condemnation, or punishment. They gradually develop a more tolerant attitude toward their inner drives, and they learn to reevaluate them in the light of existing reality rather than in terms of unconscious fantasies and traumatic events in the past. As they undergo the unique experience of expressing their deepest strivings without retaliation, they also begin to permit healthy attitudes to filter through their defenses. The therapist becomes an individual who fits into a special category, as less authority and more the friend.

The tolerant and understanding attitude of the therapist provides a peculiar attribute of protectiveness; for the patients alone are unable to accept inner conflicts and impulses and use the therapist as a refuge from danger. The conviction that they have a protector enables them to divulge their most repulsive dreams, impulses, emotions, memories, and fantasies, with an associated release of affect. Along with growing awareness of their unconscious drives with placement in the time frame of earliest childhood, the patients sooner or later discover that there is a difference between what they feel and what it actually going on in reality; they find that their guilt feeling and anxiety actually have no basis in fact.

The patients may bring up more and more painful material. Encouraged to express themselves, they begin to regard the therapist as one who bears only good will toward their repressed drives. They will continue to exhibit all of their customary interpersonal attitudes and defenses in their relationship with the therapist, but they can clarify these to

themselves under a unique set of conditions—conditions in which they feel accepted and in which there is no condemnation or retaliatory resentment.

The reorientation in their feelings toward the therapist makes it possible for them to regard the therapist as a person toward whom they need nurture no ambivalent attitudes. Their acceptance of the therapist as a real friend has an important effect on their resistances. These are genetically related to the hurt that they experienced in their relationships with early authorities. The lowering of resistances is dynamically associated with an alteration in their internalized system of restraints, for, if they are to yield their defenses, they must be assured that the old punishments and retributions will not overtake them. It is here that their experiences with the therapist play so vital a role because in it they have gained an entirely new attitude toward authority. Their own conscience is modified by adoption of a more lenient set of credos.

One of the chief aims of reconstructive therapy is to render the conscience less tyrannical and to modify it so as to permit the expression of impulses essential for mental health. Perhaps the most important means toward this alteration is through acceptance of the therapist as a new authority whose standards subdue and ultimately replace the old and intolerable ones. In the course of the therapeutic relationship the patients tend to identify themselves with the therapist and to incorporate the therapist's more temperate values. The ultimate result is a rearrangement of the dynamic forces of the personality and a reduction in the harshness of the superego.

Identification with the therapist also has a remarkable effect on a patient's ego. Progress in reconstructive therapy is registered by the increasing capacity of the reasonable ego to discern the irrationality of its actions, feelings, and defenses. The rebuilding of ego strength promotes a review of old repressions, some of which are lifted, while others are accepted but reconstructed with more solid material, so that they will not give way so easily to unconscious fears. Growth in the rational power and judgment of the ego makes it possible to identify these destructive strivings, which, rooted in past experiences, are automatically operative in the present.

Ego strength, consequently, results both from liberation of the self from the repressive and intolerant standards of the tyrannical conscience, and also identification with the accepting, non-hostile figure of the therapist. Ultimately, ego growth involves an identification with a healthy group. This is, of course, the final aim in therapy, and a good relation with the group eventually must supplement and partly replace the personal identification.

The undermining of the superego and the strengthening of the ego give the patients courage to face their fearsome impulses, such as hate. They become increasingly more capable of expressing rage openly. The possibility of their being physically or verbally attacked by the therapist becomes less and less real to them. As they resolve their hate and fear, they are likely to experience an onrush of loving emotions. Particularly where a transference neurosis has been allowed to develop, these may burst forth in a violent form, as in a compulsive desire for sexual contact. In this guise feelings may be loathsome and terrifying and may become promptly repressed. Sexuality, to the mind of the patients, may mean unconditional love or surrender or a desire to attack or to merge with another person. Inextricably bound up with such destructive feelings are healthful ones, but because the patients have been hurt so frequently in expressing tender impulses, they have customarily been forced to keep feelings under control. In their relationships with the therapist they learn that normal demands for understanding and affection will not be frustrated and that these have nothing to do with hateful and sexual attitudes.

As the therapist comes to be accepted as an understanding person, the unconscious impulses come out in greater force, and the patients discover that they are better able to tolerate the anxiety that is created by such expression. In contrast to what occurs in real life, resistance to one's divulgence is not reinforced by actual or implied threats of retaliation or loss of love. The patients then become conscious of the fact that their terror has its source within themselves rather than in an implied threat of hurt from the therapist. This insight does not help much at first, but gradually it permits the patients to experiment in tolerating increased doses of anxiety.

The development of the capacity to withstand pain makes it possible for the patients to work out more mature solutions for their problems, instead of taking refuge in repression, a defense hitherto necessitated by an inability to tolerate anxiety. The discovery that they have not been destroyed by their impulses and the realization that they have not destroyed the therapist, whom they both love and hate, are tremendous revelations, lessening the inclination to feel guilty and to need punishment, and contributing to their security and self-respect.

At this stage in therapy the patients become more critical of the therapist and more capable of injecting reality into the relationship. They attempt to test out their new insights in real life. They do this with considerable trepidation, always anticipating the same kind of hurt that initially fostered their repression. As they discover that they can express themselves and take a stand with the therapist, a new era of trust in the therapist is ushered in with a definite growth of self-confidence. Over and over they work through with the therapist their own characterologic strivings, reexperiencing their unconscious impulses and the accompanying reactions of defense against them. Gradually they become aware of the meaning of their emotional turmoil, as well as of the futility of their various defenses. The continuous analysis of the transference enables them to understand how their neurotic drives have isolated them from people and have prevented expression of their healthy needs.

A new phase in their relationships with the therapist ensues. Realizing that the therapist means more to them than does anyone else, they seek to claim this new ally for themselves. They may wish to continue the relationship indefinitely, and they may look upon the completion of therapy as a threat. Clinging to their illness may then have positive values. However, they soon begin to understand that there are reality limitations in their present relationship, and they begin to realize that they do not get out of it the things that they are beginning to demand of life, that the outside world is the only milieu in which they can gratify their needs. They find the relationship with the therapist gratifying, but not gratifying enough; their reality sense becomes stronger, and their ability to cope with frustration is enhanced. Finally, they set out in the world to gain those satisfactions that

they have never before felt were available to them.

The working-through process is not always accompanied by the intensive transference manifestations such as have been described. Indeed, the relationship with the therapist may be maintained on a more or less equable level, the working through of attitudes, feelings, and conflicts being accomplished exclusively in relation to persons and situations outside of therapy. This is particularly the case in supportive, reeducative, and psychoanalytically oriented psychotherapies in which a transference neurosis is more or less discouraged. But even in the latter therapies it may not be possible to keep direct transference from erupting; if this occurs, some of the working through will have to be focused on the patient-therapist relationship.

Again it must be emphasized that circumvention and avoidance of a transference neurosis do not necessarily limit the extent of reconstructive change that may be achieved by skilled therapists with less intensive therapies than classical analysis. Nevertheless there are some patients in whom repression is so extreme that only a transference neurosis will serve in its resolution. (See also Chapter 42)

EXPEDITING WORKING THROUGH

It is salutary to avoid reinforcing the patient's concept that one is a laboratory of pathological traits. Our focus on symptoms, conflicts, defenses, and personality distortions may divert us from accenting the sound, constructive, and healthy elements that coexist. Patients are sufficiently alarmed by their difficulties not to need constant reminders of the various ways that these obtrude themselves in their lives. In a subtle way they perceive that the therapist is more interested in their pathological traits than in other aspects, and they may respond to this reinforcement by concentrating on them at the same time that they build a shell of hopelessness around themselves. As they repetitively indulge their neuroses, and the therapist keeps pointing this out to them, they may begin to feel out of control. Ultimately, they may give up and assume the attitude that if they are unavoidably neurotic, they might as well act like heroes in a Greek legend, marching with head up to their inevitable doom.

Neurotic trends are tenacious things and do not yield by constant exposure of their existence or source. They must gradually be neutralized through replacement with more effective and adaptive substitutes. This process will require that the therapist mobilize all positive resources at the disposal of the patients. While one should not avoid acquainting the patients with what they are doing to sabotage their adjustment, and perhaps the reason why, one should at the same time point out what constructive elements are present simultaneously. For example, a saleswoman in therapy who is burdened by a need to fail, destroys again the opportunity of advancement by insulting the vice president of the company, who is in charge of her operations and who is considering her and a colleague for a post that is more interesting, better paying, and more prestigious. The patient eager to have this new job, to her own consternation finds herself engaging angrily in complaints and recriminations about the company's policies and operations charging that the vice president must in some way be involved. The patient reports to her therapist.

> *Pt.* I did it again. I was so furious with myself. I even realized what I was doing while I was letting off steam. I'm just a mess.

Improper Response

> *Th.* You aren't, but what you're doing to your life is. You shouldn't have allowed yourself to criticize your superior directly.

Proper Response

> *Th.* It's obvious to me that you care enough about yourself to be disturbed by what happened. When a similar situation presents itself that invites you to fail, you will most likely be able to anticipate your response in advance and alert yourself to any sabotage talk.

The patient should be apprised of her active need for cooperation. She must be told that one cannot change without experimenting with certain new actions. Like any experiments she must take some risks, and she must be prepared to face some failure and disappointments, even a few hurts. Successes cannot occur without some failures. The therapist should extend as much help and encouragement as is necessary— but no more. It is important that the patient assume as much responsibility as possible. Role playing here can be helpful.

To summarize, the following principles may be found helpful:

1. Patients must proceed at a pace unique for themselves and contingent on their readiness for change and on their learning abilities.

2. Reinforcement for progress is needed in the form of therapist verbal approval whenever the patient takes a reasonable step forward.

3. If resistances to movement develop, the focus on therapy must be concentrated on understanding and interpreting the patient's resistances.

4. Adjuncts, like assigning homework practice sessions, for the gradual mastery of certain problems may help deal with obdurate resistances.

5. Encouraging the patient to generalize from the immediate situation one aspect of experience, or the control of a symptom, to other experiences may be important. This eventually enables a view of the immediate disturbance in the light of the total personality structure.

6. Adjuncts like role playing may be indispensable.

ILLUSTRATIVE CASE MATERIAL

Illustrative of the working through of transference is the case of a young divorcee with a personality problem of detachment, whose marriage had broken up largely because of her general apathy. Sexually frigid and with little affectionate feeling for people, she had never been able to establish a relationship in which she could feel deep emotion. After a prolonged period of working on her resistances, she began to evince positive transference feelings toward me, as manifested in the following fragment of a session:

> *Pt.* I had a dream yesterday. We were dancing together, and then you make love to me. Then the scene changes, and there is a fellow sitting on a bench, and you kiss me and in jest ask him to leave. And then you sit down, and I lie down with my head against you. You put your arms around me. And then the scene shifts again, and you and I are in the kitchen. And my daughter, Georgia, is climbing over the sink toward the window, and I pull her in. Then I'm standing there with my son, John, in the hallway and you very professionally ask if there is anyone else I am waiting for. You came to find out about John. You forget the fact that you asked me for dinner, and I'm very let down and wake up with that let-down feeling.

> *Th.* What are your associations to this dream?

Pt. I awoke with the feeling that I'm very much in love with you. I want you to love me very much. It's a desperate feeling that I can't control.

Th. How long has this feeling been with you?

Pt. It's been accumulating over a time, but it suddenly hit me last night, and when I awoke this morning, I knew, *(pause)* This is a funny thing to ask you, but I feel sexually attracted to you. Is it ever permissible to . . .to. . . I mean *(blushes)*

Th. You mean to have an affair?

Pt. Yes.

Th. Well, I appreciate your feeling very much. It often happens that in therapy the patient falls in love with the therapist. This is understandable because the patient takes the therapist into her confidence and tells him things she wouldn't dare tell herself. But in therapy for the therapist to respond to the patient by making love would destroy therapy completely.

Pt. I can understand perfectly. But I felt that you responded to me, *(laughs)* that *you* were in love with me. I think you are the most wonderful man in the world.

Th. You may possibly feel I reject you. It is important though to explore your feelings for me, no matter what these may be.

Pt. I agree, agree with you, of course. I can't see how this happened to me though. It never happened before. It's a hell of a note, but as you say, it must inevitably happen.

There ensued a prolonged period of strife in which the patient veered from sexual to hostile and destructive feelings toward me. The following session, for example, reflects negative impulses.

Pt. I'm furious at you. I don't, didn't want to come today.

Th. Can you tell me why?

Pt. Because you've gotten, gotten me to feel like a human being again instead of a piece of wood, and there's nothing to do about it. You know very well there's nothing to do about it.

Th. You mean, now you're able to feel about people and there's nothing you can do about expressing yourself?

Pt. (angrily) Oh, please be quiet will you. *(pause)* Here you went and got me all stirred up for absolutely nothing. It's like you want to torture and hurt me.

Th. What makes you think that I want to torture you and hurt you?

Pt. I didn't say you wanted to. I don't believe I've reproached you at all. I never reproach anybody

for anything, I never have.

Th. But . . .

Pt. Have I ever implied or said one word of reproach to you? I don't believe I have.

Th. No.

Pt. No. I don't think so. I don't reproach anybody for anything. I don't want you to do anything at all, except just let me walk out of that door.

Th. Do you really want to walk out of that door?

Pt. I'm going to walk out of that door. You see, what you don't know about me yet is that I've a very, very strong will, *(pause)* You sit there in that chair, and I sit here opposite you, and you've got that lovely warm darn way of speaking, and before I reach that door, you'll freeze like an icicle. And I can do exactly the same thing, exactly the same thing.

Th. You mean just to get even with me?

Pt. Have you ever seen me try to get even with anybody? I don't think you have. I'm not a very vindictive person.

Th. Do you think I really act icy to you?

Pt. But you do.

Th. When?

Pt. I went out of here the last time ashamed of myself. I went down that street crying. I was crying. I felt you rejected me, cold to me.

Th. You felt that I rejected you? You felt that I acted cold toward you? When did I act cold toward you?

Pt. Let's drop that rejection business, shall we? It isn't a question of being rejected. It has nothing to do with it at all. And if we get right down to it, what difference does it make whether you do or you don't?

Th. It makes this difference, that I am very much interested in helping you.

Pt. If I walked out of this room, you'd never think of me again.

Th. You feel that if you walk out of this room, I'll never even think of you again.

Pt. That's exactly how I feel! Exactly what I feel. Yes. Suppose you had to do the same thing for every patient. You couldn't last, any more than any other doctor could last, any more than any trained nurse could last. They can't. *(pause)* Well, I'm feeling a lot better getting that off my chest.

Th. I'm glad you're feeling better.

Pt. Yes. I'm sure. I think you owe me quite a little time. I don't believe I've ever stayed here 45 minutes, have I? I don't think so. I've always looked at that clock and I've gone. I've gone to the second at 40 minutes after I got here. *[This is not exactly correct, but I decide not to challenge it.]*

Th. Why?

Pt. Because I don't want anything from anybody. Because I don't want one minute of anybody's time.

Th. You just want to be completely independent?

Pt. Yes, I do.

Th. I wonder if you trust me?

Pt. I've always trusted you. What do you think I'm coming here for? There isn't anybody that is forcing me to come. Who is it that drags me any place on a chain? If I didn't want to come, there isn't anybody that could make me come.

Th. Indeed. You know, too, that it's good that there's nobody that forces you to be here. It has to be completely a free-thing with you, a voluntary thing with you, a thing that you really believe in.

Pt. I don't know what I'm going to do when I have to leave you, when I'm through with this.

Th. Why?

Pt. I can't depend on anybody, see?

Th. You're afraid to get dependent on me?

Pt. I'm afraid to get dependent on any human being, because there isn't a living human being that I can trust. Not even you. I can't trust anybody on earth. And that's the truth.

Th. I can't force you to trust me, but I hope you will. I'll do everything in my power to be worthy of that trust. But I can appreciate the suffering and torment that you must go through as you begin to feel feelings for me.

Pt. But you do torment me.

Th. How do I torment you?

Pt. I think you resent me, even despise me.

Th. Did I ever do anything to give you that impression?

Pt. No, but ... I guess I must *think* you reject me. But you really don't.

The brief samples of the interviews contained here do not permit the detailed and painful elucidations of the genetic origins of the patient's problem. This was rooted in relationship to her early parenting figures. Her mother was a vain, rejecting, narcissistic woman and her father a cold, detached individual to whom she could never get close. She was made to feel that human beings should at all times control their emotions. Her dreams in therapy left no doubt in my mind that she was transferring her repressed feelings related to her father toward me. The working through of her feelings toward a more constructive solution is shown in this portion of an interview that occurred several months after the initial onset of transference:

> *Pt.* When I came to you, you were exactly what I needed at that moment, and you comforted me when I came, and for the first few weeks—it was no more than that—then I began to like you. I liked you more and more, and it was interesting to me that I could feel that way about a person because I had not up to that point. You were the first person that I felt anything for since many, many years ago. So I reasoned it out, and I felt that you were probably ... I didn't know what you were like as a man. I knew you only from a professional standpoint, what you were like. Maybe I would not feel that way if I did know you, I don't know. I was trying to tell myself I didn't know enough about you to feel that way. It wasn't anything sound. And another thing I felt was that you were probably a symbol of what I would like to have or feel for someone, that you just were a symbol. Actually, I didn't know enough about you to feel that way, and I kept telling myself that, and, during your vacation when I left I thought I didn't know how I was going to get along without seeing you. It was really the high point of my week when I came to see you. I looked forward to it, and I really enjoyed that more than anything else that I did. So, during the summer, I thought, "Well, I am going to miss him. How will I get along?" I sort of leaned on you, and I had gotten so much comfort. Then, something began to happen to me, and I felt that even if I felt that way, maybe you did like me very much, maybe you didn't. I don't know whether what you say is all professional. I felt that as far as you were concerned, even if you did like me, and I liked you as you said, which was what I had figured out for myself, that any sort of very close friendship was not possible and isn't practical. I felt that I needed you much more as a doctor than a man at that point and that I should forget about it. So it was something that I was putting on. I probably needed something, maybe it wasn't necessarily you. So I sort of started to look around at men. I was aware more of the attention they paid me. I responded more, which I had never done. I found that I was giving them a little more encouragement because I never radiated any encouragement. I felt that if I were to find someone, I was very happy that I could feel that way about someone. I really was because I didn't think I could any more, I just didn't. I missed seeing you, which was very unusual for me, because I hadn't felt that way about anyone in many years. So I started to look around; as I say I have responded, but I haven't found anyone that I do feel that way about. Of course, I haven't had the opportunity.

> *Th.* At least you are not running away and are not guilt-ridden. You may feel that if the right sort of person came along, there may be a possibility for a relationship. But what about me right

now?

Pt. Well, I'll tell you how I feel about that. When I first came here, not the first few weeks, but a little later, I felt that you did like me personally. I don't know how justified I was, but I did feel that.

Th. You mean that I was in love with you?

Pt. Not that you were in love with me, but that you were attracted to me, that you did like me. But, of course, again I said that maybe I was so keyed up; I thought maybe I had sort of colored it, which was unusual for me, because I have never in all my life responded to any man or made the first steps without his feeling a great interest in me. I have never, so that if it was so, it was different than it had ever been because that was never so before. I have never made the first move or picked someone and said I liked him and want to know him, and I'd like to be in love with him. I never felt that way.

Th. It was always as a result of somebody else's actions first.

Pt. Of somebody radiating more than the usual amount of interest. So that I felt that it was different and I was rarely wrong, I mean, I was always right, but, of course, as I say, I was in a different state of mind than I am today. I am much calmer, probably see things a little clearer. So that I felt that you didn't love me, and I hoped that you didn't. In a way I wanted it, and yet I realized that I hoped you didn't because I might respond. I just felt it was wrong because you were the wrong person, because you are my doctor. "So, find somebody else," I said to myself. (*laughs*) As a matter of fact a very funny thing happened. I ran into my uncle who referred me to you shortly after first starting with you. I was beginning to feel that way about you, and I was curious about you. I met him in a restaurant. We talked for a few minutes. He asked me how I was getting along. I said I was making progress. He asked me how I liked you, and I said very much indeed, you were grand. He said he thought so too. You were practical, and he recommended you because he thought you would be what I needed. So I said, "Is he married?" And I was blushing. So he said, "He has an awfully nice wife and some lovely children." I realized then that probably I had radiated something that I hadn't intended to. I must have radiated some interest.

Th. Your reaction to me was one that occurs commonly in psychotherapy.

Pt. I realize this.

Th. Sometimes it's necessary to have such a reaction to get well.

Pt. That's the thing, that's the reason I bring it up.

Th. You might never get well if you didn't have a positive attitude toward me. That attitude we can use as a bridge to better relationships with men. There is a possibility that you may not find a man right away. There is a possibility of that, but at least you will know that it's not because of any block in you; it's not because you have no capacity to love.

Pt. Well, it's been, and I'll tell you it's been an amazing thing. I used to wonder at it myself because I certainly am not cold. I used to wonder at myself because it didn't seem to concern me. I mean sex. That's the truth of it. But I'm getting myself interested now.

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Supportive and Reeducative Techniques during Middle Treatment Phase

With the accent on cost-effectiveness demanded by third party payers, short-term therapy has been coming into prominence, and this has tilted the scales toward goals of symptom control and problem-solving. These necessitate supportive and reeducative interventions. There are still a substantial number of therapists who believe methods aimed at symptom control, while rapidly palliating suffering and perhaps even reinstating the previous psychological equilibrium, operate like a two-edged sword. Justifiable as symptom control may seem, these skeptics insist that it fails to resolve the *underlying* problems and difficulties that nurture the current crisis. Irreconcilable unconscious needs and conflicts continue to press for fulfillment, and, therefore, they insist, we may anticipate a recrudescence or substitution of symptoms. These assumptions are based on an erroneous closed-symptom theory of personality dynamics. Symptoms once removed may actually result in productive feedback that may remove barriers to constructive shifts within the personality system itself. Even though these facts have been known for years (Alexander, F, 1944; Alexander et al, 1946; Avnet, 1962; Wolberg, LR, 1965; Marmor, 1971) and have been corroborated in the therapeutic results brought about by active psychotherapeutic methods, the time-honored credo branding symptom removal as worthless persists and feeds lack of enthusiasm for symptom-oriented techniques. The supportive process, however, may become more than palliative where, as a result of the relationship with the helping agency, the person gains strength and freedom from tension, and substitutes for maladaptive attitudes and patterns those that enable one to deal productively with environmental pressures and internal conflicts. This change, brought about most effectively through the instrumentality of a relationship either with a trained professional in individual therapy or with group members and the leader in group therapy, may come about also as a result of spontaneous relearning in any helping situation. Some dependency is, of course, inevitable in this kind of a therapeutic

interaction, the adequate handling of which constitutes the difference between the success or failure of the therapeutic relationship in scoring a true psychotherapeutic effect. Dependency of this kind, however, can be managed therapeutically and constitutes a problem only in patients who feel within themselves a pathological sense of helplessness. The sicker and more immature the patient, the stronger the dependency is apt to be. It is essential that the helping agency be able to accept the patient's dependency without resentment, grading the degree of support that is extended and the responsibilities imposed on the patient in accordance with the strength of the patient's defenses.

The evidence is thus overwhelming that symptom-oriented therapy does not necessarily circumscribe the goal. The active therapist still has a responsibility to resolve as much of the patient's residual personality difficulties as is possible within the confines of the available time, the existing motivations of the patient, and the basic ego strengths that may be relied on to sustain new and better defenses. It is true that most patients who apply for help only when a crisis cripples their adaptation are motivated merely to return to the dubiously happy days of their neurotic homeostasis. Motivation, however, can be changed if the therapist clearly demonstrates to the patient what really went on behind the scenes of the crisis that were responsible for the upset.

Supportive approaches are employed during the middle phases of treatment under the following conditions:

As a Principal Form of Therapy

1. Where the patient possesses a fairly well-integrated personality but has temporarily collapsed under severe stress, a short period of palliative psychotherapy may suffice to restore the habitual stability. Supportive techniques may also be efficacious where the problem has not yet been structuralized, as in behavior disorders in children. Actually, supportive therapy under these circumstances may be the treatment of choice in a sizable number of patients who consult a psychotherapist.

2. Patients who require more intensive psychotherapy, but are temporarily too ill to utilize reconstructive therapy, may benefit from supportive

approaches as an interim measure.

3. Supportive therapy is often mandatory in patients whose symptoms interfere drastically with proper functioning or constitute sources of danger to themselves and to others. Among such symptoms are severe depression, suicidal impulses, homicidal or destructive tendencies, panic reactions, compulsive acting-out of perverse sexual strivings, severe alcoholism, drug addiction, and disabling physical symptoms of psychologic origin.

4. Where motivation for extensive therapeutic goals is lacking in patients who seek no more than symptom relief or problem-solving, supportive treatment may prove sufficient. After such partial goals have been achieved, it may be possible to motivate the patient to work toward reconstructive goals.

5. Where the personality has been severely damaged during the formative years so that there is little on which to build, the objective may be to stabilize the individual through supportive measures. Some patients with severe infantile, dependent personality disorders, and with borderline and psychotic reactions, may be unable to tolerate the anxieties of exploration and challenge.

6. Supportive treatment may be indicated where the available time and finances are limited, or where there is extreme character rigidity, or where the personality is so constituted that the patient can respond only to commanding authoritative injunctions. Even though manifest neurotic difficulties continue in force following therapy, life may become more tolerable and the individual may adopt a more constructive attitude toward reality.

As an Adjunctive Form of Treatment during Reeducative and Reconstructive Therapy

1. Where the coping resources of the ego are failing, as evidenced in feelings of extreme helplessness, severe depression, intense anxiety, and disabling psychosomatic symptoms, extension of support is usually necessary.

2. In cases where the environment is grossly disturbed so as to impede progress, supportive techniques like environmental manipulation may be required.

MODE OF ACTION OF SUPPORTIVE THERAPY

Supportive therapy owes its efficacy to a number of factors:

1. A correction or modification of a disturbed environment or other stress source may serve to strengthen coping resources.

2. The improvement that results may permit the individual to exact gratifications essential to one's well-being.

3. The patient may fulfill, in the supportive relationship with the therapist, important interpersonal needs, the deprivation of which has created tension. The supplying of emotional needs in the relationship constitutes what is sometimes known as *transference cure*. For instance, the patient, feeling helpless, may desire the protection and security of a stronger individual on whom one may become dependent. Finding this with the therapist, the patient feels the comfort akin to a child who is being cared for by a loving and powerful parental agency. The patient is thus relieved of responsibility and filled with a sense of comfort and security. Reinforcing these effects are the influences of the placebo element and of suggestion.

4. In the medium of the therapeutic relationship, the patient may verbalize freely and gain a cathartic release for fears, guilt feelings, damaging memories, and misconceptions that have been suppressed or repressed, having no opportunity for such discharge in the customary life setting. The draining off of tension, which has been converted into symptoms, brings about relief and usually a temporary abatement of symptomatic complaints.

5. The patient may rebuild shattered old defenses or erect new ones that serve to repress more effectively offending conflicts. Supportive therapy is suppressive in nature, helping to keep conflicts from awareness or modifying attitudes toward the elements of conflict.

6. Under the protective aegis of the therapist, the patient is enabled to face and to master life problems that were hitherto baffling. Greater capacity to deal with these problems not only helps to rectify current sources of stress, but also gives the patient confidence in the ability to adjust to other difficult aspects of the environment. The resultant expansion of security may eliminate the patient's need to exploit inadequate defense mechanisms.

7. There may be alleviation of guilt and fear through reassurance or through

prohibitions and restrictions, which, imposed by the therapist, are interpreted as necessary disciplines by the patient.

8. Certain measures, like drugs and relaxing exercises, may remove tension or moderate its effects.

9. An outlet for excessive energy and tension may be supplied through prescribed physical exercises, hobbies, recreations, and occupational therapy.

THE THERAPIST-PATIENT RELATIONSHIP IN SUPPORTIVE THERAPY

The different techniques employed in supportive therapy presuppose a relationship of therapist to patient that varies from strong directiveness to a more passive permissiveness. In most cases the therapist is essentially authoritarian.

Success in treatment usually is contingent on acceptance of the therapist as a wise or benevolent authority. A consistent effort is made to establish and maintain a congenial atmosphere. Because hostile attitudes oppose the incorporation of therapeutic suggestions, it is essential to try to avoid a negative transference. An attempt is made to win the patient over to a conviction that the therapist is a helpful friend. Whenever the patient manifests attitudes that interfere with the relationship, therapy is focused on discussion and clarification in the attempt to restore the original rapport. Much skill may be required to halt negative feelings as soon as they start developing; but unless this is done, the therapist may encounter resistance that cannot be controlled.

Forcefulness of personality, and an ability to inspire confidence are important qualities in the therapist for this type of therapy. The ideal attitude toward the patient is sympathetic, kindly, but firm. The most successful therapists never derive sadistic pleasure from the patient's submission nor resent the latter's display of aggression or hostility. They do not succumb to blandishments of praise or admiration. A non-condemning, accepting attitude, shorn of blame or contempt, secures best results.

The neurotic patient may, of course, display provocative impulses and attitudes; but if the therapist is incapable of controlling his or her resentment, this practitioner will

probably be unable to do productive work with the patient. The irritation cannot usually be concealed by a judicious choice of words.

The attitudes of the therapist are important because some of the patient's responses have been conditioned by antagonistic reactions of other people. At the start of therapy the patient will expect similar displays from the therapist, especially rejection or condemnation. When such responses do not appear even under badgering, the patient's attitude toward the therapist hopefully will change. Different from how he or she acts in other relationships, the patient may begin to feel accepted as is, and genuine warmth toward the therapist may begin to trickle through. The patient may then recognize the therapist as an ally with whom one can identify and whose values one may respect.

There are therapists who attempt, in a supportive framework, to deal boldly with pathogenic conflicts by manipulating the therapeutic relationship. Here they deliberately play a role with their patients in order to reinforce or subdue the parental image or to introduce themselves as idealized parental substitutes. Transference responses are deliberately cultivated by employing permissiveness or by enforcing prohibitions graded to a desire effect. Acting a "good" parental figure is considered helpful with patients who need an accepting "giving" situation. Deprived in childhood of an understanding maternal relationship, certain patients are presumed to require a "living through" with another human being of an experience in which they are protected and loved without stint. Another role assumed by the therapist is that of a commanding, stern authoritarian figure. This is believed to be helpful in patients whose superegos are relatively undeveloped, who still demand control and discipline from the outside.

Sometimes role playing is arranged so that it simulates early patterns of parents, on the theory that it is essential for the patient to live through with the therapist emotional incidents identical in type with the traumatizing experiences of childhood. Only by dramatizing one's problems, it is alleged, can the patient be prodded out of the rigid and circumscribed patterns through which one avoids coming to grips with life. In order to mobilize activity and to release inner drives, the therapist attempts to create a

relationship that is charged with tension. The ensuing struggle between patient and therapist is said to catalyze the breaking down of the neurosis.

One may rightfully criticize this technique on the grounds that the patient may actually experience too much frustration as a direct result of the therapeutic situation. The tension and hostility that are mobilized may eventually become sufficiently strong to break through repression, with an acting-out of impulses that are destructive to the patient and to the therapeutic relationship.

A misdirected positive use of role playing is also to be impugned. Even though open demonstrations of affection may seem logical in making the patient feel loved and lovable, such gestures are usually ineffective because of the patient's ambivalence. Love is so fused with hate that the patient may completely misinterpret affectionate tokens. This does not mean that the therapist must be cold and withdrawn, for a refrigerated attitude will even more drastically reinforce the patient's feelings of rejection.

Manipulations of the relationship call for a great deal of skill and stamina on the part of the therapist. They are responded to best by relatively healthy persons. Borderline patients, schizophrenics, paranoiacs, and profoundly dependent individuals may react badly to such active gestures, and perceptive patients easily see through the play acting as not genuine.

GUIDANCE

In the supportive technique of guidance the therapist acts as a mentor, helping the patient to evolve better ways of adjusting to the reality situation. Therapeutic interviews are focused around immediate situational problems. While the therapist may formulate an hypothesis of the operative dynamics, this is not interpreted to the patient unless the dynamics are clearly manifest and the interpretation stands a chance of being accepted by the patient without too great resistance. The employment of guidance requires that the therapist encourage the patient toward a better understanding and evaluation of the reality situation, toward a recognition of measures that will correct the patient's difficulty,

and toward the taking of active steps in effectuating a proposed plan. The patient is usually required to make the choices, although the therapist may clarify issues, outline the problem more succinctly, present operational possibilities, suggest available resources, and prompt the patient to action. Reassurance is utilized in proportion to the existing need, while as much responsibility is put on the patient as one can take.

Guidance suggestions must always be made in such a manner that the patients accept them as the most expedient and logical course of action. It may be essential to spend some time explaining the rationale of a tendered plan until the patients develop a conviction that they really wish to execute it. In this choice the patients should always be led to feel that their wishes and resistances will be respected by the therapist.

There are, however, a few patients whose personalities are so constituted that they resent a kindly and understanding authority. Rather they are inclined to demand a scolding and commanding attitude without which they seem lost. Such patients appear to need punitive reinforcement of their conscience out of fear of yielding to inner impulses over which they have little control. At the start of therapy it may sometimes be tempting to respect the needs and demand of such personalities, but an effort must always be made later on to transfer the disciplinary restraints to the individual. Unless such an incorporation of prohibitions is achieved and becomes an integral part of the individual's conscience, one will demand greater and greater displays of punitive efforts on the part of the therapist. To complicate this, when one has responded to dictatorial demands, one will burn inwardly with resentment toward the therapist, and will feel self-contempt for being so weak as to need authoritative pressure.

One way of conducting the guidance interview is to try to avoid, as much as possible, the giving of direct advice. Rather, the therapist may couch ideas and suggestions in a way that patients participate in the making of decisions. Furthermore, advice should be proffered in a non-dictatorial manner so that patients feel they may accept or reject it in accordance with their own judgment.

The sicker the individuals, the more likely they will make erratic choices, and the

more they will need active guidance and direction. How long the supportive relationship will have to be maintained will depend on the strength of the patient's ego. Usually, as patients gain security and freedom from symptoms, they will want to take more and more responsibility for their own destiny. Even those persons who offer resistance to assertiveness and independence may be aided in developing incentive toward greater independence. This may require considerable time and patience, but in many instances such constructive motivation can be achieved.

ENVIRONMENTAL MANIPULATION

The special environment in which the individual lives may sponsor conditions inimical to mental health. This does not mean that mental health will be guaranteed by a genial atmosphere because personal conflicts will continue to upset the individual even under the most propitious circumstances. One may be burdened with blocks that obstruct taking advantage of available opportunities. One may initiate and foster a disturbance of the environment where none has existed in order to satisfy inner needs. Be this as it may, the therapist has a responsibility to help rectify discordant living conditions so as to give the patient the best opportunities for growth. Though the effort may be palliative, the relief the patient experiences, even temporarily, will provide the most optimal conditions for psychotherapy. It is obviously best for patients to execute necessary changes in the environment for themselves. The therapist, however, may have to interfere directly or through an assistant by doing for the patients what they cannot do for themselves.

Conditions for which environmental manipulation may be required are the following:

1. *Economic situation.*

      a. Location of resources for financial aid.

      b. Budgeting and managing of income.

      c. Home planning and home economics.

2. *Work situation.*

    a. Testing for vocational interests and aptitudes. (Referral to a clinical psychologist may be required.)

    b. Vocational guidance and vocational rehabilitation. (Referral to a clinical psychologist or rehabilitation resource may be required.)

3. *Housing situation.*

    a. Locating new quarters.

    b. Adjusting to the present housing situation.

4. *Neighborhood situation.*

    a. Moving to a new neighborhood.

    b. Locating and utilizing neighborhood social, recreational, or educational resources.

    c. Adjusting to the present neighborhood.

5. *Cultural standards.*

    a. Interpreting meaning of current cultural patterns.

    b. Clarifying personal standards that do not conform with community standards.

    c. Clarifying legality of actions.

6. *Family and other interpersonal relations.*

    a. Consulting with parents, siblings, relatives, mate, child, or friend of patient.

    b. Promoting education in such matters as sexual relations, child rearing, and parenthood.

    c. Helping in the selection of a nursery school, grade school, camp, or recreational facilities for the patient's children.

d. Referring patient to legal resources in critical family or interpersonal situations.

7. *Daily habits, recreations, and routines.*

　　　a. Referring patient to resources for correction of defects in dress, personal hygiene, and grooming.

　　　b. Referring patient to appropriate recreational, social, and hobby resources.

8. *Health.*

　　　a. Clarifying health problems to patient or relative.

　　　b. Referring patient to hospital or institution.

　　　c. Referring patient to resources for correction of remediable physical disabilities.

The therapist may have to interfere actively where the environmental situation is grossly inimical to the best interests of the patient. This usually implies work with the patient's family, since it is rare that a patient's difficulties are limited to himself or herself. Various family members may require psychotherapy before the patient shows a maximal response to treatment. Indeed, the cooperation of the family is not only desirable, but in many instances unavoidable. A good social worker can render invaluable service to the therapist here. In some cases family therapy may be required.

Where the immediate environment does not offer good opportunities for rehabilitation, the patient may be referred to resources that will reinforce the therapist's efforts, such as day-and-night hospitals, halfway houses, sheltered workshops, rehabilitation centers, and social therapy clubs. For instance, day-and-night hospitals manage even moderately disturbed patients in the community and help support their work capacities. Halfway houses serve as a sheltered social environment in which the patient's deviant behavior is better tolerated than elsewhere. The patient is capable of experimenting there with new roles while being subject to the modifying pressures of

group norms. Discarding of disapproved patterns and adoption of new attitudes may become generalized to the social environment (Wechsler, H, 1960b, 1961). Sheltered work programs have been shown to help patients make a slow adjustment to conditions and conflicts at work (Olshansky, 1960). Tolerating an individual's reactions allows the individual to restructure defenses at his or her own pace without countenancing violent or rejecting responses on the part of supervisors and employers. A reconditioning process that prepares the patient for a regular occupation in the community may in this way be initiated. Rehabilitation centers, such as Altro Health and Rehabilitation Services, provide a variety of benefits that are made available to patients and that permit them to achieve the best adjustment within the limitations of their handicaps. At such centers the following may be accomplished:

1. Handling the patient's lack of motivation and resistance to work.

2. Helping patients in their efforts at reality testing.

3. Educating patients in methods of coping with daily problems as well as in developing working skills.

4. Aiding patients in recognizing early signs of emotional upset and suggesting means of removing themselves from sources that upset them before they go to extremes.

5. Working with the patient's family to secure their cooperation and manage problems within the family structure.

6. Providing aftercare services to prevent relapses (Benney et al, 1962; Fisher & Beard, 1962).

Social therapy clubs provide an extraordinary medium for a variety of experiences, either in themselves or as part of a therapeutic community (Bierer, 1948, 1958; Ropschitz, 1959; Lerner, 1960; Fleischl, 1962, 1964; Waxenberg & Fleischl, 1965).

EXTERNALIZATION OF INTERESTS

The turning of the patient's interests away from the self may be considered

important in planning a supportive program. Hobbies, occupational therapy, and recreational activities may be considered here.

A most effective hobby is one that provides an acceptable outlet for impulses that the person cannot express directly. The need to experience companionship, to give and to receive affection, to be part of a group, to gain recognition, to live up to certain creative abilities, and to develop latent talents may be satisfied by an absorbing hobby interest.

External activities can provide compensations that help the individual to allay some inferiority feelings. Instead of concentrating on failings, patients are encouraged to develop whatever talents and abilities they possess. For instance, if they are proficient as tennis players or have good singing voices, these aptitudes are encouraged so that the patients feel that they excel in one particular field. Whatever assets the individual has may thus be promoted. Calisthenics and gymnastics, even setting-up exercises, act as excellent outlets for tensions that have no other way of being drained off.

Some patients harbor within themselves strong hostilities with needs to vanquish, defeat, and overwhelm others. These drives may have to be repressed as a result of fear of retaliatory rejection or punishment. Sometimes even ordinary forms of self-assertiveness may be regarded as aggression. The device of detachment may be used in order to avoid giving expression to what are considered forbidden impulses. For such patients hobbies that do not involve competition will be most acceptable, at first. The ultimate object is to evoke interest in a hobby that has some competitive element. The patients may come around to this themselves. For example, one patient chose photography as an outlet principally because it involved no contact with other people. Gradually, as she became more expert, she exhibited her work to friends, and, finally, she entered pictures in various photographic contests. Later on, with encouragement she learned to play bridge, which acted as a spur to an interest in active competitive games and sports.

The ability to relieve tension through activities that involve the larger muscle groups permits of an effective way of helping disquieting aggression. Boxing, wrestling, hunting, archery, marksmanship, fencing, and such work as carpentry and stone building can burn

up a tremendous amount of energy. In some individuals the mere attendance at games and competitive sports, such as baseball, football, and boxing, has an aggression-releasing effect. It must be remembered, however, that this release is merely palliative; it does not touch upon difficulties in the life adjustment of the person that are responsible for the generation of hostility.

Many other impulses may be satisfied through occupational or diversional activities. Hobbies may foster a sense of achievement and can help the individual to satisfy a need for approval. Energy resulting from inhibited sexual strivings may gain expression sometimes in an interest in pets or naturalistic studies. Frustrated parental yearnings may be appeased by work with children at children's clubs or camps.

One must expect that patients will try to employ hobbies as a means of reinforcing the neurotic patterns that rule their lives. If they have a character structure oriented around perfectionism, they will pursue their hobbies with the goal of mastering intricate details. If they are compulsively ambitious, they will strive to use their interest as a way to fame or fortune. The same driving need holds true for any other prevailing character traits.

Most patients gain some temporary surcease from neurotic difficulties during the period when they are working at a new interest; however, their troubles escalate when the hobby fails to come up to their expectations. In spite of this, diversions may open up avenues for contact with others that neutralize this reversal.

Neurotic difficulties often cause individuals to isolate themselves from the group. Pleasures derived from social activities do not lessen the tensions and anxieties incurred in mingling with people. Occupational therapy, hobbies, and recreations give the person an opportunity to regulate the degree of participation with others in a project of mutual enjoyment. Pleasure feelings to some extent help lessen defenses against people. They may even lead to the discovery of new values in relating to a group. Once the patient has established a group contact, sufficient pleasures may sustain interest. It is to be expected, nevertheless, that customary withdrawal defenses may create tension. But the benefits

derived from the group may more than make up for the discomfiture.

In some instances it may be possible to convince the patient to engage in activities or work that contribute to the general welfare of the community. This can stimulate a feeling of active participation with others and a conviction of social usefulness.

<div align="center">REASSURANCE</div>

Reassurance may be necessary at certain phases of psychotherapy. This is sometimes given in verbal form; more commonly it is indicated through nonverbal behavior, as by maintenance of a calm and objective attitude toward the patient's feelings of crisis whenever they burst out.

Verbal reassurance, when used, should not be started too early, since the patient at first may not have sufficient faith in the therapist to be convinced of the latter's sincerity. The patient may imagine that the therapist is secretly ridiculing him or her, or does not know how serious the situation really is, or is merely delivering therapeutic doses of solace without deep conviction.

In practicing reassurance, the therapist must listen to the patient with sincerity and respect, pointing out that the difficulties may perhaps seem overwhelming at present, but that there are undoubtedly more solutions than appear on the surface. Under no circumstances should the patient be disparaged for illogical fears. The patient often appreciates that worries are senseless, but is unable to control them.

One of the most common fears expressed by the neurotic person is that of going insane. Panicky feelings, bizarre impulses, and a sense of unreality lead to this assumption. There is great fear of losing control and perhaps inflicting injury on oneself or others. Fear of insanity may be justified by revelations of a mentally ill relative from whom a taint was believed inherited. It is essential to accent the facts that fear of insanity is a common neurotic symptom and that there is scarcely a family in which one cannot find cases of mental illness. A presentation may be made of the facts of heredity, with an explanation

that insanity is not inevitable even in families that have a history of mental illness. Further reassurance may be given that the patient's examination fails to reveal evidence of insanity.

Another ubiquitous fear relates to the possession of a grave physical disease or abnormality. Patients may believe that through physical excesses, or masturbation, or faulty hygiene they have procured some irremediable illness. A physical examination with x-ray and laboratory tests should be prescribed if necessary, even though negative findings may not convince the patients that their fears are founded on emotional factors. Assurance may be given to the patients that anxiety and worry can produce physical symptoms of a reversible nature. Where fears are not too integral a part of the patient's neurosis, these explanations may suffice. Even where fears are deep, as in obsessional patients, and where patients do not accept the results of the physical examination, their more rational self will toy with the idea that they may be wrong. At any rate, the absence of manifest physical illness will give the therapist the opportunity to demonstrate to the patients that their problems are not really just a physical one and that feelings of being ill or damaged may serve an important psychologic function.

Masturbatory fears are often deep-seated and operate outside the awareness of the person. Patients may, through reading and discussions with enlightened people, rationalize their fears, or they may conceal them under an intellectual coating. Either because of actual threats on the part of early authorities, or through their own faulty deductions, they may believe that their past indulgences have injured them irreparably. They may shy away from masturbatory practices in the present or else engage in them with conscious or unconscious foreboding. Assurance that they have misinterpreted the supposedly evil effects of masturbation, coupled with assigned reading of books that present scientific facts on the subject, have remarkably little effect on their qualms. They are unable to rid themselves of childish misapprehensions that seem invulnerable to reason. Nevertheless, the therapist's point of view should be presented in a sincere and forthright manner, with the statement that the patients, for emotional reasons, may not now be able to accept the explanation. Eventually, as they realize the depth of their fears,

they may be able to understand how victimized they have been all their lives by faulty ideas about masturbation absorbed during their childhood.

Reassurance may also be needed in regard to other aspects of the individual's sexual life. Frigidity, for instance, is the concern of many women who often expect that it will disappear automatically with marriage. Projecting their disappointment, some women tend to blame their mates for sexual incompetence. In therapy misconceptions will have to be clarified carefully with a focusing on possible causes of guilt and other provocative conflicts.

In men, reassurance may be required in conditions of temporary impotence. Many males are excessively concerned with their sexual prowess and have exorbitant expectations of themselves in sexual performance. Discussions may be organized around the theme that episodes of impotence are quite natural in the lives of most men. Temporary feelings of resentment toward a marital partner or attempts at intercourse during a state of exhaustion, or without any real desire, will normally inhibit the erective ability. On the basis of several such failures, the individual may become panicky, and his tension may then interfere with proper sexual function thereafter. The patient may be shown the necessity for a different attitude toward sex, treating it less as a means of performance and more as a pleasure pursuit. Reassurance that his impotence is temporary and will rectify itself with the proper attitude may suffice to restore adequate functioning.

Another concern shown by patients is that of homosexuality. Fears of homosexuality may be disturbing. It is helpful sometimes to reassure the patient regarding homosexual fears or impulses which are equated with a devalued self-image. Elucidation that a liking for people of the same sex may occasionally be associated with sexual stimulation, that this impulse is not a sign that one is evil or depraved, and that it need not be yielded to, may be reassuring. An effort may be made to explain how, in the development of a child, sexual curiosities and sex play are universal and may lead to homosexual explorations. Usually this interest is later transferred to members of the opposite sex, but in some

persons, for certain reasons, an arrest in development occurs. The patient may be informed that when homosexuality represents a basic attitude toward people as part of a neurotic problem, it need not be considered any more significant than any other problem that requires psychological treatment.

Reassurance is often necessary in the event of infidelity of one's marital partner. Where a man or woman is extremely upset because a spouse has been unfaithful, one may feel not only a threat to security, but, more importantly, a shattering of self-esteem. The therapist may affirm that infidelity on the part of one's marital partner is indeed hard to bear, but that it is far from a unique experience in our culture. The patient must be urged not to be stampeded into a rash divorce simply because of feelings of outrage. It is natural that knowledge of a spouse's infidelity does justify indignation, but in one's own interest, one must not act precipitously, even though encouraged by friends, family, and public opinion to hate and cut off from the erring spouse. There is good logic in resisting a dramatic act and not precipitating a divorce over an affair that is in all probability quite insignificant. Such reassurance may convince the patient to try to work out a better relationship with the spouse and perhaps discover why a drift from each other had occurred.

One use of reassurance practiced by some therapists is toward helping the process of ego building. Patients become so preoccupied with their defects that they are apt to lose sight of constructive aspects of their personality. The therapist here selects for emphasis positive aspects of the individual's life adjustment and personality that the patient has underestimated. Qualities of the patient may be highlighted with emphasis on how these have been sabotaged by the patient's preoccupation with troubles. Reassurance in response to inferiority feelings, however, is generally futile. One of the most common symptoms of neurosis is devaluated self-esteem, which fosters inhibitions in action, perfectionistic strivings, and feelings of worthlessness, inadequacy, and self-condemnation. Any attempt here to inflate the patient's ego by reassurance accomplishes little.

Self-devaluation may be a symptom that serves a useful purpose for the patients, protecting them from having to live up to the expectations of other people or of their own ego ideal. Rebuilding their self-esteem by reassurance, therefore, threatens to remove an important coping mechanism. Many persons who devaluate themselves insidiously do penance for forbidden strivings and desires. Reassurance here may actually plunge the person into anxiety. If patients have sufficient ego resources, reassurance even though necessary should be tempered, the patients being apprised that responsibility for investigating their patterns has to be borne by themselves. If this precaution is not taken, the patients will lose initiative in getting at the source of their difficulties, and they will tend to seek more and more reassurance from the therapist.

PERSUASION

Persuasive techniques are sometimes helpful as supportive measures, particularly in obsessive-compulsive personalities. The object is to try to master conflict by forces of will power, self-control, and powers of reasoning. Positive results are contingent on accepting the therapist as a wise benevolent authority whose mandates must be followed, (see also Chapter 9).

Persuasive suggestions have arbitrarily been subdivided into several categories. They represent a point of view and a slant on life that may not always be accurate but that, *if accepted by the patient,* may help alleviate distress. In genera}, suggestions tend toward a redirection of goals, an overcoming of physical suffering and disease, a dissipation of the "worry habit," "thought control" and "emotion control," a correcting of tension and fear, and a facing of adversity. These suggestions consist of home-spun bromides, slogans, and clichés. But their pursuit is considered justified by some therapists as a means of helping the patient control symptoms. The following suggestions are a summary of a number of different "systems" of persuasion. Superficial as they sound they are sometimes eagerly accepted by patients, who are not amenable to other approaches and seem to need a wise authority to structure their lives.

Redirection of Goals

If the patient's goals in life are obviously distorted, the patient is instructed that the most important aim in living is inner peace rather than fame, fortune, or any other expedient that might be confused with real happiness. In order to gain serenity, one may have to abandon hopes of becoming rich, famous, or successful. One may be causing oneself much harm by being overambitious. If one is content to give up certain ambitions, and to make an objective in life that of mental serenity and enjoyment, one should try living on a more simple scale. It is important to give up struggling for success. Health and freedom from suffering are well worth this sacrifice.

One can attain happiness and health by learning to live life as it should be lived, by taking the good with the bad, the moments of joy with the episodes of pain. One must expect hard knocks from life and learn to steel oneself against them. It is always best to avoid fearsome anticipations of what might happen in the future. Rather one should strive for a freer, more spontaneous existence in the present. One should take advantage of the experiences of the moment and live for every bit of pleasure that one can get out of each day. The place to enjoy life is here. The time is now. By being happy oneself, one can also make others happy.

It is profitable to concern oneself with the problems of other people. Many persons who have suffered pain, disappointment, and frustration have helped themselves by throwing their personal interests aside and living to make others happy. We are social creatures and need to give to others, even if we must force ourselves to do so. Thus, we can take a little time out each day to talk to our neighbors, to do little things for them. We can seek out a person who is in misery and encourage one to face life. In giving we will feel a unity with people.

A person may be enjoined to avoid the acting-out of a sense of despair. A pitfall into which most "nervous" people fall is a hopeless feeling that paralyzes any constructive efforts. One must not permit oneself to yield to feelings of hopelessness, for life is always forward moving. Hopelessness and despair are a negation of life. If we stop holding ourselves back, we will automatically go forward, since development and growth are

essential parts of the life process.

Overcoming Physical Suffering and Disease

The patient, who may be suffering from ailments of a physical nature, may be told that physical symptoms are very frequently caused by emotional distress. Studies have shown that painful thoughts can affect the entire body through the autonomic nervous system. For instance, if we observe an individual's intestines by means of a fluoroscope, we can see that when the person thinks fearful or painful thoughts, the stomach and intestines contract, interfering with digestion. On the other hand, peaceful, happy thoughts produce a relaxation of the intestines and a restoration of Perlstaltic movements, thus facilitating digestion. The same holds true for other organs.

Understanding the powerful effect that the mind has over the body lucidly demonstrates that physical suffering can be mastered by a change in attitudes. By directing one's thoughts along constructive lines, by keeping before the mind's eye visions of peace and health, a great many persons who have been handicapped by physical ailments, and by even incurable diseases, have conquered their suffering and even have outlived healthy people. This is because a healthy mind fosters a healthy body and can neutralize many effects of a disabling malady.

Physical aches and pains, and even physical disease, may be produced by misguided thoughts and emotions. The body organs and the mind are a unity; they mutually interact. Physical illness can influence the mind, producing depression, confusion, and disturbed thought process. On the other hand, the psyche can also influence the body, causing an assortment of ailments. In the latter instance the institution of proper thought habits can dispel physical distress.

It is natural for persons who are suffering from physical symptoms to imagine that there is something organically wrong with them. They cannot be blamed if they seek the traditional kinds of relief. But palliation is not found in medicines or operations. Relief is found in determining the cause of their troubles and correcting the cause. Worry, tension,

and dissatisfaction are causes for many physical complaints; the treatment here lies in abolishing destructive thoughts.

The first step in getting relief from physical suffering is to convince oneself that one's troubles are not necessarily organic. The difficulties may lie in one's environment, but usually they are due to improper thinking habits. If there is a remediable environmental factor, this must, of course, be remedied. Where it cannot be altered, the person must learn to change oneself so that one can live comfortably in one's difficult environment. In the latter case one has to reorganize one's patterns of thinking.

Where patients actually have an organic ailment that is not amenable to medical or surgical correction, an attempt may be made to get the patients not only to accept the illness, but also to change their attitudes toward it. It is essential to help the patients reorganize their philosophy so that they can find satisfactions in life consistent with their limited capacities.

In physical conditions of a progressive nature, such as coronary disease, cancer, or malignant hypertension, the patients may be in a constant state of anxiety, anticipating death at any moment. Here it is wise to emphasize the fact that death is as much a part of living as is life and that the horrors attached to it are those that come from a misinterpretation of nature. Life must go on. Babies are born, and people pass on to a peaceful sleep that is death. The chances are that the one still has a long useful life ahead that can be prolonged by adopting a proper attitude toward one's condition. If suffering and pain do not exist, this should be pointed out as a fortunate occurrence. The person should think about the present and avoid dwelling too much on the future. No one can anticipate what the future may bring. Accidents can happen to anyone, and even a young person in the best of health does not know when an illness or accident will strike. The only rational philosophy is to glean whatever pleasure one can from the moment and to leave the future to take care of itself. Hypnosis and self-hypnosis may be employed as aids for the alleviation of tension, pain, and physical distress.

The patients are encouraged to develop hobbies and to engage in activities that will

divert their thinking from themselves. A list of diversions that the patients can pursue may be prepared and the patients guided into adopting new interests.

Dissipating the "Worry Habit"

Patients who are obsessed with worrying about themselves may be urged to remember that much energy is expended ruminating about one's problems and fears instead of doing something positive about a solution. Worry tends to magnify the importance of petty difficulties; it usually paralyzes initiative. The worrier is constantly preoccupied with ideas of fear, dread, and morbid unpleasantness. These thoughts have a disastrous effect on the motor system, the glands, and other organs.

In order to overcome the "worry habit," it is first necessary to formulate in one's mind the chief problem with which one is concerned. To do this it will be necessary to push apprehensions boldly aside. In a seemingly insurmountable problem, one should attempt to reformulate the situation to bring clearly to mind the existing difficulty. If one is honest with oneself, one will realize that most of one's energy has been spent in hopeless despair, in anxiety, or in resentful frustration rather than in logical and unemotional thinking that can bring about tranquility.

First, it is necessary to review all possible answers to the problem at hand. Next, the best solution is chosen, even though this may seem inadequate in coping with all aspects of the problem. A plan of action must then be decided on. It is necessary to proceed with this design immediately and to abandon all worry until the plan is carried out as completely as possible. Above all the person must stick to the project, even if it is distasteful.

If the person cannot formulate a scheme, the therapist may help to do so. The patient should be told that it is better to be concerned about a constructive partial plan than to get tangled up in the hopelessness of completely resolving an apparently insoluble problem. Until the patient can work out something better, it is best to adjust to the present situation, striving always to externalize energy in a constructive way.

The patient may be urged to stop thinking painful thoughts. He or she may be told that forgetting is a process that goes on of its own accord if one does not interfere with it. Worry is a process that has been learned. One can, therefore, help oneself by controlling one's thoughts and avoiding painful ideas. If action is impossible for the moment, one can try to crowd out apprehensions by simply resolving to stop worrying.

Discussing painful topics with other people should also be avoided. If the patient must ventilate disturbing feelings, this should be done with the therapist. "Blowing off steam" and relating troubles to friends often does more harm than good because the suggestions offered are usually unsound. It is better for the patient to understand one's difficulties than to become too emotional about them. It may be necessary to ask friends and relatives to stop talking about the patient's personal problems, if such discussions are aggravating. It is understandable that people close to one will be much concerned with the patient's illness, but they must be reminded that their solicitude may aggravate the patient's condition. Trouble may often be forestalled by insisting that one "feels fine" when questioned by others about one's health.

"Thought Control" and "Emotion Control"

Patients who seem to be at the mercy of painful thoughts and emotions may be enjoined never to permit their minds to wander like flotsam, yielding to every passing thought and emotion. It is necessary to try to choose deliberately the kinds of thoughts to think and the kinds of emotions to feel. It is essential to eschew ruminating about resentments, hatreds, and disappointments, about "aches and pains," and about misery in general.

One must think thoughts that nourish the ego and permit it to expand to a better growth. A woman with multiple complaints unresponsive to various types of psychotherapy was told by her therapist that if she wants to be without pain, she must fill her mind with painless ideas. If she wants to be happy, she must smile. If she wants to be well, she must act as if she *were* well. She must straighten her shoulders, walk more resolutely, talk with energy and verve. She must face the world with confidence. She must

look life in the face and never falter. She must stand up to adversity and glory in the struggle. She must never permit herself to sink into the quagmire of helplessness or give herself up to random worries, thus feeling sorry for herself. She must replace thoughts of doubt and fear with those of courage and confidence. She must think firmly of how she can accomplish the most in life, with whatever resources she has. She must feel those emotions that lead to inner harmony.

She must picture herself as above petty recriminations, avoiding the centering of her interest around herself. Even if she suffers from pain and unhappiness, she must stop thinking about her daily discomforts. She must give to others and learn to find comfort in the joys of giving. She must become self-reliant and creative. Emancipation from tension and fear can come by training one's mind to think joyous and peaceful thoughts. But new thought habits do not come immediately. One must show persistence and be steadfast in one's application. One must never permit oneself to be discouraged. One must practice, more and more. Only through persistent practice can perfection be obtained so that the mind shuts out painful thoughts automatically.

It is not necessary to force oneself impetuously to stop worrying or feeling pain. Will power used this way will not crowd out the painful emotions. One must instead substitute different thoughts or more appropriate actions. If one starts feeling unhappy or depressed, one should determine to rise above this emotion. One should talk cheerfully to others, try to do someone a good turn; or one may lie down for a short while, relax the body and then practice thinking about something peaceful and pleasant. As soon as this occurs, unhappy thoughts will be eradicated. A good practice is to think of a period in one's life when one was happiest. This may have been in the immediate past or during childhood. One may think of people one knew, the pleasant times one had with them. This substitution of pleasant for unpleasant thoughts may take several weeks before new thinking habits eventuate.

These injunctions had an almost immediate effect on the patient. Instead of preoccupying herself with her symptoms she concentrated on putting into practice the

suggestions of her therapist, with a resultant dramatic cessation of complaints.

Correcting Tension and Fear

Where undifferentiated tension and fear exist, the patient may be told that difficulties may come from without, but that one's reactions to these difficulties are purely personal and come from within. By changing these reactions, one can avoid many of the consequences of stress. If one is confronted with tension, anxiety, or feelings of inner restlessness, it is best to start analyzing the causes. Are these emotions due to disappointment or failure? Or are they the product of a sense of hopelessness? Once the cause is found, it is necessary to face the facts squarely and take corrective steps. It is urgent to plan a course to follow and to execute this immediately. If facts cannot be altered, one must change attitudes toward them. It is essential to stop thinking about the painful side of things and to find instead something constructive on which to concentrate.

One may be unable to prevent anxious thoughts from coming into one's mind, but they can be prevented from staying there. The person must stop saying, "I can't," and think in terms of "I can." As long as one says, "I can't," one is defeated. Being resolute and persistent in saying "I can" will eventually bring results.

The first step in overcoming tension is to stop indulging oneself in self-pity. Tension will drag one's life down if not interrupted. It is necessary to learn to love life for the living. One must learn not to exaggerate troubles. One must let other people live *their* lives, and one should live one's own.

Many people suffering from tension and fear have helped themselves by saying, "Go ahead and hurt all you want; you will not get me down." Fears are best faced by courageously admitting them. They can be conquered by stopping to fight them or by refraining from trying to master them by sheer will power. Acknowledging that one is afraid is the first step. Thereafter one must determine to rid oneself of fear by developing the conviction that one will overcome it. A sense of humor is of unparalleled help here. If one laughs at one's fears instead of cringing before them, one will not be helpless and at

the mercy of forces one cannot control.

Practicing relaxation sometimes is useful. Each day one may lie on one's back, on the floor or on a hard surface, for 20 minutes, consciously loosening up every muscle from forehead to feet, even fingers and toes. The individual may then start breathing deeply, with slow, deep exhalations through pursed lips. At the same time the individual may think of a peaceful scene at the mountains or seashore. Mental and muscular relaxation are of tremendous aid in overcoming states of tension, (see also Chapter 56).

Facing Adversity

In the event patients have an irremediable environmental difficulty, they may be reminded that there are many dire conditions in one's environment that cannot be changed no matter how diligently one tries. Poor financial circumstances, an unstable mate, overactive youngsters who make noise and tax one's patience, a physical handicap, or an incurable physical illness can create a great deal of worry, tension, and anxiety. It is not so much these difficult conditions that are important as it is the reaction of the person to them. Life is usually full of struggle; but individuals need not permit themselves to get embroiled in the turmoil and misery of the world. There are many persons who are deformed, or deprived of sight, hearing, and of vital parts of their body, who live happily and courageously because they have learned to accept their limitations and to follow the rule to live life as it is right now. There are many persons who, forced to exist under the most miserable conditions of poverty, with no resources or education, are not distressed by worry or nervousness because they have not yielded themselves to their emotions.

It is a human tendency to exaggerate one's plight. If one compares oneself with many other people, however, one will discover that one is not so badly off. Individuals may not be able to achieve all of the ambitions that they have in life. They may not be as intellectual as they want to be, or as strong, or successful, or rich, or famous. They may have to earn a living at work they detest. As bad as they imagine their state to be, if they were to be faced with the possibility of changing places with some other persons, they would probably refuse to do so. They might be dissatisfied with their appearance, and may long for

features that would make them look more handsome and distinguished or beautiful and sophisticated. If this were possible, they might instead find their health had become impaired or their intellect was not up to its present level.

It is necessary to make the most out of the little one has. Every person possesses weaknesses and must learn to live with them. Each of us must pattern our life so as to make our weaknesses as little manifest as possible. We must expand all of our good qualities to the limit. One's facial appearance may not be handsome, but one may have nicer hair and teeth than many other people. These may be emphasized in hair style or proper facial expression. One can appear well groomed with well-tailored clothing. If one's voice is good, one should cultivate it. In this way one may take advantage of every good feature one possesses.

Instead of resigning oneself to a sense of hopelessness, it is wise to turn one's mind toward creative activities and outlets. It will take much perseverance to conquer feelings of helplessness and frustration, but this can be done, particularly by living honestly and courageously. The wealthiest person is one who has not riches but strength of spirit. If individuals are dissatisfied with themselves, they may try to imagine themselves as the kind of person who they would like to be. They may then find that they can do those things that they have hitherto felt were impossible. They must never yield to despair or discouragement. Crippled persons have learned to walk by sheer perseverance of will. On the other hand, one should not set goals for oneself that are impossible of fulfillment. Thwarted ambition can give rise to bitterness and greed.

A sign of character is to change those conditions that can be remedied and to accept those that cannot be changed. To accomplish this one must face the problem squarely. What is to be done about a difficult situation? What can be done? How will one go about accomplishing the change? This calls for a plan of action that, once made, must be pursued diligently without discouragement.

There are always, of course, situations one must accept. Unalterable facts must be faced. If one cannot change things as they are, one can change one's own attitude so that

one will not overreact to one's difficulties. As soon as a person has decided to make the best of things, his or her condition will improve immediately. If one is unable to possess the whole loaf, one must learn to content oneself with part of a loaf. One must disregard minor discomforts, and pay less and less attention to them. One's symptoms may be annoying, but they are not fatal. Keeping two written lists, outlining on one side the things that have troubled one, on the other side the things that have gone in one's favor, will often convince the person, after a while, that the balance is on the positive side.

It is particularly important to train oneself to overcome the effects of frustration and disappointment. These may be expressed in the form of quarreling, or holding grudges against others, or by depression or physical symptoms. There are many dangers associated with permitting oneself to become too discouraged. It is best here to forestall despair before it develops, by adopting the attitude that one will not allow oneself to get too upset if things go wrong. One must force oneself to regard all adversity dispassionately, with the idea of modifying the cause if possible, or changing one's point of view, if the cause cannot be removed.

The above persuasive suggestions do not represent a scientific point of view. However, their use is believed, especially by nondynamicalty oriented therapists, to be consonant with a pragmatic approach to therapy in certain patients who do not respond well to insight of other more sophisticated approaches.

EMOTIONAL CATHARSIS AND DESENSITIZATION

Release of painful feelings and desensitization to their effects constitutes an important supportive technique. Patients are encouraged to talk about those things in their past life or in their present-day relationships that bother them most. Their responsiveness will depend on the confidence and trust they have in the therapist.

The patient may be told that most people have bottled up within themselves memories and experiences that, though seemingly under control, continue to have a disturbing effect on them. The attempt to obliterate emotional experiences by banishing

them from the mind is not ordinarily successful. Disturbing ideas keep obtruding themselves into the stream of thought. Even when will power triumphs and suppression succeeds, casual everyday happenings may remind one of one's conflict. In addition to memories, there are also impulses and desires of which one is thoroughly ashamed and which one dares not permit oneself to think about. Among these are desires for extramarital sexual gratification, homosexual interests, hostile strivings, and impulses of a fantastic and infantile nature.

Emotional catharsis must never be foisted on patients. To force them to reveal inner fears of a traumatic nature prematurely may cause them such panic that their resistance to further revelations will be increased. Actually, the patients have built up so hard a crust of repression that it keeps them from admitting their deepest fears even to themselves. It is essential to let them feel their own way and choose their own pace with casual encouragement.

In continued discussions with the patients it may be emphasized that every individual has difficulties and problems to be ashamed of, that they also probably are no exception and may have had experiences that make them feel that they are wicked. Discussing the patient's problem in this roundabout way makes it possible to talk about worries more openly. For instance, where it is obvious that the patient has a suppressed homosexual wish, the therapist may weave into the discussions the fact that every person, at certain times in life, develops friendships with and crushes on people of the same sex. This is by no means abnormal; it is merely a developmental phase in the life of the individual. Some persons, for certain reasons, continue to have ideas that were normal at an earlier phase of growth. As a matter of fact, most people have fears of homosexuality. The patient may be told that it would be unusual not to have such ideas at one time. The patient may then casually be asked whether or not this is so. In opening up discussions about latent tendencies there are certain risks that must be countenanced. Sometimes patients prevent themselves from acting-out their desires by not thinking about or exposing them. Such persons may interpret the therapist's interest as condonation of their suppressed impulses, particularly where the therapist relieves them too freely of their

guilt. Guilt, of course, is, not too trustworthy an opposing force, but it may be the only deterrent to rebellious tendencies that the patient has. An effort to supply the patient with rational deterrents should be made where cravings may involve the patient in unforeseen dangers.

The ability of the patient to discuss impulses, fears, and experiences openly, without encountering condemnation, enables the patient to tolerate the implications of the suppressed material.

In the event patients confess to a truly reprehensible incident in their lives, the ventilation of these facts may have to be followed by active reassurance. They may be reminded that the incidents they have revealed do not necessarily pollute them, that many persons are compelled, for neurotic reasons, to do things that they regret later, and that their subsequent actions can fully neutralize what they have done. Patients may be urged to spend their energy doing something positive in the present rather than to wear themselves out regretting the past. They may, if they desire, make some restitution to any person who has been injured by their acts, or to society in general.

In cases where individuals have irrational feelings that issue out of their relationships with people or where they have phobias, they repeatedly may be urged, for purposes of desensitization, to talk about if not to expose themselves to those situations that incite painful emotions. Their experiences are then subjected to discussion, and the patients are trained to face those situations gradually, without quaking. For instance, if patients have a fear of closed spaces, they may be instructed to lock the door of their rooms for a brief instance for the first day, to increase the interval to the count of 10 the next day, then to one-half minute, extending the time period daily, until they discover through actual experience that they can tolerate the phobic situation. Other phobias may be treated in a similar way with selected pertinent suggestions. The therapist must appreciate, of course, that the patient's fears may be rooted in established conditionings and may not yield to such desensitization techniques until a behavioral analysis is instituted and tactics sensibly organized. These tactics actually are reeducative and

therefore will be discussed in the next chapter on Behavior Therapy.

MISCELLANEOUS SUPPORTIVE MEASURES

See also Chapter 56 "Adjunctive Aids in Psychotherapy"

Relaxation exercises and massage may be prescribed for muscle tension, spasms, contractures, and tremors, the patient being referred to a physiotherapist when this is necessary. Enforced rest is sometimes advised for fatigue and exhaustion in the form of a prolonged vacation or a sojourn in a spa or country place. Subcoma insulin therapy is sometimes prescribed for unyielding anxiety states, delirium tremens, and confusional syndromes. Electrical (convulsive) therapy is helpful in bipolar disorders, endogenous depression, and senile depression. Drug therapy is employed where indicated; for example, sedatives, hypnotics, and tranquilizers in excitement or insomnia, antidepressants in depression or listlessness, Antabuse in alcoholism, and glandular products in endocrine disorders. These somatic therapies will be discussed later. Inspirational group therapy is a helpful procedure in certain problems, for instance, for dependent, characterologically immature, alcoholic, drug addictive, and mentally ill patients.

Supportive measures during reconstructive treatment must be employed cautiously because the patient may invest the therapist with directive, authoritarian qualities that interfere with a good working relationship. Moreover, alleviation of symptoms and suffering may remove a most important motivation for continued treatment in some patients.

There are, nevertheless, certain circumstances under which support is necessary. The challenging of one's defenses exposes basic conflicts and may revive the early anxieties that inspired them. A period of some instability and turmoil is to be expected with reconstructive procedures, and the therapist may, where the reactions are severe, temporarily have to assume the role of a helping authority.

The specific kinds of supportive measures implemented here vary according to the

patient's needs. Where severe environmental disturbance exists, the therapist may suggest available resources that hold forth promise of mediation. The therapist may also aid the patient in resolving resistances toward utilizing the prescribed resources effectively. Active reassurance may be dispensed where the patient harbors gross misconceptions or where there is a threat of a dangerous shattering of the ego. There may be a cautious extension of advice when the patient is thoughtlessly embarking on a potentially destructive course of action. Encouragement certainly may be voiced when the patient does a significant job in thinking through a problem or in effectuating insight into action.

The degree of emotional support employed will depend upon the strength of the patient's ego. A withholding of support by the therapist, when the patient actually needs it, may be harmful. On the other hand, excessive support may interfere with assertiveness and activity. The person's reactions to support will depend on its symbolic meaning to the person. The most common response is an abatement of symptoms and a cessation of anxiety. Occasionally, however, anxiety breaks out due to fears of being overwhelmed and mutilated in a protective relationship. These reactions will have to be handled promptly, should they emerge.

REEDUCATIVE APPROACHES

See also Chapter 10 "Reeducative Therapy", Chapter 51 "Techniques in Behavior (Conditioning) Therapy, and Chapter 56 Adjunctive Aids in Psychotherapy

Reeducative measures are employed both as a complete goal-limited form of treatment and as interventions that are strategically incorporated into a reconstructive therapeutic program.

Current interest in cognitive therapy (Beck AT, 1971, 1976) accents the value of certain reeducational techniques during psychotherapy. The individual's cognitive set often determines what one feels and how one interprets reality. Utilizing this paradigm, patients are enjoined to examine how their *interpretation* of an event determines their feelings and whether the interpretation is based on facts or insubstantialities. Sometimes

patients are asked to keep a diary and jot down the thoughts that immediately precede certain feelings. In this way they learn first to identify provocative thinking patterns that inspire upsetting feelings and then to challenge the validity of their ideas.

The value of examining the connection of events with succeeding disturbing emotions is shown by the pilot study of A. T. Beck and Kovacs (1977), in which depressed patients who were treated with cognitive therapy did better than those who were given antidepressant drugs. Some forms of cognitive therapy focus on the various ego states of individuals during their daily operations. There is exploration of the interfaces of these states, elaboration of the dissimilar roles assumed during these states, explication of the multiform self-representations, and differentiations between self and object, and identification of the values and needs emerging with each ego state. In this way individuals become aware of habitual shifts in their orientations, some of the forces producing the shifts, and perhaps tactics through which control may be achieved before their emotions take over. During therapy, an integration of dissociated self- and object representations is attempted, with the aim of bringing the patient's self-concepts to a more mature level. Sicker patients, such as those who are borderline cases and those who have narcissistic character disorders, are apt to show splitting and confusion of self-object identities. Here the patients may utilize the therapist as an aspect of themselves during transference. This will call for therapeutic interventions, such as interpretations, that are more attuned to reconstructive than reeducative premises.

In some forms of reeducative therapy efforts are made to rehabilitate the individual as rapidly as possible by discovering and modifying factors that provoked the emotional illness and by surveying the available assets and liabilities in order to mobilize positive forces of the personality. In the medium of a warm relationship with the therapist, the patients are brought to an awareness of certain interpersonal conflicts that have contaminated their adjustment. Maladaptive attitudes are explored to point out to the patients the difficulties that these create for them. Individuals get viewpoints of how their reactions became conditioned and why they persist. Finally, they are helped to adjust with new, healthful, more adaptive patterns. In behavior and conditioning approaches, there is

a minimization of insight and a concentration on learning and reconditioning.

In reeducative therapy less weight is placed on exploring the origins of patterns, while more emphasis is put on reorganization of habits, regardless of their sources in constitution or in specific inimical experiences. During the process of retraining, early difficulties that originally produced disturbing character traits may spontaneously be remembered by the patient. As part of their schooling, the patients must be taught to face early childhood experiences and, if necessary, to change attitudes toward them.

The patients are encouraged to rectify remediable environmental difficulties, to adjust to irremediable handicaps while finding adequate compensations and sublimations, to enhance personality resources through education and activity, to abandon unrealistic goals, and to coordinate ambitions with capacities. The therapist concentrates on all of the healthy personality elements, actual and potential, that can neutralize, control, or rectify pathologic adjustment.

In dealing with abnormal traits and patterns, the therapist may strive to bring patients to where they can reason unemotionally, facing facts bravely, adjusting to painful memories and impulses without panic, meeting stresses of life with courage, and forsaking fantasy in thinking. Each trait that the patients exhibit may be taken up in detail, discussing its origin, purpose, value, and the ways it interferes with their happiness and adjustment. More adaptive substitive patterns may then be explored, and the patients may be urged to take positive courses of action.

A discussion of the patient's life history may reveal to the therapist that the patient has an awareness of the inordinate attachment to a domineering parent or parental surrogate who continues to infantilize him or her. Evidences of how dependency undermines the patient are brought to his or her attention, and the patient may be shown how some symptoms are produced by conflict over dependent need. If the patient evidences a desire to overcome dependency on the family, the wisdom of making decisions and of finding outlets for energy and interests may be indicated. It is to be expected, because neurotic reaction patterns are so deeply imbedded, that this advice will

not be heeded at first; but as the patient constantly experiences untoward emotions associated with the giving up of independence, the patient may agree with the therapist's observations and gradually experiment with new modes of adjustment.

Where patients are too compliant and recognize their compliance, it may be pointed out that they have probably always felt the need to be overrespectful to authority. Their security is perhaps bound up with this reaction. However, they have a right, as a human being, to their own opinions, and they need not accept the wishes or orders of other people unless they want to do so. They can review in their mind the pros and cons of any advice given them, and they may then accept or reject it as they see fit. If they do not wish to abide by the orders or judgments of other people, they can try to explain to them why their own plans seem best. Should they decide to conform with the wishes of others, they must be sure that this is what they really want, and that it is not what they feel forced to want. Above all, they must be logical rather than emotional in their choices of action. Specific ideas on how to function independently may be advanced. The help of other people with whom the patient lives may be enlisted in this training process.

An individual who is aware of a power drive may be shown how this is a dominating force in life, preoccupying thoughts and actions. Individuals may be partly aware of how they strive for power and strength in all of their interpersonal relationships. What they may not realize is how mercilessly their drive rules them and how it results in their forfeiting normal goals. The person may be advised how a power trend brings him or her into conflict with others and evokes retaliatory hostilities. It is necessary to get the patients to see the need of adopting a more mature attitude and of readjusting their standards in line with the reality situation. Other outlets than power may then be suggested to satisfy the patient's drive for self-assertiveness and self-esteem.

The same technique may be used in dealing with other compulsive neurotic patterns, such as detachment, aggression, and perfectionism. Their manifestations are repeatedly brought to the patient's attention, and the patient is shown why they stir up difficulties. The patient is challenged in his or her assumption that these are the only

means adjusting to life, and substitutive responses are suggested.

Patients may be acquainted with the ways in which their character drives operate insidiously. They may be shown that, unknown to themselves, they lash out at others, or vanquish them in actual deeds or in fantasy, or render themselves invulnerable and strong, or retreat from competition, or engage in any number of facades that become for them basic goals in life, making average pursuits meaningless.

Such unhealthy attitudes perhaps might be understandable were we to insist on what is probably not true—that they really are an inferior persons who have to eliminate adult and realistic methods of dealing with their problems. The patients must be shown the need to stop taking refuge in childhood defenses, and they must be apprised of the wisdom of facing their difficulties with decision and courage. However, because they have utilized their defenses for so many years, they must understand that these will not vanish immediately. Indeed, defenses will keep cropping up from time to time. Above all, there is no need for discouragement. When they become sufficiently strong, their defenses will no longer be required. Yet, they must not abandon their patterns out of a sole conviction that orders must be followed, or to please the therapist. Rather, as they realize the implications of their neurotic drives, they will want to substitute creative goals and patterns for those that have resulted in their present unhappiness.

The therapist should, in this way, actively encourage a conscious analysis by the patients of their customary trends as well as stimulate them to substitute new ways of thinking and acting. If the old patterns reappear, it may be necessary for the patients to try to bring them to as complete a halt as possible by deliberate effort. The patients should be encouraged to feel that they have the capacity to change, that others sicker than themselves have done so successfully.

Usually the patients will be dismayed to find that their character patterns are regarded as problems because they have accepted them as natural and normal. As they realize that these constantly bring them into difficulties with people and are responsible for much of their turmoil, they are supplied with a valid motivation to alter their scheme

of life. They are confronted with a choice for which they, themselves, will have to assume a full measure of responsibility.

Many persons faced with this choice are unwilling or unable to give up their destructive drives. The knowledge that frustration or pain will follow observance of their patterns is not enough to make them give up the gratifications that accrue from the propitiation of neurotic goals. Extreme examples of this are the alcoholic who appreciates the physical, social, and moral hardships that inevitably follow the bouts of drinking but seems unable to do anything about it, or the smoker who developing emphysema continues to live in an atmosphere of tobacco fumes, or the obese individual with hypertension who overstuffs with fattening foods. In cases where patients refuse to abandon their destructive habits or immature objectives, the knowledge that they are responsible for their own plight is healthier, from a therapeutic viewpoint, than the conviction that may have existed previously, to the effect that the sources of their misery lay outside of themselves.

Where one is convinced that one's adjustment is eminently unsatisfactory, where one realizes that one's gratifications do not compensate for the suffering that comes from indulgence of one's immature drives, where one is aware of how one's patterns interfere with mature goals, one may be motivated toward experimenting with new reactions toward people and toward oneself.

Once patterns that are inimical to adjustment are clearly defined and more adaptive substitutive reactions are suggested, a long period of experiment and training is necessary before unhealthy attitudes are replaced by those of a more mature nature.

Even where patients have the motivation to change, a struggle will be necessary to achieve reeducative effects. In spite of all good resolutions, the patients, at first, will find themselves responding automatically, in line with their customary habits. They will, however, become more and more conscious of their reactions, and, as they occur, they will better be able to subject them to analysis and control. Even though this may fail to stop them from following their usual patterns, they will become more and more aware of their

irrational motives, and they may develop greater determination to substitute more constructive behavior tendencies.

For instance, perfectionistic persons may become conscious of the fact that the impulse to do everything meticulously extends itself into every aspect of their lives and poisons relationships with people. They will see, as the therapist brings it to their attention, that the slightest failure to perform flawlessly suffices to create tension and panic. They may learn that the reason for their disturbance lies in the fact that when they are not perfect, their image of themselves is shattered and they feel unloved and unlovable. Life then becomes a constant series of frustrations, since it is obviously impossible to do things perfectly every minute of the day and still be human. The patients will, as they become aware of their inordinate expectations, find themselves toying with a more self-tolerant philosophy, which they will not wish to accept at first, probably because being mediocre is equivalent to being no good at all, and because they are unconvinced that perfectionism is not really the keynote of life. As they test the truth of the therapist's exhortations and as they realize the extent to which their perfectionistic strivings dominate them, they may attempt to restrain themselves before yielding to perfectionistic impulses. They will review in their mind the reasons why they must be perfect on every occasion. They may eventually even try to substitute for this impulse the attitude that they can do things casually without needing to be perfect.

To expedite these reeducational aims, behavior therapy may be helpful, a description of which follows in the next chapter.

51
Techniques in Behavior (Conditioning) Therapy

The Freudian economic concept of the personality as a closed energy system sponsored the idea that libido removed from one area must be relocated and that energy released by symptom removal must inevitably wreak its mischief elsewhere. The removal of symptoms, therefore, was considered irrational and the rewards dubious since energy soon displaced itself in other and perhaps more serious symptoms. No myth has survived as tenaciously as has this concept, which continues to be promulgated as dogma despite the fact that in practice symptoms are constantly being lifted with beneficial rather than destructive results.

In its early days behavior therapy was viewed by some clinicians as a viable and powerful means of bringing about symptom relief and removal. The assumption was that, even when effective, the net outcome would be primarily of an adjunctive or patching-up nature that had to be supplemented by more depth-directed, nonbehavioral approaches geared toward the total personality. Contemporary behavior therapy, however, is multidimensional and aims, in systematic fashion, at the modification of every relevant facet of the personality. This will include both maladaptive behavioral excesses (e.g., tics) and/or deficits (e.g., lack of assertion). It will embrace affective and cognitive modes of functioning; it will stress control from within (self-control) rather than control from without. It will take the form of a collaborative project with the patient rather than a *laissez faire,* "leave it to the patient to decide or not to decide," direction, on the one hand, or authoritarian direction, on the other.

Behavior therapy as it developed was rooted in concepts derived from conditioning and learning theory (Hilgard, 1956; Kimble, 1961), particularly from formulations of Pavlov, Skinner, and Hull, as well as from experimental and social psychology (Brady, 1985; Paul & Lentz, 1977; Pomereau & Brady, 1979). It was based on the hypothesis that since neurosis is a product of learning, "its elimination will be a matter of unlearning"

(Wolpe, 1958). It gradually embraced a wide and seemingly disparate array of procedures, all of which share certain common attributes: an unswerving allegiance to data and the methodology of the behavioral scientist, a rejection of metaphysical concepts and mentalistic processes, and predilection for what is now known as social learning theory (Wolpe & Lazarus, 1966; Bandura, 1969; Wolpe, 1971; Birk et al, 1973; O'Leary & Wilson, 1975). These techniques may be directly physiological or narrowly S-R (stimulus-response) in nature (e.g., aversive conditioning), highly imaginal (e.g., real-life—graded desensitization of an elevator phobia), stimulus specific (e.g., thought stoppage), stimulus situation complex (e.g., assertion training, behavioral rehearsal), of a contractual nature (e.g., contingency contracting), directly cognitive (e.g., cognitive behavior therapy, rational emotive therapy) conducted with the individual or in groups, or utilizing complex interpersonal interactions as in group behavior therapy (not to be confused with behavior therapy in groups), etc. etc. Affects, cognitions, and behavior will all come within the purview of the behavior therapist of the 80s and 90s (as contrasted with the behavior therapist of a decade ago) indicated by the outcome of carefully engineered behavior analysis of the total situation. As more therapists apply themselves to this area of treatment, they introduce their own original procedures and unique interpretations regarding operative learning mechanisms. The rapid growth of behavior therapy and the introduction into its orbit of a profusion of techniques had led to some confusion, although attempts are being made to establish a methodical way of looking at the different approaches (Brady, 1985) as follows: 1. The situations where problem behaviors occur, i.e., which situations exaggerate and which ameliorate the behaviors; 2. the special ways the problem behaviors manifest themselves and the intensity of their manifestations; 3. the effect of the behaviors on the patient and on others, as well as the consequences to the patient, to others, and to the environment; 4. the personal assets and resources available to support anticipated changes, and the areas in the environment on which we may draw for help; and 5. the possible impact on the patient and on others of anticipated improvement or cure. The past life and conditionings that have acted as a seedbed for problem behaviors, and the past and present reinforcements that have initiated and are now sustaining the behavior are also examined. A hierarchy of problem behaviors is

composed on paper with the object of establishing a priority regarding which problems to select for immediate focus and which for a possible later focus. Goals in therapy are discussed in terms of what the patient wants from therapy and what changes in behavior are necessary to achieve this. Some behavior therapists recommend a *Behavioral Self Rating Check List* (Cautela & Upper, 1975), which contains 73 kinds of behavior it is possible to change. The therapist must agree that the patient's goals are acceptable and not unreasonable. Next, a definition of the problem includes the situations in which problem behaviors occur, their frequency, the patient's thoughts and feelings that accompany them, the environmental consequences, and their effect on the behaviors. A clinical assessment, including history-taking, follows. Certain forms may be used, such as a *Reinforcement Survey Schedule* (Cautela & Kastenbaum, 1967) and the *Fear Survey Schedule* (Wolpe & Lang, 1964).

The patient may be asked to write down the reactions during an episode where problem behaviors occur (e.g., a phobic inspiring situation). The patient is also asked to quantify the reactions, to write down the number of times a day the symptoms occur, and to note the circumstances that surround their appearance. What is searched for are the stimuli that set off problem behaviors and their reinforcements. In several interviews sufficient information should have been gained. After presenting the therapist's hypothesis of the patient's difficulty and gaining acceptance of this, a treatment plan is devised and a contract with the patient drawn up. Therapy focuses on set goals. Should the individual fail to respond well in relation to the limited selected target, a wider range of targets, perhaps calling for different behavioral techniques, may be required.

The practice of behavior modification is most expediently executed where the therapist and patient both agree on the behaviors to be altered or required, on immediate and ultimate goals, and on the methods to be employed to achieve these objectives. Where the patient is unable to make adequate decisions, these determinations are sometimes made with a relative or other representative, who is kept informed about progress and changes in goals or methods. An assessment of the problem initially (the "behavioral analysis") includes the history of the behavioral difficulty, the circumstances under which

it now appears, its frequency, and the consequences following its occurrence. A careful record of the frequency of the distortion is generally kept during therapy by the patient or a member of the family. A search for overt or hidden reinforcements that maintain the noxious behavior is also pursued. The formulation of the treatment plan will depend on many factors, including the type of symptom, the forces that bring it about and maintain it, and the kind of environment in which the patient functions, including the influence of individuals with whom the patient is living.

The chief avenues to behavioral therapy are through desensitization modeling and cognitive approaches, and operant (instrumental) conditioning.

There are literally hundreds of techniques currently available to behavior therapists. Superficially, these might seem to share few common elements, ranging, as they do, from the naively simple to the complex, from the strictly physiological to the totally cognitive, etc. However, at least in principle if not always in fact, all possess certain common characteristics: acceptable only if adequately validated for the contemplated purpose; preceded by behavioral assessment, monitored throughout the ongoing intervention, and outcome evaluation carried out; stemming no matter how loosely from some form of clearly articulated learning theory framework.

SYSTEMATIC DESENSITIZATION

Techniques organized around classical conditioning are tailored for anxiety situations such as phobias, the product of unfortunate associations that continue to burden the individual without too much secondary gain or other subversive benefits. Therapy consists of a progressive desensitization to the anxiety situation, either by a slow exposure to gradually increasing increments of the anxiety stimulus, under as pleasurable or otherwise rewarding circumstances as possible, or by a mastery of fantasies of such stimuli in ever increasing intensity in the presence of an induced state of inner relaxation. Even where the anxiety situation is highly symbolized—for instance, phobic projection, which nonbehavioral therapists view as a product of deep inner conflict—it may be possible to overcome the symptom without the formality of insight. However, an

understanding of the sources of the problem may be helpful in avoiding a relapse by dealing correctively with some of the core problems that initiate the anxiety. This, too, would be taken into account by modern behavior therapists in their treatment strategy without recourse to concepts such as the unconscious or the achievement of insight. On the other hand, insight alone, without reconditioning, may leave the symptom unrelieved. An understanding and use of behavioral approaches can be helpful even to the practitioner who aims at personality reconstruction. These techniques may be especially valuable during phases of treatment where the patient offers severe resistances to the execution of insight into action.

While increasingly deemphasized in the armamentarium of the behavior therapist, perhaps the best known approach, and the easiest one to learn, is that of desensitization. In desensitization methods anxiety-provoking cues are presented in a positive or pleasurable climate. These cues must be graduated so that the responses that they evoke are always of lesser intensity than the positive feelings that coexist. In this way the aversive stimuli are gradually mastered in progressively stronger form. The method is most readily applicable to anxiety that is set loose by environmental cues. In the arrangement of stimulus hierarchies both environmental and response-produced cues are listed to encompass as many complex aversive social stimuli as possible. The most common positive anxiety-reversing stimulus, jointly presented with and calculated to neutralize and eventually extinguish the aversive stimuli, is muscular relaxation, often induced by hypnosis.

To his use of this technique Wolpe (1958) has given the name "reciprocal inhibition." Treatment is initiated by the construction of an "anxiety hierarchy." The patient is given the task to prepare a list of stimuli to which he or she reacts with unadaptive anxiety. The items are ranked in accordance with the intensity of anxiety that they induce. The least anxiety-provoking stimulus is placed at the bottom. The most disturbing stimulus is put at the top. The remainder are placed in accordance with their anxiety-arousing potential. The patient is then hypnotized and relaxed as deeply as is possible. In the trance it is suggested that the patient will imagine the weakest item in the anxiety hierarchy. If the

patient is capable of doing this without disturbing the relaxation state, the next item on the list is presented at the following session. With each successive session the succeeding intense anxiety stimulus is employed during relaxation until "at last the phobic stimulus can be presented at maximum intensity without impairing the calm relaxed state." At this point the patient will presumably have ceased to react with the previous anxiety, and to be able to face in life "even the strongest of the once phobic stimuli."

Wolpe denies that his therapy is useful only in simple phobias. He believes that even difficult "character neurosis" can be treated, since they consist of intricate systems of phobias that have been organized in complex units. "This," he says, "is not remarkable, if as will be contended, most neuroses are basically unadaptive conditioned anxiety reactions." Wolpe insists that in contrast to measures of success by all methods of therapy, ranging from traditional counseling to psychoanalysis, of a recorded 50 percent, his special method brings about an "apparently cured" and "much improved" rate of over 90 percent. It is important, however, to stress, as do sophisticated behavior therapists, that the presenting complaint is not necessarily either the one that requires desensitization or, if it is, that it may not be the one that should be given sole, or even primary, attention. For example, to desensitize an attorney to a fear of public speaking (the presenting complaint) may be of far less significance than desensitization to the fear of losing face should the attorney not win the case. Which desensitization strategy to employ, or whether to employ desensitization at all, or what other necessary behavioral techniques to employ in the restructuring of this particular individual's life can only be determined by a detailed and comprehensive behavioral analysis of the total life style of that individual and the relevant contingencies operating in the individual's life and the lives of meaningful others.

Attempts to standardize Wolpe's procedure have been made by Lazovik and Lang (1960). The pretraining procedure of five sessions includes the construction of an anxiety hierarchy (a series including the phobic object, graded from most to least frightening). Training in deep muscle relaxation after the method of Jacobson (1938) is followed by training in hypnosis, efforts being made to get the patient to learn to visualize hypnotic scenes vividly. Eleven sessions of systematic desensitization follow the pretraining period.

During these the patient is instructed to relax deeply, and items on the anxiety hierarchy are presented as scenes that are to be visualized clearly. The least frightening scene is presented first. When this is experienced for about 3 to 10 seconds without anxiety, the next item in the hierarchy is introduced. All scenes are presented at least twice. If any of the scenes make the patient anxious or apprehensive, the patient is instructed to raise the left hand a few inches. Should this happen, the scene is immediately discontinued and not repeated until the next session; rather, the last successfully completed item of the hierarchy is presented. From 2 to 4 scenes are attempted during each session of 45 minutes. The authors confirm Wolpe's method as remarkably effective for treating cases of phobia and insist that there is no substitution of other fears. This has also been my personal experience.

Edward Dengrove has prepared a leaflet for "fearful" patients that introduces them to the technique of systematic desensitization:

(Reprinted here with the permission of Dr. Dengrove)

The type of treatment that is being offered to you is known as systematic desensitization. It is based upon scientific studies of conditioned reflexes and is particularly helpful to persons who are fearful. It makes little difference what these fears are: whether of closed places, or being alone, walking alone, driving or flying; or whether one fears loss of self-control, criticism by others, and the like.

Kindly list *all* of the fears that disturb you. Make the list as complete as possible. We will go over the list together and reduce it to its basic units. Treatment will be directed to each individual fear.

The next step will be to teach you how to relax. There are several methods by which this may be accomplished. The particular method that suits your needs will be chosen. This is very important, for the more relaxed you are, the more rapid your progress to health. You cannot be relaxed and remain anxious or fearful at the same time.

When you are completely relaxed—not partially, but completely—I shall present to your visual imagination a series of situations. These will be based upon your presenting fears. They will be organized in series, graded from the most mild to the most intense. Each forms a hierarchy.

As you visualize each scene in the relaxed state, you may find yourself unmoved by what you see. Or you may experience an uneasiness or restlessness (anxiety). This is a critical point in treatment, and must be signalled to me. No matter how slight, I must be made aware of it.

I may ask, "Do you feel relaxed? Do you feel at ease?" If you do, then move your head up and down ever so slightly. If you do not, move it from side to side.

This is a critical point, for we can only proceed as fast as you are able to accept these visualized situations with ease. I shall not push or prod you. It is only by the ability to maintain your relaxed state that you are able to overcome these fears.

The desensitization takes place gradually by getting you to cope with small doses of anxiety at first, then gradually increasing the dosage a small amount at a time.

With children, desensitization is done in a less subtle manner. Consider a child who is afraid of dogs. The child is held by a trusted person who allows him to suck on a lollipop and point to a dog on a leash in the distance. A little later, the child, still held, is encouraged to view a dog through a pet-shop window. Still later, he is brought closer to a dog; and later, closer still. With the pleasure of the food and security of being held by a trusted person, the child gradually overcomes his fear. At first there are pictures of dogs, then toy dogs, small, friendly dogs, medium-sized dogs, and so forth. At last, he will be able to reach out and touch a dog.

This gives you a clue to a second part of treatment. You are to do the very things that you fear. One cannot overcome a fear by avoiding it, as you have done in the past, nor by trying to drown it out with continued medication. Medicine is helpful, but only a crutch, to be reduced and gradually thrown away.

The same principles of gradual desensitization must be employed. You are not to attempt any activity that produces overwhelming anxiety. However, you can and should try those tasks that are only mildly upsetting, at the same time attempting to quiet yourself. If the anxiety persists, stop what you are doing, for this will only set you back. Instead, return to doing those things that you can do without getting upset.

With this approach you will find yourself gradually doing more of these tasks that you avoided in the past. One can get used to almost any new situation that is approached gradually.

Interestingly, as the milder fears are overcome, the more strong ones lose their intensity and lessen, much as the contents of a gum machine diminish with the discharge of each piece of gum. The more one attempts with relaxation, the more rapid the improvement. But one must keep in mind that these attempts deal only with those productive of mild anxiety.

A warning: everyone must proceed at his or her own pace. Some slowly, others more rapidly. There is no reason to feel guilt or shame if one's progress is slow. The process of desensitization cannot be hurried by rushing into highly anxious situations. You will not be thrown into the water and made to swim or sink on your own. At times, under the pressure of need or anger, a few of you will make large strides but this is the exception to the rule.

Consider the woman who is afraid to leave her home. Her first move is to step

outside her front door and back again into the house. From there she gradually makes it to the street in front of her home, then around the house—by herself or with someone or while someone trusted is in the house. Each day this is extended until she is able to walk a house away, then two houses, then half-a-block; with someone, without someone, with someone at home, with no one there. Again, no new step is made until the previous step is mastered, and until it can be accomplished without any anxiety whatsoever. Each fear is attacked individually, daily or as frequently as this can be done.

Gradually you find yourself doing things without thinking about them. Sometimes it will be only after you have done something that you realize you have done it without forethought or anxiety. It may be that someone else will point out to you that you have done something you would not have attempted in the past.

A cooperative spouse is not only helpful and understanding but an essential part of this approach. He or she can be tremendously important to this undertaking. Marital problems tend to hold back progress and should be resolved.

It is by doing what we do in the office, and what you do for yourself away from the office, that will lead you to health. One or other of these techniques may be used alone, but when both are employed, progress is so much faster.

Systematic desensitization is sometimes expedited by the use of drugs, like Brevital, 1% solution, in small doses (Brady, 1966; Friedman & Silverstone, 1967). Slow intravenous injections to produce relaxation without drowsiness are particularly valuable for patients who are unable to relax or who are extraordinarily anxious. Pentothal (2% solution) is preferred by some therapists to Brevital.®

IMPLOSIVE THERAPY (FLOODING)

Implosive therapy is a modality utilized to help extinguish avoidance responses (e.g., phobias) as an alternative to relaxation-desensitization treatment (Kirchner & Hogan, 1966; Hogan & Kirchner, 1967; Stampfl, 1967). Exposure to a fear-provoking stimulus with no attempt to escape from it will tend to weaken the strength of the stimulus (Boulougouris & Marks, 1969). The patient here is instructed to approach the phobic situation and to tolerate it (by relaxing the muscles and by trying mentally to change the meaning of the danger imagined to invest the situation).

Eventually it is hoped that the fear will be extinguished. The therapist may model the proper approach behavior as an example of how controls can be established. Experience

convinces that in vivo desensitization is superior to desensitization through imagery, as, for example, in systematic desensitization. However, desensitization through imagery may be used as a preliminary therapy in order to reduce the level of an intense anxiety reaction that can prevent the patient from even attempting to expose oneself to a real situation. A trusting relationship with the therapist is of the greatest help to the patient whose terrors have kept the patient from confronting the phobic situation.

A massive form of in vivo desensitization, *implosive therapy or flooding,* exposes the patient to fear-provoking stimuli, escape from which is not permitted. Induced exaggerated forms of fearful imagery related to the phobia may precede actual immersion in the phobic situation, the therapist purposefully magnifying the sinister nature of the fantasy stimulus. After the patient learns to tolerate the imagery, the real stimulus in force is employed. Remaining in a fearsome position until the anxiety disappears may result in substantial improvement or cure. In some cases where a phobic situation exists outside the office, the therapist accompanies the patient to the site (bus, subway, elevator, funeral parlor, crowded street, etc.) and stays with the patient through the latter's anxiety attack until it is dispelled. In other cases, particularly where the patient for physical reasons cannot endure too strong anxiety, withdrawal from the scene is permitted as soon as the patient feels moderately uncomfortable. In obsessive-compulsive reactions the exposure is to the stimuli that produce the rituals and the patient is discouraged or blocked from engaging in them. For example, in hand-washing compulsions produced by touching dirt, the therapist first models rubbing the hands on the shoes or the floor and then enjoins the patient to do the same. The therapist sits with the patient, encouraging the patient not to go to the bathroom to scrub the hands. The results with this kind of therapy have been encouraging; however, "The therapist must not back away from the elicitation of anxiety, no matter how uncomfortable the patient becomes, and must not terminate the session before the extinction of anxiety is complete" (Seligman, 1979). Agreement must be reached with the patient in advance of using this technique that the patient will be willing to tolerate a certain amount of discomfort in overcoming the handicap, the advantages in time-saving being pointed out. It cannot be emphasized enough that the therapeutic alliance must be a firm one in order for the patient to trust the massive exposure to

flooding techniques. Time may have to be spent consolidating the relationship prior to suggesting the technique to the patient.

The exact way flooding works is not entirely known. There are so many variables in therapy that one cannot credit results exclusively to the methods employed, since the skill of the therapist, personality, case selection, etc. crucially influence results. Be this as it may, implosive therapy in the hands of a skilled operator may dramatically cure certain phobias.

Some patients reject implosive therapy out of panic, or they may not physically be able to tolerate the great anxiety release because of cardiac illness or a vulnerable ego structure that may shatter with resultant psychosis. Here systematic desensitization is best or *graded* exposure, where approach to the phobic object or situation in small steps is employed (Wilson, GT, 1980). In both flooding or graded exposure, the therapist or empathic assistant may accompany the phobic patient to the situation that requires mastery and this can have great reassurance value. It is important here that the therapist withdraws from the therapy gradually to avoid a dependency stalemate.

In extremely upset patients intravenous infusions of a short-acting barbiturate are sometimes helpful. The patient at the start of therapy may be given a slow intravenous injection of Pentothal® (thiopental sodium) in dilution of 2%, sufficient to produce relaxation without drowsiness. Pentothal® is available in 500 mg vials in combination packages with diluent of 20 mL vial of sterile water. Some therapists utilize a 1.25% concentration (Hussain, MZ, 1971), but the diluent here should be sterile sodium chloride to prevent hemolysis. Convenient sterile prefilled cartridge-needle units (Tubex, Wyeth Laboratories) are also available with 1½ grains of Pentothal.® A very slow injection of the drug is essential to avoid sleepiness. Once relaxation is obtained, the patient is shown pictures related to the phobic object or phobic situation and asked to picture himself or herself touching or holding the object or being involved in the situation. This continues throughout the session, the patient being asked to continue to imagine being immersed in the scene. Where artificial objects similar to the phobic object can be obtained (snakes,

worms, mice, roaches, etc.), the patient is enjoined to handle these. The session is brought to an end with the patient in a drug-relaxed state. As mastery occurs, sessions are conducted with lesser and lesser amounts of the drug and finally without it. Some therapists prefer a *1%* solution of Brevital® (methohexital sodium) to Pentothal.®

Home practice sessions may be valuable for some patients. These can cover a wide range of themes. A paradoxical technique that I have found valuable for some phobias is illustrated by the following directions given to patients:

> Running away from fearful situations or trying to crowd out of your mind a fearsome thought only reinforces your fear. If you practice producing the fearful situation deliberately in your mind as completely as possible, while studying your bodily reactions, you will begin extinguishing the fear. If when you are not practicing the fear comes upon you, do not push it aside; try to exaggerate it, experiencing the fear as fully as possible. Practice bringing on the fear at least three times daily. If you have a sympathetic friend whom you can talk to about your reactions while practicing, this can help.

OPERANT CONDITIONING

Techniques of operant (instrumental) conditioning, in which the subject is active in bringing about a situation toward achieving reward or avoiding punishment, supplement classical Pavlovian conditioning procedures (Krasner, L, 1971). Essentially, these techniques consist of reinforcements in the form of rewards or the withdrawal of an aversive (punishing) stimulus or event as soon as the subject executes a desired act. The subject is free to respond or not to respond instead of, as in classical conditioning, being passively subjected to events over which there was no control. The techniques are designed to strengthen existing constructive responses and to initiate new ones.

Operant approaches depend on the fact that human beings like other animals are influenced toward specific kinds of behavior by the reinforcers they receive for this behavior. Where a desired behavior is sought, the patient must first be able to accept the desirability of this behavior in terms of the rewards that will accrue from it. Many patients are confused regarding appropriate courses of action. The therapist's positive attention and approval following a remark that indicates a willingness to try a tactic, or the

execution of the desired behavior itself, or approximations of this behavior, may be reinforced through nodding, utterances of approval, or paying rapt attention to these desirable responses, or by granting material rewards. However, when the patient repeats a pathological pattern or verbally indicates nonproductive choices, the therapist may act disinterested and fail to respond to this behavior.

Operant conditioning works best in an environment that can be controlled. It is indicated in nonmotivated patients in institutions whose behavior must be modified to enable them to adjust more appropriately. The "token economy" of Ayllon and Azrin (1968), established in a state institution, illustrates an imaginative use of substitutive reinforcers. Since the desired reinforcers (ground passes, TV, cigarettes, canteen purchases, trips to town, and ordering items from a mail order catalogue) would not in all cases be immediately produced, tokens to exchange for these when available were found to be effective. Tokens were earned for better self-care and for work on and off the ward. The results in terms of morale and behavioral improvement, which in some cases led to recovery, were astonishing.

Bachrach (1962) provides an example of anorexia nervosa treated by operant conditioning techniques. Since food obviously did not have its expected reinforcing characteristics, a study was made of the stimuli that could act as reinforcers. Because the subjects enjoyed visits from people, music, reading, and television, they were at first deprived of these by being put in a barren room. Being visited by people, listening to records, seeing television, or reading books were made contingent upon eating and weight gain. In a little over a year of such operant conditioning, the patients' weight increased twofold.

Ayllon and Michael (1959) describe an experiment in operant-conditioning therapy done on the ward of a mental hospital by the nursing staff working under the supervision of a clinical psychologist. The patient sample consisted of 14 schizophrenics and 5 mentally defective patients. The kind of disturbing behavior (psychotic talk, acts, etc.) in each patient was recorded along with the nature and frequency of the naturally occurring

reinforcements (giving the patient attention, social approval, candy, ciagrettes). Then the nurses were instructed to observe the patients for about 1 to 3 minutes at regular intervals, to give them reinforcements only during desirable behavior, and to ignore undesirable behavior. Nonsocial behavior was to be reinforced temporarily if it replaced violent behavior. For instance, two patients who refused to eat unless spoon fed had a penchant for neat and meticulous appearance of their clothing. The nurses were instructed to spill food on their clothing during periods when they resisted feeding and to present social reinforcements when the patients fed themselves. The patients soon spontaneously began to reach for their spoons and eventually were feeding themselves. In a group of mentally defective patients who were collecting papers, rubbish, and magazines in their clothing next to their skin, the nurses were instructed not to pay attention (i.e., not to reinforce) this behavior, while flooding the ward with magazines to overcome the shortage. The hoarding tendency was overcome.

In the experimental control of behavior the specification of the response is usually simple to describe, but the identification of the stimulus that brings on the response may be obscure. Hence, one must work toward the desired response employing appropriate scheduled reinforcements in terms of what the subject considers to be significant rewards. At first, the most that can be expected are approximations of the final response. Reinforcement is restricted progressively to responses that are closer and closer to the end response. In this way behavior is shaped. Complex behavior patterns may be evolved by developing a series of coordinated responses, linking them together like a chain. Thus, employing food as the reinforcing stimulus, Ayllon and Michael (1959, 1964), as described above, brought chronic schizophrenics out of their disturbed behavior and psychotic isolation. Lindsley (1960) has also written about the operant conditioning of severely sick patients, and N. R. Ellis and his colleagues (1960) have had some interesting experience in retraining disturbed mental defectives.

Operant conditioning is suited for the removal of habits and patterns that serve a neurotic function from which people derive some immediate benefit (such as delinquent behavior, temper tantrums, etc.) at the expense of their total adjustment. It is also helpful

in developing new constructive patterns that are not in the individual's current repertoire. In the main, the treatment procedure consists of an identification of the untoward patterns and a careful delineation of the stimuli that bring them about. Next, the nature of the reinforcements to be employed are determined (attention, food, bribes, etc.) as well as the nature of any aversive stimuli that may help to interrupt the pattern to be corrected. In general, reinforcements are withheld (or aversive stimuli applied) when the behavior to be corrected is manifested, but reinforcements are given (or aversive stimuli removed) when substitutive and more adaptive behavior is displayed. In this way the individual is helped to develop more frustration tolerance and to control untoward behavior in favor of acts for which rewards are forthcoming.

Ferster (1964), in an article that details the tactics of operant conditioning, describes the treatment of autistic children. As is known, tantrums and destructive behavior in autistic children are usually reinforced by the persons with whom the children are in contact by their yielding to the children and satisfying their whims. Thus, the children may have learned that they can get candy if they scream loud enough or bang their head on the floor. Much of the child's behavior is operant, being contingent on reactions from the social environment. Ferster found that food was the most effective reinforcing agent. The sound of the candy dispenser prior to the release of candy acted as a secondary reinforcer. With some training, coins became the conditioned reinforcer, the coins operating devices within the room that could deliver the candy reward. Later, the coins were to be held for a period prior to their use before the reward was allotted. Then five coins were to be accumulated. Delays were increased by introducing a towel or lifejacket that later could be used in swimming or water play (another reinforcer) following the experimental session. While the repertory of the autistic child was limited, it was possible for the child to develop some frustration tolerance and controls.

Next, Ferster examined the circumstances in the early life of the child that originally had brought about, and still could bring about, behavioral disorders. The parental environment was also put under surveillance to see what factors weakened the child's performance, the resultant behavior, and the effect of this behavior on the people

surrounding the child. This was done to determine what reinforcements were operating and the possible ways of discouraging such reinforcements. It is likely that the atavistic and uncontrollable behavior of the autistic child starts with the reinforcement of small magnitudes of behavior such as whining. A shaping into violent responses occurs by differential reinforcement. By refusing to provide reinforcements of the child's behavior, we may expect the child gradually to abandon the behavior (extinction). Changing the environment gradually may be helpful in this respect, since the habitual reinforcing agencies on whom and which the child depends on are no longer present. By withholding positive reinforcements and rewarding conduct that slowly approximates adaptive behavior, it may be possible to effectuate behavioral change not only in psychotic children but also in psychotic adults without using aversive stimuli.

The techniques of operant conditioning are particularly suited for patients who are not accessible for traditional interviewing techniques, e.g., delinquents, psychopaths, drug addicts, psychotics, and mental defectives. The results may be rewarding where the reinforcements stem from objective environmental sources, such as reasonable and relatively nonneurotic individuals with whom the patient is in contact. The results are not so good where the agencies, such as parents, participate in the family neurosis and support the patient's acting-out as a way of satisfying their own needs. It is indeed difficult to prevent reinforcement of the patient's untoward behavior in many families since the inspiring motives are usually unrecognized and subject to conscious denial. Thus parents may become frustrated when their child begins to get better. Subtly the child may be maneuvered back to the old way of behavior with restoration of the defensive protesting of the parent.

Where the reinforcements are of an inner, perhaps unconscious nature, such as sexual excitation and a masochistic desire for punishment, operant conditioning may be of little use. For example, where shoplifting in a well-to-do matron occurs against all reason, it is difficult to find external reinforcements to put this antisocial behavior to halt in case stealing serves to gratify unsatisfied urgent unconscious orality with needs for compulsive acquisition.

In intelligent patients, however, a recognition of some of their unconscious motivations may enable them to execute the principles of operant conditioning for themselves. An executive in a large business firm, presumably happily married and adjusted, periodically would involve himself with prostitutes, whom he enjoined to strap him down to a bed and beat him unmercifully. Struggling to escape from this humiliation, he responded with a strong orgasm. After this experience his shame and guilt feelings, as well as his fears of being discovered, overwhelmed him to the point of depression and suicidal impulses. Although he pursued every device at his command, including exercise, prayer, and involvement in charitable activities to counteract his desire, his intervals of abstinence from flagellant desires would, without reason, be interrupted and he would go forth again toward another beating orgy.

In studying this case it was determined that what particularly delighted this man was sailing in Long Island Sound, where he had a boat. This, it was felt, could be employed as a reinforcement for the ability to control his masochism. It was first necessary, however, to add to the leverage of his will power some understanding of the meaning of his peculiar deviation. This, it was determined from dreams and free associations, related particularly to spankings from his mother during his childhood when he masturbated or was otherwise "bad." A fusion of orgiastic feelings with punishment apparently was the conditioning underlying his symptom. The origins of this affiliation were blunted but memories were activated through analytic techniques. This provided him with a new motivation to decondition himself. A plan was organized so that sailing was to be indulged only in the intervals of control. If a relapse occurred and he acted out his masochism, sailing was to be avoided for a month thereafter. If the impulse appeared and he could control it, he was rewarded by taking a short sea voyage (which he enjoyed as much as sailing) to Bermuda. During the winter, if he had been able to vanquish his symptom, he was to take a sailing vacation in southern waters. Within a year of this regime the patient's symptom was arrested, and whenever the desire returned minimally, he was able to overcome it by reviewing the history of the original development of the symptom. Coordinate with symptom improvement was a better personal and sexual relationship with his wife.

The problem in utilizing operant conditioning as an adjunctive technique consists in finding external reinforcements that are sufficiently interesting and important for patients to induce them to challenge patterns that have open and subversive values. However, if the therapist reviews areas of interest with a patient who is willing to cooperate, a sufficiently provocative reward or diversion that will help incite the patient to change may be uncovered.

The schedules of reinforcement may preferably be arranged at varying intervals and at unpredictable times. This is to produce an anticipatory set and to help prevent the extinguishing of a response that may come about if the patient expected reinforcement uniformly as a consequence of a new behavior. It may so happen that circumstances make it impossible to reward new behaviors each time. If the patient does not envision fulfillment without fail, the patient will not be too disappointed and angry when reinforcements do not appear. Rather, the patient will anticipate their arrival at some point.

Other conditioning techniques have been employed. For instance, Efron (1964) helped a patient stop uncinate seizures by inhaling from a vial odors of various aromatic chemicals (these had been proven effective in controlling the seizures) that were conditioned to a nonspecific visual stimulus, namely an inexpensive silvered bracelet. This was done by presenting simultaneously every 15 minutes, for a period of 8 days, the concentrated odor of essence of jasmine and the bracelet. The instructions were to stare intently for 15 to 30 seconds at the bracelet while sniffing a vial of jasmine. Except for 7 hours of sleep at night, the conditioning continued during the rest of the 17-hour period. At the end of 8 days of conditioning, the bracelet alone presented to the patient produced the effects of jasmine, which receded in a few seconds when the bracelet was removed from the patient's sight. The patient was exposed to reinforcements twice a day for the next week. A spontaneous seizure developing during the second week was stopped by the patient's merely staring at the bracelet for a few seconds. Thereafter the bracelet continued without fail to arrest seizures.

An excellent account of conditioning techniques toward painless childbirth is given by Bonstein (1958). Contained in the article are general suggestions for pain control.

Conditioning techniques have been utilized as diagnostic aids. Gantt (1964), employing the methods of Krasnogorsky and of Ivanov-Smolensky, has described a method for the study of motor conditional reflexes that can be applied to psychiatric diagnosis. Through the use of his technique he claims to be able to distinguish psychogenic from organic psychoses. This is because in psychogenic problems patients inhibit the expression of the elaborated conditional reflex, while in organic psychoses they fail absolutely in the function of forming new adaptive responses. L. Alexander (1964), employing a conditional psychogalvanic reflex technique, has developed a test for the differentiation of physical from psychogenic pain. Ban and Levy (1964) describe a diagnostic test based on conditioned-reflex therapy that measures evidence of change in patients exposed to any treatment regime. Conditioned-reflex techniques have also been employed to investigate the effectiveness of drugs in psychiatry (Alexander, L, 1964). How conditioning may enter into the genesis of attacks of asthma is discussed by Dekker, Pelser, and Groen (1964).

PUNISHMENT AND DEPRIVATION

Behavior therapists now recognize that punishment rarely works as a means of halting undesirable behavior. It is usually temporary in its effect and likely to exaggerate rather than solve problems. Getting individuals to stop hurtful activities because they get adequate rewards in exchange is much more effective. The patients may not be able to anticipate the rewards that accrue from constructive behavior until they have yielded their destructive activities, and it will be necessary for the therapist to provide interim reinforcements.

A child who consistently misbehaves, who refuses to eat, sleep, or give up childish habits like thumb-sucking and bedwetting will frustrate the parents and provoke angry responses. The parent will be tempted to punish the child for refusing to cooperate. This may do little other than to mobilize the child's guilt feelings and lead to self-punitive

activities (masochism) or to stimulate retaliating anger and defiance. Logic has little to do with these reactions. Or the parent may be tempted to remove certain privileges, such as taking away something that the child enjoys (e.g., allowance, desserts, or TV viewing). The consequences of such deprivation are usually the same as punishment. Yet punishment and deprivation may rarely be an expedient in temporarily stopping destructive behavior that the child refuses to halt. For instance, of their own accord, older children who are mercilessly beating a younger sibling may be forcefully required to retire to their rooms until they feel they can control themselves. But the expedient of punishment or deprivation must be used only in emergencies to put a stop to immediate destructive outbursts that do not yield to reason, verbal reprimand, or the ignoring of the behavior. In any event, the punishment or deprivation should be reasonable and never so drastic as to leave an enduring residue of anger and desire for revenge. It should always be used in conjunction with positive reinforcement for constructive behavior.

Far more effective are actions that tend to *extinguish* improper behavior. This may require little more than refusal to reinforce the behavior by paying too much attention to it or being ostensibly provoked by it. Thus, a parent may interrupt an undesirable activity by diverting a child's attention and substituting another activity for the disturbing one. Reinforcing the substitute activity by providing a proper reward for its indulgence will help extinguish the unwanted activity.

AVERSIVE CONTROL

There are times when all methods employed to halt disturbing behavior, particularly those that are life threatening or destructive, may fail, and the therapist may, with the consent and cooperation of the patient, have to resort to measures of blocking the behavior by associating it with unpleasant stimuli (Cautela, 1967; Rachman & Teasdale, 1969; Lovibond, 1970; Meletsky, 1980).

Aversive conditioning is sometimes employed to overcome certain undesirable behavioral components. Emetic drugs (apomorphine or emetine hydrochloride) were used for years in the treatment of alcholism by conditioning methods. Miller, Dvorak, and

Turner (1964) have described a technique of establishing aversion to alcohol through the employment of emetics in a group setting. A unique form of aversive stimulus-paralysis and suppression of respiration through intravenous injection of succinylcholine-chloride dihydrate has been reported by Sanderson et al. (1964). In addition to drugs, electric shock has been employed as an aversive stimulus for a variety of syndromes (McGuire & Vallance, 1964). Needless to say, unless one has an excellent working relationship with a patient, aversive conditioning poses some risk and may play into a patient's masochistic need. And, as noted in the preceding section, punitive conditioning is never employed in isolation by the modern behavior therapist; nowhere is this more evident than in the behavioral treatment of the alcoholic (Franks & Wilson, 1975). Hypnosis may be induced, if desired, and the aversive conditioning, if it is essential to use it, employed in the trance state.

In certain cases self-induced aversive conditioning may be helpful in controlling violently upsetting thoughts or impulses, such as occur in compulsive-obsessive reactions. The patient is supplied with a toy "shocking machine." This may be purchased in a store that sells tricks for the practical joker. It consists of a simulated book with a spicy title or a pack of cards, which, when opened, delivers a shock from a battery within. The shock (buzz) is harmless, yet annoying and even frightening. The patient, with the contraption in the hands, is requested to shut his or her eyes and then bring offensive thoughts to mind. As soon as they appear, the patient is to open the book or cards and keep it open until the thoughts completely disappear. After six to ten trials patients are usually surprised to find themselves unable to bring obsessive ideas to their minds, even when they try to force themselves to do so. The patient may be asked to practice this "exercise in thought control" two times daily, with as many trials as are necessary to eliminate the obsessions or impulses, even when the patient tries to bring them on.

Aversive conditioning may give patients confidence in their ability to occupy themselves with useful rather than self-destructive concerns. Carrying the device in their pocket may become a conditioned reassuring stimulus even though it is not used. Should the patients complain that the shock is too strong, they may reduce its intensity by

interposing a piece of facial tissue between their fingers and the box. An alternative pain stimulus may be provided by a rubber band around the wrist that is snapped whenever an aversive measure is required.

A typewritten form such as the following may be given to the patient to be practiced at home:

HUMAN AVOIDANCE OR AVERSIVE CONDITIONING (HOMEWORK)*

You can help yourself to get rid of undesirable, torturesome thoughts and habits after you and the doctor or his associates have agreed that these thoughts or habits are damaging to you. Repeated practice is necessary for most people at least one or more times per day in the beginning and then at gradually decreasing intervals until the thought or habit is gone. The doctor or his associates may help prescribe the intervals and amount of time most helpful to you as well as other helpful ideas.

I. Repetitive, self-damaging thoughts (thought-stopping)**

a. Close your eyes, hypnotize, or **relax yourself** and force the repetitive thought or the picture of the undesirable habit to be **visualized** in your mind for at least 2-3 seconds.

b. Almost immediately, shout **STOP** or if this is not possible, **think** STOP or if this is not possible, **think** STOP emphatically and promptly give yourself an unpleasant buzz with the buzzer at the same moment. Holding your breath can be used with the buzzer, or something unobtrusive for you, e.g., a clenched fist can be used at the same time in place of "STOP." (**It is important that during the pleasant and restful time after you have stopped the shock, visualize a successful, positive, helpful image or valuable substitute activity.)** As soon as these secondary things (breath holding, fist, etc.) work, use buzzer less and less frequently.

Repeat this entire procedure at the same sitting until you can no longer get the thought at that time or until at least 20 satisfactory repetitions have occurred. The entire procedure is to be repeated up to six times per day for 1 to 15 weeks. This will be

prescribed in accordance with the severity of your problem and the length of time you have had it. Make a note each day on the back of an appointment card or some other record such as a homework sheet of how frequently and for what number of repetitions you have been using the buzzer, or the word STOP, breath holding, fist, etc. A list of possible pleasant thoughts, activities, assets should be available.

II. Modification

In addition, you can carry the buzzer, or special pen if you prefer, with you and use it whenever you find yourself thinking repetitively or continuing your undesirable habit. If circumstances are such that it is impossible for you to use the buzzer during the larger part of the day, think the word STOP, etc. and imagine the uncomfortable buzz when you find yourself going back to the thought or habit. This will gradually become more successful after actual practice when practice is possible. Unless good success is being maintained with the STOP, breath holding, or other simultaneous gesture, and the pleasant thought or activity substitution, report to doctor.

Note: The buzzer should be held firmly with two fingers and the buzz should not be pleasant. If it seems too much to endure, however, even though it contains only a single pen-light type of battery, a single thickness of Kleenex placed under the fingers will modify the buzz sufficiently.

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** Modified by Rothman after J. Wolpe.

Another form of aversive control is the withholding of positive reinforcements, such as the loss of certain privileges or the levying of fines, as a consequence of certain behaviors. Even though the effects of aversive control may be limited, it may have to be resorted to where self-injurious behavior cannot be stopped by any other method. For example, I have had referrals of patients with hair plucking that had failed to respond to years of insight therapy. They stopped their self-denuding habit after several sessions with a small shocking machine, which they carried with them thereafter. Obviously, desirable behavior that opposes the noxious habit should be rewarded. A variation of

aversive control is "overcorrection," whereby individuals are obliged not only to restore the original situation disrupted by their behavior, but also to engage in other corrective tasks that can prove tedious (Foxx & Azrin, 1972; Webster & Azrin, 1973).

IMAGERY TECHNIQUES

In desensitization through imagery it has been shown that the pairing of fear and relaxation responses reduces the intensity of phobic reactions. Following Wolpe's method of systematic desensitization ("reciprocal inhibition") a hierarchy of fearful situations is constructed. The overcoming of lower level fear images encourages a progressive ascension in the hierarchical scale until the top level fearful situation is mastered in fantasy. A state of muscle relaxation is first produced, along with the image of a relaxing scene. The subject is then asked to visualize the lowest level fearful image. When this is tolerated with comfort, the next higher image is introduced. Should fear arise at any point, the scene is shifted away from the hierarchy to the relaxing image, and the relaxing muscle exercises are repeated. The scene prior to the one that produced fear is then reintroduced and progression up the scale continued. As fear reduction in imagery continues, patients are encouraged to actually expose themselves to graduations of the phobic situation that brought them to therapy. It is assumed, of course, that in the initial "behavioral assessment" a study has been made of the various reinforcement contingencies and that these are considered as part of the total treatment plan. Some patients are unable to learn relaxation procedures, or cannot use imagery successfully, or hesitate to report sensations of anxiety, or are unwilling to practice for weeks without immediate relief (which is sometimes what it takes for a proper response to develop), and hence will not be able to utilize this technique.

The patient may also practice self-imagery for purposes of ego building. The patient can be given instructions that may be easily followed at home. A mimeographed or typed sheet, such as the one that follows, will enable the patient to select that which is best. A small shocking machine or snapping a rubber band on the wrists is used to deliver an unpleasant stimulus in indicated sections of the sheet. A number of useful fantasies for

self-imagery are detailed in the book by Kroger and Fezler (1976). See also Chapter 12 (Guided Imagery).

<div style="text-align: center;">

ASSERTIVE TRAINING

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Among the most annoying deficits are not being able to stand up for one's rights, rejecting criticism even of a constructive nature, acceding to being coerced or manipulated by others, expressing one's desires and preferences only with guilt or embarrassment, and countenancing rejection as a sign of being worthless and debased. These deficits are usually associated with a devalued self-image and a hypertrophied and punitive conscience. Related as they are to such basic personality distortions, it is difficult to see how they can be altered without self-understanding.

A way of facilitating self-understanding, important to enduring change, is to bring patients to awareness of their anxieties, evasions, and other defenses through plunging them into situations where they must assert themselves. Whether thinking and acting in ways consonant with a positive self-concept can in themselves correct a devalued self-image is debatable, although some therapists assume "that if a patient behaves and thinks in a manner indicating a positive self concept, he has, in fact, acquired one" (Seligman, 1979). In my opinion, some cognitive alteration is essential.

A format that is often used for assertiveness training is a time-limited group of eight to ten patients led by a man/woman therapist team. A questionnaire rating reactions to certain situations may be found helpful (Gambrill & Richey, 1975). Patients are taught to differentiate acting assertive (expressing one's rights) from acting aggressive (putting others down). Discussions involve self-assessment of assertiveness by the group members. Modest goals are then set for each at first. The actual training procedures include such techniques as behavior rehearsal, role-playing, imagery and cognitive behavior therapy (relabeling certain acts). etc. (Smith, MJ, 1975) Homework is assigned with the object of increasing assertive responses and lowering non-assertive ones. A diary is kept of experiences. Modeling by the therapist is often employed. Patients set up problem situations in which there is practice in asking for a favor, saying "no" to an

unreasonable request, making a date with a person of the opposite sex, etc. The ability to accept rejection without anger, shame, or feelings of being inferior is developed by role-playing and discussion of feelings.

<div align="center">

IMPROVING HUMAN SELF-IMAGES RAPIDLY

(some newer and some experimental methods)

</div>

INTRODUCTION: You and the doctor or his associates have agreed that a less self-critical self-image of yourself is desirable; or a self-concept in which you feel less inferior and more self-confident, or less childlike, more active at finding a new job—remedying a situation—doing more housework—getting more exercise—or more comfortable physical and social activity—or some other changes in your innermost self-concept are necessary or desirable.

Method I: **Ego Building**. Under self-hypnosis or relaxation leave yourself with the self-image of pleasant feelings and times in your life you, and possibly others, thought you were at least somewhat successful. Tell yourself, "I promise to act in accordance with this image."

Method II: A gradual stepladder of improved self-images can be used under self-hypnosis or relaxation, and you can move up this imaginary ladder of improved self-images until you feel a tinge of anxiety. Step down to the last comfortable self-image you could get. As soon as possible, act in daily life according to this improved image—as if it is now you.

Method III: Visualize your "lazy" or passive self-image as perhaps you have looked after avoiding some important work—a picture that we have agreed should be changed. After imagining this picture for 2-3 seconds, give yourself a buzz, usually until the image stops. Repeat as prescribed, usually for about 20 pictures at a sitting, with at least daily repetition. Substitute an image of a time when you were slightly more pleased with yourself each time you relax from the buzz.

Method IV: This can be used if you have been taught self-hypnosis with body imagery changes, (a) Hypnotize yourself to picture how some of your character (expressed as face and body) looks to you. Usually the doctor or his associates will have agreed with you on a given signal or word for this unconscious image to appear clearly. If you find difficulty in separating "bad mother or bad father" (or other image previously discussed with the therapist) from **your** image, i.e., they stick, then try using the buzzer to break up the fusion and leave you with an **independent self-image**, or with "good" mother and father's love. (b) Then you may attempt to modify by fusing your image with someone who has, as you and your therapist have agreed, some desirable traits you'd gradually like to work toward in a **realistic** fashion. (c) If the old image is stubborn in leaving, or fusing with the image you and your therapist have agreed upon, use the buzzer as described in Method III and #1 under AVERSIVE CONDITIONING to modify the old image by buzzing it and thereby speeding up the desired fused image. Report changes to your therapist, and keep your goals practical and within easy steps forward.

NOTE: It is most important that you keep careful records of frequency of use, and just what happens with the images, and discuss this with the therapist. These methods are not the same as daydreaming. Homework time is limited to approved and improved images as prescribed and should be tried out in reality.

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Coincident with such assertive performances, analytically trained therapists may explore individually or in a group format each individual's underlying conflicts that have been responsible for and that are sustaining devalued self-image. This combination of behavioral and dynamic therapy is offered for the purpose of giving the patient the best opportunity for correcting problems in assertiveness on a permanent level. Dynamic therapy alone over a long-term period may get at the core of the responsible personality distortions, but the treatment may bog down when, after insight is gained, the patients resist putting their insights into action. Starting off with assertive training, on the other hand, almost immediately puts the patients in a position where they are confronted by their anxiety and the defenses that prevent them from resolving their problem. They have

to deal with these as realities, not as theories.

It is interesting that in the face of this confrontation and in breaking through the resistance by practicing assertive exercises, many patients acquire insight into the dynamics of their problem. A dynamically oriented therapist will be able to expedite insight by examining and interpreting the patient's dreams, behavioral acting-out, and transference reactions. Past sources of trouble and early conflicts may surface; by working on these the therapist may connect them with the patient's current personality problems and more pointedly with the self-image pathology that expresses itself in symptoms. Even where the therapist is not dynamically oriented, some patients will put the pieces together by themselves.

Generally, in assertiveness training the patient is first taught to distinguish between assertiveness and aggressiveness. Too often they are considered identical. Assertiveness implies the need to stand up for one's rights and to refuse to relinquish one's rights. Aggression means a violation of another person's rights.

The ideal setting for assertive training is a group, although where a group is not available individual sessions can be productive. Patients keep a diary in which they record situations where they wanted or needed to act assertively, or to deny a request they felt was unreasonable, along with a notation of their feelings, their actual behavior, and their reactions to their behavior. A hierarchy of situations is constructed on paper, ranging from low level situations that are slightly difficult to handle to high level situations that the patient has found it impossible to manage. In role-playing one starts with low level situations, gradually working up to high level ones as mastery progresses. Some therapists advise the patient's utilizing a scale *(Subjective Units of Distress Scale*—SUDS) developed by Wolpe and Lazarus (1966) for record-keeping and role-playing. Other therapists employ biofeedback (EMG) to coordinate the items on the SUDS scale with subjective feelings of tension.

After role-playing promotes some confidence, the patients are encouraged to attempt low level assertive tasks in life itself, such as requesting things from people that

are not too difficult for them to give. Should failure occur, the patients are told they are not yet ready for the assignment rather than that they failed at it. Discussions of the tasks and reactions are carried on in the group, who cheer successes but do not castigate the patient for failures. Videotape feedback can be helpful in providing the patients with data on visible defenses. Progressively more demanding requests are encouraged until the patients gain confidence in asserting themselves without hesitation. A variety of other programs to enhance assertiveness may be set up, such as those of Eisler et al. (1973b; 1974), Hersen et al. (1973a, b), Whiteley & Flowers, 1977), Flowers & Booraem (1980).

The following outline, modified after J. Wolpe and prepared by I. Rothman and M.L. Carroll, provides examples of practice exercises in assertiveness:

SELF-DESENSITIZATION OR ANXIETY REDUCTION TECHNIQUES IN MAN*

A. Frequently you will be given a choice of self-relaxation or self-hypnotic techniques described in a booklet or in instructions given to you by the doctor. Practice the method you choose. Other types of training for self-help may also be shown you.

B. Make a written stepladder of situations which disturb you or are problems to you. Arrange these in order from the **most disturbing** to the **least**, or from least to most if you prefer. Please provide a clear copy of your stepladder for the doctor.

C. During your 70% successful relaxation periods, visualize dramatically (get a vivid mental picture of) yourself successfully handling the situations (going up your stepladder) from the least to slightly disturbing until you feel slightly tense, then stop. Relax until you are again at ease. This procedure should be done daily, usually for not more than 10 minutes at bedtime, or some other convenient time. This visualization should be about things you actually want and intend to do and not just daydreaming. Make it a practice to try the things you have successfully pictured yourself doing whenever possible. After a few days, longer or more frequent practice periods or several separate stepladders may be prescribed.

D. Try to record where you are on the list daily. The faithfulness with which you practice daily visualization is an indication of how much your healthy self

is willing to cooperate in the treatment against your self-destructive side. If your mind wanders from successful picturing, repeat the last successful picture. Remember that the mind can only concentrate on one thing at a time, although it may skip quickly. Bring back the thought you wish to work with for at least 2-3 seconds at a time. Your visualization will improve with practice. Stop when you feel anxiety at the same step on the stepladder more than three times, go back to a comfortable relaxation, and later add extra smaller steps between the worrisome ones.

E. The situations listed below are merely suggestions of areas which **may** be problems to you and how to handle them with this method. If any of the examples do apply to you, include them in your own stepladder (s), along with any other problem areas not listed here. Each area can be divided into **as many as 20 or more gradual steps** to visualize **and to conquer in actuality. If you** do not experience any anxiety while first visualizing situations which you find much too difficult to accomplish in real daily life, consult the doctor or his associates concerning this.

EXAMPLES:

(The first example is broken down to give you an idea of how to place situations on your own list.)

I. ASSERTION EXAMPLES:

Asserting yourself with other people without guilt, listing different types of people in order of decreasing difficulty from the boss (possible #1) to the office boy (possible #9) to the janitor (possible #15). This is a most important category for people with depression, strong self-damaging tendencies, and anxieties in dealing with other people.

Picture yourself:

(a) expressing affection openly for (1) pets, (2) children, (3) immediate family, (4) more distant relatives, (5) friends, (6) acquaintances— possibly in that order of difficulty for you.

(b) being assertive with your family, clerks, waitresses, policemen, and authority figures in the degree and order of difficulty fitting you.

(c) Discussing topics which are of interest to you with your family, other

relatives, and close friends.

(d) Making an effort and succeeding in discussing their interests.

(e) Stating your wishes without guilt to family, relatives, and close friends.

(f) Expressing disagreement without guilt to family, friends, other relatives.

(g) Following the same steps with casual friends and acquaintances.

(h) Requesting firmly that clerks, janitors, or any subordinates do their jobs promptly and properly.

(i) Expressing disagreement or your feeling of annoyance with those who do not fulfill their duties correctly.

(j) Talking about your job with fellow workers or firmly requesting that they do their share of any mutual job.

(k) Giving a report and expressing disagreement if necessary with your immediate superior in a tactful way.

(l) Giving a report and expressing disagreement if necessary to the highest superior with whom you must deal in a tactful way.

Other problem areas which can be broken down may include:

II. FEAR OF CRITICISM, REJECTION, DISAPPROVAL, OR HEALTHY DISAGREEMENT:

(a) Successfully facing sarcasm from family, friends, or associates

(b) Successfully facing direct disapproval or criticism from family, friends, or associates

(c) Successfully arguing and being unafraid of arguments

(d) Successfully facing feelings of being excluded by others

(e) Successfully facing being ignored or reprimanded

(f) Successfully dealing with persons you feel dislike you, etc

III. MEDICAL SYMPTOMS: Symptoms you have been told have no medical importance: getting busy with activities and ignoring symptoms such as rapid heartbeat, buzzing in ears, constant or intermittent pain from rheumatism, or similar symptoms if you know that they are not medically important. Arrange a stepladder of increasing time for enduring them and carrying on despite them.

IV. STAGE FRIGHT: successfully speaking to a group. Perhaps start with an empty room and gradually increase the number of people present to 100.

V. SOCIAL FRIGHT: enjoying entertaining and parties of increasing size from one friendly couple to any number of relative strangers.

VI. CROWDS: At ease in crowds of increasing size (elevators, trains, cramped quarters, open spaces, etc.).

VII. JOB SEEKING: Being at ease in applying for a job, starting with one you do not really want. Actually having several interviews before taking a job.

VIII. OPPOSITE SEX: Being at ease with members of the opposite sex, starting with someone unimportant to you and increasing periods of time and difficulty.

IX. DECISION MAKING: Being at ease in making your own decisions, without regrets and afterthought. Start with small decisions and increase importance.

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MODELING

Modeling can serve as a valuable means of social learning and personality development (Perry & Furukawa, 1980). The process involves both observational and performance aspects, theories of which have been adequately explicated in the literature (Bandura, 1977). By acting as a model, the therapist strives to provide cues for the patient that will help develop new behavioral skills, halt aberrant attitudes, and aid in problem-solving (Bandura, 1969). Both symbolic modeling (use of videotapes, films, audiotapes,

written scripts) and live modeling (the therapist performing a certain exemplary behavior like facing a phobic situation) may be employed. Multiple models have an advantage over single models since the opportunities for identification are greater. For example, a child fearful of dogs, observing other children petting a puppy may be induced to experiment with approach behaviors.

To reduce anxiety that may be aroused in the patient, relaxation exercises can be used in advance of the modeling activity. Thus, if patients have a great fear of having their blood pressure taken, the therapist may initially utilize systematic desensitization with the patients to calm them down, demonstrating the use of the blood pressure apparatus on himself or herself. Priming the patient by explaining what the patient will see in the modeling activity is also useful. Once the patient executes the modeled behavior, active rehearsal of the behavior along with reinforcements (comments of approval, material rewards) will tend to establish it more firmly.

Graded participant modeling consists of the setting up of a hierarchy of activities related to a feared object or situation. For example in a phobia of airplanes, flying is at the top of the list, and calling the airline for information about a special flight at the bottom. In between are driving to the airport, going to the counter to talk to the attendant, sitting in the waiting room, walking to the gates, watching planes landing and taking off. The therapist may model the behavior for all of these gradients, then repeat the least anxiety provoking and ask the patient to execute this. As anxiety is completely resolved, the patient is enjoined to try progressively difficult tasks until actual flying occurs.

New behaviors must of course be transferred by the patients to the settings in which they live, work and function, and here the patients may not get the same reactions and reinforcements they receive in the training settings. Preparing the patients for the trials of performance generalization and reviewing with them their experiences in the transfer of learning to different settings are an integral part of the training process.

Recommended readings that give examples of the actual modeling process itself are: Bandura et al. (1969) in relation to overcoming phobias; Melamed and Siegel (1975) in

anxiety reduction for children facing hospitalization and surgery; Csapo (1972) for correcting disturbed classroom behavior in withdrawn or disturbed children; Perry and Cerreto (1977) for training of living skills in mentally retarded persons; Hingtgen et al. (1967) for working with autistic children; Gutride et al. (1974) for helping psychotic patients reinstate adaptive behaviors; Sarason and Ganzer (1973) for rehabilitating juvenile delinquents; and Reeder and Kunce (1976) for preparing heroin addicts for adjustment following treatment. Modeling may also be used in professional training programs for counselors and therapists, e.g., to develop greater capacities for empathy (Perry, 1975).

COGNITIVE BEHAVIOR THERAPY

Recognizing that complex human behavior cannot be explained solely by conditioning paradigms, behaviorists since 1970 have turned to higher level processes, exploring what they have called "cognitive behavior therapy." As we might expect, different authorities have experimented with and developed innovative ways of implementing this new dimension. For example, some have focused on illogical thought patterns that in the past have forced the patient to draw false inferences from certain events, to overgeneralize from solitary incidents, and to fail to correct distortions even though life experience has pointed to the falsity of their assumptions (Beck, AT, 1976). Others have advocated more active training procedures, working with patients toward employing positive, constructive self-statements along with practicing relaxation techniques (Meichenbaum, 1977). Still others continue to use Ellis' (1962) technique of actively presenting rational solutions to replace the patient's maladaptive ones ("rational emotional imagery").

Instead of attempting to win patients over toward adopting a new philosophy toward life, or different attitudes toward themselves and others, as in persuasion *(q.v.)* the patients are given daily relearning exercises to change their thinking habits toward rational goals that they are trying to achieve. First, the patients are trained for several sessions in rational self-analysis to get at the basis of their problem. Next they are

enjoined to practice rational emotive imagery for a minimum of 3 10-minute periods each day during which the patients see themselves acting in constructive ways in relation to the upsetting or challenging situations in their lives (Maultsby, 1970).

Social learning precepts are prominently employed in training procedures with the object of rational restructuring of thought processes; of altering mental sets in line with optimistic rather than pessimistic expectations; of liberating oneself from the tyranny of conventional beliefs; of abandoning the notion that one has always to be right, loved, perfect, important, and happy; and of relinquishing the idea that one's past indelibly stamps out one's destiny.

Patients are aided in acquiring coping skills by (1) putting themselves into challenging or upsetting situations in fantasy and verbalizing their feelings, and (2) role-playing constructive solutions. There is accumulating experimental evidence that these techniques help to reduce anxiety and to change attitudes that create pathologic feelings and behavior. Skill in problem-solving is encouraged by showing the patient that attitudes, positive or negative, will definitely influence the outcomes; that it is essential to define and formulate the problem at hand for which a solution is needed; that alternative approaches should be designed in the event a chosen solution proves to be inadvisable; that a definite decision of a course of action must be made; and that verification of the validity of this choice in terms of achievement of set goals must finalize the process (Goldfried & Davison, 1976).

An example of how cognitive therapy is executed is provided by the treatment of depressive disorders. The cognitive theory of depression assumes that a cognitive triad exists (Beck & Young, 1985). Depressed patients have a starkly negative view of themselves, conceiving of themselves as worthless, unlovable, and deficient. They see the environment as overwhelming and believe they cannot cope with the pressures around them. They regard the future as hopeless. Events are distorted and twisted through illogical thinking to confirm these apprehensions with unjustifiable arbitrary inferences, overgeneralization, selective obstruction, and magnification. Early negative schemas,

evolved during early childhood and operative outside of awareness, act as predisposing factors and are activated by later life events. These cognitive distortions always contribute to depression with its physiological effects.

Cognitive therapy, which may be done on an individual or couples format, draws upon a number of techniques to change depressive thinking. The most difficult patients for either kind of format are severe endogenous depressions, bipolar depressions, organic brain syndromes, psychotic depression, schizoaffective disorders, and borderline personalities. Neurotic and mild endogenous depressions do best. But even in the severer depressions, cognitive therapy can be useful in combination with pharmacotherapy, milieu therapy, and supportive therapy. Apart from the usual empathic qualities essential in a therapist, considerable skill is needed along with the ability to communicate confidence and hopefulness. Goals, the specific problems to be focused on, and the agenda for each session are set collaboratively. Since patients may not understand a therapist's formulations yet avow that they do out of a need to please, the therapist should encourage feedback to make sure the meaning of the communications has been grasped. At the end of each session the therapist summarizes what has been done and asks the patient to write down the main points of the discussion. Homework assignments are important including readings, self-relaxation, and diversionary activities.

Cognitive techniques involve a search for automatic thoughts and maladaptive assumptions through questioning, imagery, and role playing. Once an automatic thought is elicited in the form of interpretations of an event, an analysis of the thought is jointly embarked on to test its validity. Here the patient's use of words may come up for study. Rectification of the habit of self-accusation necessitates reattribution of blame. Alternative solutions are encouraged, maladaptive assumptions are challenged. Faulty beliefs are analyzed. Behavioral techniques are utilized especially when a patient is highly passive and withdrawn. These include activities to improve mastery and enhance pleasure, training in self-reliance and assertiveness, role playing, and diversion techniques.

Some cognitive therapists utilize psychological inventories as part of the assessment

procedure. Among these are the Beck Depression Inventory (BDI) that scores the degree of depression, the Young Loneliness Inventory Score (Young, 1982) that reveals the degree of distress due to lack of intimate ties, and other tests. Interviewing is conducting mainly by a therapist focussing on the most distressing problem that concerns the patient and probing the "automatic thoughts" through questioning in order to understand the patient's perspective. A good area to explore at first is the inactivity and withdrawal that highlight and characterize depressive symptomology. Instead of criticizing, blaming, condemning, and reassuring the patient, the therapist continues to enjoin the patient to examine the immediate assumptions ("collaborative empiricist"). The therapist may ask the patient to select a small problem to work on together. Any suggested activity the patient brings up that can possibly bring the patient out of preoccupation with hopelessness is selected for "graded tasks" in the form of questions to break down resistance to following through with its execution. The patient may be asked to write out an activity schedule for the week. Some therapists routinely have their patients fill out the Beck Depressive Interview before each session so that progress can be monitored. Negative thoughts are chosen for questioning and probing of ways of coping with these and finding constructive alternatives. The therapist is alerted for dominant schema that control the patient's attitudes and relationships. Periodically, summaries are given to the patient of the themes that may be operating in the automatic thoughts. If the patient is planning a major decision, postponement may be recommended until a more realistic perspective is obtained.

Obviously, as one works with a patient character patterns will display themselves as reflected in the relationship to the therapist and to the therapeutic process itself. Distortions in the way the patient appraises things are clarified with the hope that through questioning and a "guided discovery" approach there will be a more realistic appraisal ("reattribution"). Continuing homework assignments may include keeping a daily record of dysfunctional thoughts by listing situations that lead to unpleasant thoughts and the stream of automatic daydreams or recollections that produce unpleasant emotions. A diary or *Weekly Activity Schedule* may also be kept to list and grade the degree of instances of mastery and pleasure. In therapy, maladaptive assumptions are continuously explored

especially "in the context of a concrete event" with the object of replacing automatic thoughts with rational thoughts. A technique *Point Counterpoint* is sometimes utilized to help such a replacement. Here in role playing, the therapist plays the devil's advocate by expressing the patient's own negative thinking while the patient defends a more rational stance. Hopefully, underlying destructive assumptions will be undermined with practice in and out of therapy. Other strategies may be devised to test the validity of one's assumptions that lead to depressive thinking and feeling. Patients are enjoined to test other hypotheses on which their assumptions, early schemas, and automatic thoughts are based. In vivo experiments within the patient's life situation are set up to test habitual beliefs and, during therapy, successes and failures are reviewed. Self-help homework assignments aid the patient in facing problems more realistically, and correcting thinking patterns that can lead to resolution of depression and to adaptive behavior.

CONTINGENCY CONTRACTING

Some behavior therapists try to direct the patient toward productive change through reinforcements in *contingency contracting.* It is agreed that the execution of desired behaviors (socialization, assertiveness, dietary abstinence, etc.) will result in certain positive rewards. The contract is drawn up between the patient and the therapist, or in couples therapy between the two partners. The selection of appropriate reinforcements may be aided by use of a *Reinforcement Survey Schedule* (Cautela & Kastenbaum, 1967). The contract is time-limited and specifies the behavior patients are to perform (e.g., smoking control, weight loss, assertive behaviors, etc.) and the rewards they are to receive for such behavior. The patients collect data in writing on the daily frequency of such behaviors and their reactions to their execution. The rewards must be reasonable, but must be sufficiently intense and meaningful for the patients to compensate them for whatever deprivations they undergo in performance of assigned tasks. The patients, for example, must feel that they are attaining a previously denied or absent prize and that they have earned it through their own efforts. If money is the reward, paid by a third party, this should not be accumulated but should be spent as soon as possible since saving may dilute the effort put into performance. Thus, a child who is rewarded with money for

certain socializing behaviors should not be requested to save the money for college. Rewards to adults may consist of vacations, trips, and various kinds of entertainment. Sometimes when patients reward themselves with money, they deposit money with the therapist, who then distributes it in accordance with a patient's compliance with the contract. In contracts between couples (contingency or exchange contracts), the desired behaviors on the part of one member are rewarded with specified behaviors on the part of the other member.

Do sought-for behaviors continue after the contract ends? The claim made by behavior therapists is that in well-conducted therapies the patient begins to enjoy the behaviors for their own sake and for what they do to self-image and self-respect.

A GENERAL OUTLINE OF BEHAVIOR THERAPY PRACTICE

There are many designs for the practice of behavioral modification. One that I have found useful follows:

1. Ask patients which behaviors they wish to strengthen and which they wish to diminish or extinguish.

2. Find out the situations under which undesirable traits or symptoms lessen or increase. Do not be concerned with explaining why the problem developed except insofar as the positive and aversive reinforcements that maintain it can be detected.

3. Select jointly with the patient (on the basis of the patient's priorities) which behaviors or reactions are to be altered first, leaning toward those that, in your opinion, are most modifiable.

4. Explore the degree of motivation of the patient for therapy, the consequences of present demeanor and the rewards anticipated from newly developed behavior. Challenge and work on the patient's motivation until it is certain that the patient unequivocally wishes to change for himself or herself and not to please others.

5. Examine in depth the behavioral constellation to be altered or strengthened, going into past history to determine the reinforcements that have

maintained the problem. Can patients clearly define what it is that they desire to change? Do they accept your formulation of the problem? If not, you, the therapist, assume an educational role to teach the patient the full implications and complete description of the behaviors that are appropriate for the desired change. Do patients clearly understand what is expected of them?

6. Identify the rewards (reinforcers) if any that are to be employed making sure that they have value for the patient. These reinforcers are made contingent on the desired behavior. A contract—verbal or, better, written — is drawn stating what is expected of the patient and the rewards for maintenance of the contract. The contract time should be made short, say a few days, with the idea of renewing the contract at the end of the contract time.

Sometimes contingency contracting is utilized, the patient and therapist deciding mutually not only on the kind of reinforcements that the patient is to receive on controlling problem behaviors or substituting constructive alternatives, but also the penalties to be imposed, if any, for perpetuation of disturbed behaviors. We, the therapists, may also impose penalties on ourselves should we not live up to our contract (appearing late for appointments, missing appointments, etc.), for example, reducing or cancelling fees. Token reinforcement systems may be set up, the patients receiving tokens for constructive behavior that they can exchange for luxuries, privileges, etc. (Ayllon & Azrin, 1968; O'Leary & Drabman, 1971). Token economies have been found to work well in some institutions and classrooms (Paul & Lentz, 1977).

7. Work out a planned schedule with patients to begin to approach their new behaviors under the least traumatic circumstances possible. If interpersonal relations are involved in the plan, the least challenging individuals are selected so that the patient may be minimally uncomfortable. In the shaping of a difficult behavior, the start should strive for minimal gains and immediate reinforcements, with the object of approximating the desired change, more and more reinforcements being given step by step as changes progress.

8. Ask the patient to keep a diary that lists each day the frequencies of new behaviors practiced. Praise is preferred for each success, but no criticism is given for failure. If no progress occurs, explore with the patient the

reasons for failure. Encourage the patient to try again and make suggestions as to new assignments that the patient is prepared to execute. Explore attitudes, beliefs, systems and other cognitions that may be acting as resistances to progress.

Behavior modeling by the therapist and role playing are introduced when necessary. If anxiety prevents the patient from following through on behavioral assignments, systematic desensitization may be tried and/or a mild tranquilizer suggested such as Xanax for a brief period of time only, recognizing its addictive potential. At each session the patient is given homework to expand on skills.

9. Where it is obvious that the patient is confused in acting in a constructive way, try behavior rehearsal (Casey, GA, 1973).

Here the therapist rehearses the patient in what to say and how to say it, covering a broad zone of interpersonal behavior, with both real and fantasied authorities and peer figures. The gestures to make, the words to say, the facial expressions to exhibit are all acted out. The rehearsal will bring out feelings in the patient that will need discussion. Sometimes it is helpful to make a recording (audio and video if available) to play responses back for the patient after each rehearsal. The therapist advantageously can play dual roles: first, that of the individual with whom the patient cannot seem to deal with in real life, and then, by changing chairs with the patient (role reversal), that of the patient with appropriate comments and gestures to indicate preferred reactions (modeling) while the patient is asked to put himself or herself in the position of the adversary. The patient may need constant or periodic coaching while this role playing goes on.

10. Individual sessions may later be complimented with family and group sessions where these are deemed helpful.

In family therapy sessions the attendant members are apprised of the circumstances that create and maintain behavioral difficulties. Appropriate ways of reacting with each other are suggested. Group sessions are usually conducted with the object of allowing each member about 10 minutes of time to describe what each has accomplished since the last session and the reactions. The members then make suggestions to each other as to

how difficulties may be overcome or progress increased.

> 11. Should a relapse occur, the best way to manage it is not to reward it with too much attention. Ignoring the relapse must be followed by adequate reinforcement when improvement resumes. Punishment should assiduously be avoided.

> 12. In the event resistance is obdurate and no progress occurs, explore frankly and openly the relationship with the patient. You as the therapist may very well look into your own feelings about the patient (countertransference) to see if you can perceive deleterious effects on the relationship.

There is, in my opinion, no reason why behavioral therapy cannot be practiced in a dynamic framework, although this may horrify some behavioral purists. Often dreams will reveal the nature of the resistance more readily than any other communication. Once the resistance is detected and explored, clarification or interpretation may turn the tide toward success in the behavioral effort.

A great deal of ingenuity is required to set up the design that will govern behavior therapy in a particular case. The treatment undergoes continued modifications in line with the observed behavioral change. Wide differences exist in the susceptibility of subjects to conditioning. However, the greater the quantum of anxiety, the more easily are conditioned responses established and the more difficult are these to extinguish. Generalized anxiety does not respond too well to behavior therapy unless it is possible to differentiate the conditioned stimuli that sponsor anxiety. It may be possible to break down anxiety or disturbed behavior into a number of phobic hierarchies and to deal with each hierarchy as a separate unit.

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Techniques in Group, Family, and Marital Therapies

Group psychotherapy is a valuable and, in some cases, indispensable treatment method. Its historical development and uses in supportive, reeducative, and reconstructive approaches have been amply delineated and some of the important bibliography listed in the respective chapters. Group therapy may be employed both as an adjunctive aid to individual psychotherapy and as a treatment modality in its own right. There are some therapists who claim that not only are the results they obtain with groups equivalent to those of individual treatment, but in many cases even superior to it. Consequently, they dispense with individual therapy, except as an adjunct to a group approach. Other therapists, not so skilled in its use, tend to depreciate the effect and "depth" of group treatment. Among experienced therapists there is a feeling that combined or conjoint group and individual therapy is the treatment of choice. Problems show up in a group setting that never become apparent in a dyadic therapeutic relationship.

Evolving in a group are a number of processes that are intimately bound up with the outcome. Among the most important are the developing group cohesiveness and mutual assistance. What one finds evolving in the group are manifestations of empathy, support, challenge, confrontation, and interpretation; availability of identification models; opportunities for introducing projective identifications; investigative explorations; and a joint sharing of problems.

Needless to say, the specific way that the group is employed; its composition; the degree of activity or passivity of the therapist; the extent of the therapist's directiveness, maneuvers, and kinds of participation; the pursuits sanctioned within and outside the group; and the nature of interpretations will vary with the skill, experience, theoretical bias, and personality of the therapist. For example, some therapists assume an almost completely detached attitude on the assumption that this will dredge up the resentments

of the group members, in the wake of which basic inner conflicts will be exposed. Other therapists cast anonymity to the winds and virtually become participating patients in the group, acting-out as enthusiastically as any other member. Both methods in the opinion of their sponsors are promoted as the "best" and even "only way" to do group therapy. Actually, there is no "best" group method; this will vary with the predilections of the therapist. After blundering through a number of sessions, each therapist will settle down to a procedure that works best for him or her.

Group therapy may be utilized (1) independently, during which both intrapsychic and interpersonal operations are considered; (2) in combination with individual therapy conducted by the same therapist ("combined therapy")—individual sessions deal with the patient's resistances, transferential responses to the therapist, and primary separation anxiety, while group sessions focus chiefly on interpersonal phenomena; (3) in conjunction with individual therapy conducted by another therapist ("conjoint therapy"); and (4) as leaderless groups particularly after formal group therapy has ended (Kline, 1975).

Meetings in independent, combined, conjoint therapy may take place one or two times weekly and, in institutional settings, even daily. They may be supplemented with regularly scheduled meetings that are not attended by the therapist ("coordinated meetings")—the members may congregate before a regular session ("pre-meetings"), after a regular session ("post-meetings"), or at other times at specially designated places ("alternate meetings"). Coordinated meetings enable patients to discuss their feelings about the therapist more freely. They are generally less formal and more spontaneous than regular meetings. Acting-out is more than a casual possibility here, which may or may not prove to be beneficial to the patient. ("Closed groups" maintain a constant membership although new members may be added for special reasons. "Open groups" operate continuously with new members being added as regular members complete therapy and leave the group.)

Treatment in group therapy may be "therapist-centered," in which therapists take a

directive and more authoritarian role, moderating member-to-member communication, presenting interpretations, and limiting the patients' intragroup and extragroup activities ("triangular communication"). It may be "group-centered," in which the group operates as the primary authority, therapists functioning in a kind of consultative role. Here peer (sibling) and authority (parental) relationships are considered equally important; rotating leadership is encouraged; there is no interference with the relationships between patients ("circular communication"), which are constantly being broken, restored, and reorganized, the therapists controlling their anxiety about neurotic alliances; or "authority-denying" ("horizontal communication") may occur in which the therapists are on an equal plane with the patients, a structured relationship between therapists and patients being considered limiting to growth. In the latter case emotional interactions are considered most important; direct experience in the group is encouraged, therapists presenting their own problems to the group ("The group can grow if I grow with them.").

The group therapist, regardless of orientation, must be a good leader, requiring skills above and beyond those of a therapist.

How a therapist conducts a group will be determined

1. By the goals that the therapist sets—supportive, reeducative, or reconstructive.

2. By the constituent members—alcoholics, drug addicts, psychotics, stutterers, delinquents, psychoneurotics, character disorders, patients with heterogeneous problems.

3. By the therapist's training—group dynamics, rehabilitation, behavior therapy, cognitive therapy, existential therapy, psychodrama, psychoanalytically oriented psychotherapy, psychoanalysis.

4. By the therapist's personal ambitions and needs—characterologic and countertransferential.

INFLUENCES OF THE GROUP ON THE INDIVIDUAL

When people gather together in a group, phenomena are mobilized that may have an

influence on each individual. One of the effects is an immediate impression of strangeness and embarrassment. This soon gives way to a realization that others present are not too different from oneself in problems, weaknesses, and ways of relating. This encourages one to express oneself openly. The person soon discovers that the group fosters free expression of feelings or attitudes on any subject. There are no social taboos on content usually avoided in everyday interactions. The ability to open up varied forbidden topics, and the recognition that fellow members harbor the same fears and doubts, can be reassuring. Apart from the emotional catharsis experienced, the individual finds that problems can be shared with others without rejection or ridicule. Self-esteem and self-confidence are thereby enhanced. The individual begins to realize that he or she is not a reprehensible person deserving of blame or repudiation. The usual drives through which one achieves status and prestige may receive no sanction in the group. Indeed, they may be dealt with harshly or analyzed in terms of their neurotic components.

Humans are group creatures constantly looking to others for acceptance and validation of their own ideas. One of the most powerful molding influences in any group is the impact of group standards and values. These can have a markedly transforming influence on the personal persuasions by which individuals customarily govern themselves. A gradual incorporation of group convictions and judgments in a cohesive and developed group tends to neutralize self-oriented neurotic needs. The presence of the therapist acts as a safeguard against prevailing group values that are inappropriate. There is some validity in the belief that patients in a group may reinforce each other's rational reactions. This is because they collectively make up the norm from which they individually deviate. This is particularly true in a therapeutic group presided over by a therapist with healthy values; it is not so true in a group left to its own destiny, which so often will be diverted and taken over by a charismatic and power-driven member with qualities of leadership.

Group patterns evolve related to the roles members assume and the ways they perceive themselves; how and when they take over leadership; the specific motives assigned to them by other members; and the existing defensive maneuvers, such as

competitiveness, struggles for control, dominance, submissiveness, ingratiation, masochistic devices, aggressiveness, and violence. The fluctuating group interaction is influenced by levels of tension that affect participation, the sharing of ideas, and decision making. Arguments, the taking over of a session by a monopolizer, coming late, absenteeism, and the formation of subgroup clusters manifesting special likings and dislikings raise tensions that stimulate corrective action; however, if tension is too high, it will paralyze action. Extremes of harmony and congeniality will also tend to subdue activity.

A successful solution to an interpersonal problem enables the individual better to extend his success to relationships with people outside the group. It is to be expected that reactions to different members will selectively indulge a full range of prejudices. Displays of awe, infatuation, disgust, anger, hate, and sexual interest may be manifested toward members identified as archaic or vulgar or idealized models. Whereas these feelings are controlled and verbalizations related to them suppressed or repressed in the usual group setting; they are encouraged and even rewarded in the therapeutic group by approval from the therapist. The reactions of the person with whom one is immediately entangled presents opportunities to examine the reasonableness or unreasonableness of one's responses. The individual gradually learns to accept criticism and aggression without falling apart. This is a most crucial lesson; indeed soon recognized is the fact that aggression and criticism can be either proper or unjustified and that one can differentiate the two and manage responses accordingly.

The effect of interpretations from other group members may be striking. The individual begins to distinguish prejudiced opinions from factual ones, and may then generalize tolerance to the world at large. The fear of becoming violent and in turn being subject to physical attack and humiliation lessen. The group judgment is a moving force that cannot be resisted. Where a number of members share an opinion about an individual or behavior, the effect may be more intense than an interpretation by the therapist. As one patient put it: "If a person in a group calls you a horse, you have a right to be indignant. If a second person in the group calls you a horse, you have a right to be insulted. If a third

person in a group calls you a horse, you better look into yourself to see if you are acting like a horse." The group strengthens the individual's ability to express feelings toward the therapist, whether rational or irrational; one may be unable to do this during individual therapy.

One of the most important consequences of being in a group geared toward reconstructive goals is learning how emotional processes operate by observing how other members talk about and solve their problems. Dynamic thinking soon becomes a dominant mode in the group. Immediate symptoms are related to basic adaptational patterns. As these are traced to destructive past conditionings, resistance and transference may be mobilized and explored. In this way the patient begins to think more dynamically about himself or herself, the genetic origins of patterns, their manifestations in his or her present life, and the defensive maneuvers they inspire. Awareness of inner psychological operations is also sharpened through emotional involvements with other group members, through one's own spontaneous discoveries, and through interpretations from fellow members and the therapist. Instead of withdrawing, as in a usual life situation, the patient is encouraged to hold his or her ground and to express and analyze feelings and defenses. It is here that a psychotherapist trained in reconstructive therapy can make the greatest impact on the patient.

ADVANTAGES OF GROUP VERSUS INDIVIDUAL THERAPY

Group therapy has certain advantages over individual treatment. It is capable of registering deep impressions by virtue of the fact that the patient is exposed to the judgments of not one person, but a host of people. In individual therapy the patient soon learns how to cope with and to neutralize the influence of the therapist. It is much more difficult to do this in a group setting. Change is scored on different levels of the intrapsychic organization. This includes one's system of values, which is altered through percussion of disparate ideologies in the group. It is much easier for the individual to recast one's standards in a setting that is a reflection in miniature of the world than in the isolated confines of the dyadic therapeutic relationship.

Diversified intrapsychic defenses come out toward members of the group with whom the patient plays varying roles. Multiple transferences, both sequential and simultaneous, are readily established. The opportunity to relate in different ways to fellow members enables the individual to work through insights in the direction of change. Thus, if the patient finds it difficult to express him or herself aggressively or assertively, practice with the least threatening member may be in order. Thereafter there may be progressive challenge to others who are more threatening. In individual treatment the therapist may continue to be too powerful a figure to override. Moreover, even though the patient masters fear and guilt, he or she may find it difficult to transfer what has been learned during individual therapy to the environment outside the therapeutic setting.

Within the group the patient feels more protected, both by the therapist and by members with whom alliances have been formed, and he or she may be able to practice new attitudes more propitiously. For example, if Mary Smith has a problem in accepting any aggression and hostility that are directed toward her, the group will offer her the opportunity of exposure to these emotions in graduated doses. She will become more and more tolerant of the resentment extended toward her. She will learn to accept criticism— to reflect on it and to see whether it is justified or not—instead of reacting automatically with indignant or violent responses. Rigid character defenses often yield in group therapy as patients observe their ego-syntonic traits operating in others.

On the other hand, one advantage of individual therapy is that the focus is on the patient's personal problems, which often become diluted in a group setting. With so many other members of the group expressing themselves, it is not always possible for the patient to clarify significant feelings at the time he or she is experiencing them. Individual therapy enables the patient to look into the private world of fantasy and conflict and to explore intrapsychic mechanisms in greater depth. It permits a concentrated working through of past difficulties developed with parental authorities.

Outlining some of the benefits a patient may derive from group therapy, we may include (1) the opportunity to see that one is not alone in one's suffering and that

problems felt to be unique are shared by others; (2) the opportunity to break down one's detachment and tendencies to isolate oneself; (3) the opportunity to correct misconceptions in ideas about human behavior by listening to others and by exposing oneself to the group judgment; (4) the opportunity to observe dynamic processes in other people and to study one's own defenses in clear perspective in relation to a variety of critical situations that develop in the group; (5) the opportunity to modify personal destructive values and deviancies by conforming with the group norm; (6) the opportunity to relieve oneself of tension by expressing feelings and ideas to others openly; (7) the opportunity to gain insight into intrapsychic mechanisms and interpersonal processes, (particularly as multiple and split transferences develop), the group acting as a unit that replicates the family setting and sponsors reenactment of parental and sibling relationships; (8) the opportunity to observe one's reactions to competition and rivalry that are mobilized in the group; (9) the opportunity to learn and to accept constructive criticism; (10) the opportunity to express hostility and to absorb the reactions of others to one's hostility; (11) the opportunity to consume hostility from others and to gauge the reasonableness of one's reactions; (12) the opportunity to translate understanding into direct action and to receive help in resolving resistances to action; (13) the opportunity to gain support and reassurance from the other members when one's adaptive resources are at a breaking point; (14) the opportunity to help others which can be a rewarding experience in itself; (15) the opportunity to work through problems as they precipitate in relationship with others; (16) the opportunity to share difficulties with fellow members; (17) the opportunity to break down social fears and barriers; (18) the opportunity to learn to respect the rights and feelings of others, as well as to stand up to others when necessary; (19) the opportunity to develop new interests and make new friends; (20) the opportunity to perceive one's self-image by seeing a reflection of oneself in other people; (21) the opportunity to develop an affinity with others, with the group supplying identification-models; (22) the opportunity to relate unambivalently and to give as well as to receive; (23) the opportunity to enter into productive social relationships, the group acting as a bridge to the world.

ORGANIZING A GROUP

In organizing a group the therapist will be limited by the patients available. Nevertheless, one should choose patients who are sufficiently advanced in their understanding of themselves to be able to perceive their patterns as they will appear in the group setting. While the clinical diagnosis is not too important, experience shows that the following conditions and patients do poorly in a group; except perhaps when implemented by an experienced group therapist in a homogeneous group within an inpatient setup through supportive or reeducative group methods.

1. Psychopathic personalities and those with poor impulse control

2. Acute depressions and suicidal risks

3. Stutterers

4. True alcoholics

5. Hallucinating patients and those out of contact with reality

6. Patients with marked paranoidal tendencies

7. Hypomanics

8. Patients with a low intelligence

The age difference should preferably not exceed 20 years. Homogeneity in educational background and intelligence is desirable but not imperative. A well-balanced group often contains an "oral-dependent," a "schizoid-withdrawn," a "rigid-compulsive," and perhaps a "provocative" patient, such as one who is in a chronic anxiety state. This variety permits the members to observe a wide assortment of defense mechanisms and to experience tensions they might otherwise evade.

The number of group members may range optimally from 6 to 10. If a therapist feels uncomfortable with a large group, then the size of the group should be reduced. Marital status is relatively unimportant. A balance of males and females in the group allows for an opportunity to project and to experience feelings in relation to both sexes, although acting-out is more likely in a mixed group.

A heterogeneous group in terms of age, sex, and syndrome is most effective for reconstructive goals. A homogeneous group, composed of patients with the same problem, is best for alcoholism, substance abuse, obesity, smoking, sexual problems, insomnia, phobias, depression, delinquency, stuttering, criminality, marital problems, divorce, and geriatric problems, although an occasional person with such problems may do well with and stimulate activity in a hetergeneous group. The goals are both supportive and reeducative. Severely handicapped persons, such as paraplegics, women who have had mastectomies, patients undergoing renal dialyses, and laryngectomized patients, feel unrelated to the norm and do better in homogeneous groups. Adolescents seem to be more responsive in same-sex, same-age groups.

In introducing the matter of group therapy to a prospective member the therapist may explain that a group is being organized for purposes of treatment. Talking over problems or ideas in a group tends to expedite getting well. The patient may then be invited to join with the statement that perhaps a group may facilitate his or her progress. This, if the patient is in individual treatment, may be presented as a "promotion."

One of the problems that plagues neurotic individuals is the loss of a sense of group belongingness. To an extent, it is because they devalue themselves and feel rejected by others; partly it is because they anticipate that their own hostility will be reciprocated. As a consequence of this isolation, they lose identity with people and thus are robbed of a vital source of security. When a suggestion is made that they enter a group, they may imagine that their worst fears will come to pass. They will then pose a number of questions that usually reflect their resistance, and#the therapist will be obliged to answer them.

The following are common questions and suggested replies:

Q. How can other mixed-up people like myself help me?

A. People in a group actually do help each other. They become extremely sensitive and perceptive about problems, and they often may be of considerable service to other members. In the group the person has an opportunity to

observe how he or she interacts and to witness the nature of reactions to one. The therapist is present during the sessions to see that it goes along well. It's normal to feel some anxiety the first few sessions which provide "grist for the mill."

Q. I would be ashamed to bring up my problems to a group of people I don't know.

A. This is understandable. It is not necessary for you to divulge anything you do not wish to talk about. [*Actually this reassurance does not retard the patient from divulging the most intimate problems readily as soon as he or she begins to articulate.*] Without your permission I shall not bring up anything about you or your problems. This is up to you. Most people fear not being able to talk in a group. In reality, being with a group with whom you can be yourself is consoling, not frightening.

Q. What am I supposed to do in the group?

A. There is no need for you to do anything special. You may talk or you may remain silent as you wish. Generally one is not as embarrassed as one would imagine.

Q. Won't these people reveal things about each other outside the group?

A. One of the rules is that no mutual confidences are to be revealed to outsiders. Should this happen (and it rarely does), the person is dropped from the group.

Q. Supposing I meet someone in the group I know?

A. When it happens, it may actually prove to be an advantage. Any problems between two people who know each other can often be worked out.

Q. Won't the problems of the other people rub off on me?

A. Without any reservation I can say, "no." On the contrary, you may gain a great deal from observing how other people face and resolve their troubles. It can be a great educational experience for you.

Q. Do I continue seeing you individually?

A. Generally yes, but we will decide how frequently. Sometimes I may want you to try the group alone, but if that comes up, we can talk about it.

Q. Can I raise any issues I want in the group, even about you?

A. Unless you do, you will not get as much benefit out of the group as you might. It is important to talk about your feelings and ideas in relation to yourself, to outside people, to the group members, and to me. That is, if you wish to do so.

Q. Supposing my feelings are unreasonable?

A. This is why the group is of such value. In life there is very little opportunity to examine the reasonableness or unreasonableness of one's attitudes and responses. The group offers you an opportunity to test your assumptions. In the protected setting of the group a person can express one's ideas and emotions.

The length of a group therapy session is approximately *H* to 2 hours. The frequency of meetings is one to two sessions weekly, with alternate sessions once weekly if desired. The best seating arrangement is in a circle.

There are many advantages in employing cotherapists in a group, provided that problems between them do not prevent their working together. The literature on the subject of cotherapy and the difficulties that can occur between cotherapists that can sabotage their usefulness and destroy the group process are pointed out by J. B. Strauss (1975). Her own study deals with the results of a questionnaire that explores the ways therapists conceptualize their problems and how they try to cope with them. A most interesting finding was the difference of role perceptions of male and female therapists. Many problems can be overcome if the cotherapists meet periodically together with a supervisor whom both respect.

THE OPENING SESSIONS

At the first session the members are introduced by their first names, and the purpose of group discussions is clarified. This will vary with different therapists and different groups. Advanced patients will already have worked through some of their individual resistances in their sessions alone with the therapist. Newer patients may need

more explanations in the group setting. The more passive-dependent the patient, the more leadership will be demanded of the therapist. The technique employed during the opening session will be determined by the therapist's orientation and level of anxiety. Many therapists who use the group as an adjunct may assume a very passive role so as to elicit spontaneous reactions from different members for use in later individuals sessions.

Some therapists begin by simply stating that the group offers members an opportunity to talk about their feelings and eventually to understand their individual patterns. It is not necessary for the members to feel compelled to reveal something that they want to keep to themselves. However, communicating freely will help them to get a better grip on their problems. For instance, each member must have had certain definite feelings about entering the group; he or she may have been embarrassed, upset, or fearful. The therapist may then attempt to elicit these emotions, and, as one member expresses freely, others will join in, leading to a general airing of difficulties shared by all.

Before the close of the first session, some therapists find it advisable to stress the confidential nature of the meetings and to caution that each member is expected not to reveal to others the identity of the members and the subject matter discussed in the group. While no member will have to divulge secrets before he or she is ready, each will be encouraged to relate any incidents involving accidental or planned contacts with other members of the group outside of the sessions. Therapists who strongly believe that acting-out is deleterious will, in all probability, discourage any contact outside of the group. Sexual involvements may be forestalled by fostering verbalization of the patients' feelings and impulses toward each other. Usually the anxiety level drops markedly at the end of the first session, but rises temporarily at the outset of the second session.

During the early stages of treatment some therapists who are anxious to prevent acting-out at any cost will, at first, assume a despotic role that contrasts sharply with their role in individual sessions. Parenthetically, this may lead to more acting-out. They may try to keep patients from exposing painful revelations before the group is ready to support them. On the other hand, free verbal interaction may be encouraged in the group in order

to bring out each member's customary facades and defenses.

Later in the course of therapy authority is shared by various members, who are, from time to time, "elevated" and "dethroned" by the group according to its needs. Often individual members in their temporary authority posts may initiate ways of eliciting meaningful material. This may take the form of giving each person an opportunity to express him or herself at each session, or there may be a much more informal arrangement with the members spontaneously expressing what is on their minds at the moment. Actually, by the time emotions are beginning to flow freely within the group, there is no further need for procedural structuring; indeed, this should not be rigidly controlled at any time. The content of discussions will vary greatly, covering current incidents of importance in the lives of each member, dreams, attitudes toward others in the group or toward the therapist, and general areas, such as family relations, sex, dependency, and competition.

In previous chapters, principles of supportive and reeducative group therapy have been described. In this chapter, principles of group psychotherapy oriented around reconstructive goals are considered. In addition, behavior, experiential, transactional analytic, psychodramatic and role playing, family, and marital (couple) interventions are considered.

LATER SESSIONS

Ezriel (1973) believed that principles of classical individual psychoanalysis could be advantageously adapted to group therapy. Essentially mechanisms of the unconscious are uncovered and their meaning explicated through interpretation. The core of the neurotic process are unconscious need structures that constantly strive for satisfaction through transference reactions and that are dynamically related to resistances. "Here-and-now interpretations" of transference maneuvers with group members does not preclude examination of extratransference projections toward persons outside of the group. However, the therapists must be constantly on the alert for covert transference manifestations that relate directly to them but are being diluted by references to others.

Interpretation of transference with the therapist ("the required relationship") brings the patient closer to behavior patterns that the patient has been repudiating ("the avoided relationship") and permits reality testing that can demonstrate that anticipated calamities will not come to pass. Often such experiences enable the patient to make a connection between contemporary life and unresolved infantile conflicts. Unconscious common group tensions lead to the development of a group structure within which each member seeks to express transference needs. The therapist can advantageously analyze the structure of the group as it displays itself in a particular session and designate the roles played by the different members, thus delineating the defense mechanisms displayed by the individual members. Interpretation can thus be both individual-centered and group-centered; ideally the focus is on the two during each session. All activity in the group, as in classical individual analysis, other than interpretation must be assiduously avoided to prevent gratification of transference needs, which, while momentarily tension relieving, keeps basic conflicts alive.

Other authorities, especially in the United States, insist that the classical model is too limiting and introduce many modifications and active maneuvers such as the structural interventions of Minuchin (1974b). A dynamic viewpoint, nevertheless, is desirable even if nonanalytic methods are employed. It is essential, however, always to attune therapy to the presenting complaints. Where this is not done, one can expect poor results.

As the group becomes integrated and develops an "ego" of its own, members feel free to air intimate vexations. The patient gains more insight into personal difficulties recognizing that many troubles previously believed unique have a common base. The therapist should, therefore, direct energies toward stimulating thinking around universally shared problems, getting responses from other group members even though the subject under consideration is out of the ordinary. The patients may be asked to talk about personal impressions of the role the therapist is playing in the group. Thereafter the group is asked to discuss the verity of each patient's assumptions.

As Grotjahn (1973) has pointed out transference is a most important element of the

group experience. He describes three trends in transference: (1) transference to the therapist and central figure (e.g., paternal figure), (2) transference to peers (e.g., sibling), and (3) transference to the group itself (e.g., pregenital mother symbol). These different transference relationships are always present simultaneously, patients treating the group as if it were their own family. In working through transference and defenses dreams are advantageously utilized; but they are utilized in a somewhat different manner than in individual therapy, the group members and the therapist associating directly to the dream especially focusing on the thoughts and feelings it evokes in themselves, without waiting for the associations of the dreamer. In this way the dream becomes a part of group experience. Sometimes the therapist's reactions to a group member may be perceived correctly by a third member and interpreted.

Many therapists practicing individual psychoanalysis contend that group therapy waters down transference reactions, minimizes regressive reactions, and neutralizes emergence of a genuine transference neurosis. Character changes in depth are, therefore, circumvented. Durkin and Glatzer (1973) have elaborated on how a constant focus on process rather than content and how selective exploration of origins of defensive behavior during group therapy can effectively bring forth pre-oedipal as well as oedipal conflicts. Systematic analysis of intragroup transferences may act as a vehicle for successful transference interpretations and can lead to reconstructive personality changes of a deep and enduring nature.

Of vital importance is the opportunity for the development of multiple transferences during which varying members of the group function as vehicles for the projection of feelings, attitudes, and relationships with important persons in the individual's past existence. Of significance, too, is the fact that the group situation allows for "split transferences"—for example, projection of a "good" mother image on one member (or the therapist or the group as a whole) and of a "bad" image on another.

The basic rule in a group setting is for members individually to express themselves as freely and without restraint as possible. This encourages the disclosure of forbidden or

fearsome ideas and impulses without threat of rejection or punishment. The patterns of some individual members usually irritate and upset others in the group, mobilizing tension and stimulating appropriate and inappropriate responses. The monopolizing of most of the session's time and competitiveness for the therapist's attention bring about rapid responses from the other members. Many patients will react to a trait in a member that they despise in themselves, even though they may not be immediately aware of possessing that trait.

Some therapists work even at the start on group resistance. For example, they may believe that mobilization and release of hostility is essential toward the development of positive and cooperative attitudes. The activity they engage in, therefore, is designed to stir up hostility and to facilitate hostile verbalizations. Other therapists try to facilitate the activity of the members as "adjunct therapists." The interactional processes virtually do put the various group members in the role of cotherapists. Under the guidance of the therapist this role can be enhanced. The specific effect of member "cotherapists" may be analytic or it may be more supportive, encouraging, accepting, and empathic, thus providing an important dimension to supplement the work of the therapist. One way to enhance cotherapeutic participation is, even at the start, to analyze motivations of one or more members to stimulate curiosity and communication. The members are invited to put themselves into the place of a member chosen for focus, e.g., to imagine dreaming the same dream as the member and to interpret the meaning.

A patient finds it easier to examine the inner feelings that have been repudiated when sensing that the group and the therapist are supportive. If expressed feelings seem to elicit a sympathetic response from other members, the ensuing discussion often leads to a lifting of tension and a sharpening awareness of the patient's neurotic patterns. In the kaleidoscopic illuminations of the group each person's vision is broadened by taking advantage of the opportunity to observe and study his or her own and other members' reactions within the group—e.g., manifestations of hostility, fear, suspicion, or sexual feeling—and to relate them to the basic character structure. In this context the difficulties and antagonisms among members may, through analysis of the operative projections, lead

to a constructive solution.

Among the therapist's activities are clarifying, structuring, focusing, timing, interpreting individual and group resistances, encouraging group interaction, and clarifying group interrelations. The therapist's ability to accept hostility and criticism from one member paves the way for other members to engage in verbalizing and a working through of their own hostile emotions.

Reactions of the patient occur in complex clusters as a release of feeling within the group is accelerated. Lack of restraint in one group member often results in a similar lack of restraint in the others. A climate that tends to remove repression enables the patient to work toward a better understanding of inner conflicts.

The matter of alternate sessions calls for special attention. Although it is regarded by some as a sanctioned vehicle for acting-out, experience shows that it can provide opportunities for free interaction, testing, and exploring. It enables some patients to speak more freely about their feelings about the therapist and thereby to consolidate their separation from parental authority. It is essential, however, that activities at alternate sessions or elsewhere involving group members with each other be reported at the regular group sessions. Acting-out members should be seen also in individual therapy.

TECHNICAL OPERATIONS OF THE GROUP THERAPIST

The role of the group leader is to catalyze participation of the various members, to maintain an adequate level of tension, to promote decision making and problem solving, to encourage identifications, to foster an interest in the goals to be achieved, and to resolve competitiveness, resentments, and other defenses that block activity. Groups have a tendency to develop many resistances; for instance, the members form cliques, they come late, they socialize too much, they get frozen into interlocking roles. The therapist has a responsibility to deal with these overt obstructions, as well as with those that are more concealed and come through in acts like passivity, detachment, and ingratiation. The group interactions will permit the therapist to witness how individuals function with

others, their enmities, and their alliances.

How the leader communicates to the group will vary with the orientation and personal idiosyncrasies of the leader. Some leaders are mercilessly authoritarian, and they take over firm control, directing the various activities with despotic regulation. Others are so passive that they scarcely make their presence known. There are therapists who conceive of their role as a benevolent authority who grace their subjects with kindly guidance. There are those who insist the the function of the leader is to liberate the affects of patients that cause their paralysis as people. This, they believe, is accomplished best not by interpretation, but by establishing meaningful, deep relationships. Accordingly, a therapist must avoid setting up as a paradigm of health or virtue, one who is falsely objective, which may be merely a cover for the therapist's omnipotence. Some therapists contend that there is no reason why the therapist cannot reveal weaknesses and grow with patients, relating to their strengths. Experience convinces, however, that most therapists will do best in group therapy if they function with some discipline and if they sensitize themselves for counter-transference manifestations, which are more easy to elicit and more difficult to control in a group than in an individual setting since they too may unconsciously experience the group as their personal family. This does not mean that one must keep oneself in a straitjacket and not react to provocations. Expression of anger toward the group when this is justified, without threatening recriminations, may be exactly what the group needs.

There is always a temptation in group therapy to allow the group to indulge in social chatter, in endless mutual analysis, and in the recounting of dreams and personal experiences at length. This interferes with proper interaction in the group. The therapist must constantly remind the members that they are not there to act as professional psychoanalysts, attempting to figure out dynamics and to expound on theory. The best use of their time is in exploring their own immediate reactions. The principle activity of the therapist will be to resolve resistances to talking about feelings regarding one another and to try to break up fixed role behavior patterns.

The specific communicative media will also vary with the training of the therapist and the goals in treatment. A recounting of dreams, and particularly recurrent dreams and nightmares, may be activated by most analytically oriented therapists, as may the reporting of fantasies and daydreams. Interpersonal interaction may be facilitated by encouraging the free association of each patient about the others in what Alexander Wolf (1950) has called "going around." Patients are enjoined to recite whatever comes to their minds about their fellow members, whether logical or not. Free association about the therapist is also invited. Interpretation is an instrumentality considered essential for the proper working-through of pathogenic conflicts.

Other therapist activities include

1. Focusing the conversational theme around pertinent subjects when topics become irrelevant.

2. Creating tension by asking questions and pointing out interactions when there is a slackening of activity in the group.

3. Posing pointed questions to facilitate participation.

4. Dealing with individual and group resistances.

5. Supporting upset members.

6. Encouraging withdrawn members to talk.

7. Interfering with hostile pairings who upset the group with their quarreling.

8. Reminding the group that communication about and understanding of mutual relationships is more important than interpreting dynamics.

9. Managing silence, which tends to mobilize tension in the group.

Role playing and psychodrama may be introduced periodically. They have advantages and liabilities, as may touching (Spotnitz, 1972).

An important aspect of the therapist's function in the group is that of gauging and

regulating group tension and anxiety. It is well known that some degree of anxiety is one of the moving forces in therapy facilitating growth and change. But anxiety can also be disorganizing—if too much of it is aroused, the group cannot function; there is low cohesiveness, and dropouts occur. It is up to the therapist to step in and deal with excessive tension and maintain not a minimal level of tension, but an optimal one. If too little tension exists, a "dead" session may be resuscitated by requesting that the members "go around" associating freely about each other. A group that has settled into pallid social interchanges may also be revived by introducing a new active, disturbed member.

Perhaps the main task of the therapist is to detect resistances of the group as a whole as well as of the individual members. The dealing with resistance will depend on its manifestations and functions. The question is sometimes asked, "Should one share one's feelings with one's patients and act as a 'real' person rather than as a detached observer?" This depends on how it is done and the kind of relationship that the therapist has with the patients. To bring out one's *serious neurotic problems* may destroy the confidence of some group members in the therapist's capacity for objectivity, as well as the ability to help them, and the impair effectiveness of the therapeutic process. On the other hand, to share *feelings and reactions* will reveal the therapist as more human and less omniscient and give the patients confidence to talk more openly about their own anxieties.

As has been mentioned, a huge variety of resistances precipitate out in group therapy. Their dissolution has resulted in many innovative techniques. In a humanistic contribution Livingston (1975) describes two major forms of resistance that block progress in group therapy: contempt and masochism (sadomasochism). These defenses may, through the assumption of a special role on the part of the leader, be broken through in what the author calls the "vulnerable moment." During such intervals a patient allows himself or herself to be open and honest, and through a constructive sharing of an experience with the group and therapist, the patient may score substantial reconstructive gains. Describing how awareness of such readiness for change came about in his own group therapy as a patient, Livingston suggests techniques, some derived from Gestalt therapy, that may facilitate the working-through process.

A particularly insidious and masked form of resistance is acting-out. The initial reaction to a therapeutic group experience is generally a profoundly inspiring one. A good deal of the reaction is marshalled by hope, the patient projecting wishes to be accepted, understood, and loved without qualification. While defenses continue to operate, these are softened by the emotional catharsis that is experienced in verbalizing to strangers and by an idealization that projects onto them. Sooner or later he or she plummets back to the original defensive baseline as the patient discovers flaws in the idealized images of the group, as criticisms, challenges, and attacks justifiably and unjustifiably are leveled at him or her; and as multiple transference reactions come forth that, unfoundedly, make the group a facsimile of the patient's original family, with some members even sicker than those of the patient's own family. Frustration, disappointment, and even despair are apt to dominate responses, and acting-out may then occur verbally and behaviorally.

In groups conducted by unsophisticated therapists the acting-out dimension may be openly encouraged, the patients being helped or goaded into unrestrained speech and behavior without relating personal responses to underlying motivations. The temporary relief of tension and the pseudo-assertive expostulations are confused with cure. Follow-up almost invariably demonstrates how futile are the results. Many of the members become welded into reciprocal sadomasochistic alliances, and therapy becomes interminable. Others find excuses to leave the group.

The ability of the therapist to establish and to maintain proper communication is the principal means of averting this therapeutic impasse. A. Wolf (1975) illustrates how a therapist may utilize his or her own personality characteristics, for example, solicitude, capacity for healthy engagement, self-discipline, and sheer human decency, to resolve resistances and to enhance interaction. He refers to methods employed by Asya Kadis, which tend to encourage working through rather than acting-out and help foster character restructuring.

The control of acting-out requires a differentiation of acting-out behavior from impulsive and compulsive acts (Spotnitz, 1973). It is generally agreed that there is a

greater tendency toward acting-out in group therapy than in individual treatment. A primary function of acting-out, according to Spotnitz, is to avoid experiencing unpleasant emotions, often of preverbal origin, that cannot be tolerated. Action becomes tension alleviating. It often conveys information in a dramatic form to the effect that the individual is unable to verbalize freely. More constructively, it may serve as a means of attempting to master traumatic events, and it may actually help prevent the outbreak of psychosomatic illness or psychosis by discharging tension. However, the validity of acting-out is always justifiably challenged unless it results in reality testing or enables a patient to master a tendency toward resistive emotional action. Under these circumstances the patient's actions may be considered constructive and in some instances even maturational. If, on the other hand, investigation reveals that emotional action serves as a resistance to communication, it must be therapeutically handled as a form of resistance. Particularly damaging are actions that are destructive to the continuity of the group or to any of its members. Inadequate communication of understanding on the part of the therapist and failure to meet the patient's emotional needs may be responsible for acting-out, which may then take the form of the patient dropping out of the group. Awareness of this contingency may help the therapist deal with such behavior at its inception.

Another type of resistance is encountered on the part of members who refuse to participate in the treatment process. Innovative therapeutic approaches here may cut through the defensive system through the use of videotape recording and playback. R. L. Beck et al. (1975) describe such a program in which dance movement therapy is employed to demonstrate how incongruence between verbal and behavioral communication as a form of resistance may be resolved. Success may sometimes be scored through this approach (whereas traditional therapeutic modes are ineffective) and can lead to a more constructive use of verbal psychotherapy.

Special patients and syndromes may also require innovative methods. The unique personality needs and defenses of adolescents (for example, their lability of affect, their struggle for identity) require an atypical format in the conduct of group psychotherapy. There are differences in respect to activity, depth and content of discussion, and roles

taken within the group. Adolescents bring into the group (which influences its Gestalt) the rapidly shifting values of the contemporary social scene and their distinctive reactions to delights and horrors of our modern technological era. Their reactions differ from those of their parents, who were subjected to a different type of social conditioning. Moreover, the ease with which runaways may survive away from home in a commune and participation in the drug culture that surrounds them must be taken into account in any group psychotherapeutic plan. Kraft and Vick (1973) present an approach that acknowledges the pressing need in adolescents for expressions of their identity and creativeness by introducing into the group psychodramatic techniques and artistic activities, such as dance or movement, music, poetry, and various visual stimuli and by employing where indicated auxiliary therapists. Major conflicts of adolescents worked through in the group included individual excessive competitive behavior versus withdrawal tendencies, inadequate outlets for emotional expression versus emotional blocking, growing up toward individual responsibility versus dependency, and self-identification versus expected role assumption and various breakdowns in defensive operations. This type of group, according to the authors, provides a growth experience for the members, results being reflected in enhanced school performance, better peer relationships, and a general strengthening of ego functioning.

Riess (1973) describes in the conduct of a group of adolescents, or family of the adolescent, a structured "consensus technique" that he believes is ideally suited for diagnostic and therapeutic purposes. In this technique a problem situation in written or oral form is presented to each member who writes out what would be the appropriate outcome or way of action. The members then discuss the "solutions" and are given a limited time to come to a unanimous decision. In the course of the ensuing interactions, individual styles, reactions, and defenses become apparent and relationship problems emerge. The results may be utilized diagnostically. By mobilizing conflict and anxiety, defensive operations precipitate out rapidly, and where the therapist is trained dynamically to deal with defenses, therapy may become catalyzed.

One of the poignant problems of the group therapist is how to deal with "difficult"

borderline patients, that is, those who do not respond to the usual tactics or maneuvers during the group session, who are extraordinarily self-involved, sensitive, dissatisfied, and angry. Their impact on the group may be intense and not always constructive, since they attempt to destroy, to monopolize, and to provoke counteraggression from other members. Moreover, they engage in struggles with the group leader that can be disturbing to the latter, to say the least. Pines (1975) has described the dynamics of the "difficult" patient, employing some of the ideas of Foulkes, Kohut, and Kernberg. He makes some useful suggestions on how to manage their reactions and resistances.

Efforts to expedite group therapy and catalyze movement have resulted in therapists' evolving their own unique techniques. Thus, Vassiliou and Vassiliou (1974) employ a transactional method "synallactic collective image technique," which actualizes psychodynamic concepts within the framework of general systems theory. Utilizing artistic creations made by group members (free paintings, doodlings, or scribblings), the participants choose, through majority vote, one creation around which discussion is organized. In this way the members "talk" to each other through a common stimulus. Gradually, as different projections evolve, communalities are compared and a "collective image" of the group emerges that revolves around a central theme with individual variations. Throughout, the therapist operates actively in a key "catalytic regulatory" role, participating continuously in the group transaction.

Encounter and marathon techniques are capable, through the intense emotional atmosphere that they create, of cutting through defenses and rapidly reaching repressed feelings and impulses rarely accessible through the use of conventional techniques. However, such active procedures are unfortunately utilized by therapists as a means of dealing with their own countertransference. Thus, the sessions may be employed as an outlet for the therapist's hostility, boredom, need for social and physical contact, desire for dramatic "instant insights," and solution of professional and personal identity conflicts. The avoidance by encounter therapists of traditional concepts and practices, such as the analysis of countertransference, is a great liability and accounts for the bulk of negative therapeutic reactions and treatment failures. A. W. Rachman (1975) points out the

importance of countertransference analysis and suggests methods of examining countertransference.

Corsini (1973) describes a "behind-the-back" (BTB) technique that may serve a useful purpose for groups of people. The problem in ordinary group therapy is that people find it hard to be honest with one another to their faces. The BTB technique is a stylized and formalized procedure that requires a minimum amount of time on the part of the therapist and is one that a suitable group may utilize. Members of the group are prepared by informing them that the method is designed to help express oneself to others and to learn what others really think of one. They are then asked to volunteer their participation as both patients and therapists. Each member in the present and following sessions is given a half hour to tell his or her story without interruption. At the end of this time the involved patient is requested to sit with his back to the group while each member talks about the "absent" member. This requires 20 to 40 minutes. The absent member is asked to face the group again while the therapist briefly summarizes what has been said. The patient is given about 5 minutes to make a rebuttal, responses being studied by the therapist in terms of denials, agreements, evasions, and other defenses. Then the patient sits in the center of the group exposed to the interrogation of the group. The therapist may interrupt these questions and terminate the session by sending the patient out of the room should emotions become too violent. It is to be expected that the patient will be upset by his inquisition, but this very turmoil causes the patient to unfreeze, better to face up to problems, realizing how he or she impresses others. At the very next session the patient is asked to summarize the meaning of the past session. The BTB technique is planned to facilitate the release of emotions and to expedite change through altered behavior.

It is sometimes propitious, in the opinion of some therapists, once a dynamic understanding of a patient's emotional problems becomes clear, to expedite change through arranging an appropriate scenario that encourages the patient to act out conflicts in a controlled way. E. E. Mintz

(1974) presents a number of such episodes from her experience with marathon groups. The procedures employed, some of which draw from psychodramatic and Gestalt therapeutic techniques, are bounded only by the imagination and dramatic proclivities of the group leader and participant members. Patients who are vulnerable or resistant to "interpretations" in individual sessions are often, with this technique, better capable of cutting into core problems and facing their difficulties. Moreover, the process stimulates the other group members to open up many personal painful areas for discussion.

Bach (1974) utilizes and describes a technique of aggressive therapeutic group leadership through participating actively in fights that occur between members of marathon groups. He considers neutrality and passive objectivity, the preferred stance of psychoanalysis, a form of alienation and not caring, which violates the intimate participative spirit of the marathon experience. The therapist "attacks" by frank verbal explosions and expressions of frustration, irritation, and indignation justified by what is happening in the group. Such actions may be leveled at a passive cotherapist who refuses to participate actively in the group work, at a whole group of "ground-rule" violators (e.g., people who avoid confronting each other with their feelings), at subgroups (e.g., those who hide in a cozy, pairing maneuver), and at individual members who manifest patterns that interfere with the group experience (e.g., monopolizing, controlling, etc.). Bach provides amusing examples of his "attack therapy," which, though seemingly countertransferentially inspired at times, appear, according to his accounts, to result in a more intimate, experience-sharing communion among the members. He expresses his philosophy of therapy in this way: "We must all relearn how to fight to regain our genuineness. Only after this are we ready to share love."

C. Goldberg (1975), on the other hand, stresses an existential stance and believes that patients can be actively taught skills in interpersonal relationships that can mediate their own and others' loneliness and despair, and which can probe ubiquitous alienation and existential exhaustion. Toward this end, the group leader actively participates in the group through openness, self-disclosures, display of congruence of feeling, and modeling of behavior. There is a minimization of verbal and nonactive interaction. Interpersonal

skills are actively taught through such methods as a deciphering of nonverbal "body language," a listing and checking of one's irrational attitudes and an exposure of one's manipulations and defenses in order to influence situations outside the group and to revise strategies and core attitudes.

Many other group interventions have been described and are contained in the annual overview of group therapy by Wolberg & Schwartz (1973) and Wolberg & Aronson (1974-1983).

<center>SPECIAL PROBLEMS</center>

It can be seen from the previous discussion that some group therapists develop their unique techniques and ways of looking at group phenomena that, while valid for them, may not be sound, plausible, or found useful by every psychotherapist. Experimenting with these procedures and ideas, however, will reveal their value.

The mangement by the therapist of special problems among patients will be essential where they obstruct group interaction. The following are some of these.

The Silent Patient

Behind silence may lurk a variety of dynamisms. Sometimes detached, withdrawn persons may be drawn out by the therapist's asking them a pointed question in relation to what is currently going on in the group: "How do *you* feel about this?" Since the response will be hesitant and unsure, more aggressive patients may attempt to interrupt to take the floor over for themselves. The therapist may block this subterfuge and continue to encourage the reluctant patient to articulate. The patient may also be asked directly to report on any dreams. Sometimes it helps to allot a certain amount of time to each member, say, 5 minutes.

The Monopolizer

The person who attempts to monopolize the session may be manifesting a power

struggle with the therapist or a masochistic maneuver to bring on the wrath of the therapist and other group members. The aggressive, narcissistic patient who insists on dominating the session will usually be interrupted by one or more members who resent this takeover. Where this does not occur, the therapist may halt the patient by asking another member what he or she is thinking about or by directing a question at the group as to whether they want the monopolizing patient to carry on all the discussion. The same tactics may apply to an interacting pair who interminably carry on a discussion between themselves.

The Quarreling Dyad

A manifestation of unresolved sibling or parental rivalry is two patients who constantly engage in verbal dogfights. This eventually becomes boring for the rest of the group and may sponsor a withdrawal into fantasy. The best way to deal with this phenomenon is by working toward each participant's tracing of the transferential roots of the enmity in order to recognize how both are projecting unconscious aspects of themselves on each other. This should not be too difficult from their dreams and associations. An interruption by the therapist of uncontrollable outbreaks of bickering is, of course, in order.

Acting-out Patients

Because groups are action oriented, because multiple transferences are set loose, because individuals other than the therapist are available for the discharge of erotic or hostile impulses, because not enough opportunity is given each patient to verbalize, and because upsetting revelations on the part of the group members may set off identical problems in a patient, acting-out can be a disturbing phenomenon in groups. The therapist may caution the members to talk out rather than to act out. The group members may be required to report at a regular session the activities engaged in between members outside the group. The therapist may try to reduce the anxiety level of the group. It is possible that the therapist's own countertransference is encouraging the acting-out. One should be constantly on guard for this. It may be necessary to reorganize the group when too many

acting-out members are present. The therapist may insist on acting-out members being simultaneously in individual therapy.

The Private Session in the Group

Some patients will attempt to utilize the group time to get a private session with the therapist. They will look at and direct their conversation to the therapist, ignoring the presence of the group. This reaction is especially common in a patient who was an only child in the family of origin or who wants to be the preferred sibling. When this happens, the therapist may ask the patient to focus remarks on the group, may question the group as to how they feel about the patient's carrying on an intimate discussion with the therapist, may ask other members to associate to the patient's verbalizations, and finally, may suggest that the patient come in for a private session.

The Habitual Latecomer

Drifting into the session after it is under way will mobilize resentment among the members, particularly where it is repetitive. This resistance should be handled as a special problem, requesting the patient to try to understand what is behind this neglectful conduct. The latecomer ultimately may be threatened with removal from the group if he or she does not come on time. This may bring to the surface the resentment toward the group that is expressed in this symptom. The group members should be encouraged to deal with this problem, not just the therapist.

The Patient Who Insists that He or She Is Getting Worse not Better

There are patients who display a negative therapeutic reaction that they are only too eager to communicate to the group. Dependent patients who have been in the group for years, and who cling to it for emotional sustenance, usually join in to complain regarding the ineffectuality of therapy. This can influence the group morale and may be disturbing, especially to new members. The therapist may handle such a reaction by nondefensively citing examples from the progress made by various members of the group to disprove the

thesis that therapy does not help and, where applicable, may point out the aim of the complainant to drive certain members (especially new members) out of the group.

The Accessory Therapist

A variety of mechanisms operate in the patient who is trying to replace the therapist. It may be a protest on the part of a dependent patient to the therapist's passivity. It may be an attempt to undermine the authority of the therapist. It may be a way of seeking favor with the therapist. It may be a gesture to compete with and replace the therapist. Irrespective of its basis, the patient may soon gather about him a group of followers as well as adversaries. The best way to handle this maneuver is to ask the other members what they think is happening, until the therapeutic pretender quiets down. The therapist may also ask the competing patient why he or she feels obliged to "play psychoanalyst."

Mobilizing Activity

Where progress has bogged down and members seem to be in a stalemate, one may stir up activity by (1) asking the group why this is so, (2) introducing psychodrama or role playing, (3) asking a member to talk about the role assumed in the group, then going around the group requesting the other members to comment, (4) asking each member to talk about feelings concerning the two people on either side of him or her, (5) utilizing one or more techniques of encounter or Gestalt therapy, (6) extending the length of a session up to the extent of a marathon session, (7) introducing several new members into the group, (8) determining the nature of the resistance and interpreting it, (9) shifting some old members to a new group, (10) introducing a borderline patient into the group whose anxiety level is high, (11) taking and playing back video tapes of the group in action, (12) pointing out which stimuli in the group release repetitive patterns in each patient and interpreting their ramifications in outside relationships.

When a Therapist Becomes Bored with a Session

In this situation the therapist may ask, "Is anybody else besides me bored with this

conversation?"Then the group could explore the basis for such a reaction.

MISCELLANEOUS GROUP APPROACHES

Preintake and Postintake Groups

Preintake groups, which act as a forum for discussion and orientation, are a valuable aspect of clinic functioning where a delay is unavoidable before formal intake. Up to 20 people may attend, and sessions may be given at weekly, bimonthly, and even monthly intervals. Parents of children awaiting intake may be organized into a group of this type, which may meet for 3 to 6 monthly sessions. Postintake groups may take place before permanent assignment, and meetings may be spaced weekly or up to 1 month apart. Here some therapeutic changes are possible as disturbing problems are introduced and elaborated. These preliminary groups serve as useful means of selecting patients for ongoing group therapy. They are worthy orientation and psychoeducation devices and help prepare and motivate patients for therapy.

Special Age Groups

Group therapy with children is usually of an activity nature. The size of children's groups must be kept below that of adult groups (Geller, 1962). For instance, in the age group up to 6 years, two or three children constitute the total. Both boys and girls can be included. Single-sex groups are (1) from 6 to 8 years, which optimally consist of three to five members; (2) from 8 to 12 years, which may have four to six members; (3) from 12 to 14 years, which may contain six to eight youngsters; and (4) from 14 to 16 years, which have the same number. Mixed-sex groups at the oldest age level are sometimes possible.

Play therapy is the communicative medium up to 12 years of age, the focus being on feelings and conflicts. It is obvious that the ability to communicate is a prerequisite here. Beyond 12 years discussions rather than play constitute the best activity medium. Techniques include analysis of behavior in the group, confrontation, and dream and transference interpretation. Both activity (during which acting-out may be observed) and

discussion take place at various intervals. Interventions of the therapist should be such so as not to hamper spontaneity. Discussion is stimulated by the therapist, and silences are always interrupted. Ideally, individual therapy is carried on conjointly with group therapy, particularly at the beginning of treatment.

Group psychotherapy with older people has met with considerable success in maintaining interest and alertness, managing depression, promoting social integration, and enhancing the concept of self in both affective and organic disorders (Goldfarb & Wolk, 1966). Where the goal is reconstructive, oldsters may be mixed with younger people.

Behavior Therapy in Groups

Behavioral techniques (Lazarus 1968; Meacham & Wiesen, 1974; Wolpe, 1969; Liberman, 1970; Fensterheim, 1971) lend themselves admirably to group usage, and results, as well as controlled studies, indicate that behavioral change may be achieved by the employment of methods such as behavioral rehearsal, modeling, discrimination learning, and social reinforcement. The group process itself tends to accelerate behavioral strategies. Homogeneous groups seem to do best, the selection of members being restricted to those who may benefit from the retraining of specific target behaviors. Thus, the control of obesity, shyness, speaking anxiety, insomnia, and phobias (flying insects, mice, closed spaces, etc.) can best be achieved in a group where the participants are focused on the abolition of similar undesirable behaviors. In institutional settings, particularly with psychotic patients, group decision making strategies may be practiced, reinforcement being offered through token economies. Short-term hospitalization for severe obsessive-compulsives, and perhaps alcoholics and drug addicts, treated in special groups of populations with similar maladaptive behaviors can often be a rewarding enterprise (Rachman, S., et al, 1971).

Individually oriented behavioral interventions [see Chapter 51, Techniques in Behavior (Conditioning) Therapy] may be employed alone in a group setting, or in combination with psychodrama, role playing, Gestalt tactics, encounter maneuvers, or

formal group therapy procedures (inspirational, educational, or analytic) depending on the training and flexibility of the therapist.

A routine practiced commonly is to see the patient initially in individual therapy to take a history, to explore the problem area in depth as to origin, circumstances under which it is exaggerated, reinforcements it receives as well as secondary gains, and goals to be approached, employing the traditional behavioral analysis. If group therapy is decided on, it is best to introduce the patient into a newly formed group with persons suffering from the same difficulties and who have approximately the same level of intelligence and knowledge of psychological processes. The size of the group varies from 5 to 10 individuals. A cotherapist is valuable and sometimes indispensable as in the treatment of sexual problems. The initial few sessions may be relatively unstructured to help facilitate the group process. The time of sessions varies from 1½ to 3 or 4 hours. During the starting sessions members are encouraged to voice their problems and to define what they would like to achieve in the sessions, the therapist helping to clarify the goals.

A. P. Goldstein and Wolpe (1971) have outlined the following operations important in group behavioral treatment: feedback, modeling, behavior rehearsal, desensitization, motivational stimulation, and social reinforcement. *Feedback* is provided with confrontation of the reactions of the other members to the patient's own verbalizations and responses. This gives the patient an opportunity to alter these if it is desired. *Modeling* oneself after how others approach and master the desired behavior is an important learning modality. The therapists may engage in role playing or psychodrama to facilitate modeling. *Behavior rehearsal* similarly employs role playing involving the patient directly. Repetition of the process with different members helps solidify appropriate reactions, the patient engaging in role reversal when necessary. Here video playbacks may be important so that patients may see how they come across. Counterconditioning and extinction methods (systematic desensitization, role playing with the introduction of the anxiety-provoking stimulus, encouraging expression of forbidden emotions in the group like anger) eventually lead to *desensitization.* The therapist provides direction and guidelines for appropriate behavior, which with the pressure of the group, helps create *motivation*

and *social reinforcement.* Support is provided the patient when necessary. Specific assignments outside the group may be given the patient.

Relaxation methods may be employed in a group for the relief of tension and such symptoms as insomnia. Any of the hypnotic or meditational methods outlined in this volume (q.v.) may be utilized; their impact is catalyzed by implementation in a group atmosphere.

Behavioral tactics are ideally suited for habit disorders related to eating, such as obesity, smoking, gambling, alcoholic over-indulgence, and substance abuse. Members for each group must be chosen who suffer from the same problem and possess adequate motivation to cooperate with the interventions.

Where problems are centered around lack of assertiveness, assertiveness training can be highly effective. Fensterheim (1971) describes his method of dealing with this problem. Groups of 9 or 10 consisting of men and women in approximately the same number, roughly homogeneous as to age, marital status, achievement, education, and socioeconomic status (to enhance modeling) meet *2½* hours once weekly. Seats are arranged in a horseshoe configuration, the opening serving as a stage for role playing and behavior rehearsal. Sessions are begun by each member reporting on the assignment proposed the previous week. Successes are rewarded with approval by therapist and members. Failures are discussed. On the basis of the report, the assignment for the following week may be formulated. Special problems will evoke discussion by the group. Members are asked to keep their own records of assertive incidents that they indulged in during the past week. Special exercises are employed with role playing depending on problems of individual members, such as talking in a loud voice, behaving unpleasantly, telling an interesting story, expressing a warm feeling toward other group members, practicing progressive expressions of anger (reading a dialogue and portraying an angry role, improvising one's own dialogue, role playing angry scenes and incidents reported by other members, and role playing scenes from one's own life and experience). About 5 to 10 minutes of each session is spent doing these exercises over a 4-month period. Roughly

10 to 15 minutes may be used for systematic group desensitization from a common hierarchy prepared by the group. At the end of each session members formulate their own next assignment or if they are blocked, this is suggested.

Phobias respond remarkably well to group behavioral methods. Here the patient selection must also be homogeneous as in assertive training. Aronson (1974) describes a program that has been successful in 90 percent of his patients completing it. The program is designed for fear of flying (but the ideas can be adapted to other phobias, such as fear of cars, ships, elevators, tunnels, bridges, high places, etc.). Initial individual consultations are geared toward establishing a working relationship with the applicant, and essentially to do a behavioral analysis, although Aronson stresses a dynamic accent. A high degree of motivation is desirable. "How much do you want to get over this fear?" may be asked. At the first session the therapist structures the program (the first five sessions devoted to a discussion of fear of flying; one or two educational briefings with safety experts, pilots, and other air personnel to answer questions; seven to eight sessions on discussion and methods of overcoming the fears). The optional size of the goup is 8 to 12 persons. Meetings are for 1½ hours once weekly. Presession and postsession meetings of ½ hour each without the therapist may be recommended. Pertinent reading materials on air travel and development should be available.

The following rules are delineated, (a) Each member will within the time limitations, be permitted to talk freely about existing fears, (b) At the second session each member is to bring in a drawing depicting the most pleasurable aspect that he or she can imagine about a commercial air flight and a second drawing depicting the most unpleasant consequences. The individual is also invited to talk about any personal dreams about travel (In recounting such dreams no associations are encouraged nor interpretations made regarding defenses.) (c) The following exercises aimed at anxiety control are introduced.

> 1. While lying down or seated comfortably on a chair, visualize all the sensations and anxieties you experience while on a plane. Simply visualizing yourself on a plane may make you anxious at first. You may find yourself

wanting to avoid thinking about it.' If so, let your mind dwell on pleasant thoughts for a while. As soon as you feel somewhat more relaxed, reenter the fantasy of being anxious on a plane. Focus initially on the least frightening aspects of flight. Gradually allow yourself to visualize more frightening fears. Each time you practice this exercise you will be able to get closer to the dangerous situation and stay with it longer. Do this exercise twice a day for a week (based on Wolpe, 1969).

2. Picture yourself in the *most pleasant* situation you can imagine. Let your mind dwell on this situation as long as possible. Then imagine yourself on a plane. Some of the positive feelings you experienced in your fantasy will come back with you and help allay your anxiety when you next imagine yourself on a plane on the ground or actually flying (based on Perls, 1969).

3. Visualize the most unpleasant situation you can possibly think of—a situation even *more unpleasant* to you than being on a plane. You will find that when you leave this fantasy and imagine yourself flying or actually on a flight, you will experience less anxiety (based on Perls, 1969).

Should any of these exercises stir up anxiety, the members must indicate this to prevent it from getting too deep, (d) Should members start feeling strongly hostile to each other, the therapist encourages verbalization and explains that strong, positive feelings among all group members will be necessary for success, (e) Talking about personal matters other than those related to fears of flying is to be discouraged. (f) After the fourth or fifth session one or two educational sessions are held with local airline representatives to answer technical questions about flying and safety measures, (g) After the eighth session the entire group visits an airport and, if possible, meets in a stationary airliner for about 1 hour. Members talk about their fears every step of the way. Around the tenth and twelfth session the group leader suggests a target date for a short flight. If too much anxiety prevails, this date can be temporarily postponed until the anxiety recedes. The leader must set the time with the airline representatives and accompany the group. After the flight the group reconvenes to discuss the reactions. (h) Members are encouraged to arrange their own flights and to continue in group therapy for a few sessions thereafter.

Other phobias may be treated in a group setting following this format, introducing

whatever modifications are essential considering the nature of the target symptom. Videotaping and playback may be employed, should the therapist possess the apparatus, particularly for role-playing exercises.

Experiential (Encounter and Marathon) Therapy

The group therapy movement has mushroomed out to include a variety of forms. The traditional model, which focused on inspiration, education, and insight acquisition, has been supplemented by groups whose objective is experiential with a wide variety of techniques. Many names have been given to these new arrangements including Gestalt, human relations training, human awareness, leadership training, T-groups, sensitivity therapy, and encounter therapy. The time element (traditionally 90 minutes) has been stretched sometimes to several hours, 12 hours, 24 hours, or several days with time off for sleep (marathon groups). Encounter therapy may be an ongoing process like any other form of group therapy, or it may be brief, from one to a dozen sessions.

A constructive group experience with a small group of people who are educationally on a relatively equal level and who permit themselves to disclose their self-doubts and personal weaknesses can be most liberating to the participants. The fact that one can expose oneself to others and reveal fears and desires of which one is ashamed, without being rejected or ridiculed, can be reassuring and strengthening. The person feels accepted for oneself, with all of the flaws, rather than for the pose presented to the world. Whereas previously the individual may have regarded interpersonal relationships as threatening, they can now embrace a sustaining richness. As communication between the members broadens, they share more and more their hidden secrets and anxieties. They begin to trust and accept themselves as they learn to trust and accept the other participants. Interpersonal confrontations, while temporarily upsetting, may even ultimately bring the individual into contact with repudiated aspects of himself or herself.

By communicating without restraint the members are enabled to learn that other individuals have problems similar to and even more severe than their own. The realization enables them to relax their guards and to open up more with one another. The

"encounters" in the group will probably sooner or later release underlying patterns of conflict, such as hostility toward certain members, excessive tendencies to defy and obstruct, inferiority feelings, unrealistic expectations, grandiose boastings, and other maneuvers that have little to do with the immediate group situation but rather are manifestations of fundamental characterologic flaws. Under the guidance of a skilled group leader the encounter group becomes a means through which the members become aware of how they are creating many of their own troubles. By talking things out they are able to correct some of their misperceptions.

Some observers would call this process psychotherapy. We are dealing here with semantics. The effects of the encounter group can be psychotherapeutic, particularly in persons who are ready for change and who already have, perhaps in previous psychotherapeutic experiences, worked through their resistances to change. But psychotherapy, in most cases, is not the achieved objective. What is accomplished is an educational realignment that challenges certain attitudes and teaches the person how to function better in certain situations. If one happens in the course of this education to change a neurotic pattern of behavior, so much the better, but it must be emphasized that psychotherapeutic groups are run differently from encounter groups. They are organized on a long-term basis and focused on neurotic symptoms and intrapsychic processes.

Even though there is some evidence that encounter group experiences may have a therapeutic effect on neurotic personality structure, our observations at the Postgraduate Center for Mental Health indicate that personality changes, when they do occur, are temporary, rapidly disappearing once the participant leaves the encounter group and returns to one's habitual life setting. We have worked with the staffs of various institutional units, including psychiatric clinics, correctional institutions, schools, and a host of professional and nonprofessional organizations. Our delight at "depth" changes brought about by encounter techniques has been generally short-lived when we do follow-up studies after a reasonable time has elapsed. This fact does not depreciate what the encounter group can do for a participant, because in many instances it does alert the individuals to many neurotic shortcomings and motivates them to seek psychotherapy on

a more intensive level. Many of our "cured" encounter clients have later asked for thorough psychotherapeutic help, once they have an inkling of their problems.

The usual marathon group exposes group members to constant association of approximately 30 hours, generally in the course of which a 5-hour break is taken. During the first 15 hours of interaction there is a gradual sloughing off of defenses, and, in the last hours, a "feedback" is encouraged in which the therapist enjoins the patients to utilize the understanding of themselves to verbalize or execute certain constructive attitudes or patterns. Highly emotional outbursts are encountered with this intensity of exposure, and corrective emotional experiences seem to occur. The therapist participates actively with the group, expressing his or her own reactions to the members but avoiding interjecting personal needs and problems. A variety of techniques may be employed. For example, at Esalen a combination of theories and methods were used, including Perls' Gestalt therapy, Freud's unconscious motivational ideas. Rolfs structural integration and body balance, Lowen's bioenergetic theory, Moreno's psychodrama. Shutz's encounter tactics, and other sensitivity training methods (Quaytman, 1969). Some of these techniques have more recently been taken over by Erhard Seminars Training (EST).

Experiential therapies are sometimes resorted to by psychotherapists when their patients have reached a stalemate in individual or group therapy. In many cases the specific working on the resistance resolves such blockage of progress without the need for dramatic interventions. However, in spite of this, there are some patients who seem unable to move ahead. Productions dry up, boredom develops, motivation to continue therapy dwindles away. Under these circumstances some therapists have found that referring their patients for encounter therapy or a weekend marathon suddenly opens them up, producing a flood of fresh material to work on, and sponsoring more enthusiasm for continued treatment.

Not too many therapists are qualified to do experiential therapy. Apart from that which may be gained by participation as a patient in encounter groups or in several marathons, it requires a special personality structure of great extraversiveness,

spontaneous enthusiasm, and histrionic inventiveness. Sufficient flexibility must exist to permit a rapid switching of tactics and changing of formats to meet individual and group needs. The role of the leader will vary, of course, with the individual. Most therapists view themselves as participant observers who, while admitting and sharing some of their own problems, hold themselves up as models of expected behavior. Emotional stability of the therapist and control of countertransference are under these circumstances vital. The presence of a trained cotherapist is often of value in the service of objectivity. Both therapists who do marathon therapy and patients who receive it are usually enthusiastic. Follow-up studies have been more conservative as to the actual benefits. The immediate experience may be an intensely moving one, and participants usually believe that they have benefited and are reluctant to end their relationship. They feel that they have acquired a new understanding of themselves. Often they do. But we may anticipate that benefits will not persist unless the environment to which the member returns reinforces the new behaviors and attitudes that have been learned. This is usually not the case, however. One would anticipate that unless some intrapsychic change has occurred, the old defensive balances will usually be restored. It is for this reason that results will be best if the individual continues in individual or group therapy to work on the significance to him or her of the encounter or marathon experience.

It has been the practice, unfortunately, to offer encounters or marathons for unscreened applicants willing to pay the price of admission on the theory that even a bit of confrontation, challenge, and encounter can provide fruitful bounties. Undoubtedly, there are persons who may get a good deal out of an intensive interpersonal experience without formally entering into structured psychotherapy. This does not compensate for the unstable souls, balanced precariously on the razor edge of rationality, who can be damaged by exposure to such groups. There are some patients (usually borderline cases) who cannot tolerate the intense emotional relationships of the marathon experience (Stone, WN, & Tieger, 1971; Yalom & Lieberman, 1971). Such individuals may develop frank psychoses as a result of breakdown of their defenses. Unless the therapist is well trained and does diagnostic interviews on all applicants (which is not often the case), he or she is risking trouble, however infrequent this is reported.

Even where an initial diagnostic study qualifies a person for this type of therapy, difficulties can occur in those with fragile defenses. The task of the leader is to pick out of the group those members who in their speech and behavior are beginning to lose control. Removing such vulnerable persons from the group, temporarily by assigning to them isolated tasks and perhaps giving them supportive reassurance in a brief interview, may permit some of them to reenter the group when their reality sense is restored. The therapist will have to interrupt any challenges or attacks that are levied at such persons, refocusing attention elsewhere.

Generally, the individual entering an experiential or marathon group is instructed in the responsibility that he or she has in the group, the need for physical restraint and abstinence from drugs and alcohol, and the fact that while one's behavior in the group is related to one's life style, that there may be new and better ways of relating that one can learn. Sometimes a contract is drawn up as to what changes a person desires to achieve. Accordingly, the individual may gauge for oneself how far ahead to move. Emphasis is on the "here-and-now" rather than on the past.

As to encounter techniques, these vary with the inventiveness of the leader. In a small group the members may be asked to "go around" and give their impressions of all the other members, positive and negative. The leader may then say, "Reach out and put your hands on the shoulders of the person next to you. He or she will do likewise. Look into each other's eyes and say whatever comes into your mind." Or, "Hold the hands of the person next to you, and describe what you feel these hands are saying."

Utilizing art materials (crayons, chalk, pastels, etc.), the members may be asked to draw anything that represents how they feel and also how they would like to feel. The group later associates to or discusses these productions. The same may be done with clay or plasticene materials.

Two members may be asked to approach each other in front of the group and to communicate in nonverbal terms, i.e., by touching, gestures, facial expressions, etc. The group then discusses the nature of the communication.

Schutz (1967a) has described a number of "warm-up" and other techniques that may be used. One technique in helping a person give up rigid controls and distrust of others is to encourage him or her to stand with back to the therapist and to shut the eyes and fall straight back with trust that the therapist will surely prevent falling. Patients show many defenses to this maneuver, and the discussion of their fears and other feelings provides a stimulus for elaboration in the group. Later members may try this maneuver with each other when they develop confidence in permitting themselves to fall back.

Many touching maneuvers are employed for the same purpose. One is to invite patients to stretch out on a couch and to have them lifted by many hands and passed along, their bodies being stroked in the process. Associations to this are, as may be imagined, often interesting. In encounter groups, participants often play out their needs, impulses and conflicts not only through "verbal interchanges but also various nonverbal devices such as touching, massaging, holding, hugging, dancing, exercising, playing games, eyeball to eyeballing, acting out dreams and fantasies, etc." (Harper, 1975). Such groups which encourage an unrestrained expression of emotion may be helpful, at least temporarily, for inhibited, repressed individuals who require peer approval and modeling by a leader who also enjoins them to come forth with their feelings. But they may be harmful to vulnerable individuals who, having let the lid off their emotions, are left with residues of guilt and confusion after the group has disbanded. Dangers come from lack of provision for adequate postsession discussion, clarification, support, and interpretation; from inadequate selection procedures for members; and from inexperienced and untrained leaders who, though high in enthusiasm, are low in therapeutic understanding and sophistication.

Negative outcomes with experiential groups are to be expected in view of the superficial screening of the participants and the large number of untrained leaders who contact these groups with few or no limits on the selection of techniques. It would seem propititious to set up certification and licensure requirements for potential leaders of encounter groups to minimize hazards (Hartley, Roback, & Abramowitz, 1976).

It is to be expected that when people come together for an extended therapeutic experience that hopes are high and that there may be unreasonable expectations of benefit. Despite efforts to control postures and defenses and to substitute for them conventional modes of relating, the facades soon break down, particularly when the individual is criticized and challenged. The close contact, the extended time period of interaction, the developing fatigue, and actual and implied pressures for change all add to the uniqueness of the experience. Intimacies develop that the participant needs to control since subgroups and pairing are strongly discouraged. As the individual realizes the consequence of one's acts for the reactions of others, motivation for change may be increased. This is further augmented by reinforcements that one receives in the form of group approval for any changes that are exhibited. Where patients are not in ongoing groups or individual therapy, it is advisable to schedule a follow-up meeting 3 to 4 weeks later to discuss postmarathon impressions and experiences.

Because many participants have failed to achieve the hoped for relief from alienation, personal growth, and self-realization, the popularity of encounter groups has waned during the past decade.

The literature on encounter (experiential groups) has proliferated since the mid 1960s. The following are recommended: Back (1972), Burton (1969), M. Goodman (1972), Kuehn and Crinella (1969), E.E. Mintz (1967), Perls (1969), Rabin (1971), C.R. Rogers (1970), M. Rosenbaum (1969), Strean (1971-1972). The list continues to grow. Ample material has in the past been published on marathon therapy. A sampling follows: Bach (1966, 1967a-d), Casriel and Deitch (1968), Dies and Hess (1971), A. Ellis (1970), Gendzel (1970, 1972), J. Mann (1970), Rachman (1969, 1975), Sklar et al. (1970), Spotnitz (1968), Stoller (1967, 1968), Teicher et al. (1974), and Yalom and Lieberman (1971). In recent years interest in marathons has diminished.

Transactional Analytic Groups

Transactional analysis is a highly structured group of procedures, developed by Eric Berne in 1950, that is designed to help people achieve an expanded awareness of their

interpersonal operations. It is predicated on the idea that human beings carry within themselves a threefold set of directives that influence their behavior in positive and negative ways. The first group of prescripts are residues of parental conditionings, the individual functioning as if driven by the values and attitudes of the parents. When this happens the "parent" (P) within is said to take over. The second group of regulations are the survival remnants of the "child" (C) and consist of immature promptings and habitudes, parcels of the past. The third group, the "adult" (A), is the logical, grown-up self that mediates a reasonable disposition. These divisions roughly correspond to Freud's superego, id, and ego; indeed, there is much in transactional analysis that parodies traditional dynamic formulations. What is unique and original about the method is the crisp, humorous, provocative language tabs assigned to different patterns that people display in their relationship with each other. This enables some persons, confused by the complex concepts and vernacular of psychoanalysis, to acquire insight into their drives and defenses rapidly, to accept more readily responsibility for them, and to work toward a primacy of the "adult" within themselves. It is little wonder that the volumes *Games People Play* by Berne (1964) and *I'm OK—You're OK* by T. Harris (1967) have stirred the popular imagination, plummeting the books to the top of the best-seller list.

Not all therapists, however, are able to do transactional analysis. What is required is a combination of special traits that include an extremely keen sense of humor, a facility for dramatics, a quick ability to perceive patterns as they come through in the patient's speech and behavior, and a unique capacity to label their use with relevant salty titles.

Treatment in transactional analysis begins with several individual interviews. Patients are instructed in the dynamics of the transactional approach and may be given assigned readings (Berne, 1964; Harris, 1967). A treatment "contract" is drawn up describing the goal of therapy in a specific and clear-cut way, and the patient is introduced to the group. Four overlapping phases of therapy are generally described (Karpman, SB, 1972).

The first phase is structural analysis concerned with understanding and recognizing

"ego states," which objectively demonstrate themselves in body attitudes, tone of voice, vocabulary, and effect on others. Only one ego state manifests itself within the person at a time. Thus the individual's "parent" (P) may come through in vocabulary and behavior expressing what is right and wrong and what people should or should not do. The parent can be prejudiced, critical, pompous, and domineering, or nurturing, sympathetic, forgiving, reassuring, smothering, oversolicitous, infantilizing. The "adult" (A) is the "sensible, rational, logical, accurate, factual, objective, neutral, and straight-talking side of the personality." The "child" (C) can be "free," i.e., happy, intuitive, spontaneous, adventurous, and creative; or the child can be "adapted," i.e., showing reactions akin of those of parents like being sulky, frightened, guilty, sad, etc. The patient in the group during the first several weeks is encouraged to identify the ego states within oneself and as they come through in one's behavior toward the others in the group. The patient learns also of "skull transactions" (i.e., the internal dialogue that goes on between the ego states) as well as ways of "getting the trash out of your head" (i.e., the adult decision to start new internal dialogues—"A 'go away' or 'That's my Parent talking' often quickly helps a patient 'divorce the parent' "). Catchy slogans are used to identify and describe attitudes of P, A, and C. Decision making, views of the world, modes of cataloging external information, and even examining resistance to therapy are referred to the separate outlooks of parent, adult, and child.

The second phase of therapy is transactional analysis (TA), which deals with the clarifying and diagraming of conversations with others, as by drawing arrows from one of the ego states of the person to one of the ego states of the other person. One's child may talk to another's child ("fun talk"), or adult to adult ("straight talk"), or parent to child ("helpful talk"). Various combinations can thus exist. In a group a patient's transactions can be drawn on a blackboard. In this way the patient learns the typical "games" that he or she plays with people. Transference is handled as a "typical transaction" and the precedents traced to early family transactions.

The third phase is "game analysis." "Games" are involved transactions of a number of people that lead to a "payoff" unless interrupted. They have social and psychological

dimensions. Repetitive patterns and defenses are defined by provocative or humorous titles enabling the individual to accept them as part of the personality without too great anxiety. This is one of the virtues of transactional analysis. It is less apt than other dynamic therapies to set up resistance to the acknowledgment of destructive drives. The individual is more likely to accept the fact that he or she is driven by neurotic drives if these are presented humorously as universal foibles. The patient becomes less defensive and more willing to relinquish them.

One of the four basic positions is taken toward the world: (1) "I'm OK, you're OK," (2) "I'm OK, you're not OK," (3) "I'm not OK, you're OK," (4) "I'm not OK, you're not OK." Games are played for figurative "trading stamps" for the purpose of collecting important prizes. "For instance, a man needing only two more books of 'mad' stamps comes home from work, starts a fight with his wife, collects the two books of 'mad' stamps, and cashes them in at the bar for a justifiable drink." Discussion focuses on developing rapidly an awareness of both social and psychological levels of behavior—not in abstract terms but by recognizing how one utilizes people to perpetuate one's own aims ("payoffs"). Sooner or later, the individual is able to interrupt the games (avoid being "hooked," achieve a "quit point") before they eventuate into his habitual acting-out patterns. Thus a cynical attitude toward the games provides motivation to stop them.

The fourth phase is "script analysis." A script is the individual's life plan evolved in early childhood. A "script matrix" charts the relationship with the parents and the crucial injunctions that have circumscribed the individual's life. The "script story" delineates the patient's life pattern and outlines the predicted end of the script. In the course of exploring the script early memories may be revived. The object of working with scripts is to give up old unwanted ones and "get a new show on the road." " 'Permission' in therapy is given to break the 'witch mother' injunctions. This is followed by a necessary period of up to 6 weeks of protection for the new ego, and this is dependent on the therapist having more potency than the witch parents. Patients gain a final autonomy in therapy and choose their own style of life or even live script free.' " Countertransference is recognized. "The therapist should be alert to detect witch messages in his own script and should not pass

these on to his patients."

Transactional analysis for groups at one time attracted a sizable number of therapists, some of whom joined the International Transactional Analysis Association, which held seminars and study groups in many cities. Clinical membership was acquired after 2 years of supervised therapy and a written and oral examination. Publication on the subject has been ample, although interest somewhat has drifted away from transactional analysis during the past few years.

Psychodrama and Role Playing

Moreno (1934, 1946, 1966b) created a useful group therapy method, "psychodrama," which he first introduced in 1925 and that has evolved into a number of clinical methods, including sociodrama, the axiodrama, role playing, and the analytic psychodrama. Many of these have been incorporated into modern Gestalt, encounter, and marathon therapy.

In the hands of a skilled therapist psychodrama is a valuable adjunct in helping patients work through resistances toward translating their insights into action. The initial tactic in the group is the "warm-up" process to facilitate movement. This may take the form of the director (the therapist) insisting that the group remain silent ("cluster warm-up") for a.period. As tension mounts, it will finally be broken by some member expostulating about a problem, the verbalizations drawing a "cluster" of persons around the member. Other members may similarly come forth with feelings and stimulate "clusters" interested in what they are saying. Soon the whole group is brought together around a common theme. The "star" chosen is the person whose personality reflects the problem area most clearly. Another warm-up method is the "chain of association." Here the group spontaneously brings up fears and associations until an engrossing theme evolves. The star chosen is the person who is most concerned with the theme. A third warm-up is initiated by the director ("directed warm-up") who, knowing the problems of the constituent members, announces the theme. A "patient-directed warm-up" is one in which a patient announces to the group the subject with which he or she would like to

deal.

The star is groomed for the roles to play with representatives of important people in the patient's past and current life, selected from other group members ("auxiliaries") whose needs for insight preferably fit in with the parts they assume. The director facilitates the working together of the group on their problems, while focusing on one person (the "protagonist"). Among the techniques are (1) "role reversal," during which a protagonist and auxiliary reverse positions; (2) "the double," another member seconding for and supporting the protagonist; (3) "the soliloquy," characterized by a recitation by the protagonist of self-insights and projections; and (4) "the mirror," auxiliary egos portraying what the protagonist must feel.

By forcing themselves to verbalize and act parts, the members are helped to break through blocks in perceiving, feeling, and acting. Sometimes the therapist (the director) decides which life situations from the patient's history are to be reenacted in order to work at important conflictual foci. A technique often followed is that assumed by "auxiliary egos," who are trained workers or former patients "standing in" for the patient and spontaneously uttering ideas and thoughts that they believe the patient may not yet be able to verbalize, thus helping "to bring his personal and collective drama to life and to correct it" (Moreno, 1966a). As the patient reenacts situations, not only the self role, but also roles of other significant persons in his or her life, such as parents or siblings. The therapist, in the role as "director," may remain silent or inject questions and suggestions. Material elicited during psychodrama is immediately utilized in the presence of the "actor" patient and the group "audience." This technique usually has an emotionally cathartic value, and it may also help the patient understand problems revealed by one's personal actions and thoughts as well as those reflected by other members of the group. By venting feelings and fantasies in the role of actor, the patient often desensitize to inner terrors, achieves hidden wishes, prepares for future contingencies, and otherwise helps to resolve many deeper problems and conflicts. Psychodrama may, instead of being protagonist-centered, i.e., focused on private problems of the patient, be group-centered, concerning itself with problems facing all members of the group.

A valuable function of the auxiliary egos is to represent absentee persons important in the life of the protagonist. Auxiliary egos, thus, are best recruited from those persons present in the group who come from a sociocultural environment similar to that of the patient. The auxiliary egos portray the patient's own internal figures, forcing the patient to face them in reality. In this way the symbolic representatives of the inner life are experienced as real objects with whom the patient has an opportunity to cope. The director enters into the drama that is being portrayed with various instructions and interpretations. Choice or rejection of the auxiliary egos is vested in the protagonist or the director. Since auxiliary egos are representations, they may play any role, any age, either sex, even the part of a dead person whose memory is still alive in the protagonist. If necessary, and where the protagonist can tolerate it, bodily contact is made between the patient and the auxiliary ego to supply reassurances and to restore aspects of closeness that the protagonist has lacked. Thus, a person who never experienced real "fathering" may get this from the actions of an auxiliary ego.

Props are sometimes used, such as an "auxiliary chair" which may represent an absentee personage. Living or dead family members may be portrayed by several empty chairs around a table, each chair in fantasy being occupied by a different relative. In the dramatic interactions the protagonist may play the role of the relative with whom there is momentary concern by sitting in the special chair and speaking for that person. Sometimes a tall chair is employed to give a protagonist sitting in it a means of assuming a position of superiority. A fantasy prop sometimes used is the "magic shop," in which the shopkeeper dispenses to all the members of the group imaginary items cherished by each in exchange for values and attitudes that are to be identified and surrendered by each member.

Role reversal is a useful technique in psychodrama, two related individuals, for example, taking the role of one another expostulating how they imagine the other feels or portraying the behavior of the other. Where a protagonist is involved emotionally with an absent person, the latter may be portrayed by an auxiliary ego.

Rehearsal of future behavior is an aspect of psychodrama. The protagonist here will play out a situation that necessitates the execution of skills or the conquest of anxiety that is presently felt to be unmastered. Verbalizing inner doubts and fears, and applying oneself to the task of overcoming these, may be helpful in easing one through actions in real life.

The controlled acting-out of fearsome strivings and attitudes helps to expose them to clarification. Thus, obsessive gentleness may be revealed as a defense against the desire to lash out at real or imagined adversaries. A protagonist so burdened may be encouraged to swing away at imagined persons who obstruct. A woman whose spontaneity is crushed may be enabled to dance around the room, liberating herself from inhibitions that block expressive movement. A suicidal person may portray going through the notions of destroying himself in fantasy, thus helping the therapist to discuss openly an impulse that otherwise may be translated into tragic action.

Moreno (1966a) explains the value of psychodrama in these words:

> Because we cannot reach into the mind and see what the individual perceives and feels, psychodrama tries, with the cooperation of the patient, to transfer the mind 'outside' the individual and objectify it within a tangible, controllable universe. ... Its aim is to make total behavior directly visible, observable, and measurable.

In this way, patients are presented "with an opportunity for psychodynamic and sociocultural reintegration."

The psychodramatic technique has given rise to a number of *role-playing methods* that are being applied to education, industry, and other fields. Recognizing that the mere imparting of information does not guarantee its emotional acceptance or its execution into action, role playing is employed as a way of facilitating learning (Peters & Phelan, 1957a,b). As an example, a group of four participants and a group leader may be observed by four observers who sit apart from and in the rear of the participants. Initial interviews of 1 hour with each participant and observer are advantageous to determine motivations, expectations, and important psychopathological manifestations. Preliminary mapping of the procedure considers group combinations, problems to be considered, objectives and

desired modes of interaction. A short warm-up period is employed at the beginning of each session to establish rapport. Then the participants are assigned roles in a selected conflict situation. A discussion by the group of the issues involved, with delineation of possible alternative courses of action, is followed by the leader's interpretation of why various participants reacted the way that they did. Repetition of the conflict situation with the same participants gives them an opportunity to try out new adaptive methods and tests their capacities for change. It also fosters reinforcement of a new mental set. At the end of the session the group leader renders ego support in the form of praise for individual contributions and reassurance to lower any mobilized tension or anxiety. Approximately six 1-hour group sessions are followed by individual consultation with each member to determine ongoing reactions. Another series of six group sessions, or more, may be indicated. These procedures, while effectively altering attitudes and promoting skills, may not effectuate significant changes in the basic personality structure. More extensive role-playing tactics have been described by Corsini (1966) that are designed to deal with extensive inner conflicts.

Quality of Change in Group Psychotherapy

One must not be deceived regarding the quality and depth of changes observed among members of a group as a consequence of continued interaction. Changes are dramatic: the attacking and aggressive person becomes quiet and considerate; the dominant individual shows abilities to be submissive; the withdrawn person comes out of a shell and relates flexibly to the other members; the dependent, clinging soul is encouraged to express assertiveness. These effects will become apparent, sooner or later, as products of both group dynamics and the interpretive activities of the therapist and group members. But whether there will be a transfer of learning to the outside world sufficient to influence a better life adaptation is another matter. Often what we find in group therapy (as we witness it also in individual therapy) is that the individual fits the group reactions into a special slot. The role played in the group is disparate from the roles in other situations. The group expects one to behave in certain ways, and one obliges. It offers a shelter from the harsh realities of the external world. One can "be oneself" in the

group; but defenses may be checked at the therapist's door, and when leaving the therapist's office or the group at postsessions and alternate sessions, one may reclaim them. Only in this haven of safety can one trust oneself to act differently.

This confounding resistance is testimony to the fact that interpersonal change is not the equivalent of intrapsychic change. The former change may merely reflect the acquisition of a new set of social roles that the individual fastens onto and that enhance the repertoire of patterns. It is like acquiring a new wardrobe to be worn on special occasions. The individual underneath remains the same. From this one must not assume that group therapy is of no real consequence. Intrapsychic changes are possible if the person has the courage appreciably to test the changed assumptions and to apply new learning in the group to the other roles played in life. The therapist has a responsibility here in seeing that the patient does not lock into a comfortable stalemate in the group. The patient may be asked whey there are differences in his or her feelings and behavior inside as compared with those outside the group, and if there has been no change, why not. Sometimes the patient's resistance is a persistence of the desire to recreate the patient's original family in the group, with all the ambivalences that this entails from which the patient refuses to break loose. Supplementary individual sessions may be specifically applied to these questions.

FAMILY THERAPY

Families are composed of units of individuals engaged in continuing interrelationships that significantly influence mutual behaviors. Pathology in one member can have a determining effect on the entire family system, which, in turn, will modulate the degree and form of individual dysfunctions. Therapeutic interventions therefore must concern themselves with the organizational distortions of the family as a system. It follows from this that correction of psychopathology in any one or more members presupposes a restructuring of the family organization, which is, to say the least, a difficult undertaking. At the start of treatment, the therapist is usually confronted with the fact that the family, dysfunctional as it may be, has reached a level of stability (homeostasis) that

tends to resist modification. Attempts to alter faulty indigenous communication patterns, or efforts to move family boundaries outwardly toward remedial community resources are apt to be resisted. Family therapy is designed to deal with these rigidities (Gurman & Kniskern, 1981).

Contemporary techniques in family therapy are not uniform even though many of them are implemented under the rubric of presumably standard theories. They are essentially organized within the framework of three schools: structural family therapy, strategic family therapy, and intergenerational family therapy (Steinglass, 1984). Structural family therapy (Minuchin, 1974b; Minuchin & Fishman, 1981) focuses on the behavior of the family during the treatment session, and searches for patterns of alliance between two or more members as well as the firmness of their boundaries. Strategic family therapy emphasizes the symptomatic consequences of bad problem-solving. Homework is often assigned in the form of tasks for the different members, sometimes employing ambigious instructions. Patterns of communication may also be explored (Watzlawick, Weakland et al, 1974; Watzlawick et al, 1967), family problem-solving tactics investigated (Haley, 1976), and certain remedial or paradoxical tasks prescribed (Haley, 1976; Selvini-Palozzoli et al, 1978; Madanes, 1981). Intergenerational family therapy searches for patterns of "fusion" and "differentiation" that are passed along from one generation to another (Bowen, 1976). The theories and techniques of these three schools may seem worlds apart, but the effect on families of all of them can be significant when practiced by skilled and empathic family therapists.

Such practice can become quite involved, necessitating an understanding of individual and group therapy, systems theory, sociology, and group dynamics. During treatment the therapist must skillfully weave back and forth among the various members as resistance, transference, and defensive manifestations break loose. Countertransference is a fluid phenomenon in the process; identification with one or more the patients in the group commonly occurs. Since the actual difficulties are produced by the behavior of the individuals in the system, the resolution of such difficulties will necessitate changes in the behavior of the persons involved in the disorganizing

interactions. This is sometimes referred to as the "interactional" approach in family therapy. Problems are not regarded as the tip of the iceberg, so to speak, emerging from buried inner manifestations, but as the iceberg itself. A good number of the therapeutic interventions are directed at the activities that are being used as "solutions" to control or eliminate undesired behavior. These activities usually sustain and reinforce the difficulty. Since such solutions often serve merely to aggravate the problem, therapy is concentrated on eliminating these futile solutions. New problem-solving methods are encouraged, focused on behavioral alterations rather than intellectual insights. A behavioral change in any member of a system can produce a change in the entire system. Accordingly, treatment may concentrate on the member who is most responsible for bringing about difficulties in the system, although the family as a whole is taken into consideration.

Many models for family therapy exist—and are still developing as psychotherapists of different professions, with varying theoretical viewpoints, evolve modes of working in relation to the needs of families and the structure and function of the agencies through which treatment is being implemented (Sager & Kaplan, 1972). Understandably, therapists have special ways of looking at family pathology and they organize their ideas, as has been pointed out, around favorite systems, such as behavioral family therapy, structural family therapy, psychodynamically oriented family therapy, and systems family therapy. Yet a therapist's clinical operations with families are influenced more by individual style of working with patients and the therapist's own unresolved family problems than by the theories espoused. This results in many different forms of practice that vary in such areas as selection of the unit of intervention (i.e., identified patient and parents, or total immediate family including siblings, extended family, distant relatives, etc.); time allotted to sessions (1 hour to several days [marathon family therapy]); duration of therapy (one session to many months); activity during sessions (listening, supporting, challenging, confronting, guiding, advising, censoring, praising, reassuring, etc.); relative emphasis on insight and behavioral alteration; and employment of adjunctive procedures (videotaping, use of one-way mirrors, role-playing, etc.).

How to manage resistance in family therapy is another area of discrepancy. Families

struggle to maintain the homeostasis of a neurotic family system by preserving pathologic ways of relating. A great many of the current writings about family therapy specify contrasting ways of dealing with such resistance, and one is impressed with the lack of agreement for proper management of this disturbing phenomenon.

Sometimes family therapy is undertaken in clinics and family organizations, particularly those dealing with children for the purpose of reducing waiting lists. Under these circumstances therapy may be started even at the first interview as part of the intake and diagnostic process. Sometimes a group of workers visit the family in the home after an intake interview with the family and a diagnostic interview with the child (Hammer & Shapiro, 1965). Visiting the home has certain advantages since the members will demonstrate less defensiveness at home than at the clinic or office, displaying habitual reactions more easily.

Multiple therapists are often employed, circumventing to an extent the countertransference that develops in a one-to-one relationship. Individual therapy may be done concurrently by the different members of the team with selected members of the family (Hammer, 1967). Resistance is also more easily managed when more than one team member approaches a patient from a different perspective. The family facade is then more easily dissolved, and family members are more readily motivated to relate with their inner and latent feelings.

Sundry problems are experienced by therapists when dealing with another therapist who is treating a member within the family group. Disagreements will occur in observation, in emphasis of what is important, in diagnosis, and in the type of intervention best suited for specific situations. Competitiveness between therapists may interfere with their capacity to be objective. They may be offended by disagreements with or criticisms of their operations. There is finally the matter of expense and the finding of qualified professionals who can make their time coincide with that of the therapist. Opportunities are obviously better in a clinic than in a private setting, since fixed staff is available. There is an advantage in doing multiple therapy in a training center since a trainee may gain a

great deal working with a more experienced therapist. Constructive collaboration between therapists tends to reinforce the impact of interpretations. It helps the resolution of resistance.

Working with a family group may serve purely as a diagnostic procedure, to spot psychopathology, and to aid in the assignment of therapists to individual family members who most need help. The focus may be on the relationships between parents, parents and children, and parents and grandparents. If a tangible problem exists, this may constitute the area around which explorations are organized. Short-term goals usually deal with a family crisis (Bar-ten, 1971). Long-term goals are fluid and have to be adapted to the needs of the family. The objective, for example, may be to hold the members together in a fragmented family. It may be to help adolescents separate and find their own individuality. Sometimes asking each member of the family "What would you like to see changed in the family?" helps provide a focus. Each member may have a different idea about what should be changed. This will give the therapist valuable clues. At the end of the first session, a statement may be made to the family by the therapist as to what the problem seems to be.

It is vital in family therapy to understand and to respect the cultural background. The therapist must not deviate much from the accepted cultural system since this will offend some of the members and create resistance. Sometimes it is helpful to introduce an individual into the family group as a cotherapist who is part of the same subcultural setting, and who is capable of better translating the family code. This individual must, of course, have had some training at least as a paraprofessional.

Desirable goals of family therapy include resolution of conflicts, improved understanding and communication among family members, enhanced family solidarity, and greater tolerance for and appreciation of individuality (Zuk, 1974). All of these goals may not be achievable. In crisis resolution, for example, the total of one to six sessions, *which is the maximum number* acceptable to many lower-class families, may achieve little other than an overcoming of the immediate emergency. Somewhat more extensive are the objectives of short-term family therapy, which, though of longer duration, still may

produce little other than symptom reduction, largely because of the reluctance of the family members to involve themselves in extensive verbal interchange. Middle-class families are more willing to regard therapy as a learning experience and, accordingly, do not set strict time limits on treatment, usually accepting up to 25 to 30 sessions. They are often rewarded with more enduring changes. Sophisticated middle-class and upper middle-class families are generally better disposed to the more extensive goals of long-term therapy, e.g., alteration of values.

It is surprising how much can be done in from 3 to 15 family sessions, but follow-up individual or group therapy may be required. Parents soon begin to realize that problems that have exploded into crises have a long history, the roots of which extend into their own early upbringing. Guilt feelings, defensiveness, indignation, and attacking maneuvers may give way to more rational forms of reaction when even a partial picture of the dynamics unfolds itself.

Individual therapy may be done conjunctively with family therapy or at phases when work on a more intensive level is required. For instance, a husband whose authority is being challenged may require help in mastering his anxiety and in giving him some understanding of what is happening. Or a mother and father may need education regarding the processes that go on during adolescence, which can help them understand and deal with their own rebellious child. The family therapist, accordingly, will need the combined skills of the individual therapist, group therapist, sociologist, educator, and social worker.

A number of ethical issues are involved in doing family therapy (Morrison et al. 1982; Hines & Hare-Mustin, 1978; Sider & Clements, 1982). Among these is the question of whose interest is primary, the individual being seen by the therapist or the family? Maintaining the integrity of the family and its other members may mean sacrificing goals that the individual wants desperately to achieve. For example, where a married man seeks a divorce because of an involvement with another woman, should the therapist encourage this knowing that a family with small children and a handicapped wife, who by herself

cannot manage the household, will have to be devastated by the family break-up? Another issue is the matter of confidentiality. Are therapists privileged to reveal information that seems vital for other family members to know? Further questions involve such points as to whether traditional ideas of an ideal family model should be held sacrosanct, whether the same therapist who does family therapy should also see individual members when they need it, how and when to arrange for conferences between outside therapists doing individual therapy with a group member and the family therapist, and whether members should be encouraged to reveal all, some, or no secrets they have concealed.

Doing family therapy is not without its risks, since the neurotic disturbance of one or more members may be the penalty the family is paying for holding itself together. Complementary symbiotic patterns may, when examined and resolved, tend to leave the members without defenses and worse off than before. A child's rebellion may be the only way that the child can preserve his or her integrity against a neurotic or psychotic parent. To interfere with this show of automony may prevent the child from achieving any kind of self-actualization, resulting in crippling inhibitions. Disorganization of the family structure may be a consequence of insight into the neurotic basis for the existing relationships. Divorce, for example, may enable a woman with colitis to live her life without abdominal pain. But she may find herself, as a result, in empty waters, isolated and burdened with children she may not be able to rear by herself. Her need for her husband may then become painfully apparent. Mindful of these contingencies, it is important to work against the too rapid precipitation of drastic changes in the family structure. It is here that life experience as well as professional experience will stand the therapist in good stead. Intensive individual psychotherapy may have to be employed at points where drastic changes in the life situation are imminent.

Some family therapists insist that the initial consultation include all family members. This is possible where family therapy is specifically requested. Usually one member of the family applies or is sent for help; this will necessitate one or more preliminary interviews prior to involving the entire family. Dealing with the resistence of a family to the securing of help, or of a patient to involving the family will call for skillful explanation and

negotiation. All members of the immediate family and important members of the extended family as well as intimate friends are best included at least at the beginning. The therapist must be prepared to deal with explosive anger and accusations, channeling and defusing these to prevent the withdrawal of key members and breakup of treatment before it gets a start.

Great tact is needed in avoiding the show of favoritism since members usually attempt to woo the therapist to their side in the arguments that ensue. A delicate point is how to handle personal "secrets" revealed to the therapist during an individual session, the exposure of which may have an unforseen effect, good or bad, on the family. It is best that the therapist treat the secret as confidential information and that members themselves make the decision when, if ever, to reveal what they dread bringing to light. Another important point is the matter of establishing a verbal contract regarding the areas to be dealt with and the hoped for objectives in order to avoid later misunderstanding. Sessions are usually held once weekly for 1½ to 2 hours. It goes without saying that the goals of selective problem solving will require fewer sessions than those of extensive reconstructive changes in the family members. Video recording with playback is a strikingly useful tool, and among the techniques is "crossconfrontation," during which a family unit is exposed to tape recorded excerpts demonstrating interactions.

Insofar as actual techniques are concerned (supportive, reeducative, and reconstructive), the existing styles are many even within the same practice models—structural, behavioral, psychodynamic, family systems, strategic, or experiential. An example of one stage of a structure, of diagnostic technique is described by Satir (1964a & b). The total interview consists of seven tasks.

The first task ("Main Problem") involves interviewing each family member separately, starting with the father, then the mother and the children in order of their age. Each is asked to discuss briefly: "What do you think is the main problem in your family?" They are each requested not to discuss their answers with other family members until later. Then the same question is asked of the group as a whole, gathered together in the

interviewer's office. They are requested to arrive at some kind of consensus. This will expose the interactions and defenses of the members.

The second task ("Plan Something") is composed of a number of parts: (1) The family as a whole is requested to "plan something to do as a family." This enables the therapist to see how the family approaches joint decisions. (2) Next each parent is requested to plan something with all of the children and then the children to plan something that they can all do together. (3) The father and mother are asked to plan something that they can do as a couple. This reveals data of the operation of family subunits.

The third task ("The Meeting") includes the husband and wife only. The question asked them is, "How, out of all the people in the world, did you two get together?" The role each spouse plays in answering this is noted.

The fourth task ("The Proverb") consists of giving the husband and wife a copy of the proverb, "A rolling stone gathers no moss." Five minutes are devoted to getting the meaning from the couple and coming to a conclusion. They then are asked to call the children in and teach them the meaning of the proverb. This enables the therapist to perceive how the parents operate as peers and then as parents, how they teach things to their children, and how the children react.

The fifth task ("Main Fault and Main Asset") requires that the family sit around a table; then each person is given a blank card on which to write the main fault of the person to the left. The therapist, after stating that this will be done, writes two cards and adds them to the others. These contain the words "too good" and "too weak." The therapist then shuffles the cards and reads out the fault written on the top card. Each person is asked in turn to identify which family member has this fault. This exposes the negative value system of the family and prepares the family for the phase of treatment when the task is assigned to avoid open and direct criticism. Following this, each person is requested to identify his or her own main fault. This is succeeded by the assignment for each person to write on a card what he or she admires most about the person to the left. The therapist also fills out two cards: (1) "always speak clearly" and (2) "always lets you know where

you stand." Experience shows that this part of the task, which is most difficult, exposes the positive value system of the family.

The sixth task ("Who is in charge") consists of asking the family, "Who do you think is in charge of the family?" This yields clues regarding how members perceive the leadership structure and their feelings about it.

The seventh task ("Recognition of Resemblance and Difference") requests the husband and wife to identify which of the children is like him or her and which like the other spouse. Then each child is asked which parent he or she believes to resemble most and the similar and the similar and different characteristics possessed in relation to both parents. The parents are also asked how each is like and unlike the other spouse. This points to the family identification processes.

These structured interviews last from 1 to 1½ hours and are employed as research diagnostic, and therapeutic tools. The network of communication patterns forms the basis for therapeutic intervention.

Further active procedures include (1) preparation of a list by each member of what they would like to see changed (this may act as a focus for negotiating a joint decision), (2) asking the family to discuss a recent argument, (3) asking each member to discuss what he likes and dislikes about other members, (4) changing the seating order periodically, (5) using puppets with members talking through them.

Zuk (1971a), Minuchin (1965, 1974b), and Minuchin and Montalvo (1967), have outlined a number of other strategies along structural lines that therapists have found useful. A search is instituted for alliances and splits in the family, the existing power hierarchies, family modes of conflict management with restoring authority lines, rearranging alliances, and reconstituting normal boundaries. Seating rearrangements and homework tasks are instituted to promote these objectives. Passivity on the part of the therapist will bring few rewards. The idea of allowing a family to engage in a free-for-all squabble often accomplishes nothing more than to encourage greater antagonism

between the members. Providing some structure in the session, on the other hand, can be most helpful. This is done by asking specific questions, directing the different members to explore certain areas of feeling, and suggesting what behavior changes should be undertaken. Goals for the family are set by the therapist, at the same time that the family members are encouraged to utilize their own resources in moving toward behavior change. For diagnostic purposes, if the therapist deems that it is appropriate to do so (and that the family will not be lost after the first session), it may be advisable to observe an undirected family in action in order to get a biopsy of the existing pathology and the distorted lines of communication. Once this is done, the therapist will be in a better position to structure, guide, direct, educate, and set goals.

In psychodynamic models insight and self-understanding are the goals of a family therapy with emphasis on the unconscious promotion of patterns of behavior, and the relationship of such patterns to past conditionings. The systems model, such as that of Bowen (1960), stresses the need for differentiation from one's family in order to achieve true identity. The understanding and resolution of relationship triangles that exist within the family is essential. A search for transgenerational transmission of problems is executed in quest of helping the patient achieve self-differentiation. In the strategic model resistance is not bypassed but joined, nondangerous symptoms may paradoxically be encouraged, and unusual home assignments given to the members. In assigning tasks in family therapy, the therapist attempts to alter the existing family system by asking members to engage in unusual activities that are foreign to their customary roles. This entails some risk because the assignments may spark resentment and sabotage. To avoid this, some therapists join the neurotic system by paradoxically emphasizing that for the time being the members must keep things as they are. Then, when the confidence of the family is gained, slow alterations in role are suggested followed by more extensive changes.

In the behavioral model, some therapists find a self-rating check list such as the one by Cautela and Upper (1975) useful as an assessment tool. An effort is made to identify the stimuli that activate symptoms and problem behaviors. Can these be controlled? How

does the patient participate in bringing them on? Further information is occasionally obtained by the patient filling out certain standardization forms (Walsh, 1967, 1968). Observation of the patient in actual situations where problem behaviors occur (with family at home, in phobia mobilizing situations, etc.) may be helpful if this can be arranged. The use of visual imagery to identify cognitive elements associated with problem behaviors has been described by Meichenbaum (1971). The next step is quantification of the problem. The frequency and duration of problem behaviors are charted, recording how often and under what circumstances difficulties occur (Homme, 1965). A man with headaches, for example, is given homework to report the days and times when his headaches appear, the immediate circumstances preceding the onset of headaches, the consequences of his headaches to himself and others around him, and what if anything he does to relieve them. The third step is examining the reinforcing contingencies. Are there any gains the patient derives from symptoms or problem behaviors, like sympathy from those around him, freedom from responsibility, etc. If so, can these reinforcers be supplied by altered activities less destructive to the patient? Is the patient aware of such gains? A woman with periodic fainting spells was brought to the realization that these episodes focused attention on her by her family. Assured regarding their functional nature by the family physician who had been summoned to several such emergencies, the therapist suggested the family show studied neglect after a spell. On the other hand, the members were to lavish attention and praise on the patient when she engaged in constructive family activities. The fourth step is outlining the treatment plan. Once sufficient information is available, a hypothesis is presented to the patient, the treatment plan is formulated, agreement is reached on the focus and goals, and a contract is executed.

In actual family therapy practice several of these models may be combined depending on the kinds of problems that must be treated. The management of socially aggressive children especially constitutes a challenge to parents in our contemporary society. Belligerent and hostile children can stir up trouble for the entire family. A number of approaches have developed dealing with this specific problem; one of the best known being the methods developed by G. R. Patterson and his associates (Patterson & Gullion,

1968; Patterson, 1971; Patterson et al, 1975). A social learning approach teaches families to discover the ways in which they reinforce the disturbed child's behavior and how unwittingly they are taught to respond destructively to the child's provocations, thus adding fuel to the fire. Some techniques include immediate *isolation* of the child for 3 to 5 minutes (no more) when misbehaving, writing a contract with the child defining desirable and undesirable behaviors and prescribing good behavior that may be swapped for privileges.

Hostility that emerges in family therapy often derails the therapeutic process. How to deal with it is an important technical question. Usually the hostility is directed at a selected member who may be the identified patient or a parent who may be blamed for the events leading to the crisis. Unless hostile interchanges are interrupted, the status quo will tend to remain. One method is to divert the hostility by asking questions related to nonpersonal areas: the housing situation, arrangement of rooms, daily routines, employment, certain historical events, etc. Some therapists, who feel they have a good relationship with the family, sometimes try to focus the hostility on themselves to take it away from the scapegoated member. This may be done by asking: "I wonder if there is something I have done or not done that upsets you. I am suggesting that you are really angry at me." Opening up areas of transference can be highly productive at times, but the therapist must be able to control his or her own countertransference. The best way of dealing with hostility, of course, is to interpret it in terms of the personality needs, and defenses of the attacker. This is possible only after a therapeutic alliance has been established, the family pathology comprehended, and the dynamics of the individual family members understood.

The most difficult problem that the therapist will encounter in family therapy is the need and the determined effort (despite protests avowing a desire for change) to maintain the status quo. Yet there are healthy elements that exist in each family on which the therapist can draw. It is important to emphasize these in therapy rather than the prevailing psychopathology.

Reconstructive family therapy may require sessions for several months or several years, depending on the family pathology and goals. It is often articulated with individual or group reconstructive psychotherapy for family members who need special help. The focus here is on intrapsychic experience. The methodology will vary with the relationship designs and the communication systems. The focus is on transferential reverberations and resistances. During the group session it may become apparent that the "identified patient" is not the one who needs most intensive help. Since the patient may be responding to neurotic provocations from another family member, the latter may be the one who should be seen individually. The following case-history brings this out:

> The primary patient is a 22-year-old man whose chief symptom is undiluted anxiety that interferes with his functioning. His relationships are highly competitive with males, the patient assuming a submissive self-castigating role. With females the patient detaches, fantasies of sexual engagement inspiring anxiety. At home the family is involved in constant quarreling, the patient engaging principally with his father, complaining that his father is excessively passive, manipulated by his mother, who is extraordinarily demanding of and ambitious for him. The two younger sisters display rebellious and withdrawal tendencies that have not yet become too pathological. In individual sessions the father presents himself as a misunderstood martyr. During the first few family sessions, however, it becomes obvious that he dominates and incessantly criticizes the family, especially the mother. The patient and sisters constantly take pot shots at him for acting too strong and dictatorial. The father responds with the expression that any weakness is inadmissible; it is important to deny illness or fear. This, it soon follows, is a pattern that prevailed in the father's own family. The father's father forced himself to work almost constantly as a duty. He died from a cardiac attack at an early age after refusing to see doctors for what seems to have been anginal pains. The father expresses admiration for his own father's "guts." During this recital the patient slumps in his chair interrupting with deprecatory comments. On questioning, he admits feeling defeated and under attack. Recognizing the father's role in stirring up the family, the father was referred for interviews with a therapist. This resulted in a rapid abatement of the patient's symptoms and a more congenial atmosphere at home.

A multiple family group of several families from the same background and socioeconomic level permits mutual exploration of common problems, the ability to observe difficulties in a more objective light, and the availability of a peer group to whom a family can relate who can help educate and be educated (Laqueur, 1968, 1972). The family code is more likely to become translated by a peer family than by a therapist who may come from a different background.

In reviewing 58 outcome studies of family therapy as compared to alternative treatments (i.e., individual therapy, group therapy, hospitalization, and drug therapy) Kniskern and Gurman (1980) found that 41 (i.e., 70 percent) of the family therapy outcomes were found to be superior, 15 (i.e., 25 percent) were found to be equal, and only two (i.e., 4 percent) were found to be inferior. Many of the primary patients in the studies complained of clinical problems (such as depressions) for which individual psychopathology traditionally is believed implicated. However, the authors, probably with good reason, state that interactional difficulties, such as marital problems, are the most likely conditions to respond best to family and conjoint marital therapy. Compared to such approaches, individual therapy, concurrent marital therapy (where one therapist sees each partner separately), and collaborative marital therapy (where each spouse is seen by different therapists) produce less impressive results. What is interesting, nevertheless, is that individual psychopathological difficulties, other than interactional problems, do respond well to good family therapy methods. Family therapy is highly desirable because the problems do not start or stop with the patient. The least that can be accomplished is the achievement of better lines of family communication and a softening of scapegoating. Family therapy may be one of the most effective ways of reducing rehospitalization, in addition to safeguarding maintenance medication. Many problem families exist, the members sometimes being entangled in complex interpersonal difficulties that seem impossible to unravel. The untrained therapist is apt to encounter insuperable difficulties with these families. On the other hand, an effective family therapist may accomplish good results impossible to achieve by another method.

MARITAL (COUPLE) THERAPY

Marital therapy is important for a variety of reasons. First, it presents an in vivo scan of the relationship operations of the patient who seeks treatment vis-à-vis the marital partner. From a diagnostic viewpoint this is advantageous because it reduces speculation about the patient's interpersonal psychopathology. Second, it enables enlisting the cooperation of the spouse toward helping the patient execute a therapeutic program for management of severe symptoms by serving in the role of cotherapist. Third, it permits

observation of and dealing with emerging anxieties and defenses of the spouse that ordinarily might sabotage the progress being made by the patient. Fourth, it permits a more direct entering into and correction of the communication system of the patient as it displays itself in emotional interchanges. Marriage is a vehicle through which people constantly try to satisfy an assortment of needs and influences. It is often regarded by neurotic people as a way of overcoming defects in their own development and handicaps in their current life situation. The marital partner is therefore cajoled, seduced, or terrorized to perform and is held responsible for any deficiency in projected assignments. This imposes an enormous burden on the healthier of the two spouses since the demands made are usually impossible to fulfill.

On top of it all, the habitual hostilities, anxieties, defenses and coping devices that have plagued the individual since childhood become transferred over to the most conveniently available recipient—the spouse. The expression of such improprieties is complicated by reactive guilt feelings, remorse, and attempts at reparation, which in turn invite attack from the injured spouse, perpetuating the continuing chain of indignation, anger, and counterattack. Couples often get locked into this sadomasochistic circuit. It would seem that the battling partners need each other to act out mutual neurotic needs, which insidiously may keep the marriage together while serving as a platform for combat. A final neurotic gesture is the blaming of each other for personal shortcomings, mediocrities, failings, and even symptoms. Disillusionment is inevitable unless the spouses are willing to compromise. But where the needs of a marital partner are too insistent and the initial idealization and expectancies are too high, the explosive mixture gradually accumulates until detonated by some (perhaps minor) incident that will tend to blow the marriage apart. One severely neurotic member preying on a more healthy spouse is bad enough, but where both members are working on each other, the atomic stockpile builds up to frightening proportions.

Marriage calls for intricate adjustments. It involves not only dealing with one's personal difficulties but also the normal problems and the irrationalities of one's partner. Because marital adjustment is one of the most difficult and stressful human challenges, it

is little wonder that so many people get disturbed under its impact. Problems in marriage and difficulties with a spouse account for almost 50 percent of the reasons why people seek professional help (Martin & Lief, 1973; Sager et al, 1968).

The task of marital therapy is twofold. First, it endeavors to help the patient overcome disturbing symptomatic complaints. Second, it strives to keep a shaky marriage together where there is even a small chance of its success, strengthening the couple's psychological defenses in the process, or, if the marriage cannot be saved, helping the partners separate with a minimum of conflict and bad feeling, particularly where children are involved.

Marital relationships are commonly sabotaged by the emotional defects of one or both partners. Where a marriage has deteriorated and the couple is motivated to work toward its betterment, there is a good chance that with proper treatment the relationship will improve. This does not mean that all marriages can be saved. In some cases the "chemical" combination of the union is irreconcilably explosive. Husband and wife are too much at loggerheads in their ideas, values, and goals to achieve even a reasonable meeting of the minds; or there is a barrenness of love and unabating cruelty toward each other; or sexual incompatibilities exist of too great severity; or there is uncontrollable and continued violence toward the children. Many couples are already virtually separated but still living together interlocked in a marital death grip from which they cannot loosen themselves before coming to therapy. Here the marriage may not be worthy of saving. The goal, as has been mentioned, may be to help the couple master their guilt and achieve the strength to separate. Generally, however, where couples are not too contentious and are willing to face their feelings and examine their behavior, marital therapy can help a marriage survive.

Marital therapy techniques draw from multiple fields, including psychoanalysis, behavior therapy, family therapy, group therapy, marriage counseling, child therapy, and family casework. Although the objects are the mastery of neurotic suffering and alteration of the relationship between the couple, a hoped-for, and usually serendipitous objective is

intrapsychic change, which surprisingly may come about in those with a readiness for such change and relief from the distracting cross-fire between the two spouses. Conceptual schemes for the actual conduct of marital therapy are not unified, but the most successful approaches stress the importance of communication (Watzlawick et al, 1967; Minuchin, 1974) toward effecting changes in the transactional system. A system behavioral approach is particularly helpful, concentrating "on observable behavior and rules of current communication (Bolte, 1970; Hurvitz, 1970; Kotler, 1967; Mangus, 1957) without immediate recourse to a historical 'Why'" (Berman & Lief, 1975).

Greene (1972) has pointed out that the great variations in marital patterns require flexibility in therapeutic techniques. He proposes a "six-C" classification of therapeutic modalities:

I. Supportive Therapy

    A. Crisis counseling

II. Intensive Therapy

    A. Classic psychoanalytic psychotherapy

    B. Collaborative therapy

    C. Concurrent therapy

    D. Conjoint marital therapy

    E. Combined therapies

      1. Simple therapy

      2. Conjoint family therapy

      3. Combined-collaborative therapy

      4. Marital group psychotherapy

"Crisis counseling" stresses sociocultural forces in the "here-and-now" situation. The

"classic approach" is the usual dyadic one-to-one relationship with both partners seeing separate therapists who do not communicate. The focus here is on the individual's personal difficulties with the marriage as the backdrop. It is used where one partner has severe acting-out problems of which the other partner is unaware (e.g., continuous infidelity or homosexuality), where there is preference for this approach, where one partner refuses to share the therapist, and where spouses have widely divergent goals in terms of the marriage problem. The "collaborative approach" is similarly dyadic, but it sanctions communication between the two therapists by regularly scheduled meetings (Martin & Bird, 1963). The same therapist treats both partners individually in the "concurrent approach," which is aimed at bringing about insight into behavior patterns as they affect each member (Solomon & Greene, 1963). This approach results in the lowest divorce rates. Where strong sibling rivalry attitudes exist, or where there are severe character disorders, psychoses, or paranoid reactions, the concurrent approach cannot be used.

These dyadic methods may be educationally oriented, focused on the marital relationship and on strategies of straightening it out by utilizing a variety of counseling and behavioral techniques. Should it become apparent that the patient has a severe personality or emotional problem being projected into the marital situation, individual psychotherapy may be indicated. In a considerable number of cases the marital equilibrium will be restored, and the spouse will change with the stabilization and better adaptation of the patient. However, where the spouse is incapable of change and the patient is unable to adapt to this impasse, the marriage will continue as a traumatic source for both.

The "conjoint marital approach," which is the most common form (Satir, 1965; Fitzgerald, 1969), is used both for counseling and intensive therapy. Here the partners meet jointly with the therapist at the same session. This approach fosters communication between the partners and brings out more clearly the marital dynamics. With the "combined therapies" (1) the "simple" form combines individual, concurrent, and conjoint sessions in various arrangements; (2) "conjoint family therapy" includes one or more of

the children; (3) the "combined-collaborative" form permits regular meetings of the partners together with the two therapists at the same session; and (4) "marital group therapy" consists of group therapy with four couples and one or two therapists (Blinder & Kirschenbaum, 1967; Framo, 1973).

Thus, there are many ways of working with couples but one of the most popular short-term methods is based on a social learning model and involves no more than 12 to 16 one hour to 1£ hour sessions. (Hahlweg & Jacobson, 1984; Jacobson & Margolin, 1979; Lieberman et al. 1980; Stuart, 1980). Such behavioral marital therapy focuses on securing better communication, relationship, conflict reducing, and problem solving skills through an active, directive approach aided by consistent assigned homework exercises. Usually the therapist sets the agenda with input from the couple regarding progress or difficulties with the homework assignments.

We would make an assumption that if the couple appears for therapy or counseling they are interested in staying together. We would assume also that at one time they had a good relationship. Accordingly, it might be a strategic start in therapy to ask the couple how they originally happened to meet and how they got along at the beginning. From this the history of their difficulties would naturally follow. In recalling the circumstances of their early meeting and the congeniality that existed at one time, it may be possible to get the couple off the track of their bitterness and disillusionment with each other. Many couples forget that they have had a pleasing or happy background at one time, a foundation on which they can repair their present demoralization and wreck of a relationship. Talking about a happier past may give the two partners some hope that they can overcome their bitterness and develop better modes of communication and problem solving.

The actual techniques that are employed will vary with goals in treatment and whether we envisage therapy as solely a means of restoring harmony to the distressed couple or whether structural personality changes in one or both partners are possible. Where deep personality problems exist in one or both of the members, marital therapy,

which is a short-term approach, will probably need reinforcement with individual dynamic therapy, since negotiation of differences may prove to be of no avail. Some therapists start with the short-term goal and only later move toward a more intensive process when it becomes obvious that severe personality problems interfere with progress.

In certain cases one member comes for treatment with the presenting complaint of a symptom, such as migraine, depression, agoraphobia or other neurotic disorders even though the true source of stress that provokes the symptom lies in the marital relationship. Indeed, a denial mechanism may exist of such severity that the therapist will have to approach the marital problem obliquely. In most cases however marital stress becomes an important complaint, but the patient may believe that nothing can be done about it since, in the opinion of the patient, the partner refuses to cooperate.

It is rare that marital difficulties are totally one-sided. It is rare, too, that the mate will not come in to see the therapist if the latter handles the situation correctly. The presenting patient may be asked if he or she can convince the mate to come in to see the therapist. The following is from a recording of an interview:

> *Pt.* She's impossible. She won't listen. She says I'm nuts and it's all my doing—the mess we're in. I can't talk to her.

> *Th.* Do you think she would come into see me if you asked her?

> *Pt.* I already asked her to come here with me, and she refused. Frankly, I think it would be a waste of time.

> *Th.* You must have had some hope that coming here would help the situation.

> *Pt.* I suppose I'm looking for magic. I know she won't change.

> *Th.* Would you mind if I telephoned her to come to see me about your problem? I would tell her it will be of help to me in helping you if she could give me an idea of what you're like. *(smiles)* Sometimes this defuses things. She won't feel I'm getting her here to accuse her.

> *Pt.* By all means, maybe she'll come in if you convince her it's all my fault.

> *Th.* I'm sure it isn't, but I'll do my best to ease her into talking things out.

The entire object of getting the mate into the therapist's office is to start a relationship with her or him. By listening with an empathic ear, emphasizing how difficult things must be, the therapist usually can gain confidence. In the case cited the following telephone conversation took place:

Th. Is this Mrs. B?

Mrs. B. Yes.

Th. This is Dr. Wolberg. I hope you will forgive me for calling you. I know it's an imposition. But your husband came in to see me, as you know.

Mrs. B. Yes, I do.

Th. I know it's been extremely difficult for you. But it would help me to help your husband if you could come in and tell me a little bit about him, and about what's happening.

Mrs. B. If I came in, I wouldn't stop talking. *(laughs)*

Th. So much the better, you could give me an idea of him and what has been going on. It must have been very rough.

Mrs. B. I'll be glad to come in.

The interview with Mrs. B went along smoothly, and little difficulty was experienced in starting therapy with the couple.

Unless one of the marital partners is paranoidal or completely unwilling to alter the marriage relationship, it should not be too difficult to convince both members to work with the therapist. The design of therapy will vary with the presenting problems and the preferred style of the therapist. Some therapists begin joint sessions immediately after the initial interview. Others prefer seeing the mate alone to assess the problem before starting joint sessions. It is helpful to ask each partner about the relationship their parents have had with one another. Sometimes just talking about this, patients discover that they are acting out roles patterned after parental models.

Where a marital problem is acknowledged by both partners and they seem willing to do something about it, the couple may be seen together right from the start of therapy. But where denial mechanisms are strong, it may be advantageous for the same therapist to

begin individual therapy separately with both spouses, different appointments being given the two (*concurrent marital therapy).* They may not yet be ready for couple therapy, which can be instituted later. Where hostility between the partners is high, and appropriate communication is difficult, the therapist may be able to start a relationship individually with each partner, being wisely careful not to fall into the trap of being used by either against the other. It takes a good deal of ingenuity to do this. The therapist may anticipate competitiveness for attention, desires to be the preferred one, misinterpretations of what the therapist says to support an importunate demand on the part of one spouse, and resentment at the partner and therapist for presumed collaboration. Where the spouse of the patient seeking help refuses to see the therapist, one may try a referral to another professional or suggest that there be a personal selection of a therapist. In such a case the different therapists sometimes may have conferences to exchange information and discuss developments and plans (*collaborative marital therapy).* Where the spouse absolutely refuses any kind of therapy, treatment may be started with the presenting patient alone (*individual marital therapy),* trying to influence the reluctant partner indirectly.

Assuming that one is finally able to bring the partners together in therapy, the initial session may be initiated by asking each of the partners to discuss why they are coming for help as each sees it. The couple may then be queried as to how they originally met and how they happened to decide to get married or to live together. Whenever the two get into an argument or fire charges at each other, the therapist may interrupt the negative exchanges and get them back to talking about positive things that were or are happening. Some therapists find it helpful to spend at least one session alone with each of the spouses, reviewing the past histories, experiences, and problems of each particularly their relationship with each other, sexual and otherwise. At individual sessions, information may come up that will not readily be exposed in joint sessions. The matter of confidentiality should be stressed. Some therapists rely heavily on questionnaires to fill out such as the "Areas of Change Questionnaire," "Marital Status Inventory," the "Dyadic Adjustment Scale," the "Marital Precounseling Inventory," the "Marital Activities Inventory," and the "Sexual Interaction Inventory" (Wood & Jacobson, 1985), which will

help in developing a treatment plan.

We usually find that central to many of the problems of marital couples are difficulties in communication. Behavioral approaches to communication training contain a number of procedures geared toward acquisition of communication skills with provision for feedback instructions and behavioral rehearsal. Dynamically oriented therapists may use these as part of their treatment with marital problems.

During joint sessions the therapist will have observed patterns of communication issuing out of the interaction of the couple, and will be able to offer the couple information about their verbal and nonverbal exchanges (criticisms of one by the other, attacks, praise, protectiveness, etc.) in descriptive terms without interpreting the deeper meaning or motivations for such exchanges (which, of course, can be made in a dynamic approach). Immediate feedback to both partners of provocative and disturbed communication patterns may help break the chain reaction of attack, counterattack or retreat that is characteristic of the couple's verbal interactions. With adequate preparation, video feedback may also be used with some advantage. In employing feedback the therapist should not lose any opportunity to comment on *positive* communication patterns in the hope of reinforcing these. Thus when a partner praises his or her mate the therapist may say, "I liked the way you complimented (or praised) him (her)."

Generally couples are not fully aware of their abrasive thrusts at each other or their corrosive answers to comments. Following an unjustified verbal blast, the therapist may ask a partner to reconsider what the spouse has said and then to give an alternative response. Sometimes the therapist may model a response, playing the roles of both the husband and the wife to avoid a sense of discrimination or favoritism. Cotherapists, if this is the format, may each play the role of one of the spouses and model communication.

Behavior rehearsal is an important part of the relearning process, in that couples may practice in order to increase their skills of communication. Here the therapist provides instructions and modeling if necessary, giving continuing feedback. A valuable technique is *role reversal,* each spouse taking the role of the other in talking about a

special situation. In this way, marital partners may teach each other problem-solving skills.

One of the most common difficulties is the insistent use of aversive control strategies by one or both partners ("If you do that again, I'm going to leave you"). Verbal threats and coercion increase until the only way left to deal with mutual intimidation is by detachment techniques, which cause estrangement from one another, further enhancing conflict. By arriving at some sort of agreement regarding areas of change through discussion, an avenue is opened for problem-solving which can be kept alive and expanded by proper reinforcements. Before changes in behavior can be proposed, however, there must be a clear definition of the problem (Jacobson & Margolin, 1979).

The sessions in a short-term format are generally highly structured and understandably call for a good deal of empathy, flexibility, and playing of many roles. "The therapist serves as a director, sympathizer, teacher, evaluator, instigator, and a juggler balancing these roles while providing perspective and insight as necessary." (Wood & Jacobson, 1985).

It is important to inform a couple that they should expect no immediate improvement in their relationship but after a few sessions devoted to studying the problems, they should *if they cooperate with the procedures that will be prescribed,* notice that matters between them are taking on a more optimistic turn. In this way, one can forestall the disappointment that follows when magical expectations of immediate change do not come to pass. Generally, some precipitating factor will have brought the marital conflict to a head and the couple will be anxious to talk about it. The discussion, arguments, angry displays, and frustrations that become manifest will be like a biopsy of the basic pathological issues. A therapist who steps into a marital melee will have more than was bargained for, particularly when each of the participants attempts to recruit the therapist as an ally against the other partner. It is here that the therapist may become emotionally involved, being tempted to fulfill the roles of arbiter, judge and high priest, rendering verdicts, making decisions, establishing criteria, and setting values. Personal

standards and prejudices will unfailingly impose themselves and the therapist's own unresolved problems will vigorously come to the fore.

A great deal has been written about countertransference in psychotherapy, but in no other area than marital therapy is it apt to be so pronounced, particularly in cases where the therapist's own marriage is a mess. No wiser words have been said than for the marital therapist to look at his or her own marital values before the marriages of others can effectively be dealt with. Even though a therapist has some personal problems, an awareness of these and of how judgment may be warped by certain offensive behaviors or attitudes on the part of the therapist's patients should permit greater objectivity. The therapist therefore should carefully avoid being brought into assuming the role of a referee or judge who decides who is right or who is wrong; or ally with one or the other antagonists. This may be difficult for some therapists to do since it is natural to try to assess blame. A guiding principle in marital therapy is to try to search out and to enhance the strengths of a relationship not the weaknesses. Consequently, the therapist may emphasize positive factors that exist and to remind the couple that their relationship has not always been a bad one. A good deal of time may also have to be spent in talking about existing environmental problems that have initiated or that are sustaining the difficulties between the two.

It is important from the outset not to express any condemnatory attitude toward either partner for behavior or characteristics that they are exhibiting either in the interview or outside. There will be ample opportunity later to interpret what is happening, and this is aimed toward insightful rather than punitive objectives. A woman may resent the role that she believes her husband expects of her as a dutiful wife, and she may respond by being defiant and neglectful. Her husband may counterattack by detaching himself from her and the family and by impotence. The chasm of misunderstanding grows deeper and deeper until each has accumulated an enormous bag of justifiable grievances. A therapist who takes sides will probably lose both patients. Once the dynamics become clear, the therapist may point out the inevitability of misunderstanding on the basis of the background, upbringing, value systems, and

pressures that are being exerted by the partners on each other without laying down strict rules about male and female roles. If the therapist has the confidence of the couple, they will turn to him or her for some constructive guidance, which may be offered without being dictatorial about what should be done. It may be pointed out that difficulties exist in all relationships and that some compromise is always necessary, the ground rules to be negotiated through constructive communication.

Willy-nilly, the therapist will find a role assigned, by both members as an arbiter, guide, and potential ally to justify mutual opinions, disgruntlements, and claims. It takes a good deal of fancy footwork to avoid being maneuvered into a judgmental role. Countertransference is to be expected, and one's ability to detect one's own prejudices and predilections borne out of one's background and experience will help keep the therapeutic situation afloat. There are instances where one mate is manifestly unfair in behavior toward the other, or in liberties assumed, and the therapist may find it difficult to remain neutral. It will take ingenuity to get one mate to alter his or her behavior or to help the other member accept the situation with whatever compromises can be negotiated.

For example, one of my male patients who had married late in life, insisted on staying out late "with the boys" two nights weekly. His wife objected on the basis that she felt neglected and lonesome. At interview it was apparent that she suspected infidelity, which she tried to substantiate on the basis of decreasing frequency of intercourse. I was able to convince her, from my interview with her husband, that staying out late constituted a means by which some husbands maintain their independence which is being threatened by feelings of increasing devotion to their wives. This is what happened in this particular case. The husband, a detached person, had avoided close involvements with women until he met his wife. Thwarting his need for independence would, I hazarded, result in increasing detachment from her as a defense and perhaps a development of impotency. The patient's depression, related to hostility at being challenged and "browbeaten," lifted as his wife recognized the dynamics and accepted her husband's need for greater freedom. Joint sessions during which each partner unburdened themselves and

traced their attitudes to past experiences resulted in a firming up of the relationship.

Taking an area in which a desire for change has been expressed, each member may be asked to discuss briefly how he or she believes the issue may be resolved with the object of negotiating an agreement on a suitable solution. Communication and problem-solving skills are studied here. Some therapists provide each of the couples with a checklist and a rating scale to score daily happy and non-pleasing exchanges (Patterson, 1976; Weiss & Cerreto, 1980). These instruments have a therapeutic value in pointing out areas of possible improvement as well as providing the therapist with a means of comparing the appraisals of both members.

All of the foregoing measures are useful in devising a treatment plan that is discussed with the couple and to which the couple can add input. Agreement to abide by the terms of the plan is best obtained to enhance the collaborative effort. To repeat, the therapeutic process focuses on increasing positive and eliminating coercive and aversive exchanges. It is hoped that this will spontaneously be developed and carried through by both members. Any difficulty that emerges offers an opportunity for trouble-shooting to analyze the problem and to provide alternative solutions ("brain storming"). Communication skills are taught by suggestion and modeling and are practiced both during sessions and as part of homework. The ability to accept criticism and to have the courage to avoid responding in kind to a negative remark or act is encouraged.

Contracts may be negotiated to try to help firm up behavioral changes. Contingency contracting which operates on the basis of quid pro quo conciliations plays an important part in marital therapy, particularly in its behaviorally oriented forms. Here couples by negotiation come to a written agreement of what each member has to do in the relationship to produce changes with which both members are in harmony.

In contingency contracts each partner promises to alter some aspect of behavior the other partner finds disagreeable. Contingency contracting is for those in whom verbal resolutions alone are not sufficient to put a restraint on their impulsiveness. The presence of a legal-like document helps to promote compliance with prescribed behaviors. When

carried out, positive actions produce reciprocal pleasing responses that act as reinforcers for mutually constructive behaviors. The contract should be specific, spelling out exactly the kind of activities to be executed; otherwise arguments may break out as to meanings of vague expressions. The behavioral changes of each should also be sufficiently equivalent so that both partners feel they are getting an equal share of benefits.

One must keep in mind that the very behaviors that a spouse grumbles about may subversively be reinforced by certain actions of the offended spouse because such behaviors satisfy unconscious needs or defenses in the latter. Thus, a woman complaining about infrequency of sexual relationships may during the sexual experience act in a disinterested, bored, or sarcastic manner. In this way, she punishes the very behavior she desires to increase. When we investigate why these ambivalent attitudes exist, we may find that, in spite of a surface interest, sexuality is laden with a great deal of fear, guilt, and shame. Or her anger at or disgust with her husband forbids carnal intimacy. Or perhaps there is a prohibitive incestuous barrier to sexual activity. Such dispositions, which have their origin in earlier conditionings, might cause us to anticipate that the wife would be unable to halt her punishing activities even though in the contingency contract she promised to do so. This may actually be the case in instances where underlying needs and defenses are intensely and urgently pressing. On the other hand, even where such tendencies act as negative reinforcers, experience teaches that people can exercise a considerable degree of willful control over inner impulses, and through self-discipline and continuing practice gradually master adverse predispositions. It is, of course, helpful to provide in the contract positive reinforcements of some kind for the control of repugnant reactions. In the case cited, the husband may reward his mate for refraining from her customary reactions with praise and some material or behavioral bounty that is significant to his wife. Where no improvement in the sexual situation occurs, however, it may be necessary to utilize a more psychoanalytically oriented approach aimed at expanding the couple's understanding of their motivations and behavior.

The matter of confidentiality is especially important. The patient is told that information given in private sessions will not be revealed to the other member of the

couple. The members may be encouraged to talk freely and not hold anything back, but that is up to them. The therapist will not bring up topics that are taboo unless asked to. This encourages the disclosure of secrets so one can work with what comes out.

It is to be expected that where couples have been living in neurotic symbiosis that an alteration in the accustomed response of one member to the other's provocations will arouse anxieties in one or both members. Resistance will generally take the form of a desire to halt joint sessions. Interpretations of the resistance and the reasons behind it are necessary to keep the couple in therapy.

During sessions one may observe physical movements between husbands and wives that serve as forms of nonverbal communication to convey emotional meanings. These are in the form of approach and separation movements and, at different stages of treatment, seating rearrangements among couples, which may be explored with the object of analyzing the underlying dynamics. In the process one may observe one's own countertransference responses, which one should attempt to understand and to resolve.

While the therapist may make suggestions from time to time, it is vital that patients be made aware of the fact that they must work out their own solutions utilizing their own free will.

There are several impasses that may occur in marital therapy. One of the most difficult is the spouse who has a fixed position about divorce. This usually means that he or she does not want therapy except to try to convince the mate to accept the position. Often the lawyer of one mate may be responsible for this impasse. Another problem is when one member of the couple is in individual therapy with another therapist who differs in philosophy and goals from the marital therapist. Then a conference with the other therapist may be in order. Once contact has been established, coordinated therapy may be essential to break up an impasse. Where the marital breakdown has proceeded to a point of no return, both therapists may encourage utilizing divorce mediation procedures to minimize the trauma on the partners and children.

Important adjuncts to marital therapy are role playing and sexual therapy methods (Masters & Johnson, 1970; Kaplan, 1974). Alger (1967a) illustrates the use of the paradigmatic approach in marital therapy, the goal of which is to imitate a pattern one of the partners displays by acting out a part. Alger (1967b) also employs videotape recordings and playback in couple's sessions. His technique consists of a video recording of the first 15 minutes of a joint marital session, which is immediately played back over a television monitor. The participants may ask to stop the recording at any point to comment on the effect of their behavior on others. Viewing themselves as they talk and interact stimulates a great deal of feeling and expedites communication. Video viewing is now being employed with increasing frequency (Alger & Hogan, 1969; Berger, MM, 1969).

The presence of two therapists (cotherapists) lessens the possibility of exclusive alliances and of a dyadic impasse (Alger, 1967a; Markowitz, 1967). Each of the therapists may function as an alternate ego for one of the patients aerating ideas and sentiments the patient does not dare express. In this way the patient may gain the strength to face impulses and attitudes on the periphery of awareness. Substantiating the value of cotherapy are four truisms: (1) Two heads are better than one. (A second therapist may be able to illuminate areas missed by the first. Each may be able to correct bias and detect countertransference in the other.) (2) One therapist may support a patient under attack by mate when he or she needs a helping hand. (3) One therapist may engage in confrontation and challenging maneuvers while the other therapist interprets reactions of the patient or supports the latter if necessary. (4) Two therapists lessen the danger of the therapist being utilized as a judge or as a guru who knows and gives all the answers.

A mixed male-female team has advantages in providing opportunities for identification. The disadvantages of cotherapy are competitiveness and friction between the therapists and alliances of one therapist with one patient against the other therapist and the other patient. These may be modified by conferences together or in some cases with a trusted colleague acting in a supervisory capacity. There are advantages and disadvantages in conjoint marriage therapy with a husband-and-wife team (Bellville et al, 1969). The inevitable differences arising between the therapist couple are more volatile

and unrepressed than in an unrelated couple and can threaten the therapeutic process. In their resolution, however, they offer the patient couple an opportunity to observe how a well-related couple negotiate differences, make compromises, and adapt themselves to each other's individual way of looking at things. It stands to reason that the therapist couple both must be reasonably adjusted, have an understanding about the therapeutic process, and preferably have been in personal therapy or coupled therapy themselves.

The behavioral approaches described may not be able to help marital difficulties that are too firmly anchored in intrapsychic disturbances. The prescription of tasks and exercises that are intended to influence couples to be less abrasive toward each other, to communicate more constructively, and to foster a balanced relationship will therefore not succeed in those couples whose behavior is intractably motivated by urgent unconscious needs and impelling inner conflicts. For example, if a wife transferentially relates to a husband as if he represents a hateful brother with whom she was in competition during early childhood, she may resent being nice to him and continuously fail in her therapeutic assignments. A husband who is struggling with a dependency need, idealizing his wife as a mother figure who must love, nurture and take care of him, may be unable to give up acting irresponsibly, resisting the independent role his wife insists he must assume as a condition for more fruitful living together.

We should not minimize the utility of the various persuasive, behavioral, and cognitive techniques practiced to expedite marital congeniality. They can be valuable, but they will miss their mark if one utilizes them while ignoring the enormously important developmentally inspired motivational forces that are constantly maneuvering marital partners to act against their best interests. These more insistently dictate the terms of conduct than any injunctions, maxims, precepts, recipes, prohibitions, and interpretations.

Whether or not the therapist deals with factors of transference or projective identification and utilizes dreams will depend on the training of the therapist, the goals desired, and the level of understanding of both patients. Dramatic results are sometimes obtained where marital partners associate to each other's dreams. This helps them

become less defensive with each other. By the same token, transference phenomena brought out into the open as they relate to the therapist and to each other, aired without restraint, will bring forth emotions that with proper interpretation can prove helpful. Sager (1967) points out that it is important for anyone doing marital therapy "to be aware and work through reactions to, and general philosophy regarding, maleness and femaleness, maturity, marriage roles, career, money, relationship to children, and a host of other cathected concepts." Flexibility and tolerance for values other than their own are important assets for marital therapists.

The hope is that change occurring in the office and at home will be generalized to other relationships. Any relapses provide opportunities to anticipate future problems. The couple is requested to search for any cues that can trigger difficulties and to practice dealing with them before trouble precipitates.

In many cases progress is enhanced by couples working together in couple groups. As communication improves and relationship skills consolidate, intervals between sessions are increased. Couple groups may continue for a while without the presence of the therapist. Problems and relapses are anticipated and ways of managing them are discussed.

Follow-up sessions with the marital partners after therapy are wise to prevent a falling back into the old destructive patterns, the intervals between follow-up visits gradually being increased in the event improved adjustment continues.

53
Homework Assignments

One of the most neglected aspects of psychotherapy is assigning homework through which patients can facilitate means of controlling or eliminating self-defeating patterns. It is often assumed that the lessons absorbed in the therapist's office will automatically carry over into everyday life. This cherished hope does not always come to pass. The average patient generally dissociates the learnings in the therapist's office from behavior at home, at school, at work, and in the community. After psychologically purging oneself during a session, outside the office the patient often slips back into familiar patterns. It can be helpful, therefore, in consolidating therapeutic gains to insist that therapy does not stop with the exit from the treatment room. The patient must put into practice what is learned during the sessions in order for any change to register itself permanently. And when treatment has ended, the patient will certainly need to reinforce new modes of coping by continuing homework; otherwise, in returning to the customary environment, relapse may be inevitable.

The assigned tasks are usually related to what is immediately going on in therapy, whether they involve exploring the nature of one's problems, charting the frequency of symptoms and recording the circumstances under which they appear, recognizing the constructive and destructive elements in the immediate environment, observing behavioral patterns and reinforcing those that are adaptive, picking out situations that enhance or lower self-esteem, studying one's relationships with people, examining dreams and fantasies, or seeing what resistances block the putting of understanding into productive action. Practice sessions devoted to assertive and other constructive forms of behavior are especially helpful. Some of the assigned exercises strive to inculcate new values and philosophies that contribute to a more productive adjustment. A relaxing and ego-building audio recording as well as assigned readings are additional useful accessories.

Instructions may be given the patient along the following lines:

1. *Look squarely al your immediate life situation.* What elements are to your liking? Are these elements good for you and constructive, and do they need reinforcement? Or should they be minimized or eliminated because they get you into problems? What elements are destructive? What can you do to make them less destructive? Should they be eliminated completely? How can you go about doing this? Once you have decided on a plan of action, proceed with it a step at a time, doing something about it each day.

2. *What patterns of behavior would you like to change, patterns that should be changed?* How far back do they go? Do you see any connection between these patterns and things that happened to you as a child? Realize that you may not have been responsible for what happened to you as a child, but you are responsible for perpetuating these patterns now, for letting these patterns ruin your happiness at the present time. *You can do something about them.* When you observe yourself acting these patterns out, STOP. Ask yourself are you going to let them control you? Say to yourself, "I am able now to stop this nonsense," *and do it.* For example, every time you beat yourself and depreciate yourself, or act out a bad pattern and say you are helpless to control it, are you doing these things to prove that you are defenseless and that therefore somebody should come along and take care of you? Are you punishing yourself because you feel guilty about something? It is easy to say you are a crippled child and that some kind person must take care of you. But remember you pay an awful price for this dependency by getting depressed, feeling physically ill, and destroying your feelings of self-worth. Every time you control a bad pattern, reward yourself by doing something nice for yourself, something you enjoy and that is good for you.

3. *What patterns of behavior would you like to develop that are constructive?* Would you like to be more assertive for instance? If so, plan to do something that calls for assertiveness each day.

These assignments may be given verbally to the patient in the therapist's own words. If a relaxing and ego-building cassette tape has been made, remind the patient that results are contingent on utilizing the tape preferably at least twice daily. Keeping a diary and jotting down one's reactions and discoveries may prove to be a valuable adjunct.

In addition to the above, some patients may benefit from a printed or typewritten set of directions, such as suggested below. These may be adapted to specific problems. The list may be given to and discussed with the patient shortly before termination.

1. *Whenever you get upset or your symptoms return or get worse, ask yourself why this is so.* Try to establish a relationship between the symptoms and happenings in your environment. Did something occur that made you feel guilty or angered you or that you didn't like? Are you punishing yourself because you feel guilty? Is something going on in your relationship with a person who is close to you or with the people who are around you that is hard for you to take? Or is something bothering you that you find difficult to admit even to yourself? It is often helpful to keep a written record of the number of times daily that your symptoms return and approximately when they started and when they stopped. If you jot down the things that happened immediately before the symptoms started, and the circumstances, if any, that relieved them, you may be able to learn to control your symptoms or eliminate them.

2. *What are the circumstances that boost and the things that diminish the feelings about yourself?* When do you feel good about yourself and when do you feel bad? Are these feelings connected with your successes or your failures? What makes you feel inferior, and what makes you feel superior? Do you feel better when you are alone and away from people, or do you feel better when you are with people? What kind of people?

3. *Observe the form of your relationship with people.* What tensions do you get with people? What kind of people do you like and dislike? Are these tensions with all people or certain kinds of people? What do people do to upset you? In what ways do you get upset? What do you do to upset them or get yourself upset when you are with them? What do you do and what do they do that tends to make you angry? What problems do you have with your parents, mate, children, boss, associates at work, authorities, people in general? Do you tend to treat anyone in a way similar to the patterns that you established with your father, mother, siblings? How is your reaction to people above you, below you, equal to you? What are your expectations when you meet a very attractive person of the opposite sex? Do you try to make yourself too dependent on certain people?

4. *Observing daydreams or night dreams.* A useful outline for observing the meaning of one's day or night dreams includes three questions: What is

your feeling about yourself in the dream? What problem are you wrestling with in the dream? By what means do you reach, or fail to reach, a solution to the problem that presents itself in the dream?

Recurring dreams are particularly significant because they represent a continuing core problem in one's life. Again, whenever possible, you should attempt, if you can, to relate the content of your dreams to what is happening in your life at that time. One man found that he had recurring dreams of bloodshed but that those dreams only occurred after he had made an attempt to assert himself by asking for a raise in pay or by going out with a girl that he liked. He was much surprised to discover that his frightening dreams were actually evidence that he still had some old childish fears about standing up for himself.

5. *Observing resistances to putting understanding into action.* Expect inevitable resistance when you try to stop neurotic patterns. And there can be tension and fear when one faces a challenge that formerly has been evaded. When delaying and avoidance continue to occur, it is well to question the reasons for the delay and ask why one is afraid—and then to take heart and deliberately challenge the fear to see if it can be overcome.

The disciplined practice of these principles of self-observation can lead to progressive growth. Patterns have to be recognized and revised if one is to achieve more satisfying goals in life. But as everyone knows, the habits of years give ground grudgingly and slowly. Ideally, however, the process of personality understanding and growth is marked by several discrete features: There is the awareness that one's problems do not occur fortuitously but are intimately connected with the events (especially the human interactions) of one's life. For a given individual there is a certain quality of human event that generates anxiety, conflict, and stress. These phenomena, once detected, may lead next to a searching for the origin and history of these patterns. It is not impossible to see how these patterns operated as far back as a person can remember—perhaps even the very earliest memory contains something of the same thing. Seeing the conditions under which fears originate, and under which they are not retriggered, one may next determine whether one can be more the master of one's life rather than a victim of it. Could we be different from the way we have always known ourselves to be? And ever so slowly, we may challenge one habitual childish fear at a time, pushing ourselves to break out of the

prison of our neurotic self-defeating patterns. Success breeds success, and victory leads to victory. Defeats are reanalyzed in accord with their place in the psychic structure. Seeing ourselves defeated by the same old enemies, we are buoyed up in knowing that formulations about our personalities are correct, and we are then encouraged to fight on. Increasingly, we can express a claim to a new life; we find ourselves able to be more expressive. Self-recriminations diminish. Our capacities expand, and we gratify more of our needs. Feeling less frustrated in life, and therefore less angry, we can enter into relationships with people with more openness and a greater ability to share.

These are idealistic goals, but they represent a guide along the way toward greater self-observation and richer living. Fidelity to the practice of self-observation, together with the actual translation of understanding into action, can be a lifelong quest marked by high adventure and notable results.

The knowledge of oneself and how one reacts continues to constitute a health and mature behavior.

The above tasks given to the patient as an assignment in therapy can provide material to be discussed during the treatment hour. In addition to problem solving and symptom control, an attempt may be made to alter the individual's sense of values by developing a different way of conceptualizing himself or herself and of coping with the stresses and strains of everyday life.

Evolving a More Constructive Life Philosophy

One of the ways psychotherapy influences people is by helping them to develop new values and philosophies of living. However, the history of the majority of patients, prior to their seeking therapy, attests to futile gropings for some kind of philosophical answer to their dilemmas. The search may proceed from Christian to Oriental philosophies, from prurience to moralism, from self-centeredness to community mindedness. What at first seems firmly established soon becomes dubious as new ideas and concepts are proffered by different authorities. It is far better to evolve philosophies that are anchored in some

realistic conception of one's personal universe than to accept fleeting cosmic sentiments and suppositions no matter how sound their source may seem. Even a brief period of psychotherapy may till the soil for the growth of a healthier sense of values. We may be able during this span to inculcate in the person a philosophy predicted on science rather than on cultism.

The question that naturally follows in a therapy program is: Can we as therapists expedite matters by acting in an educational capacity, pointing out faulty values and indicating healthy ones that the patient may advantageously adopt? If so, what are the viewpoints to be stressed?

Actually, no matter how nondirective a therapist may imagine him or herself to be, the patient will soon pick up from explicit or implicit cues the tenor of the therapist's philosophies and values. The kinds of questions the therapist asks, the focus of interpretive activities, confrontations and acquiescences, silences and expressions of interest, all designate points of view contagious to the patient, which the patient tends to incorporate, consciously and unconsciously, ultimately espousing the very conceptual commodities that are prized by the therapist. Why not then openly present new precepts that can serve the patient better? Superficial as they sound, the few precepts that can be tendered may be instrumental in accelerating a better adjustment.

The precepts presented to the patient for practice at home may embody persuasive suggestions on how to isolate the past from the present, modes of managing anxiety, learning to endure a certain amount of tension and anxiety, tolerating a certain measure of anger and hostility, handling frustration and deprivation, correcting remediable elements in one's environment, adapting oneself to irremediable elements in one's life situation, using willpower to stop engaging in destructive activities, stopping unreasonable demands on oneself, challenging a devalued self-image, deriving the utmost enjoyment in life that is possible, and accepting one's social role. Not all patients need these directives, but they may be helpful especially in supportive and reeducative programs. But even in reconstructive therapy there are many patients who can benefit from them. The degree of

authoritativeness in giving suggestions will vary ranging from highest in supportive therapy and lowest in reconstructive therapy.

Isolating the Past from the Present

All persons are victimized by their past, which may operate as mischief mongers in the present. A good adjustment presupposes modulating one's activities to present-day considerations rather than resigning to promptings inspired by childish needs and misinterpretations. In therapy the patient may become aware of the early patterns that repeat themselves in adult life. This may provide one with an incentive for change. On the other hand, it may give the patient an excuse to rationalize defects on the basis that unalterable damage has been done by the parents, who are responsible for all of his or her trouble. The therapist may remind the patient that the patient, like anyone else, has a tendency to project outmoded feelings, fears, and attitudes into the present. Early hurtful experiences undoubtedly contribute to the patient's insecurity and to devalued self-esteem. They continue to contaminate one's adjustment *now,* and, therefore, must try to overcome them. Thus, the therapist would make a statement similar to the following:

> *Th.* Ruminating on your unfortunate childhood and bitter past experiences are indulgences you cannot afford. These can poison your present life if you let them do this. It is a credit to you as a person to rise above your early misfortunes. Attempt to restrain yourself when you fall back into thinking about past events and you no longer can control or when you find yourself behaving childishly. Remember, you may not have been responsible for what happened to you when you were a child, but you *are* responsible for perpetuating these patterns in the present. Say to yourself, "I'm going to release myself from the bonds of the past." And work at it.

Handling Tension and Anxiety

The patient may be reminded that tension and anxiety may appear but that something positive can be done about them.

> *Th.* Every time you experience tension, or any other symptoms for that matter, ask yourself why? Is it the immediate situation you are in? Is it something which happened before that is stirring you up? Is it something you believe will happen in the future? Once you have identified the source of your tension or trouble, you will be in a better position to handle it. The least that will occur is that you will not feel so helpless since you know a little about its origins. You will then be in a better position to do things to correct your trouble.

The idea that one need not be a helpless victim of symptoms tends to restore feelings of mastery. A patient who was given this suggestion went to a new class. While listening to the lecturer, she began to experience tension and anxiety. Asking herself why, she realized she was reacting to the presence of a classmate who came from her own neighborhood and knew her family. She then recognized that she felt guilty about her interest in one of the men in the class. This happened to be the real reason why she registered for the course. She realized that she feared the neighbor's revealing her interest in the man to her parents if she sat near him or was friendly to him. She then thought about her mother who was a repressive, punitive person who had warned her about sexual activities. With this understanding, she suddenly became angry at her classmate. When she asked herself why she was so furious, it dawned on her that she was actually embittered at her own mother. Her tension and hostility disappeared when she resolved to follow her impulses on the basis that she was now old enough to do what she wished.

Tolerating a Certain Amount of Tension and Anxiety

Some tension and anxiety are inherent parts of living. There is no escape from them. The patient must be brought around to the fact that one will have to tolerate and handle a certain amount of anxiety.

> *Th.* Even when you are finished with therapy, a certain amount of tension and anxiety are to be expected. All persons have to live with some anxiety and tension, and these may precipitate various symptoms from time to time. If you do get some anxiety now and then, ride it and try to figure out what is stirring it up. But, remember, you are no worse off than anyone else simply because you have some anxiety. If you are unable to resolve your tensions entirely through self-observation, try to involve yourself in any outside activities that will get your mind off your tensions.

Tolerating a Certain Amount of Hostility

If the patient can be made to understand that he or she will occasionally get resentful and that if the reason for this is explored, the patient may be able to avoid projecting anger or converting it into symptoms.

> *Th.* If you feel tense and upset, ask yourself if you are angry at anything. See if you can figure out what is causing your resentment. Permit yourself to feel angry if the occasion justifies it, but

express your anger in proportion to what the situation will tolerate. You do not have to do anything that will result in trouble for you; nevertheless, see if you can release some of your anger. If you can do nothing more, talk out loud about it when you are alone, or engage in muscular exercises to provide an outlet for aggression, like punching a pillow. In spite of these activities you may still feel angry to a certain degree. So long as you keep it in hand while recognizing that it exists, it need not hurt you. All people have to live with a certain amount of anger.

Tolerating a Certain Amount of Frustration and Deprivation

No person can ever obtain a full gratification of all of one's needs, and the patient must come to this realization.

> *Th.* It is important to remember that you still can derive a great deal of joy out of eighty per cent rather than one hundred percent. Expect to be frustrated to some extent and learn to live with it.

Correcting Remediable Elements in One's Environment

The patient may be reminded of the responsibility to remedy any alterable factors in one's life situation.

> *Th.* Once you have identified any area of trouble, try to figure out what can be done about it. Lay out a plan of action. You may not be able to implement this entirely, but do as much of it as you can immediately, and then routinely keep working at it. No matter how hopeless things seem, if you apply yourself, you can do much to rectify matters. Do not get discouraged. Just keep working away.

Adjusting to Irremediable Elements in One's Life Situation

No matter how much we may wish to correct certain conditions, practical considerations may prevent our doing much about them. For example, one may have to learn to live with a handicapped child or a sick husband or wife. One's financial situation may be irreparably marginal. There are certain things all people have to cope with, certain situations from which they cannot escape. If the patient lives in the hope of extrication from an unfortunate plight by magic, he or she will be in constant frustration.

> *Th.* There are certain things every person has to learn to accept. Try your best to alter them as much as you can. And then if some troubles continue, just tell yourself you must live with some of them, and resolve not to let them tear you down. It takes a good deal of courage and character to live with your troubles, but you may have a responsibility to carry them. If you

start feeling sorry for yourself, you are bound to be upset. So just plug away at it and build up insulation to help you carry on. Say to yourself: "I am not going to respond to trouble like a weather vane. I will remedy the trouble if I can. If I cannot, I will adjust to it. I will concentrate on the good things in my life and minimize the bad."

Using Will Power to Stop Engaging in Destructive Activities

One of the unfortunate consequences of a dynamic approach is that the patient believes the idea that he or she is under the influence of unconscious monsters that cannot be controlled. The patient will, therefore, justify the acting-out on the basis of "automatic repetition-compulsions." Actually, once the patient has a glimmer of what is happening, there is no reason why the cooperation of will power cannot be enlisted to help inhibit himself or herself.

> *Th.* If you know a situation will be bad for you, try to divert yourself from acting it out even if you have to use your will power. There is no reason why you can't work out substitute solutions that are less destructive to you even though they may not immediately be so gratifying. Remember, a certain amount of deprivation and frustration is normal, and it is a complement to you as a person to be able to give up gratifications that are ultimately hurtful to you. Remember, too, that some of the chief benefits you get out of your symptoms are masochistic, a kind of need to punish yourself. You can learn to overcome this too. When you observe yourself acting neurotically, stop in your tracks and figure out what you are doing.

A conventional housewife was involved sexually with two of her friend's husbands. She found herself unable to resist their advances, even though the sexual experiences were not particularly fulfilling. She felt ashamed and was guilt-ridden by her actions. There was obviously some deeper motive that prompted the patient to act out sexually, but the threat to her marriage and relationship with her husband required an immediate halting of her activity. I remarked to her: "Until you figure out some of your underlying feelings, it is best for you to stop your affairs right now. How would you feel about stopping right now? Let's give ourselves a couple of months to figure out this thing. Frankly, I don't see how we can make progress unless you do." The patient reluctantly acquiesced; but soon she was relieved that somebody was supporting her inner resolution to resist. The interval enabled us to explore her disappointment with her husband, her resentment toward him, and to find outlets for her desires for freedom and self-expression in more appropriate channels than sexual acting-out. If the patient has been

given a chart detailing the interactions of dependency, low feelings of independence, hostility, devalued self-esteem and detachment, their manifestations as well as reaction formations to neutralize them, he or she may be enjoined to study the chart and see how one's own drives and needs, with their consequences, fit into the overall design.

Stopping Unreasonable Demands on Oneself

Pushing beyond the limits of one's capacities or setting too high personal standards require sober self-assessment. Are they to satisfy one's own ambitions or those of parents? Are they to do things perfectionistically? If so, does the patient feel greater independence or stature as a person when he or she succeeds?

> *Th.* All people have their assets and liabilities. You may never be able to accomplish what some persons can do; and there are some things you can do that others will find impossible. Of course, if you try hard enough, you may probably do the impossible, but you'll be worn down so it won't mean much to you. You can still live up to your creative potentials without going to extremes. You can really wear yourself out if you push yourself too hard. So just try to relax and to enjoy what you have, making the most out of yourself without tearing yourself to pieces. Just do the best you can, avoiding using perfectionism as a standard for yourself.

Challenging a Devalued Self-image

Often an individual retires on the investment of conviction of self-devaluation. What need is there for one to make any effort if one is so constitutionally inferior that all of the best intentions and well-directed activities will lead to naught? It is expedient to show the patient that he or she is utilizing self-devaluation as a destructive implement to bolster helplessness and perhaps to sponsor dependency. In this way one makes capital out of a handicap. Pointing out realistic assets the patient possesses may not succeed in destroying the vitiated image of oneself; but it does help to reevaluate potentialities and to avoid the despair of considering oneself completely hopeless. One may point out to the patient instances of personal successes. In this respect, encouraging the patient to adopt the idea that he or she can succeed in an activity in which he or she is interested, and to expand a present asset, may prove to be a saving grace. A woman with a deep sense of inferiority and lack of self-confidence was exhorted to add to her knowledge of horticulture with

which she was fascinated. At gatherings she was emboldened to talk about her specialty when an appropriate occasion presented itself. She found herself the center of attention among a group of suburbanites who were eager to acquire expert information. This provided her with a means of social contact and with a way of doing things for others that built up a more estimable feeling about herself.

Logic obviously cannot convince a person with devalued self-esteem that he or she has merit. Unless a proper assessment is made of existing virtues, however, the person will be retarded in correcting the distorted self-image.

> *Th.* You do have a tendency to devalue yourself as a result of everything that has happened to you. From what I can observe, there is no real reason why you should. If you do, you may be using self-devaluation as a way of punishing yourself because of guilt, or of making people feel sorry for you, or of rendering yourself helpless and dependent. You know, all people are different; every person has a uniqueness, like every thumbprint is unique. The fact that you do not possess some qualities other people have does not make you inferior.

Deriving the Utmost Enjoyment from Life

Focusing on troubles and displeasures in one's existence can deprive a person of joys that are one's right as a human being. The need to develop a sense of humor and to get the grimness out of one's daily life may be stressed.

> *Th.* Try to minimize the bad or hurtful elements and concentrate on the good and constructive things about yourself and your situation. It is important for every person to reap out of each 24 hours the maximum of pleasures possible. Try not to live in recriminations of the past and in forebodings about the future. Just concentrate on achieving happiness in the here and now.

Accepting One's Social Role

Every adult has a responsibility in assuming a variety of social roles: as male or female, as husband or wife, as a parent, as a person who must relate to authority and on occasions act as authority, as a community member with obligations to society. Though one may feel immature, dependent, hostile, and hypocritical, the individual still must try to fill these roles as completely as possible. If the patient is destructively involved with another person with whom one must carry on a relationship, like an employer, for

example, he or she must attempt to understand the forces that serve to disturb the relationship. At the same time, however, one must try to keep the relationship going in a way that convention details so that personal security will not be jeopardized.

> *Th.* One way of trying to get along with people is to attempt to put yourself in their position and to see things from their point of view. If your husband [wife, child, employer, etc.] is doing something that is upsetting, ask yourself: "What is he [she] feeling at this time: what is going on in his [her] mind? How would I feel if I were in his [her] position?" At any rate, if you can recognize what is going on, correcting matters that can be resolved, adjusting to those that cannot be changed; if you are able to relate to the good rather than to the bad in people, you should be able to get along with them without too much difficulty."

The form by which the above guidelines are verbally or graphically communicated to the patient will vary, and each therapist may decide whether they are useful in whole or in part for specific patients. Reading assignments may also be given and suggestions for continued self-education made after therapy has ended. A full list of reading materials will be found elsewhere (see Ch 56, "Bibliotherapy").

IV
The Terminal Phase of Treatment

54
Goals in Terminating Treatment

Theoretically, psychotherapy is never ending, since emotional growth can go on as long as one lives. Consequently, it is necessary to employ some sort of yardstick in order to determine when to discontinue treatment.

The problem of goals in psychotherapy is one about which there are differences of opinion. On the one hand, there are those who believe that a definition of goals is vital in any psychotherapeutic program. On the other hand, there are many professionals who consider goals to be an extremely arbitrary matter—a manifestation of the authoritarianism of the therapist who seeks to impose on the patient artificial values and standards. "Goallessness" has been mentioned as the procedural stance essential to technical analytic work (Wallerstein, 1965). Nevertheless, therapists of different orientations aim at outcome targets that reflect their special conceptions of dynamics.

Psychological processes may be conceived of in many ways including:

1. As energy exchanges within various divisions of the psychic apparatus (the Freudian hypothesis).

2. As interpersonal events mediated by characterologic distortions (the neo-Freudian hypothesis).

3. As forms of faulty learning and conditioning (the Pavlovian hypothesis).

Goals in psychotherapy are fashioned by theoretical conceptions of personality. Thus, in Freudian theory the goal in therapy is genital maturity in which fixations of libido on pregenital levels that foster regression have been resolved. In neo-Freudian theory the objective is self-actualization that frees the individual in interpersonal relationships, enhances self-image, and expands creativity and productiveness. In conditioning theory it is the extinction of destructive old patterns and the learning-through-reinforcement of

new and adaptive ones.

Irrespective of how one feels about the uses made of them, goals are understandably of concern to the psychotherapist, for success or failure in the treatment effort can be gauged only in the context of set objectives. Before describing goals, however, we must admit that judgments of "success" in psychotherapy are really a matter of definition and may be viewed differently from the standpoints of the patient, society, and the therapist.

SUCCESS JUDGMENTS

From the Standpoint of the Patient

There is a story about a man who confided to a friend that he had just successfully completed an extensive course of psychotherapy. "Why did you need psychotherapy?" asked the friend. "Because," revealed the man, "I thought I was a dog." "Was the treatment successful?" queried the friend. "Decidedly," replied the man, "feel my nose."

Estimates by the patient as to what has been accomplished in therapy are in themselves not a reliable index of therapeutic success. Most patients regard symptomatic relief as the best measurement of positive gain. This index, however, is not a completely valid one in assaying the effectiveness of treatment.

Symptomatic improvement may be achieved in several ways. First, it may be associated with the giving up of vital aspects of personality functioning. For example, where anxiety and guilt are aroused by sexual impulses, the abandonment of all forms of sexual expression may relieve symptoms. Or where close interpersonal relations are conceived of as dangerous, the patient may, in the course of therapy, detach from people, the bargain that the patient makes with anxiety here cannot be regarded as successful therapy, even though suffering is relieved. Second, the patient may, during treatment, propitiate certain neurotic drives, gaining thereby a spurious kind of security. Thus, one may make oneself dependent on the therapist, acquiring a regressive fulfillment of security needs. Symptoms will abate as long as one conceives of the therapist as a

bountiful, loving, and protecting parent. This happy situation may, nevertheless, be placed in jeopardy whenever the therapist fails to live up to the patient's expectations. Under these circumstances we cannot consider the surcease of symptoms a sign of cure. Third symptom relief may be produced by the repression of damaging conflicts. Many annoying but relatively innocuous symptoms may be blotted out of awareness in the course of supportive therapy, only to be replaced by substitutive symptoms of a more serious nature. Thus, the symptom of anxiety may be relieved during therapy by repressive techniques of one sort or another. Anxiety equivalents may, however, appear in the form of psychosomatic complaints. Damage to viscera may later eventuate, of which the patient is not conscious until an irreversible somatic ailment develops, perhaps years after the presumed "success" in therapy had occurred.

The patient's estimates of failure in therapy must also not be accepted at their face value, since concepts of failure are based on a false premise. Thus, one may consider treatment unsuccessful where hoped for ideal traits have not been achieved. For example, one patient may have secret notions of being a genius, that are now latent but that will be released through therapy. Another patient may regard therapy as unsuccessful unless one has developed complete equanimity and the ability to remain tranquil, to endure tension, and to vanquish discomfort, even in the face of the most devastating environmental conditions. The failure to develop these and other traits, which are, in the patient's mind, considered indices of health, security, and self-esteem, may cast a shadow on even estimable therapeutic results.

From the Standpoint of Society

Judgments as to success in therapy from the standpoint of social standards must also be held suspect. The patient's family, mate, or friends may have ideas about the kind of individual that they want the patient to become that may not correspond with standards of mental health. For instance, parents may expect and even demand that the therapist mold the patient into a creature who is cooperative and pleasant at all times and who never challenges parental authority. A mate may insist that the patient develop a

personality that tolerates his or her own shortcomings and never gives vent to resentment. Friends may have stringent standards of character that might apply to themselves but not necessarily to the patient.

The culture or subculture may also impose arbitrary norms that differ from those of the patient or of the therapist. Political and economic forces in one group may make for a value system that is not accepted by, or acceptable to, another group. Thus, a "normal" individual in a totalitarian framework would be expected to submit willingly to the yoke of dictatorship and to subordinate personal freedom for the welfare of the state. In another cultural framework the individual's personal rights and the ability to make one's own choices would be paramount; one would not be expected to yield completely to authoritative demands. It is accordingly, important not to regard as goals of normality traits and drives that, though culturally condoned, may prove to be at variance with mental health.

From the Standpoint of the Therapist

The therapist may fashion therapeutic goals around certain set standards and values. These may relate to personal concepts of normality or to a general ideal of mental health.

One may, reflecting cultural concepts, pronounce certain traits as normal believing that the patient must acquire these before being considered emotionally balanced. Another therapist may personally operate under a cherished set of attitudes that constitute for one the highest goal. Thus, if a value is put on ambitiousness, perfectionism, detachment, dependency, narcissism, or power devices, one is apt to consider these real assets toward which one must aim the therapeutic sights. A word of caution must especially be voiced in regard to that group of attitudes collectively embraced under the term of compliance. A reasonable compliance to authority is a necessary thing, but compliance is too often utilized by neurotic persons as a form of security. This is most often the case in those cultures in which the child is considered a relative nonentity who is expected to submit without question and to yield without complaint to the dictates and

commands of the stronger, more authoritative individuals with whom the child lives. Where therapists themselves have been reared in an atmosphere that makes compliance tantamount with good breeding, they may expect the patient to adopt a submissive attitude. The patient may sense this trend in the therapist and try hard to please, even at the price of crushing self-strivings and needs for independent thought and action. Therapists may also, because of their own character structure, consider any aggression a sign of recalcitrance and ill will. They must be careful not to try to pattern their patients after their own image, for they, themselves, may be the victims of values that are basically faulty.

From the Standpoint of Mental Health Objectives

"Ideal" objectives of mental health are many. They require that the person be capable of deriving pleasure from creature comforts in life—from food, rest, relaxation, sex, work, and play. The individual is capable of satisfying these impulses in conformity with the mores of the group. Mobilizing whatever intellectual and experiential resources are required, one is able to plan creatively and realistically and to execute one's plans in accordance with existent opportunities. This involves an appraisal of one's aptitudes and limitations, and a scaling down of one's ambitions to the level of one's true potentialities. It includes the laying down of realistic life goals, an acceptance of one's abilities and a tolerance of one's shortcomings. Presupposed is a harmonious balance between personal and group standards, and those cultural and individual ideals that contribute both to the welfare of the self and of the group. The individual must be able to function effectively as part of the group, to give and to receive love, and otherwise to relate oneself congenially to other humans. One must be capable of engaging in human relations without indulging neurotic character strivings of detachment, needs to dominate or to be enslaved, or desires to render oneself invincible or perfect. One must be able to assume a subordinate relationship to authority without succumbing to fear or rage and yet, in certain situations, be capable of assuming leadership without designs of control or power. One must be able to withstand a certain amount of disappointment, deprivation, and frustration without undue tension or anxiety when these are considered to be reasonable, shared, or

necessary to the group welfare or when the consequences of impulse indulgence entail more than their worth in compensatory pain. One's capacities for adjustment must be sufficiently plastic to adapt to the exigencies of life without taking refuge in childish forms of defense or in fantasy. To achieve a healthy self-regard an individual must have a good measure of self-respect, the capacity to be comfortable within oneself, a willingness to face the past and to isolate from the present anxieties relating to childhood experiences. The individual must possess self-confidence, assertiveness, a sense of freedom, spontaneity, and self-tolerance.

Unfortunately, limitations are imposed by a variety of factors on the achievement through therapy of such ideal goals. Chief among these are obstacles within the patient, such as lack of incentives for change, diminished ego strength, and practical considerations of insufficient time and money. Additionally, society itself imposes insuperable embargoes on certain aspects of functioning. It supports many neurotic values that necessitate the maintenance of sundry defenses for survival reasons. A personality structure that is ideally integrated might actually serve as a source of conflict where the individual has to operate in the framework of a severely neurotic culture.

TOWARD A PRACTICAL GOAL IN THERAPY

Modem philosophers contend that achievement of enduring happiness, while worthy of pursuit, is undoubtedly a dream. Total adaptation must be measured against the backdrop of humanity's continuing involvement with violence, exploitation, and devastation of the earth's resources. These and other inescapable calamities are bound to disturb our equilibrium. Achievement of the most ambitious goal in therapy— reconstruction of the personality structure—would theoretically be most helpful in adapting to society's ills while sponsoring constructive efforts to rectify them. However, goals in therapy are more or less patient regulated. No matter how well trained and skilled the therapist may be, nor how extensive the desire to reconstruct the patient's personality, the latter is always in a position to veto the therapist's intentions. The patient is in a position strategically to thwart the ideal goal of personality maturation—the most

difficult of all objectives. Irrespective of how thoroughly conversant we, the therapists, may be with the technique of reconstructive psychotherapy, our efforts may prove unsuccessful.

Even where conditions are most favorable, reconstructive efforts may fail. The patient may be able to afford extensive psychotherapy and to make the necessary time arrangements; he or she may desire to achieve deep change, yet may gain little or no benefit from therapy. This fact has confounded many therapists as well as their patients who are wont, as a result, to regard reconstructive psychotherapy as ineffectual.

When we investigate failures in reconstructive therapy in patients who are adequately motivated, we find a number of operative factors. The patient may have sustained such personality damage during the formative years of life that the chances for complete growth are remote. The secondary gain factors may be so powerful as to make health a handicap rather than an asset. Environmental conditions may be irremediably destructive, and the patient may need some neurotic defenses in order to survive them. Disintegrative forces within the personality may be so strong as to threaten to break loose with the employment of uncovering procedures. Finally, neurotic symptoms or character distortions may constitute the only means of adjusting the patient to conflicts, even though one possesses insight into their nature.

There are some patients who can make an adaptation solely by employing such neurotic facades. While partially debilitating, they help prevent regression and the upsurge of disintegrative tendencies. Thus, a psychosomatic ailment may serve to drain off hostile and masochistic impulses which, deprived of a somatic expression, may shatter the ego and produce a psychosis.

While the ideal goal of absolute resolution of blocks in personality maturation, with achievement of complete functioning in all areas of living, is a cherished aim in every patient, in practice very few people if any can reach this objective. Lorand (1946) recognized this when he said that in doing psychoanalysis it is sometimes essential to satisfy oneself with "practical" though superficial results that permit the patient to get

along more satisfactorily than before therapy. Many other analysts years ago also recognized the impossibility of achieved ideal goals.

Clara Thompson (1950), in an excellent discussion of what constitutes a "cure" in therapy, describes the need for goal modification. She contends that the patient (1) must be relieved of neurotic suffering, (2) must also be able to relate to others with a minimum of unrealistically perpetuated attitudes that have their origins in early significant relationships, (3) must be capable of achieving as complete a development of personal powers as education and life circumstances will permit. If life situation and the culture in which functions are favorable, he or she will be most capable of relating to the group constructively; if not favorable, he or she may have to learn to endure relative isolation. As long as the person does not deceive oneself through neurotic escape mechanisms, one may remain reasonably healthy even under inimical conditions. However, since we live in a sick society, some neurotic compromises are necessary in order to function. An absolute cure is thus not possible. As long as the person is relieved of anxiety, inferiority feelings, and other destructive elements and is capable of coping effectively with life difficulties as they arise, this may constitute as much as can be done in treatment.

While classical analysts in theory contend that theirs is the only therapy that can regularly and deliberately bring about deep and permanent changes (Strachey, 1937; Menninger, KA, 1958; Wallerstein, 1965), they are not so confident that they can in practice always achieve these all-embracing results. Annie Reich (1950) considers that the bringing about through analysis of an absolute state of health "would appeal to the narcissistic omnipotence fantasies of the analyst." She adds that an analyst cannot hope to produce perfect human beings, that one should be content if one frees a patient from symptoms, enabling ability to work, to adjust to reality, to engage in "adult object relations," and to accept some limitations. Oberndorf (1942) speaks of a "practical success" of symptomatic relief, and admits that in many psychoanalytic cases "the structure of the disorder with recovery of infantile memories has not been worked out, to say nothing of being worked through." Wallerstein (1965) remarks, "Suffice it to say, that though the most ambitious of therapies in its overall outcome goals, in practice analysis

often achieves no more than other less ambitious therapeutic approaches."

These formulations actually repeat what Freud himself conceded were limitations in man's capacities for change. In "Analysis terminable and interminable" (1937) he stated that what analysis accomplishes "for neurotics is only what normal people accomplish for themselves without its help," namely, a "taming" of their instincts to bring them into harmony with the ego. Where the ego for any reason becomes enfeebled, as in illness or exhaustion, the "tamed" instincts "may renew their demands and strive in abnormal ways after substitution satisfaction." Proof of this statement is inherent in what takes place in sleep when in reaction to the lessening of the ego's forces there is an awakening of instinctual demands. In altering the character structure, Freud was pessimistic of the outcome. It was not possible, he said, to predict a natural end to the process. "Our object will be not to rub off all the corners of the human character so as to produce 'normality' according to schedule, nor yet to demand that the person who has been 'thoroughly analyzed' shall never again feel the stirrings of passion in himself or become involved in any internal conflict. The business of analysis is to secure the best possible psychological conditions for the functioning of the ego; when this has been done, analysis has accomplished its task."

R. P. Knight (1941) has condensed the aims of psychoanalytic therapy as follows:

1. *Symptom disappearance.*

2. *Improvement in mental functioning* with (a) understanding of the childhood sources of conflict, the part played by precipitating reality factors, the modes of defense against anxiety, and the specific character of the morbid process, (b) tolerance of the instinctual drives, (c) realistic self-appraisal with the ability to accept oneself objectively, (d) relative freedom from enervating tensions and crippling inhibitions, (e) liberation of aggressive energies required for "self-preservation, achievement, competition and protection of one's rights."

3. *Improved adjustment to reality* with (a) better interpersonal relationships, (b) more productive work capacity, (c) ability to sublimate more freely in recreation and avocations, and full heterosexual functioning.

A realistic approach to all forms of psychotherapy, including psychoanalysis, recognizes principles of goal modification. It acknowledges that we may have to content ourselves with the modest objective of freedom from disturbing symptoms, the capacity to function reasonably well, and to experience a modicum of happiness in living. The patient may continue to be burdened by outbursts of neurosis, which escapes control from time to time. Realistically, some habitual activities will have to be circumscribed, and certain protective devices developed that are a bit restrictive in certain areas. Yet one will be as well adjusted as most persons, which means that average life objectives can be reached while living with some handicaps.

In the process of modifying goals, cognizance is paid to the fact that while each person is capable of change, there are various levels of change—from the altering of relatively superficial attitudes to the modification of the deepest strata of personality. The strength of the ego in itself may bear no relationship to the extensiveness of goals approached during therapy. Thus, in many patients with strong egos, who have successfully dealt with infantile conflicts through repression, compensation, and sublimation and whose present illness consists of a breakdown of these defenses, the goals may advantageously be oriented around mediating the stress situation that has provoked collapse, restoring to the person the habitual defenses.

In patients with a weak ego who have dealt with infantile conflicts unsuccessfully, with a serious thwarting of maturation, one may also have to be content with the goal of restoring repression and of strengthening defenses to bring the person back to customary equilibrium.

There are, in general, three types of patterns that exist in all persons that influence potentialities for personality modification even with depth therapy.

1. *Conditionings acquired during the preverbal period of life that have become so integral a part of the individual that they continued to operate in a reflex way.* Reorganization of these paradigms may be unsuccessful even after prolonged reconstructive or conditioning therapy, especially where they fulfill important needs, promote gratifications, or serve as defenses.

Surviving in almost pristine form, they defy logic and resist corrective influences.

2. *Systems developed in early life that have been symbolized, then repressed and repudiated because they mobilize anxiety or foster such intense guilt that they cannot be acknowledged.* These patterns, often related to sexual, aggressive, and assertive needs, may break through periodically in direct or modified form rationalizations for them being elaborated. Alteration of these configurations may be possible once insight into their nature is gained, their pleasure or adaptive values harnessed, and motivation for their obliteration developed with substitution of more adaptive trends. Where pleasure gains are high and sacrifice of such gains is resented, or where substitution of more mature ways of behaving is resisted, insight will not remove or control their expression. Here selective reinforcements may be partially successful.

3. *Patterns developed in later childhood and in adult life of which the individual is aware.* One may be able to modify or to control these patterns through will power once one understands their nature and consequences. Yet one may also be motivated to retain these destructive modes because of their pleasure and anxiety-reducing values.

Amendment in all of these categories is possible. Some changes come about "spontaneously" in the medium of a rewarding, bountiful environment that does not repeat the frustrating upsetting experiences of the past. They may be the consequence of a constructive human relationship that acts as a corrective experience, rectifying distortions in past relationships. They occur most frequently, however, through a good psychotherapeutic experience with a skilled empathic therapist, the patient gaining some cognitive understanding of one's conflicts, drives, and defenses, and being helped to develop new ways of reacting and relating. In all persons some residues of the disturbed past will remain irrespective of how bountiful one's environment may be, how exhaustively one knows oneself, or how thoroughly one has relearned new patterns.

Were we, in summary, to attempt the definition of a practical goal in therapy, we might say that it is *the achievement by the patient of optimal functioning within the limitations of one's financial circumstances, existing motivations, ego resources, and the reality situation.* Such a goal would put upon the therapist the responsibility of resolving

the patient's resistance in working toward the ideal objective of personality reconstruction. It would, however, admit of the expediency of adopting modified goals, such as dealing with only those aspects of the patient's problem that can be practically handled during the present therapeutic effort.

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Technical Problems in Termination

The conditions under which termination of therapy is indicated are

1. Achievement by the patient of planned treatment goals.

2. Decision by the patient or therapist to terminate on the basis of incomplete goals.

3. The reaching of an impasse in therapy or the development of stubborn resistances that cannot be resolved.

4. Countertransference that the therapist is unable to control.

5. Occurrence of physical reasons, such as moving of the residence of patient or therapist.

TERMINATING THERAPY UPON REACHING SET GOALS

Therapy may be terminated after the patient has achieved planned goals, such as the disappearance of symptoms, the mediation of environmental stress sources, the acquisition of greater happiness, productivity and self-fulfillment, the resolution of difficulties in interpersonal relationships, or the establishment of creative and productive patterns in living, with the evolution of greater emotional maturity. It is to be hoped that some intrapsychic structural changes will have occurred in which, through a reworking of infantile conflicts, new defenses crystallize and adaptive solutions for old conflicts take place.

With the accomplishment of the purposes of therapy, termination is best effectuated by discussing the possibility of ending treatment with the patient, handling any resistance displayed, warning of the possibility of relapses, and inviting the patient to return after therapy has ended whenever necessary or desired.

Discussing Termination with the Patient

In advance of the termination date it is wise to discuss with the patient the matter of ending therapy. A tapering-off period may be suggested, and a termination date set, which ideally should be from 6 to 8 weeks. The frequency of sessions may be reduced, and the intervals between visits steadily increased. The following is an excerpt from a session with a patient with a phobic disorder who has achieved adequate improvement in therapy:

> *Th.* It sounds as if you are reaching the end of treatment. How do you feel about stopping?
>
> *Pt.* Oh, of course I am glad that I am feeling so well, and I am very thankful to you, doctor.
>
> *Th.* Actually, you did the bulk of the work. Of course, we could go on with treatment indefinitely, reaching more extensive goals in your personality development, but frankly I don't see the need for that, unless you do.
>
> *Pt.* Well, I suppose I can benefit, but as you say, I am comfortable and happy now with Jim *[the patient's husband]* being so much better now to live with, and all these fears and things are gone now.
>
> *Th.* If you agree with me that we should begin to terminate, we can cut down our visits to a session every 2 weeks for the time being and then space them at intervals.
>
> *Pt.* All right, doctor.

During the tapering-off period, any relapses or resistances are handled, sessions being again increased, but only if the patient's condition demands this. In occasional cases it may be decided to terminate therapy abruptly without tapering off, in order to expose the patient to a complete break with the therapist. Forced to function on one's own, the patient may marshal inner strength more rapidly.

Handling Resistances to Termination

If the therapist has conducted the treatment sessions with the full participation of the patient, and if the therapist has avoided playing too directive a role, termination will not pose too great a problem in the average patient. In supportive therapy, however, where the patient has accepted the therapist as a guiding authority with whom he or she has conformed, or in insight therapy where the patient has, on the basis of a residual

dependency drive, made the therapist a necessary factor in adjustment, termination may present difficulties.

Termination of therapy is no problem in most patients who are adequately prepared for it, or who are characterologically not too dependent, or who are seen for only a few sessions and discharged before a strong relationship with the therapist develops, or who are so detached that they ward of a close therapeutic contact. It may, however, become a difficult problem in other cases. Patients who in early childhood have suffered rejection or abandonment by or loss of a parent, or who have had difficulties in working through the separation individuation dimensions of their development are especially vulnerable and may react with fear, anger, despair, and grief. A return of their original symptoms when the termination date approaches will tend to confound the patient and inspire in the therapist frustration, disappointment, guilt feelings, and anger at the patient for having failed to respond to therapeutic ministrations.

In some patients in whom no manifest dependency operates in the relationship with the therapist, termination may still be troublesome. The patient may be fearful of giving up the protective situation in the therapeutic relationship. Memories of past suffering and anxiety may cause a patient to want to hold on to the security achieved, even at the cost of continuing in therapy indefinitely. M. Hollander (1965) has pointed out "that the role of being a patient in psychotherapy, like being a student in school or a patient on a medical service, may become a way of life instead of a means to an end."

The therapeutic tasks prior to termination with all patients involve analysis of the dependency elements in the relationship, a search for needs in the patient to perpetuate dependency, and a helping of the patient to achieve as much independence and assertiveness as possible. A shift in the character of the relationship may be necessary where the therapist has operated in a directive manner. Here the therapist behaves non-directively with the patient, with the object of helping the patient establish new goals and values.

Resistances in the average dependent patient are multiform. Some patients bluntly

refuse to yield dependency, adopting all kinds of dodges, even to relapse in their illness, in order to demonstrate their helplessness. Other patients exhibit a profound fear of assertiveness, perhaps promoted by a neurotic equation of assertiveness with aggression. Resolution of such resistances may consume a great deal of time.

In some patients, and especially in the third phase of treatment (see Chapter 48) it may be necessary to interpret continuously to the patient the reasons for this self-paralysis and to emphasize the need to make one's own choices no matter how revolutionary these may seem. The patient may be told that if a person has never developed full confidence in oneself as an individual, the right to experience oneself as an independent being may be startling. The insidious operation of this dependency may be illustrated, and the patient may be shown how dependency has crippled efforts toward self-growth. In the relationship with the therapist it is natural for the patient to expect the therapist to give the answers and to make the patient's decisions. Should the therapist do this, however, the patient will never develop inner strength. The therapist may keep emphasizing the patient's need to take complete responsibility for personal decisions. The patient may be apprised of the fact that some of decisions may be wrong; but even though one makes mistakes, the very fact that they are one's own mistakes will teach more than being told what to do at all times. The therapist does not want to withhold support from the patient, but it is necessary to do so now out of consideration for the patient's right to develop.

When the patient accuses the therapist of being cold and distant, the therapist may say:

> The reason I'm not more demonstrative is that if I were to act like the traditional authority, it would eventually infantilize you; you would have to keep me around as a leaning post the rest of your life. You'd have to come to me for every decision with such queries as, "Am I doing something wrong?" or "Am I doing the right thing?" Rather, it's better for you to make mistakes, bad as they may be, and to feel that these are your own decisions than for me to tell you what to do.

A definition of the nondirective nature of therapy is given with the object of supplying the patient with an incentive to take responsibility. This will not serve to

liberate the patient completely from dependency demands. Neurotic attitudes and behavior patterns will continue to press for expression. The patient may still exhibit toward the therapist the same insecurity, submissiveness, and aggression that he or she always has manifested toward authority. Habitual ineptitudes in dealing with life and people, destructive acting out and continuing detachment may go on, but with a slight difference: doubts that these aberrations are really necessary.

The following excerpt of a treatment session with a patient resisting termination illustrates some of these points:

> *Th.* You want me to tell you exactly what to do, how to do it, and when. If you really feel that you just don't have strength to do things for yourself, I will do them for you, provided you understand it isn't going to be of help to you if I make your decisions. I'll leave it up to you to decide. If you really feel as bad as you say you do, and you haven't got the confidence to make your own decisions, I'll let you depend upon me, if you *really* want that. *[This statement is offered as a challenge to the patient. There are very few patients that take advantage of it. This patient actually has become quite assertive through therapy but is evincing a regressive dependency reaction to prevent termination.]*

> *Pt.* I do feel just as badly as I told you, but at the same time I can hang on to various little things, one of which is that I long ago accepted the idea that you know what you're doing and I don't want to go against it. [*She seems to doubt the wisdom of her desire to have me function as a parental image.]*

> *Th.* You don't want to go against what I have outlined as the best for you? What do you feel about making your own choices and your own decisions completely, with absolutely no help from me?

> *Pt.* Oh, I think it's great, except that there doesn't seem to be much I can do about it.

> *Th.* Well, what do you think would happen if I told you what to do, if I took you over and acted like a parent?

> *Pt.* I feel two ways about it. I feel, first of all, that it might be an excellent idea because I'm certainly amenable to letting you take me over. But the other way I feel about it is that all this time I've been trying to, more or less, cooperate with you. I trust your judgment and I can see very well that keeping throwing decisions at me is what will in the end make me self-sufficient. Yes, I can see it, but right now I just can't imagine it ever happening or my being able to stand on my own feet. I feel very much as if I have slipped constantly downward during the last few weeks. *[This is since termination was suggested.]* That's all. I mean it's not as if I don't have lucid moments every now and then, but they're very few and far between.

> *Th.* All right, then would you want me to play the role of telling you what to do on the basis that you can't come to decisions for yourself?

Pt. If it was making decisions, I might be able to do it; but I just can't see any decisions to make. There's nothing clear-cut. I don't know where I am at all.

Th. So that you'd like to just let yourself be taken care of by somebody?

Pt. It sounds nice, but I know perfectly well that it wouldn't be so good for me.

Th. You mean my making the decisions for you wouldn't be so good?

Pt. Well, certainly not.

Th. But some people seem to want that.

Pt. Grown people?

Th. Yes, grown people. Their feeling about themselves is so diminutive, their capacity to function so low that they want a parent watching over them all the time. If you'd like to adjust on this level all your life, you'd need to have me around to make your decisions for you indefinitely.

Pt. And then if I wasn't living here, I'd try to find someone else to do it, if I let you go ahead with this plan. *[This is a healthy reluctance to accepting dependency.]*

Th. If you don't develop strengths within yourself so you can figure things out and plan your life and follow it through, right or wrong, then you're going to need somebody around all the time.

Pt. I'd rather not depend on you then.

Because the therapist operates in a more passive role, the patient will be encouraged to act with greater assertiveness, to initiate actions, and to follow them through. There is increasing incentive to take personal responsibility for one's actions, to make plans and express choices. Failure may occur, but there will be successes too. And inner strength will grow on the bedrock of successes. New feelings of integrity and a more complete sense of self will be developed.

Ego growth will thus be catalyzed during the terminal phase, eventuating in the patient's desire to manage one's own life. Such growth is contingent to a large extent on the continued permissiveness of the therapist and the persistent encouragement of the patient's activity and self-expressiveness. The fact that the patient successfully figures things out during the session eventually shows the patient that he or she is not at all at the mercy of forces on the outside. Ultimately the patient comes to the conclusion that one can

live one's life, not because one is given permission, but because one has the right to do so. The patient feels equality with the therapist and a growing sense of self-respect. The self-confidence developed in therapy promotes an extension of assertive feeling toward the extratherapeutic environment.

The proper conduct of therapeutic sessions during the terminal phase of therapy requires that the therapist be so constituted that he or she can permit the patient to feel equality and to allow separation from treatment. The personalities of some therapists are essentially so authoritarian that they will not be able to function on equal terms with their patients. Automatically they will set themselves up as leaders, making judgments, giving directives, and setting goals for the patient that they insist must be followed. They may respond with hostility if challenged or abused by the patient. This is least apt to occur where the therapist has had personal psychotherapy and can analyze and control neurotic countertransference before it acts to interfere with the treatment situation.

Even the therapist who has undergone personal therapy may manifest attitudes that support the resistances of the patient to termination. There may be a compulsion to overprotect or domineer the patient and thus an inability to assume a nondirective role. Economics may play a part when new referrals are scarce, and the therapist anticipates hard times ahead. This may lead to interminable therapy, until the patient forcefully asserts himself or herself by the marshalling of aggression, and in this way violently breaks ties with the therapist.

In some instances the therapist may have to be contented with only partial reduction of the patient's dependence. Here the dependency is reduced as to innocuous a level as possible, by encouraging contact with an outside group or, in sick patients who require prolonged treatment, by maintaining a casual therapeutic relationship at extended intervals over an indefinite period.

Warning of the Possibility of Relapses

No matter how thoroughly the patient's neurotic patterns seem to have been

eradicated, particularly in reconstructive therapy, shadows of old reactions persist. One may be incapable of eliminating them completely, as one cannot obliterate entirely the recorded tracings in the brain of aspects of the patient's past. Under conditions of great insecurity, when the patient's sense of mastery is threatened, or during periods of disappointment, frustration, and deprivation, old defenses and strivings characteristic of past neurotic modes of adaptation are apt to be awakened.

Symptoms may return insidiously without the patient even being aware of having entered into the old conflictual situations that propagated them. Thus, migrainous attacks may recur in a man who, having learned to channel hostility constructively and to avoid competitive relationships that create damaging resentment, changes his job to one where he is judged solely on the basis of comparison of his productivity to that of other employees. A woman with a propensity for dependent involvements may experience a return of her helplessness and her symptoms when she falls in love with, and acts submissive toward, a power-driven individual who constitutes for her an omnipotent father figure. Unconsciously she has yielded to a childish yearning for complete protection, and she is again paying the price in shattered self-esteem and its attendant symptomatic penalties.

It is essential for the patient to realize that getting well does not guarantee further nonexistence of symptoms. Indeed when confronted with truly crucial decisions some patients respond with a return of complaints. Also when stress becomes too powerful to manage, a temporary relapse is possible. However, if the causes of any relapse are investigated and analyzed, not only will the patient have the best opportunity of subduing suffering, but will also be in a better position to forestall the future return of symptoms. Some therapists find it profitable to tell patients at termination that they do not consider a person cured until a relapse or two has occurred and been overcome. Such a warning may prevent a patient from classifying therapy as a failure should recrudescence of symptoms ensue. It alerts one to the insidious operation of inner anxieties and promotes continuing self-analysis. The ability to utilize lessons learned in therapy strengthens newly acquired traits and expands personality growth. The therapist may tell the patient:

You are apt to get a flurry of anxiety and a return of symptoms from time to time. Don't be upset or intimidated by this. The best way to handle yourself is first to realize that your relapse is self-limited. It will eventually come to a halt. Nothing terrible will happen to you. Second, ask yourself what has been going on. Try to figure out what created your upset, what aroused your tension. Relate this to the general patterns that you have been pursuing that we talked about. Old habits hold on, but they will eventually get less and less provoking.

Inviting the Patient to Return for Further Sessions

The therapist may advantageously invite the patient to return for additional interviews in the event of a relapse the patient cannot work out alone. Should the patient take advantage of this invitation, it will be possible for the therapist rapidly to help the patient gain insight into the patterns that have been revived, to connect this understanding with what the patient already has learned in therapy, and to analyze why the patient was unable to deal with the relapse through his or her own efforts. This review will usually occasion much relief in the patient and provide a greater sense of mastery. Relatively few sessions will be required to effectuate this objective.

The patient may also desire to return to therapy in order to achieve more extensive objectives. Growth is a never ending process, and the patient may be so dissatisfied with the present status that a more exhaustive self-inquiry will be insisted on.

For example, a patient in an anxiety state, mobilized by involvement in a love affair that she has been unable to control with her habitual character defense of detachment, may utilize the therapeutic situation to break the relationship with the young man of whom she has become so hopelessly enamored. Restoring her detached defenses and again functioning satisfactorily without anxiety, she may decide that she has accomplished her treatment objective. However, because she has become aware of a conflict that makes close relationships dangerous for her, necessitating withdrawal, she may develop, after she has stopped treatment, an incentive to return to therapy for more extensive work. She will do this with a new goal in mind; namely to be able to relate closely to a person without needing to invoke her defense of detachment. With this expanded motivation, a reconstructive approach may be possible.

A suitable way of terminating therapy is to consider the increased spacing of sessions part of the treatment plan. As soon as the therapist decides on treatment termination, the patient is instructed that it is important to extend the intervals between sessions as part of the treatment plan. A 2-week interval is followed by increasing intervals between sessions. When it becomes apparent that the patient is coping well, a yearly session is planned.

Encouraging the Patient to Continue Therapeutic Self-Help

A consistent application of what has been learned in psychotherapy is essential. The patient may be encouraged to engage in self-observation and to challenge neurotic patterns directly should they return, both by trying to understand what brought them back and by actively resisting and reversing them. In some cases the patient may be taught the process of self-relaxation or self-hypnosis to help reduce tension when upset and also to enable the patient, through self-reflection, to arrive at an understanding of elusive precipitating factors that have revived conflicts.

Even where there has been only supportive or a more superficial type of reeducative therapy, the patient may be inspired, as much as possible, (1) to utilize will power for the purpose of facing reality situations, (2) to push one's mind away from ruminative obsessional thinking and preoccupations, (3) to cultivate, if possible, a sense of humor about oneself and situation, (4) to develop the philosophy of living in the present rather than regretting the past and dreading the future, (5) to practice expressing controlled resentment in justifiable situations, and (6) to examine any tensions, anxieties, or irrational impulses in terms of possible meanings, connecting them with what one knows of one's basic neurotic patterns. These precepts and others contained in Chapter 53 on Homework Assignments may be extremely helpful. Self-help relaxation methods, meditation, the playing of an audio tape that the therapist prepares for the patient for purposes of relaxation and ego building, may be prescribed for some patients. See also Chapter 57.

TERMINATING ON THE BASIS OF INCOMPLETE GOALS

Therapy may have to be terminated prior to the achievement of planned goals. There are a number of reasons for this, most important of which is insoluble resistance. Thus, a patient may, with psychotherapy, lose certain symptoms, but other symptoms may cling to one obstinately. One may relinquish many neurotic patterns but continue to exploit a few without which one may feel oneself incapable of functioning. One may develop a number of new potentialities, yet be unable to progress to as complete emotional maturity as either the patient or the therapist may desire. Working on resistance accomplishes little, and the therapist may then deem it advisable to interrupt treatment.

A countertransference obstacle that may require resolution is a too strong ambition in the therapist who expects too much from a patient. Therapeutic objectives may have to be scaled down considerably in certain individuals. Thus, we may be dealing with a sick borderline patient who is on the verge of a schizophrenic break and who is insistent that he be brought in therapy to a point where he can be more normal than normal. This wish, while admirable, is not realistic, for the patient does not possess the fortitude to endure the rigors of a reconstructive approach. Because he does not have sufficient ego strength to work out a better adaptation, one may have to make a compromise with projected goals.

Sometimes therapy is started with a patient whose motivations are unalterably defective. For instance, a woman may have a tremendously arrogant notion of her capacities, and she may seek treatment solely because she has read somewhere that psychotherapy can bring out an individual's buried potentialities. The bloated self-image that the patient supports may be the only way she has of counteracting feelings of inner devastation or of rectifying a contemptuous self-image. Therapy with such a patient may be extremely difficult and may have to be terminated due to impenetrable resistance.

The therapist may be confronted with a patient whose life situation obstructs his or her progress. The environmental difficulty is so irremediable that possibilities of correction are remote, and hence the patient must be helped to live with it or be

desensitized to its effect. Or the patient's symptoms may possess so strong a defensive value that their removal will produce a dangerous reaction. Therapy may have to be terminated on the basis of only partial symptomatic relief.

It may be impossible, due to other obstructions, to get some patients to progress beyond a certain point in therapy. To continue treatment may prove discouraging to the therapist and undermining to the patient. It is better here for the patient to retain some neurotic drives than to be exposed to interminable and frustrating therapy to which, in all probability, the patient will be unable to respond.

As soon as the therapist decides that maximum improvement has been obtained or that a stalemate has been reached, the therapy may be brought to a halt by utilizing the techniques described for termination after the achievement of planned goals. The therapist will, however, have to explain the reason for termination in such a way that the patient does not arrive at the conclusion that matters are hopeless and that no further progress is possible. Thus, the patient may be told that therapy has alleviated some symptoms, has brought about an awareness of basic problems, and has pointed the way to a more productive life. Because the patient's difficulties have existed a long period, resistances may persist for awhile. Putting lessons learned in therapy into practice, however, will provide the best opportunity to achieve a more complete development.

The mere mention of termination, and the discussion of resistances that seem to have blocked progress, may stimulate incentives to break through these hindrances. If a termination date has been set, the patient may work through resistances prior to the expiration date. On the other hand, the termination techniques may not resolve the many impediments to further change. Yet, after the patient has left treatment, spectacular progress may be experienced. The fact that no headway was made while in therapy may have been due to the operation of a subtle transference situation that acted as resistance. For example, hostility toward the therapist may have expressed itself in a refusal to go forward; or dependence on the therapist may have taken the initiative away from the patient. Once the patient is functioning away from therapy under one's own power, such

resistances diminish and a spurt in development is possible.

Planned Interruption of Therapy

Instead of outright termination, a vacation from treatment may be suggested. During this period the learnings from therapy should be put into practice. The interruption can serve as an opportunity to observe the exact manner that one's personal problems interfere with proper functioning and to analyze what hindrances come up in trying to cope with such problems on one's own. The proposed interruption may be presented to the patient as in the following excerpt:

> *Th.* It seems to me that we have reached a plateau in your therapy and that a vacation from treatment may be indicated. How do you feel about that?
>
> *Pt.* I just can't seem to get any further. I've been thinking of that. How long would you suggest?
>
> *Th.* Suppose we plan on a month's vacation. After a month call me, and we'll arrange an appointment.
>
> *Pt.* Do you believe that will be of help?
>
> *Th.* I do. You might observe yourself during this period and see if you can determine what is happening, what stirs up your symptoms and what alleviates them. We might learn something important, and the interlude may help pull you out of the plateau.

Transferring the Patient

Sending the patient to another therapist may sometimes be preferable to outright termination. Where one seems unable to deal with the patient's resistances, or where one cannot control destructive countertransference, or, for any other reason, feels incapable of helping the patient any more, the decision may then be that the patient will do better with a different therapist. Sometimes a transfer is arranged when it is presumed the patient will benefit by a kind of therapeutic experience other than that provided by the present therapist. For instance, a therapist trained mainly in reconstructive approaches may feel that the patient needs supportive therapy and may consequently want to refer the patient to a professional person who is highly skilled in supportive techniques. Or a change to a therapist of the opposite sex may be considered advisable. Should a transfer be indicated,

the therapist may discuss the matter with the patient as illustrated in this fragment of a session:

Th. For some time I have felt that we haven't been making very much progress.

Pt. Yes, I was worried about this. I wondered if you were getting impatient.

Th. Of course not, except that sometimes a snag like this does happen, and a person may be able to work it out better with another therapist.

Pt. You mean you want me to see somebody else?

Th. My desire is for you to get well. What would you feel about seeing someone I would recommend and who I believe can help you? I have a feeling you may do better with another type of technique, and Dr.＿＿＿ is very excellent at this.

Pt. Well, I don't know.

Th. Why don't you talk to Dr.＿＿＿ after I determine that he has the time for you? Then, after a couple of sessions you can see how you feel.

Pt. If you think this is best, I'll do it.

Th. I do, and I'll make all the arrangements and call you.

TERMINATION NOTE

At the time of termination a note should be entered in the patient's case record indicating the reasons for termination, the patient's condition of discharge, the areas of improvement, the patient's attitude toward the therapist, the recommendations made to the patient, and the final diagnosis. A form, such as in Appendix H may be found useful.

FOLLOW-UP

Prior to discharging the patient, then it is advisable to ask whether he or she would object to receiving an occasional letter from the therapist asking regarding one's progress. Most patients are delighted to cooperate and consider the therapist's gesture a mark of interest in their development. Follow-up letters, briefly inquiring into how things have been progressing, may be sent to the patient yearly, preferably for at least 5 years. This enables the therapist to maintain a good check on what has been happening over a

considerable period of time. The patient's replies to the follow-up inquiry may be entered in the case record, and, if necessary, a brief notation may be made of the contents.

Follow-up is an essential practice where one wishes to determine the efficacy of one's clinical activities. It is an important aspect of outcome research. In doing follow-up we must remember that a single contact may not tell us too much. A person does not live in a vacuum after completing psychotherapy, and many intercurrent events can temporarily augment, detract from, or destroy the benefits of treatment. Thus an individual who has achieved a good result and has left therapy in a satisfactorily improved state may be subject to catastrophes that are beyond one's power to avoid or resolve. One may be in a state of depression at the time of follow-up but can later rally and pull oneself out of despair. This may not be evident unless provision is made for further contacts. Personal interviews are far more useful for follow-up than,, communication by mail, although practical considerations, such as changes in domicile to a remote area, may pose problems. Sometimes follow-ups done over the telephone may be much more satisfactory than by mail. However, patients tend to be more guarded here than in private interviews even where they have had a good relationship with their therapists.

Ideally, appraisals of the patient by other persons with whom the patient is living or working can be helpful, but this may be difficult to arrange. A simple statement of "feeling better" or "worse" means little unless areas of improvement or decline are delineated. Unless the case record has detailed categories of problems and deficits existing at the start of treatment estimates of change may be inaccurate. Researchers who have had no personal contact with a patient are especially handicapped, but even the primary therapist may without recorded backup be prejudiced by optimistic hunches.

PATIENTS' REACTIONS TO THE END OF THERAPY

What follows are some reactions voiced by patients when they finished therapy:

1. All people have problems, and I know now that mine are no worse than anybody else's.

2. I realize I considered my symptoms a sign of weakness. I realize they aren't. I don't pay attention to them and they pass. They aren't such a big deal now.

3. One of the big problems I had was considering myself the center of the universe. It now isn't so important for me to feel so important.

4. When I was so full of guilt, I felt I would burst. When I talked things out, I realized my standards were a lot more strict than those of other people. As a matter of fact, I would purposefully do things to prove I was bad; now I don't have to.

5. The price I would pay for my indulgences was just too high. So I don't burn the world up! So I don't get as much of a bang out of doing ridiculous things! The quietness I feel more than compensates for the high life I was leading.

6. Why knock yourself out climbing on top of the heap? You're nowhere when you get there. You kill yourself trying. I was so ambitious and perfectionistic that I had no time for living. Now I try to find pleasure in little things, and it works.

7. I don't have to blame my parents anymore for my troubles; whatever happened, happened. Why should I let the past poison my present life? I feel I can live now for what life has to offer me right now.

8. I used to torture myself about the future. Worry about it so much I couldn't enjoy anything. I knew I was silly, but I couldn't stop it. Now I just don't care. I do the best I can now and I know the future will happen as it will happen no matter how much I worry about it. I take things as they come.

These ideas are not capricious whims. They are formulations developed after a working through of important conflicts. They indicate an attempt at solution of basic problems, which permit of a style of living more in keeping with reality.

Interestingly, the essence of such precepts may be found in proposals and rules of living laid down by poets and philosophers from the earliest times that humans recorded their hopes and fears and formulated ways of resolving them. Sometimes individuals arrive at such philosophies spontaneously without therapy, usually during emotional

crises that force upon them adaptive ways of thinking and behaving. Sometimes the philosophies are evolved as a result of authoritative pressures or out of respect for leaders whom the individual elevates to a protective or powerful position. A good psychotherapeutic experience, however, will give the individual the best opportunity to remold values and to arrive at a more constructive way of being and living.

Part V.
Special Aspects

The principle adjuncts in psychotherapy are relaxation exercises, biofeedback, somatic therapy, hypnosis, narcotherapy, videotape recording, and bibliotherapy.

RELAXATION EXERCISES AND MEDITATION

A certain amount of tension is a normal phenomenon, and every human being experiences it as a concomitant of daily living. It is probably helpful to problem solving and creative adaptation. In psychotherapy it acts as a stimulant to experimentation with new modes of defense and behavior. In excess, however, like too much anxiety, it paralyzes productive work and provokes a variety of physiological and psychological symptoms that divert the victim from concentrating on therapeutic tasks. Its control, consequently, becomes an expedient objective. While the therapeutic relationship serves to solace the patient, it may not be sufficient to subdue pathological tension. Minor tranquilizing drugs are effective, but they have side effects and may, in susceptible persons, lead to habituation. Fortunately, there are other available modes of tension control that can serve as an adjunct to psychotherapy.

As explained in a previous chapter, there are a number of ways that relaxation may be achieved, including meditation, Yoga practices, self-hypnosis, Zen, autogenic training, biofeedback, and simple breathing exercises. In all of the foregoing similar general principles prevail (Benson et al, 1974).

In meditation there is a *control of external stimuli.* This is achieved by a quiet environment devoid of distractions. An isolated room, a secluded seashore, or quiet woods can suffice. Other people may be present provided that they too participate in the relaxation experience, maintaining strict silence. Experienced meditators are able to "turn off" in almost any environment, withdrawing into themselves, but this will not apply to the

great majority of people. Second, *attention is focused* on a simple sound, the repetition of a word or monotonous phrase, or gazing at an object. Some subjects utilize a metronome or listen to their own quiet deep breathing; some stare at a spot in the ceiling; still others recite to themselves a syllable or meaningless expression ("mantra"). Whenever the attention wanders and thoughts and ideas invade one's mind, the subject is enjoined to return to the fixation stimulus. Third, a free-floating, unpressured, languid, unresisting attitude must prevail: the *individual surrenders to passivity.* As images, reflections, ruminations, sentiments, and varied thoughts emerge from inner mental recesses, the subject lets them drift by without concentrating or being concerned with them. This is probably the most difficult task for the subject to learn, but with practice there is less and less focus on performance and greater ability to let things take their own course. Fourth, *a comfortable position* is essential, such as sitting in a chair or, if one is nimble, kneeling. Lying down is conducive to sleep and may defeat some of the aims of the experience.

The specific technique that one employs to achieve the relaxation experience is largely dependent on what is most meaningful for the individual. Some persons are so impressed with the mysteries of the esoteric Eastern philosophies that they are especially attracted to these.

In the practice of Zen Buddhism the meditation experience (Zazen) plays an important part. This, performed in a quiet atmosphere, with eyes open, the mind drifting while focused on breathing, produces a unique kind of physical-mental experience. Strived for are episodes of deep clarity (samadhi), of enlightened unity (satori), and a buildup of energy (joriki). To learn this type of meditation, one practices in a group (sangha), preferably under the guidance of a Zen master.

Transcendential meditation is perhaps the most widely employed form of relaxation utilized in the United States. Introduced by a guru, Maharishi Mahesh Yogi, it resulted in a movement that had gained momentum over the years with development of a large number of societies distributed throughout the land. The method continues to be used by some individuals. It is taught by a trained instructor who designs a word, sound, or phrase

(mantra) presumably uniquely fitting to the subject, which is supposed to remain secret. This constitutes the fixation object.

Other forms of meditation include Yoga, Sufism, Taoism, Krishna Consciousness, and a wide variety of nonreligious practices focused on achieving a higher reality and greater knowledge than can be gathered through the senses. This is done by finding a "unity of being" in the quietness of inner tranquility. Each brand of relaxation has its devotees who attest to its singular usefulness. An excellent review of meditation is found in the book by Carrington (1977).

A description of the method designed by Dr. Maria Fleisch and Joan Suval, of basically two aspects of meditation therapy follows.

> One involves effort and concentration, focusing attention upon a particular object or sensation, and the other, a simple watchfulness and observation, allowing a free flow of perceptions. The aims of this approach to meditation are twofold; to give a "total rest to the mind," relieving tension and anxiety, and to clear the mind, so that it is more aware and better able to cope with everyday problems.

> The meditation therapist begins the group session by suggesting that the meditators close their eyes, take a deep breath, release it slowly, and allow their shoulders, chest, arms, legs, etc., to relax—to "let go completely." For a few moments focus will be on different parts of the body so that tension can be released in those areas. The therapist may then suggest that the meditators direct their attention for a while to the natural movement of their breathing, or to see if they can be aware of the various pulsations and sensations going on within the body. Other areas of focus could include listening to the sounds coming from the outdoors, or the footsteps in the halls, or the steady vibration of an air conditioner. The meditators are reminded throughout this part of the session that if certain thoughts distract their attention, they should simply observe that this is happening, refocusing their attention each time this occurs.

> After 10 to 15 minutes of this aspect of the meditation involving effort and concentration, the therapist then suggests that the meditators now allow their attention to move wherever it is attracted—to a sound, a sensation, a thought— permitting a free flow of perceptions, an "effortless awareness." The therapist reminds the group, from time to time, that it is fine if thoughts are coming and going easily without causing any disturbance, but if the meditator finds that he or she is becoming anxious because of *thinking* about thoughts, one should then focus attention for a few moments on an area such as one's breathing, sensations within the body, sounds outside, etc., until the thoughts have subsided and one feels calmer. Then the meditator can return to watching a free flow of perceptions. Sometimes the therapist will ask the meditators to open their eyes "halfway" so that their gaze is directed downward for a few moments. This allows the meditator to discover that

the watchfulness and effortless awareness can be going on even when the eyes are open. The therapist ends the meditation by once again suggesting that the meditators take a deep breath, exhale slowly, and gradually open their eyes.

Meditators are encouraged to schedule a 15-to 20-minute formal meditation period for themselves at home, either in the morning or the evening, or both, following the same procedure as outlined above. In addition, the therapist points out that this watchfulness and effortless awareness can go on while the person is involved in everyday activities—traveling on a bus, in a train, walking, listening to a conversation, observing the thoughts one has following an argument, etc. This allows one to be in closer "touch" with one's thoughts, feelings, what one actually IS at each particular moment of observation. Often when a meditator is simply watching a free flow of perceptions in this way, repressed thoughts can come to the surface. The meditation therapist stresses the importance of moving away from thought that creates tension and anxiety, calming the mind by focusing attention on an area that is not one of conflict, and then, when the mind is clear and quiet, allowing one to look once again at the thoughts or the situation that had caused the disturbance. When the mind is quiet and free from anxiety, it can see more easily which thoughts are negative and destructive and which are positive and constructive.

It should be pointed out that this approach to meditation is different from that of transcendental meditation, which limits itself to a formal meditation period, with the meditator concentrating attention on the silent or verbal repetition of an assigned "mantra" or Sanskrit word or phrase, so that one can enter into a state of relaxation. As indicated earlier, relaxation and concentration are important aspects of the meditation, but even more vital and beneficial is that this practical approach involves an effortless and choiceless awareness that the meditator can incorporate into daily life, enabling one to be in closer contact with oneself and to function more effectively in relationships.

In addition to the formal meditation period, the therapist answers questions that are asked and stimulates group discussion whenever possible. A strong supportive personality is an important requirement for the meditation therapist, who must also be watchful that there not be overdependency on the part of the meditators. The therapist can avoid this by encouraging individuals to meditate at home and throughout the day, modifying their approach according to their own needs and convenience.

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An outline such as that in Table 56-1 may also be given to the patient as an alternative method.

Meditation is employed not only as a means of tension control but also by some therapists as a way of facilitating imagery and free association. This is akin to the injunctions by early analysts to their patients to shut their eyes and allow themselves to relax completely, and then report the thoughts and phantasies that paraded themselves

before their minds. As an adjunct in psychoanalytically oriented psychotherapy, meditation, like hypnosis, may release transference feelings that must be dealt with as part of the treatment process.

Biofeedback is another way of achieving relaxation through the use of instrumentation. This allows an individual to recognize and influence certain internal bodily states, like muscle tension, that interfere with relaxation. Among the most useful instruments are the electromyograph and temperature machines. Except where certain pathological physiological states exist, like very marked hypertension, dangerous tachycardia, and arrhythmias and severe migraine, there may be little advantage over the simple relaxation exercises outlined above for tension control.

Schultz's autogenic training (Schultz & Luthe, 1959; Luthe, 1969) is another way of achieving tension control. An outline of modified autogenic training exercises is included at the end of the following section on biofeedback.

What all forms of relaxation correctly done achieve is a decrease in activity of the sympathetic nervous system with lowering of the heart rate, respiration, oxygen consumption, blood lactate level, blood pressure, muscle tension, and probably an increase in alpha brain waves. Where highly charged emotions and conflicts lay dormant, their upsurge into awareness may reverse these physiologic changes, but the proper technique will suppress such interferences. Hypnosis can be useful for the relaxation response, but where the object is to release repressed components through suggestion, cathartic liberation of emotions can occur. However, should strict tension control be the objective, there is no attempt made in hypnosis to probe for conflicts.

For many years this author has utilized hypnosis for simple tension control and has taught patients self-hypnosis (which can easily be learned), shying away from ego-building or exploratory suggestions so as to limit the extraneous suggestions and to focus the objective on relaxation. The technique is simple. The patient is enjoined to practice for 20 minutes, twice daily, sitting in a comfortable chair in a quiet room, shutting the eyes and breathing gently but deeply, concentrating on the sound of one's breathing. The

patient is then asked to relax muscles progressively starting with the forehead and working down to the fingertips and then shoulders to toes. The reverse can also be done, that is, starting with the toes and slowly relaxing muscle groups to the forehead. Finally, the patient counts very slowly from 1 to 20 listening to his or her breathing. After the count the patient is enjoined to let the mind become passively languid, avoiding concentrating on thoughts and ideas. Should these obtrude themselves, the patient is to revert back to listening to breathing. In a short period these exercises may be learned achieving what the more complex meditation practices accomplish without unnecessary adornments. In some instances this author has made a cassette recording for the patient utilizing the format outlined in the section on hypnosis later in this chapter, but eliminating the ego-building suggestions and summation of suggestions. Such relaxation practices have been extremely helpful to patients under excessive tension, without interfering with the psychotherapeutic process.

A letter written by a physician who personally tried meditation to reduce pressures and tensions explains some of the benefits to be derived from it:

> I'm getting back to meditating twice a day instead of just once (after four months of down to once a day). It really makes a big difference for me to have regular meditation. It certainly helps me see things in the larger perspective and less egotistically and egocentrically. Also it's a recharging of my mental battery, clearing the static of constant mental chatter out by tuning in to a clearer, more positive channel. You know, I actually feel much more "free-floating" after meditating—like the contrast between having all that subconscious mental chatter and no mental chatter brings the chatter back into acute focus. It seems like I then have greater access to my subconscious. I feel more creative, more in control, and less driven somehow.

BIOFEEDBACK

Through the use of electronic instruments it has been shown that an individual may become aware of changes in bodily functions of which one is usually ignorant, including skin temperature, blood pressure, muscle tension, and brain wave patterns. Changes in these functions activate the instruments designed to measure them and deliver signals (sounds or lights) to the subject permitting one to become aware of certain feelings or states of mind that influence alterations in the studied parameters. The subject gradually

learns how to reproduce such feelings or states to secure desired physiological effects. Body and mind become affiliated through this feedback process so that eventually the individual can reproduce reactions without the use of instruments. The full value of biofeedback must still be evaluated. It has certain substantiated uses, but whether it is superior for this purpose to other techniques (yoga, autogenic training, meditation, self-hypnosis, progressive muscle relaxation, drug treatment, psychotherapy) has not yet been determined. There are some individuals who are extremely impressed with and hence responsive to gadgetry. A powerful placebo effect accompanies biofeedback instrumentation (Frank, 1982) but this does not entirely account for the benefits.

The conditions for which biofeedback may be helpful are generally those of any relaxation training program, i.e., conditions associated with tension and anxiety, either their raw manifestations or the somatic consequences. Biofeedback also serves to induce a state of relaxation during the application of behavioral techniques such as systematic and in vivo desensitization. Finally, it has some use in psychodynamic psychotherapy by helping the patient develop initial rapport with the therapist on the basis that something positive is being done for one. The patient is provided with a technique of controlling anxiety and thus may be more willing to participate in the painful task of exploring repressed needs and dealing with repudiated ideas and conflicts. Moreover, the patient will react to the instrumentation and to the routines expected of one with usual characterologic manipulations and defenses that can provide the therapist with ample dynamic material for scrutiny. During interviewing biofeedback encourages the release of imagery. Anxiogenic themes may be verbalized, particularly by thermal and electrodermal instrumentation, facilitating the exploration of significant fantasies, memories, and conflicts.

Biofeedback is particularly acceptable to those who are fearful of the labels of psychotherapy and mental health, such as executives suffering from tension and psychosomatic symptoms who do not wish to compromise their chances for advancement by having it appear on their record that they received "treatment for mental illness." Usually a patient is seen once or twice a week by the therapist, and is also encouraged to

practice exercises at home each day and when symptoms occur. Twenty to forty formal sessions are usually required to learn tension reduction through instrumentation.

Biofeedback is being employed in Raynaud's disease, migraine, cardiac arrhythmias, hypertension, phobias, bruxism, torticollis, low back pain, cerebral palsy, peripheral nerve-muscle damage, upper motomeurone hemiplegia, some cases of tardive dyskinesia, Raynaud's syndrome, temperomandibular joint pain, insomnia, narcotic withdrawal, attention deficit disorder, tension headaches, asthma, irritable colon, fecal incontinence, chronic pain, seizure disorders, and neuromuscular ailments with reported promising results. But biofeedback cannot be recommended for everyone. It is valueless in serious psychiatric problems and it may create anxiety in some patients such as paranoid conditions. In combination with psychotherapy it proves most helpful, and therefore treatment should be executed or supervised by a trained psychotherapist. It requires time for learning, studied application, and practice, in which not all patients are willing to indulge. It requires also instruments that may be an expensive investment. In spite of these drawbacks, biofeedback is an area whose full possibilities and applications have opened up a fertile field of research (J. Segal, 1975). A number of volumes of collected research on feedback have already appeared as well as critical reviews of the literature (Basmajian, 1983; Gaarder & Montgomery, 1977; D. Shapiro & Schwartz, 1972; Blanchard & Young, 1974). A journal, *Biofeedback and Self-Regulation* has been published.

In the technique of biofeedback "a meditative state of deep relaxation is conducive to the establishment of voluntary control by allowing the individual to become aware of subliminal imagery, fantasies, and sensations" (Pelletier, 1975). This facilitates a link between physiological and psychological processes. The combination of relaxation exercises and biofeedback instrumentation facilitates identification of subjective imagery and physiological sensations that are quieting to the bodily organs.

Where a patient with a serious gastrointestinal, cardiovascular, migrainous, or psychosomatic illness is unable to achieve relief through psychotherapy with the adjunctive use of relaxation exercises, biofeedback training should be considered. Which

instruments to employ will depend on the illness and the learning capacities of the patient. Many practitioners have found the galvanic skin reflex (GSR) electromyograph (EMG) and temperature machines most useful.

In muscle tension retraining through the use of an EMG information may be obtained regarding muscular activity below the threshold of sensory awareness. One may measure the average intensity of neuron firing in microvolts on a meter. An audible feedback delivers sounds registering increases in muscular activity, and by utilizing a threshold control one may provide conditions for optimal training. Where muscle relaxation is the goal, the threshold is set at a high level to produce sound; and as the patient learns to relax, the sound lessens then disappears. The electrodes are in a band that fits around the muscle to be utilized for training purposes. The most useful location is the forehead, the electrodes being placed about 1 inch above the eyebrows.

Signals are picked up not only from the frontalis muscle, but also from other muscles in the head, face, and neck. Thinking activates anxiety thoughts, which can cause a rise in muscular activity. "Turning off thinking" causes a fall.

Relaxation of the frontalis muscle tends to generalize to the entire body. When the level reaches below 4 microvolts, the subject may report a feeling of weightlessness or floating and alterations in the body image. This may create temporary anxiety and increase muscle tension. Should this happen, the patient is reassured that these sensations are normal and to enjoy them. As tension decreases, those patients who are repressing anxiety strongly may experience a sudden burst of anxious thoughts and feelings. Should this happen, the patient is encouraged to verbalize them. In this way biofeedback may be useful in dynamic psychotherapy (Glucksman, 1981, Adler & Adler, 1972). Biofeedback can create a state of relaxation helpful in verbalization during psychotherapy and desensitization procedures in behavior therapy. The effect on the therapeutic alliance is generally a constructive one and the learning of self-regulation may have an influence on the establishing of inner controls.

When the subject has been able to maintain EMG activity below 4 microvolts for

about 15 minutes, one should instruct the subject to examine internal sensations and feelings associated with deep relaxation in order to recreate the state without the feedback unit. In this way muscle relaxation may be obtained rapidly without the use of instruments.

GSR gives data as to emotional arousal, and its control may help lessen tension. The blood volume may also be assessed by special machines, especially through temperature measurements, in this way redirecting the blood flow from one area of the body where blood engorgement causes symptoms (e.g., the brain in migraine attacks) to other areas (e.g., the hand). A blood pressure apparatus and an electrocardiographic (EKG) machine are also employed to control blood pressure and the heart rate. The electroencephalogram (EEG) is occasionally used in epileptic patients to teach them to increase the sensorimotor density rhythm in order to reduce the frequency of seizures. There is some evidence that penile tumescence, the operation of sphincters, repiratory activities, optic and stomach functions may be mediated through special instruments in this way, helping impotence, fecal incontinence, excess gastric acidity, asthma, and myopia. The work in these areas is still incomplete.

To control migraine, it is necessary to learn control of blood circulation in the brain to minimize engorgement of the blood vessels. Utilizing the thermal machine, one may learn to send the blood flow from the head to the hand. The machine has two probes that record the surface temperature (a measure of the blood flow). To monitor blood flow between the head and hand, one probe is placed on the forehead, the other probe on the middle finger of the right hand. The thermal unit (machine) detects minute changes in temperature differential. As a difference in temperature occurs between forehead and finger, a slowly pulsed audible tone will be heard in the earphones. The sound means the blood is flowing in the right direction. Training sessions after the relaxation exercises should last no longer than 5 to 10 minutes.

There is no reason why biofeedback cannot be utilized in combination with behavior therapy (e.g., systematic desensitization) and dynamic psychotherapy. In this way the

patient monitors their own anxiety level by EMG feedback and becomes more insightful of his or her fantasy material in an atmosphere of objective detachment (Budzynski et al, 1970).

A useful means of achieving relaxation prior to biofeedback instrumentation is Schultz's autogenic training or a modification of this as in [Table 56-2]. Practically no scientifically controlled studies exist that truly establish the effectiveness of biofeedback, but the clinical reports are optimistic, perhaps overly optimistic. There is danger in this overoptimism of misuse of the method, and of arousing false hopes that biofeedback is a panacea. Should this happen, we may expect a backlash reaction leading to the denigration and premature elimination of biofeedback as a viable technique. What is needed are carefully designed studies with adequate controls.

A good text is the one by Gaarder and Montgomery (1977). Affordable monitoring modules are now available that measure physiological activities with considerable accuracy.

SOMATIC THERAPY

In a previous chapter the rationale and indications for the somatic therapies have been detailed (Chapter 9). In this section we shall consider some practical applications helpful for the psychotherapist in deciding which patients require medicaments adjunctively and which drugs to prescribe. If the therapist is a non-physician, it will be necessary to work collaborated with the prescribing medical person, supplying the proper data in order that the most suitable drug be selected.

Somatic therapy has proven itself to be a great boon to patients suffering from schizophrenia, endogenous depressions, manic phases of manic-depressive psychosis, acute puerperal psychosis, and severe toxic confusional states. Moreover, somatic treatments have had a positive effect on the morale of patients and their families and have helped to increase discharge rates of mental hospitals (Freyhan, 1961). The prevailing attitude of the public regarding the hopelessness and incurability of severe mental illness

has given way to optimism that dread psychiatric diseases may now be interrupted and perhaps even cured. Employed in outpatient departments of hospitals and clinics, somatic therapy has brought early psychoses to a halt before they have progressed to a point where patients have had to be institutionalized. It has also helped in the rehabilitation of chronic psychotic patients.

Somatic therapy, particularly drug administration, has also exerted a beneficial effect in psychotherapy (Linn, 1964; Kalinowsky, 1965; Kalinowsky & Hippius, 1969; Hollister, 1973). While some therapists continue to shy away from the use of medications, situations do arise during psychotherapy when drugs may prove helpful, even in psychoanalysis (Ostow, 1962). An important factor is to prescribe drugs in sufficient dosage and over a sufficiently long period to test their efficacy.

Pharmocotherapy

Psychotropic drugs during the past two decades have proven themselves to be of incalculable value in dealing with the biological correlates of certain mental and emotional disorders. They have not replaced psychosocial interventions, which concern themselves with the developmental, conditioning, extrapsychic, interpersonal, social, and philosophic-spiritual links in the behavioral chain. Nevertheless, in rectifying biochemical and neurophysiological dysregulations, they have by feedback influenced positively the various other bodily systems in the interests of better adaption. While they do not cure the disease, they alleviate many of the symptoms. Thus they have influenced, beyond the placebo effect, a variety of unwholesome behavioral symptoms, such as hyperactivity, agitation, excitement, violent rage, listlessness, social withdrawal, thinking disturbances including hallucinations and delusions, depression, tension, eating disorders, panic and anxiety. Initial improvements have been sustained, and many patients on a drug regimen even for over 10 years have not been deprived of any of their vital functions (Redlich & Freedman, 1966). Drug therapy helps to keep psychotic patients out of hospitals and enables them to assume some productive role in the community. During psychotherapy it

permits of a modulation of anxiety, particularly where the individual is so immersed in dealing with its effects that one is unable to apply oneself to the tasks of psychological exploration and working through. It may make disturbed patients more accessible to psychotherapy. It also reverses some depressive reactions that drain energy and block initiative. All patients on psychoactive drugs should be under close medical supervision.

The exact action of drugs is not entirely known; however, they appear to act both on the underlying disorder and on the secondary reactions (e.g., withdrawal, undermined self-esteem, etc.) of a patient to illness. They may dissociate symptoms from their attached emotional components; for example, the psycho-inhibiting medicaments, namely phenothiazines, can isolate delusional systems in schizophrenia. They may make available more psychic energy, thus enabling the patient to deal more readily with his or her conflicts. For instance, the energizing drugs vitalize the individual and increase general feelings of well-being. They may disrupt the psychic organization, giving symptoms a new meaning, as during psychedelic experiences with LSD. Tranquilizing and energizing drugs are sometimes employed singly or in combination (e.g., Trilafon and Elavil from two to four times daily), and with this alone (with no uncovering of dynamics and no insight) the patient may achieve a psychological balance. Lowinger et al. (1964), in a follow-up study on drug treatments as the exclusive therapeutic agency, found that the favorable outcome rates were comparable to other treatment approaches in similar patients. After a short period of time on medication some patients will reconstitute themselves; others may require prolonged drug administration. The dosage should be reduced in elderly patients and children. In selecting alternate drugs, it is important to inquire as to what has been effective in the past with the patient and with relatives who were or are on medications (since genetic factors influence drug responses).

Among the impediments in utilizing psychotropic drugs are:

1. Their side effects, such as allergic responses—hepatocanalicular jaundice with the phenothiazines and tricyclic antidepressants, and agranulocytosis with the phenothiazines and occasionally imipramine (Tofranil) and amitriptyline (Elavil); pigmentary reactions in the skin, lens and cornea with phenothiazines; cardiac changes with certain phenothiazines and

tricyclic compounds (especially Mellaril and Tofranil).

2. Their tendency to produce adverse physical and behavioral reactions—for example, hypotension with the phenothiazines and MAO inhibitors; adrenergic crisis in the sympathetic amines (amphetamine, dextroamphetamine); hypertensive crises with MAO inhibitors when tyramine foods are eaten; dyskinesia and Parkinsonism with the neuroleptics; problems in males of impotence and retarded ejaculation and anorgasmia in females. Antidepressant drugs may be contraindicated in some cardiac arrhythmias and in pheochromocytoma, and used with great caution in thyroid disease, angle-closure glaucoma, prostatic hypertrophy and renal failure.

3. Properties that lead to habituation—for instance, the sympathetic amines (Desoxyn, Dexedrine), the barbiturates (Nembutal), meprobamate (Miltown), chlordiazepoxide (Librium), and diazepam (Valium).

Side effects and allergic responses are not too common and mostly are annoying rather than dangerous. They do not justify discontinuing drug treatments. They usually occur during the early states of administration and may be controlled by antagonistic substances (like Cogentin or Artane in Parkinsonism). A disturbing and lasting effect of phenothiazines on chronic psychiatric patients in long-term therapy is tardive dyskinesia, which may not respond to any treatment. Habituating drugs, such as sedatives and hypnotics, may be regulated and should be at least temporarily discontinued after their effects have registered themselves to the benefit of the patient.

Some psychiatrists avoid personal prescription of tranquilizers in reconstructive therapy when they are needed on the basis that this introduces a guidance-supportive element in the relationship. If tranquilizers are indicated, they recommend that the patient consult the regular family physician. Actually, the giving of tranquilizers need not interfere with the management of reconstructive therapy, for the patient's reaction to the therapist as a guiding authority may be handled as part of the treatment process. Prescribing tranquilizers, giving interpretations, sending monthly bills, canceling appointments, and any other active transactions will be utilized by the patient as vehicles around which ideas about authority are organized, providing rich material for study. The

non-medical therapist will certainly need the cooperation of a physician, preferably a psychiatrist, in the event that prescription of a drug is necessary.

In review, drugs are no substitute for psychotherapy. But, as has been indicated, drugs can provide adjunctive help during certain phases of psychotherapeutic management. Caution is essential in prescribing drugs for minor emotional illness, not only because of their potential side effects, and the existence of allergies and sensitivities in the patient, but also because the temporary relief from symptoms that they inspire may induce the patient to utilize them as the first line of defense whenever conflict and tension arise, to the neglect of a reasoned resolution of a developing problem. In certain personality types tranquilizing and energizing drugs may come to fashion the individual's way of life, dependence on them producing a habituation whose effects are more serious than the complaints that they initially were intended to subdue. These disadvantages should not act as a deterrent to the proper employment of such medicaments, which, in their judicious use, will tend to help, not hinder, a psychotherapeutic program. Side effects and tendencies to habituation may be managed if therapists alert themselves to developing contingencies. A great deal of prudence must be exercised in evaluating the worth of any drug, since, as more and more medicaments are introduced into the market, their virtues are flaunted with spectacular and often unjustified claims.

In the main, tranquilizing drugs are employed in psychotherapy during extreme anxiety states when the patient's defenses crumble or when the patient is so completely involved in protecting him or herself from anxiety as to be unable to explore its sources. In neurotic patients the principal medicaments employed for anxiety are Xanas, Librium, Valium, and Serax. In borderline patients who are decompensating (depersonalization, extreme anxiety, psychotic-like ideation) low doses of neuroleptics, e.g., Stelazine and Haldol may be temporarily tried. In schizophrenia associated with apathetic and depressive symptoms, Stelazine and Trilafon may be employed. In schizophrenic excitement, Thorazine is an excellent drug, although, in office practice, Mellaril is effectively used. In psychotic reactions with apathy and withdrawal, Stelazine and Trilafon are helpful. Manic phases of manic-depressive psychosis may be approached with lithium

and Haldol. For mood elevation in mild depressions, Ritalin may sometimes be employed, especially in older people. For moderate and neurotic depressions the monoamine oxidase (MAO) inhibitors, Nardil and Parnate, are sometimes utilized, recognizing the side effects and dangers that may accompany their use. Tofranil, Desipramine, and Norpramine apply themselves well to retarded depressions, while Elavil is often helpful in agitated depressions. For suicidal depressions electroconvulsive therapy is preferred. In drug addiction and alcoholism certain drugs may be valuable—for instance, methadone in the former and antabuse in the latter.

People react uniquely to drugs, not only because of their constitutional physiological makeup, but also because of their mental set, their attitudes toward the medication, and the specific lines of their expectation influencing both beneficial and side effects. Experimentation will be required in dosage and type of drug. The very young and the very old may exhibit a sensitivity to drugs that require either a reduction of dosage or contradict their use. Drug administration must be under the direction and control of a qualified psychiatrist who first examines the patient and then prescribes the best chemical adjunct. The psychiatrist should see the patient periodically thereafter to ascertain the results of drug treatment, to manage side effects, and to alter the dosage when necessary.

The monitoring by laboratory tests of blood levels of psychotropic medications may be important in patients who are not responding well to these medications. Patients show variations in their absorption of drugs from the gastro-intestinal tract as well as in the metabolism of the drugs. If drugs other than the principal one are being taken, these may influence the absorption process causing blood levels that are too low for clinical relapse or too high with precipitated toxicity. Many patients forget or refuse to follow proper drug intake regimens and monitoring of blood levels can detect whether too little or too much medication is being used in order to regulate side effects, and to ensure compliance. Standard therapeutic dosages do not influence all patients the same way, some under-responding and others experiencing toxic effects. Moreover, in patients with cardiovascular illness on antidepressants, for example, careful monitoring may enable maintaining the patient on a therapeutic level with the lowest drug concentrations to

reduce the risks. The monitoring of neuroleptic blood concentrations in schizophrenia helps identify the optimal plasma levels for good dopamine receptor binding at the lowest concentrations thus reducing extra-pyramidal effects and the danger of tardive dyskinesia.

ANTIPSYCHOTIC DRUGS (NEUROLEPTICS)

Neuroleptics are used to reduce or eliminate the symptoms of psychosis in conditions such as schizophrenia, psychotic depression, mania, schizoaffective disorder, delirium, drug-induced psychosis and paranoid disorder. Such symptoms include disordered thinking, delusions, hallucinations, suspiciousness, extreme anger, markedly aggressive behavior, and agitated excitement. Given in periods of remission from psychosis, antipsychotic drugs may prevent a relapse and social and cognitive deterioration.

How these drugs work is not yet clearly known, but it is believed that they regulate at the receptor level the activity of the neurotransmitter dopamine (which operates excessively in schizophrenia). These medications also block other receptors producing quinidine-like activity and calcium-channel blockade, which may produce some undesirable side effects.

There are five distinctive classes of antipsychotic drugs for clinical use in the United States that are equally effective in antipsychotic activity, but vary in their pharmacologic profiles. This is all to the good since different individuals respond better to some of these classes than to others. The first and oldest class of drugs are the phenothiazines, which are of low potency, and hence require high dosage to be effective. Three common forms are available which vary slightly in chemical composition and produce somewhat different side effects. For example, the aliphatic phenothiazines (like chlorpromazine or Thorazine) produce marked sedation and are often used in overactive and aggressive psychotic patients. They do, however, lower the blood pressure (hypotension) and moderately promote extrapyramidal symptoms such as tremors, rigidity and masklike facial expression (Parkinsonism), which may necessitate neutralization by an antiparkinsonian

drug. The second variant of phenothiazines is the piperidine phenothiazine group like thioridazine (Mellaril), which has the same effect as Thorazine but produces a lower incidence of extrapyramidal symptoms. The third variant is the piperazine phenothiazine group like trifluoperazine (Stelazine), perphenazine (Trilafon), and fluphenazine (Prolixin), which because of higher potency require lower dosage, hence produce less sedation and lowering of blood pressure (hypotension). Their disadvantage, however, is the higher incidence neurological (extrapyramidal) symptoms.

The second class of neuroleptics, the butyrophenones, have much the same effect as the piperazine phenothiziazines. The most widely used of these is halperidol (Haldol) which has a reduced tendency to cause undesired sedation, anticholinergic effects and hypotension, but a high incidence of extrapyrmidal symptoms. The third class are the thioxanthenes: Thiothixene (Navane) which has similar side effects as Stelazine, Trilifon, and Prolixin; and chlorprothixene (Taractan), which has some properties like Thorazine. The fourth class is represented by dihydroindolone Molindone (Moban) and produces moderate side effects. The fifth class consists of dibenzoxazapine or loxapine (Loxitane) which often produces sedation and extra-pyramidal symptoms, but only moderate hypotension and anticholinergic effects. New drugs will undoubtedly come into the marketplace that exercise antipsychotic effects without the danger of tardive dyskinesia. For example, an investigative drug, Clozapine, has been found effective without the side effects of the neuroleptics. But even Clozapine has its destructive side effects in some cases affecting the blood through production of agranulocytosis.

The present available drugs vary in their choice and degree of receptor blockage, and hence the propensity for side effects. Excessive dopamine receptor blockage results in extrapyramidal movement disorders and tardive dyskinesia; blockage of muscarinic acetylcholine receptors are anticholinergic causing urinary retention, constipation, dry mouth and memory dysfunction; histamine receptor blockage produces sedation, weight gain and hypotension, tachycardia and lightheadedness. By selecting drugs that have a lessened capacity for side effects, disturbing symptoms can be minimized. Since patients respond differently to medications and only a clinical trial can determine which

neuroleptic will best be tolerated. Some therapists start therapy with the older drugs like chlorpromazine (Thorazine), thioridazine (Mellaril), or fluphenazine (Prolixin), and only where uncomfortable side effects occur do they shift to drugs with a lower receptor affinity like molindone (Moban) and loxapine (Loxitane).

Given any of the commonly used antipsychotic drugs administered over an adequate period in proper dosage, they all exert approximately the same antipsychotic influence. Side effects may be different among the different groups and often the selection of a medication is determined by whether we want to eliminate a selected side effect. Thus he anticholinergic sedative reaction of drugs like Thorazine, Mellaril, and Taractan may be troublesome for some patients and here we would use the less sedating drugs like Haldol, Prolixin, or Stelazine. On the other hand extrapyramidal symptoms, like restlessness, (akithesia) muscle spasms (dystorila) and muscle rigidity (parkinsonism) are intolerable in susceptible patients and Mellaril, Navane, or Moban would be used, with less of an extrapyramidal effect. In elderly or cardiac patients, a selection of drugs should avoid those that lower blood pressure or depress heart action, e.g., Thorazine, Mellaril, and Taractin. If dangerous toxic reactions occur, the more innocuous drug Moban is best to use. It is important not to mix the different neuroleptics. In elderly patients who display disturbing or unmanageable psychotic symptoms as part of an organic brain syndrome, severe depression, mania, paranoidal condition, or schizophrenia, antipsychotics may be indicated, but because of susceptibility to toxic reactions in the elderly, the dose should be reduced to one-third to one-half of the usual adult dose. High potency medications in small amounts like Prolixin and Haldol are preferred, administered in divided small doses to avoid the anticholinergic sedative and autonomic effects of the low potency drugs. However, extrapyramidal neurological side effects may occur with high potency medications. Sometimes medium potency drugs, like Trilafon work well with older patients, and in cardiac conditions Moban and Haldol may be prescribed.

Since there are some patients who seem to respond better to some classes of drugs than to others, after trying one medication for a sufficiently long period with gradually increasing dosage and achieving no success, one may then experiment with a new drug. In

spite of some reports regarding the stimulating effect of the high potency antipsychotics like Prolixin, Permitil, and Haldol, there is little evidence for this and they should not be prescribed for this purpose. High potency neuroleptics like Prolixin, which have neurological (extrapyramidal) side effects and which may retard sexual functioning should be avoided where these effects are likely to upset a patient, for example, a paranoid individual. Too early use of long-term single dose injections (Prolixin Decanoate, Haldol Decanoate) may be responsible for noxious effects.

In adolescent schizophrenia, disturbed thinking and behavioral patterns may be helped by neuroleptics although the dosage must be monitored and adjusted in relation to the degree of impairment produced by side effects. The low potency sedating antipsychotics, like Thorazine and Mellaril are best avoided in favor of the high potency drugs like Stelazine, Navane, Prolixin, and Haldol, which are less sedating.

There is some evidence pointing to the positive effects of low doses of antipsychotics in certain borderline and schizotypal personality disorders. In patients with symptoms of "psychotism," illusions, ideas of reference, obsessive compulsive symptoms, and phobic anxiety, Goldberg, et al. (1986) found that Thiothixene (Navane) in an average daily dose of 8.7 mg produced favorable results. Soloff et al. (1986) discovered that an average dose of 7.24 mg of haloperidol (Haldol) relieved symptoms of depression, anxiety, hostility, "psychotism," and paranoid ideation in borderline patients.

Rapid intensive "neuroleptization" has not fulfilled promises of great effectiveness as compared to standard treatment. Time may be needed before results become apparent. Attempts to reduce this time by massive increases of dosage succeed in toxicity more often than in treatment success. After several weeks of studied treatment without results, trials with increased daily doses (like 1200 mg Thorazine or equivalent) may be in order.

Side effects are to be expected in all of the neuroleptics no matter which are chosen, and the patient should be told that they are usual and indicate the drug is having an effect. Should the patient continue to be drowsy, the bulk of the dose may be administered at night which will help sleep. Dryness of the mouth usually abates. Constipation may appear

in older people. Rarely, some female patients develop a secretion from the breasts; they may manifest a weight gain and amenorrhea. Because skin sensitivity is increased, patients should be warned not to expose themselves deliberately to the sun during summer months. If skin sensitivity to sun lasts, Narvane is the best drug. Should dizziness occur due to postural hypotension, the patient may be instructed to stand up slowly from a lying or sitting position. Parkinsonism is considered by some authorities to be a welcome sign, a guidepost to maximum dosage. If it or dystonia or akithesia occurs, the patient should receive Artane (1-6 mg daily) or Cogentin (1-2 mg two or three times daily), or Kemadrin (2.5-5 mg three times daily). A rare side effect is agranulocytosis, and if the patient complains of a sore throat, a white blood cell and differential count should be obtained. In the event agranulocytosis is present, the drug should be immediately discontinued, and a medical consultation obtained to forestall complications. Jaundice is not too important, occurring mainly in 0.5 or 1 percent of older people. Reactions of skin, retinal, and corneal pigmentation are very rare.

Some side effects can be especially distressing and are usually responsible for patients discontinuing medication. Such side effects should therefore be anticipated, discussed with the patient, and managed by prolonged supervision. Without supervision one can expect a high incidence of drug disuse and relapse of illness. Anticholingeric effects may be neutralized by some medications, like bethanechol (Urecholine) or in emergencies by physostigmine (Antilirium). Among recipients of high potency drugs, extrapyramidal neurologic symptoms are reversible with the discontinuance of medication or can be neutralized by appropriate drugs like benztropine (Cogentin), trihexyphenidyl (Artane), diphenhydramine (Benadryl), and amantadine (Symmetral). The muscle spasms of the tongue and mouth (dystonias), the "restless legs" and fidgetiness (akithisias), tremors of the extremities and difficulties in walking (parkinsonism) can alarm the patient and relatives, but are not really too serious since they can be alleviated readily with appropriate medications mentioned above.

One complication is serious and develops in about 20 to 25 percent of patients, especially older persons on prolonged exposure to antipsychotic drugs, although in some

cases it may develop in young patients after 3 to 6 months of therapy. This is tardive dyskinesia with peculiar movements of the tongue, jaws, face, and extremities. Withdrawal from drugs at first exaggerates the symptoms. No form of therapy has proven consistently successful. Another very serious but rare complication is the "neuroleptic malignant syndrome" that is not related to dose or drug interactions most likely to occur in young men, patients with brain disorders, and those subjected to heat stress, physical exhaustion, and dehydration. Long-term use (beyond 6 to 12 months) of neuroleptics is justified only when there are disturbing symptoms of schizophrenia, paranoia, and certain neurological diseases that do not respond to psychosocial treatments alone; short-term use (for up to 6 months) should be restricted to acute psychosis, severe mania, or agitated depression that are not relieved by alternate therapies. Where tardive dyskinesia appears, neuroleptic and anticholinergic medications should be discontinued. Low doses of benzodiazepines may be tried and psychosocial treatments intensified. Some patients, however, because of the severity of their illness, will still require neuroleptic therapy. In this case, a chemically dissimilar neuroleptic should be tried other than the one that precipitated the reaction. In view of possible malpractice suits, patients and relations should be appraised of risks and benefits in using and continuing neuroleptics, if they are required after a year, and record of notations of this filed in the case records. In all cases, psychosocial treatment should be utilized and neuroleptics lowered in dosage or stopped where the patient is capable of getting along without them.

Benefits from drug therapy do not usually occur immediately, but may require 3 or 4 weeks before results are seen. Side effects, however, may be experienced early in therapy and should not encourage premature termination of medication unless they are serious. A trial of 6 to 8 weeks with proper dosage is advisable and if some dysphoric side effects develop these should be treated with proper medications such as Cogentin.

Some caveats and routines are important to mention. Combinations of antipsychotic drugs are occasionally used to achieve a better balance between therapeutic and adverse effects, but this practice is generally avoided since psychotic drugs do not differ in their impact on target symptoms, and in combination may increase side effects. Neuroses,

character disorders, anxiety reactions, and alcoholic upsets should never be treated even in low dosage with this powerful class of medications because of the risk of side effects. Before using drugs, a complete physical examination, blood count, liver profile and electrocardiogram should be done. In starting therapy the dosage is best at a low level (equivalent of 100 mg of Thorazine) and the dosage titrated upward watching the therapeutic response and side effects. Since absorption of medication is delayed by food and decreased by antacids, administration should be between meals and 2 hours after antacids. Following a few days of therapy, the total dosage may be given at bedtime provided the blood pressure does not decrease too drastically. Megadoses of drug should be avoided, but adequate dosage must be maintained (e.g., the equivalent of 400 to 600 mg of Thorazine for an acute schizophrenic episode). Inadequate doses yield side effects without therapeutic benefits. Finally chronic schizophrenia with symptoms of withdrawal and apathy usually will not respond to any of the neuroleptics. Because of the complications occurring in drug therapy it is important that a psychiatrist experienced in pharmacotherapy be put in charge of this dimension of the treatment process.

Maintenance drug therapy may be required and should be given in the lowest dosage (usually about 20-30 percent of the acute treatment doses) to keep the patient in some kind of functional equilibrium. More than 50 percent of schizophrenic patients rapidly relapse in a psychosis without drugs as compared with less than 20 percent of those on antipsychotic agents. How long to continue medications is difficult to assess. One rule of thumb is to extend treatment with drugs for 1 year after the first attack, for 2 years after the second; and indefinitely after the third attack. "The safest guideline is to use the least medication for the shortest time necessary ..." Baldessarini (1977). In all cases the rule should obtain to reduce the quantity of drug slowly once optimal symptom control has been obtained. This may be accompanied by total abstinence once, then twice weekly to allow the patient to try to make a drug-free adjustment. Psychotherapy and environmental adjustment to relieve the patient from undue stresses should be coordinately instituted. Should symptoms return, the dose levels can be adjusted upward. There are some patients who will need periodic drug therapy for the rest of their lives. Yet it is at least theoretically possible to secure adjustment in most cases without medication,

provided adequate educational, rehabilitative, and psychotherapeutic facilities are available and utilized. Even hardcore institutional mental patients on long-term maintenance drug therapy have been withdrawn from medications with benefit where social-environmental treatment programs were organized (Paul et al, 1972). With the increasing incidence of malpractice lawsuits involving tardive dyskinesia, the prescription of neuroleptics has become more carefully controlled. The estimate that a large percentage of psychiatric and geriatric patients on psychotropic drugs for 2 to 3 years have some symptoms of this complication is inspiring a more conservative use of major tranquilizers and a more sensitive diagnosis of early signs of their devastating side effects. Many states are mandating the patient's right to informed consent as a prerequisite to the employment of psychotropic drugs. The fact that studies indicate a more benign course for schizophrenia than the hopeless outlook in past years, and an understanding of how improved community care, better work opportunities, and social integration can constitute the preferred treatment plan is sponsoring a more aggressive drug-free orientation (Warner, 1985).

Because some patients who require maintenance therapy are loath to use oral medications or forget to take them, parenteral long-acting phenothiazines (Prolixin Enanthate, Prolixin Decanoate, Haldol Decanoate) may be given. Such maintenance antipsychotic drugs have been found to play a crucial role in the prophylactic treatment of patients with schizophrenia who resist oral therapy. Nonmotivated patients may be brought in to the doctor's office by a relative. As a last resort, some reward, by arrangement with the relative, may be given the patient by the doctor (e.g., his allowance) each time he appears for an injection. In a sizable number of patients schizophrenia that has existed for years may "bum out," particularly where the environment poses few stresses and the adaptive level has improved. Should relapse follow on withdrawal, medications may be reinstated.

Mania. Lithium carbonate (300-600 mg taken three times daily) is an effective therapeutic and prophylactic agent (with no undue sedative effect) for bipolar disorders (manic-depressive psychosis) where manic attacks are part of the recurrent illness. It has

also been used in acute nonorganic psychosis where an affective element exists. Some depressions, unresponsive to antidepressants have been helped by administration of lithium. Certain cases of schizophrenia (Hirschowitz et al, 1980) and alcoholism (Merry et al, 1976) are said to be responsive. Since lithium acts slowly, an excited, manic reaction may require initial antipsychotics, like Haldol or Thorazine orally or parenterally. This use is temporary since side effects may occur with the combination. The patient may be started on 300 mg of lithium three times daily, serum levels being tested twice during the first week. The usual dose is 600 mg three times daily, but this must be individualized and regulated by the blood level response. Regular determination of lithium serum levels by a good laboratory at least every month to maintain the proper concentration is essential. The range of lithium levels is kept between 0.8 to 1.5 milliequivalents (mE_ql) but during maintenance can be as low as 0.6 or 0.4 mE_ql tested every 2 months. Side effects are tremor, dry mouth, stomach discomfort, muscular weakness, fatigue, and a metallic taste. Urinary, cardiac and blood problems may develop with sensitivity to lithium and overdose. Because of its effect on the kidneys and other organs, lithium should be prescribed and the patient closely observed by a psychiatrist skilled in its use. Where a manic patient fails to respond to lithium, alternative drugs like carbamazepine (Tegretol) and clonazepam (Clonopin) may be tried.

A thorough examination of kidney function is in order prior to lithium administration, since lithium is excreted through the kidneys and impairment of kidney function may lead to lithium toxicity. Lithium also affects the thyroid gland and an examination of this organ may avoid complications. Toxicity may occur at usual therapeutic serum concentrations of lithium, so monitoring of side effects is important especially in the elderly and brain damaged. Signs of toxicity include weakness, tremor, ataxia, drowsiness, tinnitus, nausea, vomiting, nystagmus, seizures, coma, urinary symptoms, gastric distress, hand tremor, and thyroid effects. Lithium should be avoided in severe renal or cardiovascular disease, and where there is dehydration and sodium depletion.

Antipsychotic drugs are considered non-habituating, and withdrawal symptoms are

rare. However long-term administration should be accompanied by periodic blood and liver studies (Bloom et al, 1965). Some therapists make it a rule to have their patients who are on substantial medication examined every three months neurologically, in order to forestall development of unfortunate complications.

<div align="center">ANTIDEPRESSANT DRUGS</div>

On the whole, antidepressant drugs are inferior to electroconvulsive therapy in the treatment of severe and suicidal depressions. They do have an important utility, however, in non-suicidal depressions provided that the selection of the drug is one that will fit in with the prevailing profile of symptoms. A caution to be exercised relates to the fact that antidepressants tend to intensify schizophrenic reactions and, especially in bipolar depression, to precipitate manic symptomatology.

Helpful in overcoming fatigue and oversedation is the sympathomimetic amine: dextroamphetamine   (Dexedrine) and methamphetamine (Desoxyn), which are not used much today due to the potential for abuse. Methylphenidate (Ritalin) and Pemoline (Cylert) are similar in their effects to the sympathomimetic amines, but relatively weaker. Hyperkinetic children (ages 6 to 14) with both organic brain syndromes and functional disorders respond well to d-amphetamine, which has a calming rather than stimulating affect on them (Zrull et al, 1966). Amphetamine dependency may have serious consequences in the form of restlessness, irritability, insomnia, weight loss, aggressiveness, and general emotional instability (Lemere, 1966). Personality changes may progress to outright psychosis, the form of disorder being patterned by existing inner psychological needs and mechanisms (Commission on Alcoholism & Addiction, 1966). Prolonged addiction may result in permanent organic damage to the brain. It is essential, then, that administration of amphetamines be very carefully supervised.

Imipramine (Tofranil) is particularly valuable in inhibited endogenous depressions, approximately one-third being arrested and one-third improved. It is probably not as effective as ECT (minimum of eight treatments), but it may be a substitute where for any reason ECT cannot be easily administered. Imipramine has also been found useful in

enuresis (Munster et al, 1961) panic reactions, and bulimia (Klein & Davis, 1969, Pope et al, 1983).

Since in some cases it may produce insomnia, Kuhn (1960) recommends that the first dose of imipramine be given at bedtime. If the drug helps the patient sleep, it may be taken throughout the day. If insomnia occurs, it should not be given after 3 pm. Starting with one 25-mg tablet three times daily, the dose is increased by one tablet each day until eight tablets daily are taken. When the symptoms remit, the dose is reduced by one tablet daily until a maintenance level is reached. Older people respond more intensely to imipramine and may do well on the smaller 10-mg tablets. Because agranulocytosis has been reported, occasional blood checks are recommended. Imipramine is contraindicated in glaucoma. Should side effects of a disturbing nature occur (skin itching, confusion, loss of appetite, etc.) the drug should be stopped and a phenothiazine substance administered. If an MAO inhibitor (Parnate, Nardil, Marplan) is being taken, this should be discontinued for at least 2 weeks prior to introducing imipramine, since the combination is dangerous. Kline, differing from the majority of opinion, claimed that small doses of one can be used in combination with the other (Kline, NS, 1966). This defection has now recently been substantiated by others who claim that some patients resistive to all conventional therapies have been helped by a combination of a tricyclic and MAO inhibitor drug (Ayd, 1986). Agitated depressions may require a neuroleptic like Thorazine or Trilafon in addition to imipramine or a sedative antidepressant like Elavil. Following ECT, imipramine may be prescribed for a period to reinforce the antidepressive influence. Anticholinergic side effects include dryness of the mouth, tachycardia, arrhythmia, sweating, dizziness, constipation, visual disorders, urinary retention, and, occasionally, agitation, which may be controlled by regulating the dosage. In many cases the total dose can be given at night. Imipramine can produce orthostatic hypotension and tachycardia, and prolong atrioventricular conduction time. It must be used with great caution in patients with bundlebranch disease of the heart. Side effects of arrhythmia may be treated with physostigmine (2 mg intramuscularly or intravenously very slowly injected).

The newer imipramine and amitriptyline substances—desipramine (Norpramine,

Pertofrane) and nortriptyline (Aventyl)—appear to be no more effective than the parent compounds. They do have more stimulating properties and hence appear best suited for retarded depressions. Since they aggravate preexisting anxiety and tension, they should not be used where these symptoms are present, except perhaps in combinations with a sedative- tranquilizer.

Amitriptyline (Elavil) is a useful antidepressant with more sedative features than imipramine. Benefits are usually felt within a few weeks (Feldman, PE, 1961; Dorfman, 1961). Depression, tension, loss of appetite, disinterest in the environment and insomnia may be reduced or eliminated in somewhat more than half of the patients to whom the drug is given. It is administered in 25 mg dosages three times daily, increasing the dose by 25 mg daily until a 150-mg daily intake has been reached. In some cases a dose of 200, 250, and even 300 mg will be required. Older patients do well with a smaller dose, 10-mg tablets being substituted for the 25-mg tablets. The side effects, the contraindications, and the incompatibility with the MAO inhibitors are similar to those of imipramine. Elavil potentiates alcohol, anaesthetics, and the barbiturates, and the quantities of the latter substances, if taken, should accordingly be reduced. Where a psychotic (delusional) depression exists, a combination of amitriptyline and a neuroleptic like perphenazine (Triavil for example) provides better results then either drug alone.

Monoamine oxidase (MAO) inhibitors, such as tranylcypromine (Parnate) and phenelzine (Nardil), while less successful than ECT, Tofranil, and Elavil, have some use, especially in the neurotic or hysterical depressions (Dysthmic Disorder) or where a tricyclic cannot be used as in glaucoma, cardiovascular disease, or prostatic enlargement with urinary retention. There is some evidence that they are especially useful in panic disorder, bulimia, and atypical depressions. If a patient has not responded to a tricyclic in 3 to 6 weeks, one can go from a tricyclic to a MAO inhibitor after a waiting period of 2 weeks. Beneficial effects may not occur for about 3 weeks. MAO inhibitors must not be given with other medicaments such as cold tablets, nasal decongestants, hay fever medications, "Pep pills," antiappetite medications, and asthma inhalants. Cheeses, pickled herring, chicken livers, beer, Chianti wine, coffee and tea in quantity, and over-the-counter

cold remedies must also be eliminated from the diet. Side effects with the MAO inhibitors are potentiation of other drugs (such as barbiturates and amphetamine), hypotension, constipation, dysuria, reduced sexual activity, edema, and occasional liver toxicity (Ayd, 1961a & b). Such side effects may require an adjusting of the dose. N. S. Kline (1966), differing from other authorities in this country, contends that oral amphetamines and monoamine oxidase inhibitors are not incompatible and that the combination often eliminates the abrupt letdown that is a drawback in using MAO inhibitors alone.

Doxepin (Sinequan) is a useful antidepressant that has fewer side effects than Tofranil or Elavil. It may be given for neurotic depression, depression associated with alcoholism, depression or anxiety related to organic disease, and psychotic depressions with associated anxiety including involutional depression and manic-depressive disorders. It is relatively safe for and well tolerated by elderly patients. The dose for mild or moderate depression is 25 to 50 mg three times daily and for severe depression 50 to 100 mg three times daily. It may be used when the patient is taking guanethidine for hypertension in contradistinction to other tricyclics.

In the event the tricyclics (Tofranil, Elavil, Sinequan) produce too great sedation, Ritalin (10-20 mg) after breakfast may be prescribed. A nonbarbiturate hypnotic, like Doriden or Noludar, may be used for insomnia. Birth control pills should not be taken since they depress the plasma level of tricyclics. Patients over 60 should not be given the total dose at nighttime. Rather, one-half the dose after the evening meal and one-half at bedtime should be prescribed. After recovery the total dose should be continued for 3 months, then gradually lowered over several months, and finally discontinued. If the patient fails to respond to tricyclics, a MAO inhibitor (Nardil, Parnate), as mentioned, may be tried with the usual precautions. Some patients find the anticholinergic effects of the standard antidepressants intolerable. When this occurs the therapist may try one of the newer tetracyclic drugs such as trazodone (Desyrel). Because of its sedative effect it may be given at nightime which can be valuable for light sleepers. Maprotiline (Ludiomil) and trimipramine (Surmontil) are other antidepressants sometimes tolerated well despite their anticholinergic and other side effects. In the event a depressed patient has a cardiac

illness, wellbutrin (Buprion) may be considered a good choice. This drug has few anticholinergic or sedative effects. Amoxapine (Asendin) is another medication that acts more rapidly than the other antidepressant and it has a wide range of actions useful in mild as well as psychotic depression.

Combinations of drugs have been developed for treatment of agitated and anxious depressions (Smith ME, 1963). For example, Triavil and Etrafon are mixtures of perphenazine (Trilafon) and amitriptyline (Elavil). This combination is supplied in several strengths, as outlined in Table 56-3. Other combinations are Parnate and Stelazine, Nardil and Trilafon, and Thorazine and Dexedrine, the doses being adjusted in accordance with which target symptom (depression, anxiety, agitation) is most in need of control. Such combinations are considered unnecessary by some authorities who advise giving single drugs in adequate dosage and adding accessory drugs only when it is necessary to control certain symptoms not influenced by the original drug.

It is advisable in prescribing antidepressants to instruct and reassure patients regarding possible side effects. The patient should be given a typewritten sheet, such as in Appendix T, including dosages and times to take pills. This is especially necessary for geriatric patients who have a tendency to forget. The patient should be instructed that no alcohol is to be taken for the first 2 weeks of using antidepressant medications. However, after this one can, if desired, drink moderately provided that the medication is not taken at the same time.

If a patient is coordinately using other medications for a physical condition, these medications may dictate the preferred antidepressant to use. For instance, in hypertension where guanethidine (Ismelin, Esimil) is being taken, doxepin (Sinequan) is a suitable antidepressant to use.

ANTIANXIETY DRUGS (ANXIOLYTICS)

It is unsound to assume that a high level of anxiety is needed to motivate a patient for therapy or to make greater efforts to explore one's problems. While tolerable anxiety

and tension may require no medication, there is no reason to withhold psychotropic drugs where the patient is in real discomfort. A double-blind study by Whittington et al. (1969) with an unrelated outpatient population experiencing anxiety showed a greater perseverance in and acceptance of treatment of those receiving psychotropic drugs as compared with those receiving placebos. The fact that the patient gets relief from medicaments prescribed by the therapists seemed to help the relationship and to give the patient greater confidence in continuing therapy. The main anxiolytics are the benzodiazepines that are among the most frequently prescribed substances and owe their popularity to their effectiveness in subduing anxiety, calming stress, and quieting psychosomatic symptoms. They attach to highly specific receptor sites in the brain potentiating the inhibitory effects of the neurotransmitter GABA (y-aminobutyric acid). In higher dosage they possess a high level of safety, but in sensitive persons and the elderly they may produce ataxia, and when mixed with alcohol the combination can be dangerous. On the whole, however, their beneficial influence far outweighs their untoward consequences and they have an important place in the therapeutic armamentarium. Tolerance to benzodiazepines is very much less than to other anxiety agents like barbiturates, prolonged use of which necessitates increased doses of the drug to secure the same effects.

There is some difference in the profiles of the different benzodiazepines due mainly to the duration of their half-life which is determined by their rate of elimination. Diazepam (Valium) acts rapidly and maintains its effect due to slow elimination. Chlordiazepoxide (Librium) acts more slowly and also has a long half-life. Chlorazepate (Tranxene), halazepam (Paxipam), and prazepam (Centrax) produce metabolites similar to Valium, and apart from their rate of absorption very much act in the same way. Alprazolam (Xanax) and lorazepam (Ativan) have the shortest half-life of the benzodiazepines.

Over the years some diazepines have been differently utilized, for example, chlordiazepoxide (Librium) for alcoholic withdrawal symptoms, lorazepam (Ativan) and alprazolam (Xanax) for anxiety with depression, hydroxyzine (Atarax, Vistaril) for allergic reactions and itching, alprazolam (Xanax) for some panic reactions and agorophobia, and

flurazepam (Dalmane), triazolam (Halcion), and temazepam (Restoril) for insomnia.

All of these drugs should be employed with caution since tolerance and habituation is possible with prolonged use. To prevent withdrawal reactions the drugs should be discontinued gradually in those who have used them for more than 2 months, or in some cases even less, especially short-acting varieties like Ativan, Xanax, Halcion, and Restoril. For example, in the use of Xanax, dose reduction of no more than 1 mg every 3 days is advisable. Withdrawal symptoms generally consist of anxiety, depersonalization, and various physical symptoms that may frighten the patient greatly. Where large doses of medications have been taken and withdrawal is sudden, symptoms similar to barbiturate withdrawal, e.g., convulsions, may occur.

In prescribing anxiolytics, symptoms can sometimes be used as a guide for determining which tranquilizers to use. Thus, inhibited, motor-retarded, and anxious patients may do best on diazepam (Valium); the overactive, anxious patients on chlordiazepoxide (Librium); and the hostile, anxious patients on oxazepam (Serax). Where anxiolytics fail to control anxiety in borderline patients, close to a breakdown, one may try neuroleptic drugs like Stelazine. Other than this one should never use neuroleptics in nonpsychotic patients. Occasionally, barbiturates like phenobarbital work better in some anxiety-ridden patients than any other drugs. There are some anxieties that do not respond to any psychotropic drugs. These are often found in obsessive individuals who cannot stand the emotional straightjacket that tranquilization imposes on them. Anxiolytics are sometimes used along with antidepressants and major tranquilizers where anxiety is great.

Of all the minor tranquilizers, diazepam (Valium), chlordiazepoxide (Librium), and alprazolam (Xanax) are probably most used. With the introduction of buspirone (BuSpar ® Bristol-Myers Company, Evansville, Illinois), which holds promise of being an ideal anxiolytic drug, and whose influence is not through sedation, we may possess an important therapeutic and research tool. Most neurotic anxieties can be treated psychotherapeutically without drugs. It is only where the anxiety is so intense that the

patient cannot function or because the anxiety interferes with psychotherapy that drugs should be used. In some cases where the patient as a result of psychotherapy is ready to face a fearful situation but avoids this, a drug can help to break through. There is, however, a tendency to overdose. One way of regulating the dosage of tranquilizers is suggested by Hollister (1974) with Valium. Two hours before bedtime the patient is enjoined to take 2.5 mg Valium and to make a note whether he or she falls asleep earlier than usual, sleeps longer, and has a slight hangover next morning. If these do not occur, 5 mg are taken the second night. Should the patient still not respond, 10 mg are taken the third night. The hangover effect may be sufficiently great to last the patient throughout the day. If not, one-fourth of the evening dose may be taken during day.

The indications for Valium and Librium besides anxiety are certain depressions that may respond to its mildly euphoriant effect. They are also valuable in treating the agitation of chronic alcoholics in alcoholic withdrawal, including delirium tremens. In *severe* anxiety relatively large doses of Valium may be necessary. The starting oral dose is 5 mg three or four times daily. The patient is asked to telephone in 3 days to report how he or she feels. If there is no effect, the dose is raised to 10 mg four times daily so that the patient takes a total of 40 mg. The patient should be seen 4 days later, and if the symptoms continue, the dosage may be raised to 20 mg three or four times daily. The evening dose may be the largest one in the case of insomnia. When the patient feels better (tranquilization, mild mood elevation, increased appetite), one dose may be removed; 2 weeks later, a second dose is removed; 4 weeks later, all but the evening dose is taken away. Such regulation of the dosage will tend to prevent addiction. With higher doses patients may become ataxic and drowsy. Should this happen, the dose is lowered (it requires about 4 days to eliminate the drug from the system; consequently side effects may last during this period). Rapid symptomatic relief in alcoholic agitation, acute delirium tremens, hallucinosis, acute anxiety, and acute phobic and panic reactions may sometimes be obtained with 50 to 100 mg of Librium injected intramuscularly or intravenously, repeating in 4 to 6 hours if necessary. Caution in the use of Librium is to be heeded in older people who may become ataxic with even moderate doses.

Meprobamate (Miltown, Equanil) is another drug that has anxiety-alleviating properties when given over a sufficiently extended period, but is now not used as frequently as before having been replaced by the more effective and less habituating benzodiazepines. Indications for meprobamate are similar to those of chlordiazepoxide, except that it should not be employed in depressed patients. It is particularly useful where skeletal muscle spasm is present. The symptom profile of anxiety and tension may be helped with 400 mg three or four times daily, which may slowly be increased to as much as 2400 mg daily, this high dose being maintained for only a short time. Allergic reactions (fever, urticaria, bronchial spasm, angioneurotic edema) should be treated by discontinuing the drug and administering antihistamines, epinephrine, and possibly cortisone. Dependence and habituation are possible, consequently meprobamates should not be used for more than 3 months. Withdrawal from high doses should be gradual over a 1- to 2-week period.

Other minor tranquilizers include oxazepam (Serax) and alprazolam (Xanax). Serax (15-30 mg three or four times daily) has been utilized to control anxiety, neurotic depression, alcoholic tremulousness and withdrawal. The agitated reactions of older people also may respond to Serax (10 mg three times daily). Xanax in recent years has proven itself to be an effective anxiolytic and has additionally antidepressant and antipanic effects.

These minor tranquilizers have a disadvantage of leading to addiction over a long-term period, although the addiction potential of the benzodiazepines has been exaggerated. In a study of the long-term use of Valium, Hollister et al. (1981) found that in 108 patients suffering from severe pain and muscle spasm due to musculoskeletal disorders of the spine, who had been treated with the drug over an average period of 5 years, with a median dose of 15 mg/day (ranging from 5 to 40 mg/day) 83 percent of patients claimed benefit and "...diazepam seemed to retain its efficacy and did not lead to any clear-cut abuse". Nevertheless, withdrawal symptoms do occur when stopping benzodiazepines even where therapeutic doses have been used no matter how gradual withdrawal takes place and the reactions can be distressing (Ayd, 1984). Where a person

has an addictive personality (alcoholic, barbiturate user, etc.), it is best not to prescribe anxiolytics. Some new investigational antianxiety agents are in the process of being tested. One such non-benzodiazepine substance, buspirone (BuSpar), which has recently been released is helpful in patients with a generalized anxiety disorder. It has few side effects, is nonsedating, and has less potential for withdrawal symptoms, and less abuse potential.

In obsessional individuals who cannot tolerate losing control or not functioning with top efficiency, lowering performance may prove so upsetting as to obliterate any benefit from these drugs. Such persons may be taught to monitor their own minimal doses while being given reassurance to quiet them down.

Benzodiazepines are diminished in effectiveness when antacids and anticholinergic drugs (often sold over the counter) are concomitantly used.

Propranolol (Inderal) in doses of 10-40 mg three or four times daily may be of value in anxieties associated with beta adrenergic overstimulation, as in psychocardiac disorders. Inderal and other beta blockers require high doses, in which case careful monitoring of the heart is necessary to prevent excessive depression of cardiac function. Studies have shown that beta blockers are less effective in chronic anxiety and with agoraphobic or panic attacks than diazepam (Valium) although there is a possibility of addiction with the latter drug when utilized over a long-term period.

SEDATIVES, HYPNOTICS. AND PSYCHOSTIMULANTS

Since the advent of the benzodiazepines barbiturates have suffered a setback in popularity. Yet, in a few selected cases, they may still be the best drugs to use as daytime sedatives. Butabarbital (Butisol), phenobarbital sodium, and Tuinal in small dosage may be utilized here. However, in most cases the benzodiazepines are being employed for sedation as well as insomnia.

Insofar as insomnia is concerned, many substances have been used, abused, and then discarded in mankind's quest for a harmless substance that can hasten and sustain

sleep. We still do not have such a substance, but currently the least harmful, though still not perfect are the benzodiazepines, which have now replaced alcohol, bromides, opiates, barbiturates, ethchlorvynol, glutethimide and methaqualone as the most frequently prescribed drug for insomnia. Chloral hydrate is still employed occasionally as a safe and effective hypnotic although some patients complain about its unpleasant taste and irritating effect on their stomachs.

Benzodiazepine hypnotics are useful aids if taken occasionally when stress distracts the normal sleep tendency. When taken regularly for sleep insurance, hypnotics eventually defeat their purpose by exercising a generally negative effect. Without a pharmacological "straight jacket" no sleep is anticipated with the feared consequence of not being able to function alertly or at all the next day. On the other hand, where benzodiazepines are not prescribed, a stressed individual may resort to alcohol or more dangerous drugs which cannot be monitored.

The most popular benzodiazepines are the long-acting flurazepam (Dalmane) with a half-life of 78 to 200 hours, the short-acting temazepam (Restoril) with a half-life of 9.5 to 12.5 hours, and the ultra short-acting triazolam (Halcion) whose half-life lasts only 1.5 to 2.5 hours. Elderly persons who require daytime alertness and good psychomotor performance are best given triazolam (Halcion) in dosage of 0.125 mg, which may be increased to a limit of 0.5 mg. It is also given to persons who require a short boost in sleeping like those with jet lag with awakening in the middle of the night. Temazepam (Restoril) in dosage 15 mg to 30 mg is helpful to those who anticipate sleep difficulties. Flurazepam (Dalmane) with a dosage of 15 to 30 mg is highest in sedation and may impair performance. It has a utility for individuals who require at least some sedation.

Psychostimulants are now very rarely utilized for depression and diet control because of dangers of habituation. Amphetamines (Dexedrene, Desoxyn), methylpheni-date (Ritalin), cocaine, and pemoline (Cylert) are easily acquired illicitly, and are used and abused by large groups of people for their stimulant effect, their control of overeating, and the relief of fatigue. Consistent use of agents such as amphetamines is likely to induce an

organic brain syndrome with manic and paranoidal symptoms.

Some of the stimulants are medically indicated being for the treatment of certain syndromes (Baldessarini, 1972; Wobraich, 1977, Sprague & Sleator, 1973). Attention deficit disorders of children, hyperkinesis, poor impulse control, low frustration tolerance, and emotional lability may often be helped by dextroamphetamine (Dexedrine) or methylphenidate (Ritalin). Since the response to stimulants varies from child to child, adjustment of recommended dosage upward or downward will be necessary. These drugs have a calming effect on a hyperactive child and lessen the risk of later emotional problems that evolve from the acting-out and defensive patterns developed as a result of the hyperkinetic and attention deficit symptoms. In narcolepsy the heightened drowsiness, loss of muscle tone, and uncontrollable need to sleep may respond to high doses of amphetamine and methylphenidate, reinforced if necessary by imipramine.

PSYCHODYSLEPTIC (PSYCHOTOMIMETIC) DRUGS

Employed for the setting of model psychoses (see Chapter 9) LSD-25, mescaline, and psilocybin were once advocated to induce perceptual and cognitive crises in patients, release emotions, promote abreaction, revive memories, and open up channels to the unconscious. The effect on the individual was influenced by the environmental setting, the existing relationship with the therapist and activity of the therapist. Some patients, frozen in their affects, suddenly were transported into a psychedelic experience which enabled them to restructure their value systems somewhat after the manner of a mystical experience (see Chapter 10).

The extraordinary perceptual and hallucinatory irregularities induced by these drugs unfortunately appeal to adolescents in rebellion, thrill seekers, and psychopaths who subject themselves to a wondrous "widening of consciousness" in quest of new insights and powers. "It permits you to see, more clearly than our perishing mortal eye can see, vistas beyond the horizons of this life, to travel backwards and forwards in time, to enter other planes of existence, even—to know God" (Wasson, 1963). Psychiatric patients, disappointed in psychoanalysis, hypnosis, drug therapy, and electroconvulsive therapy

(ECT), often express a demand for the drug on the basis of its vaunted effects on the psyche. Unfortunately, on the debit side of the ledger is the capacity of psychodysleptics, particularly in vulnerable borderline patients, of sweeping away defenses that keep the individual in some kind of functional relationship to reality. "Our accumulating day-to-day experience with patients suffering the consequences of the hallucinogens demonstrates beyond question that these drugs have the power to damage the individual psyche, indeed to cripple it for life" *(JAMA,* 1963).

Favorable reports on LSD therapy with almost every syndrome have been published by Abramson (1956a & b), Bender et al. (1962), Chandler and Hartman (1960), S. Cohen and Eisner (1959), Cutner (1959), Dahlberg (1963a & b), Eisner and S. Cohen (1958), Feld et al. (1958), Heyder (1964), D. J. Lewis and Sloane (1958), Martin (1957), Sandison and Whitelaw (1957), Savage et al. (1964), Schmiege (1963), Simmons et al. (1966), and Whitelaw (1959). The book, *Uses of LSD in Psychotherapy* (Abramson, 1960), published by the Josiah Macy, Jr., Foundation, has a wealth of experimental and clinical data. The paper by Spencer (1964) also contains material helpful in evolving a technique. A conference held at South Oaks, Long Island (NY), devoted to LSD therapy expounded its potentialities (Abramson, 1966). LSD has been particularly recommended in the treatment of alcoholism (Hoffer, 1965; Jensen, 1962; Kurland et al, 1966, 1971; McCabe et al, 1972; Mac Lean et al, 1961; Pahnke et al, 1970; Savage et al, 1969, 1973; Smith, CM, 1958).

Beneficial uses in group psychotherapy have been described by Bierer (1963) who claims good results for LSD (in combination with methedrine) in "acute neuroses and for some sex difficulties. In addition, our experience with LSD as one aspect of an individual and group psychotherapeutic program for psychotic patients has been sufficiently encouraging to merit its continued use on an experimental basis." Bierer insists that it is not dangerous to treat psychotic, psychopathic, and emotionally immature patients with LSD. Eisner (1964) has also described the facilitating use of LSD in group therapy.

More recent work has shown that beneficial effects with single large doses of psychodysleptic drugs, or multiple small dose usage are not sufficient to justify

recommending this therapy as adjuncts to psychotherapy. On the contrary, it may exert an adverse effect on the psyche in the form of an immediate "bad trip" and more insidiously repetitive frightening flashbacks.

This should not deter from continuing careful research on how psychodysleptic drugs influence mental functioning. The problem of evaluating the effect of these substances in psychotherapy is as great as, if not greater than, that of assessing any other adjunct in psychotherapy. Of basic importance is how the therapist (who must be with the patient for 5 hours or more) works with and relates to the patient who is under the influence of the drug. Where the patient becomes too upset, the psychosis may rapidly be abolished by intravenous administration of 50 mg of chlorpromazine. Motor activity is reduced by chlorpromazine, verbal objectivity lessened, anxiety resolved, feelings of unreality and depersonalization abolished, and though hallucinations or somatic delusions continue, the patient may not react to them adversely.

What is essential in utilizing hallucinogens experimentally is familiarity with the effects of the particular drugs employed. Sufficient time must be spent with a patient prior to the administration of the drug to establish a working relationship and a feeling of trust. The therapeutic surroundings must be congenial, and the therapist and preferably a psychiatric nurse should be with the patient during the period the drug is in effect (which may be as long as 10-12 hours) to render support if necessary.

Recently a new drug MDMA (3-4-methylene-dioxymethamphetamine) has been employed experimentally in the attempt to enhance psychotherapy (The Psychiatric Times, 1986). This drug is said to evoke a highly comfortable experience that invites intensification of feelings and self-exploration. The drug is taken in doses of 75-175 mg by mouth and its effects begin in 30-45 minutes. It is said to have few complications. Although the drug has been around for at least 15 years there have been few publications. It awaits further testing before its general use can be recommended.

ORTHOMOLECULAR PSYCHIATRY AND MEGA VITAMIN THERAPY

There is a theory that schizophrenia is the product of an endogenous hallucinogen that accumulates in susceptible individuals as a result of faulty metabolism. Implicated frequently, it is avowed, is adrenochrome, formed from oxidation of adrenalin and released in large quantities by the excessive methylation of noradrenalin. On the basis of this theory, Hoffer (1966, 1971) administered large quantities of nicotinic acid (3 g or more daily), which he and his associates believed could restore metabolic balances. The theory, as well as the cure, have been rejected by a number of scientific investigators who have been unable to confirm the chemical changes postulated. Nevertheless, a sizable group of psychiatrists (who call themselves "orthomolecular" psychiatrists, a term originated by Linus Pauling) have endorsed the value of large quantities of vitamins (nicotinic acid, nicotinamide, vitamin B6, vitamin C, vitamin B12, and pyridoxine) for schizophrenia in combination with other accepted therapies, such as phenothiazines, ECT, and psychotherapy.

A task force of the American Psychiatric Association was appointed to examine the claims and appraise the results of megavitamin therapy. The report rejected both the theory and practice of orthomolecular treatments (Lipton et al, 1973). The extravagant claims of the orthomolecular psychiatrists in the public media were considered unfortunate. According to the task force, it has been impossible to replicate the results of the advocates of this form of therapy. Other studies, such as a five year multihospital project sponsored by the Canadian Mental Health Association, have concluded that large doses of nicotinic acid (3000 mg per day or more), the cornerstone of megavitamin therapy, have no therapeutic value other than as a placebo.

Against these reports, the orthomolecular psychiatric group have claimed unfairness and bias. Members of the group cite their own research, including doubleblind studies, that substantiate the value of megavitamin treatments in acute cases, often in conjunction with ECT and other therapies (Hawkins & Pauling, 1973). They repudiate the results of attempts to replicate their findings on the basis that the research designs have been faulty. Hoffer claims that where the megavitamin program outlined by him has been followed exactly, all reports published have duplicated his original claims. Pauling (1974) insists

that "There is evidence that an increased intake of some vitamins, including ascorbic acid, niacin, pyridoxine, and cyanocobalamin, is useful in treating schizophrenia and this treatment has a sound theoretical base."

The controversy illustrates the difficulty of validating outcome research findings where faith or lack of faith in the modality, along with nonspecific therapeutic elements, are unavoidable contaminants.

Electroconvulsive Therapy

Public and legislative distaste for electroconvulsive therapy (ECT), distortions promulgated by movie depictions of the method, malpractice insurance rates 400 percent higher than rates where practitioners do not use this modality, and professional misunderstanding about its operations and utility have tended to cast a shadow on a technique that in syndromes for which it is intended is better, quicker, and in some ways less dangerous than pharmacotherapy. While few people are frightened by the use of electricity in converting an arrhythmic heart to alpha rhythm, applying electricity to the skull to regulate mental rhythms bring out visions of medieval torture, inhumane manipulations of the mind, and irretrievable brain damage that have not vanished with the publication of countless studies detailing the established virtues and safety of this most misunderstood intervention. The facts speak for themselves. ECT is more effective and safer than psychotropic drugs for serious debilitating and suicidal depressions. In the hands of competent operators it is painless and without danger. A convulsive seizure that lasts 15 seconds in an anesthetized, relaxed patient results in no pain, no discomfort, and no recollection of the procedure. Only four serious complications occur in 100,000 treatments and this figure includes the treatment of 90 year olds. Compare this figure with any current medical and surgical procedure existing today. The argument that it should not be used because we do not know how it works is preposterous. We do not know how aspirin works or how electricity works, but we utilize both with benefit. Misused, both can be dangerous, and ECT in the past has been misused by applying it indiscriminately to minor emotional problems that it could not possibly influence.

ECT cures three-quarters of depressed patients in contrast to the best antidepressant drugs that relieve symptoms in from one-half to two-thirds cases. It has saved many lives that otherwise would have been extinguished by suicide. "Clearly ECT has demonstrated its efficacy beyond doubt. It should not be permitted to fall into disuse; if it is abandoned, patients will suffer." (JAMA, 1979). A panel organized by the National Institutes of Health, conceding that the risks of serious side effects are relatively low, gave ECT an endorsement to the effect that "not a single controlled study has shown another form of treatment to be superior to ECT in the short-term management of severe depressions." (Science, 1985). The most bothersome side effect is, in most cases, temporary memory loss for the period immediately surrounding the period of ECT and "some patients suffer no memory loss at all." The panel noted that the complication rate was 1 in 1700 treatments and the mortality risk no different from that associated with the use of short-acting barbiturate anesthetics. The question then is why there is such persistent and fierce opposition to ECT. For example, not long ago the citizens of Berkeley, California voted overwhelmingly to ban the use of ECT within the city limits (Science News, 1982). Even some psychiatrists maintain a continuing prejudice despite new technical developments in the concomitant use of muscle relaxants, anesthesia, unilateral electrode placements, hyperoxygenation, and monitoring of seizures that reduce complications.

While ECT is effective in catatonia, its use in other forms of schizophrenia is controversial since antipsychotic drugs are usually adequate although blighted by the risk of tardive dyskinesia. In manic patients lithium has replaced ECT except in rare cases where violent excitement necessitates immediate intervention. In neurotic depression (dysthymic disorder), psychosocial and pharmacological approaches are the preferred treatment modalities rather than ECT. ECT has not been found useful for chronic schizophrenia, and adjustment disorders with depressant moods. Informed consent is required from the patient who is presented with the options available, the possible benefits and risks, and the sequelae of confusion and memory loss. Obviously the family must be involved in the decision-making process. Before treatment is started drugs such as monoamine oxidase inhibitors and lithium should be discontinued. A thorough physical

and neurological examination is essential and any cardiac problems are closely monitored. Agitated and excited reactions and intense chronic anxiety will require concentrated ECT sessions until the symptoms are under control. ECT has been employed as a preventive measure in manic-depressive psychosis, being administered bimonthly or monthly following full recovery. More commonly following ECT, the prescription of antidepressant drugs or lithium (in bipolar disorders) is usually carried out as a preventive measure.

Adjunctive drugs have been employed with ECT, although caution prescribes that drugs like neuroleptics be employed only after the course of ECT is ended except in severely resistant patients (with the caution that the morning dose should not be given prior to ECT).

It is essential in using ECT to make sure that an adequate number of treatments are given. In general, depressions and manic excitements require approximately six or eight ECTs.

For the most part, the therapist will refer patients for ECT who are severely depressed. An adequate number of treatments (generally three) are needed during the first week where the patient is a suicidal risk. Following this, one treatment at weekly intervals may suffice. A total of 6 to 10 ECTs are usually required. Intervals should be so spaced that the patient is prevented from developing confusion and excessive memory loss. Excited and panicky schizophrenic or borderline patients may also require referral. Here treatments on the basis of three times weekly may be needed, reduced only to control confusion or regression. The last few treatments are given once weekly. In a few cases "maintenance ECT" has been used on a prolonged basis to keep the vulnerable patient from dissociating. Usually, however, borderline patients with a depressive or panicky overlay which interferes with psychotherapy may be made more accessible and kept from memory impairment by one, two, or three or more ECTs spaced sufficiently apart (Kalinowsky, 1965). Memory loss for recent events generally reverses itself within a few weeks.

Unilateral ECT reduces the post-treatment confusion and memory loss of

conventional bilateral ECT by placing the treatment electrodes over one side of the head only: the nondominant hemisphere (usually the right side in a right-handed individual). Generalized seizures are obtained with this method, which is otherwise given with anesthesia and muscle relaxation exactly as bilateral ECT. The striking absence of memory loss with unilateral ECT permits treatment to be given on a daily basis (Abrams, 1967). The depression-relieving effects of unilateral ECT are less than for bilateral ECT (Abrams, 1972), however, and this observation has stimulated attempts to increase the therapeutic effects of unilateral ECT by giving more than one treatment in a single session (Abrams & Fink, 1972). If there is no pressure of time and no clinical urgency (e.g., suicidal risk, progressive weight loss, reckless overactivity), unilateral ECT should be given initially, changing to bilateral ECT only if improvement has not occurred after four to six ECTs. Unilateral ECT is also useful for ambulatory patients or those whose work requires unaltered memory function during the treatment course. Unilateral ECT may also be used to avoid cumulative memory loss (retrograde amnesia) in patients who have improved after receiving their first few treatments with bilateral ECT.

Concentrated regressive ECT in the form of two ECTs daily to produce an organic brain syndrome is not recommended. Following ECT treatments, antidepressants for unipolar or lithium for bipolar depression may be given to forestall relapse.

The immediate consequences of ECT are confusion, headache, and transient memory loss. The confusion and headache disappear shortly, but memory loss may persist for weeks.

Basic Suggestions for Proper Drug Usage: Summary

There is a general agreement among clinicians regarding the selection and use of psychotropic drugs although the methods of employment may vary depending on the degree of expertise and the nature of the patient population. Standard medications and practices do exist which have been tested and validated in rigorous trials. A number of basic rules are in order: (1) One should never allow oneself to be influenced by anecdotal accounts of "novel" drug therapies. More often than not the drugs are worthless if not

hazardous. (2) Nutrient supplements do not substitute for time-tested agents. (3) Non-medical therapists must refer patients in need of drug therapy to psychiatrists qualified in pharmacotherapy. (4) The patient should be informed about the likelihood of using medications at the beginning of treatment in the event there is a drug-responsive disorder. (5) A negative transference should be suspected where there is noncompliance with prescribing instructions (Sussman, 1983). (6) Should a patient fail to respond to properly selected and administered medications, referral for specialized help with experimental drugs should be made only to a practitioner or clinic with experience in new pharmacological agents.

The proper use of psychotropic medication should result in maximal benefits for the patient at a minimal degree of risk. There is much more involved in pharmacotherapy than knowing the proper drug to select and writing a prescription. The following suggestions may be helpful.

1. Take a history of each patient regarding previous and present psychotropic drug usage, including which drugs were effective, the dosage, and any side effects. Ask about the use of psychotropic medications by other blood relatives. Due to genetic factors, the patient may have similar reactions to the same drugs. Inquire into existing physical illness since certain conditions may be dangerously aggravated by some drugs. For example, if the patient is taking certain medications for illness, these may be incompatible with some psychotropic drugs, for example, guanethidine for hypertension and tricyclics for depression do not mix.

2. A diagnosis is important in order to prescribe the proper drug; thus neuroleptics would be used for schizophrenia, lithium for mania, and antidepressants for psychotic depression.

3. Try to avoid some drug combinations, like hypnotics and antidepressants; they can lower the desired effect. Where combinations are necessary, one should be aware that the total therapeutic effect may be reduced. Thus, benztropine (Cogentin) to eliminate parkinsonian symptoms may lower the plasma level of a neuroleptic drug so that psychotic symptomatology can reappear, necessitating greater dosage.

4. Side effects tend to be dose-related. However, some patients experience adverse

drug reactions at the lowest doses, while other patients tolerate extremely high doses with no unwanted effects. Management of intolerable drug related symptoms involve lowering the dosage to the lowest possible therapeutically effective level, or switching to a drug with a lower side effect profile. For example, a patient who experiences severe extrapyramidal reactions to haloperidol (Haldol), and is unable to tolerate the anticholinergic effects of an antiparkinsonian drug (Artane, Cogentin, Kemedrin), may be given chlorpromazine or thioridazine that cause extrapyramidal reactions far less frequently.

5. Adequate dosage over a sufficiently long period is essential to test the efficacy of a drug. Build up dosage as rapidly as possible and sensible. If a patient fails to respond to one class of drugs during a sufficiently long time, switch to one of the other classes, as from aliphatic phenothiazines (Thorazine, Mellaril) to the butyrophenones (Haldol), to the thioxanthenes (Navane), to the dihydroindolones (Moban). If the patient still fails to respond after two months of antipsychotic or antidepressant drug therapy, the chances are the individual is not a good candidate for pharmacotherapy. Failure to respond to a benzodiazepine antianxiety or hypnotic drug within the first week should raise doubts about the eventual efficacy of the drug. Patients who benefit from benzodiazepines experience some reduction of anxiety or insomnia, even at low doses, at the outset of treatment.

6. Since most drugs are retained in the body for relatively long periods, a single total dose at nighttime, once a therapeutic effect has been obtained, is preferable to multiple doses during the day. Sleep is enhanced, and there is less tendency to forget to take the medications.

7. If a patient has had a good premorbid personality, has related well to people, and has broken down only under the impact of extremely severe stress, psychological treatments are likely to be most effective. The use of drugs may only be necessary for extremely severe or recalcitrant symptoms. An "acute psychotic break," particularly in a young person, may really be an identity crisis, a consequence of drug abuse, or a phase of a seizure disorder. It is better, therefore, not to prescribe psychotropic medications routinely. In many cases hospitalization suffices to stabilize the patient. One may wait a few days and then institute psychotherapy and reassurance to see if the patient's inner strengths will suffice to bring about a remission.

8. Where possible, concurrent psychotherapy should be employed in a psychotropic drug regimen to help reduce destructive interpersonal patterns, to lower self-imposed standards impossible of attainment, to teach social skills, and to facilitate environmental adjustment. Psychotherapy will enable the patient to make an adaptation more rapidly without the need, or with a reduced need, for medications.

9. Patients should be informed of the nature of side effects associated with psychotropic drug use. When antipsychotic drugs are prescribed, patients and their families should be told of the nature of extrapyramidal symptoms, particularly acute dystonic reactions. The therapist should not fear that an open discussion of side effects will deter the patient from agreeing to take medication, particularly if it is made clear that the benefits of treatment outweigh the risks. Patients receiving short-acting hypnotic drugs should be warned of possible rebound insomnia on the nights immediately after medication is discontinued.

10. Several drug preparations are marketed that contain fixed combinations of compounds with different clinical indications. The most widely used combination drugs are Triavil and Etrafon (both of which contain antipsychotic perphenazine and antidepressant amitriptyline) and Limbritol, a combination of chlordiazepoxide and amitriptyline. These three combination drugs may account for 20 percent of all prescriptions of antidepressant drugs. Nevertheless, except in a few special circumstances, there is little rational basis for the use of these combinations since the mixture of the drugs in fixed doses exposes the patient to unnecessary amounts of at least one of the compounds. This, in turn, causes a higher incidence of side effects. Whether drugs are used alone or in combination, dosage should be individualized according to clinical response.

11. Every class of psychotropic medication has been shown to increase the risk of birth defects. Though evidence that antipsychotic drugs produce congenital malformations is contradictory, the teratogenetic effects of lithium, anxiolytics, and tricyclic antidepressants is documented. Considering the consequences of birth defects for the parents and offspring, it is strongly suggested that women who intend to become pregnant or who are pregnant be managed by nonpharmacological modalities. If the use of medication is being considered for psychotic women, hospitalization is advisable to see whether a structured secure environment obviates the need for drugs. In cases of depression during

pregnancy, ECT is preferable to antidepressant medication. However, at times drug therapy is unavoidable, particularly when the patient's illness threatens the lives of both herself and the fetus.

12. The therapist should be mindful of the fact that according to the law patients have a qualified constitutional right to refuse psychotropic and antipsychotic medications, and this right has been recognized by a number of federal courts. In cases of incompetency, judgment about drug treatment decisions must be entrusted to a court.

13. Discussion with patients who require maintenance drug therapy can be reassuring to the patient, even to schizophrenics when informed about tardive dyskinesia. No increase in relapse or treatment noncompliance need be anticipated. (Munetz & Roth, 1985).

14. A patient who consents to take a drug should be told the name of the medication, whether it is intended to treat the disease or relieve symptoms, and how important it is to take it regularly, how to tell when it is working, what to do if it is not working, when and how to take it (before or after meals), how long to continue taking it, side effects and what to do about them, possible effects on driving and work with precautions on what to do, and interactions with other medications. (Drug and Therapeutic Bulletin, 1981).

15. Useful texts in pharmacotherapy are: Appleton and Davis (1980), Baldessarini (1984a & b), Hollister (1978),Klein et al. (1980), Mason and Granacher (1980), Simpson (1983).

CONFRONTATION

Psychodynamic theory and psychoanalytic methods are often accused of helping patients avoid responsibility for their behavior, blaming inner conflicts foisted on them by their parents or by past experience over which they had no control. In confrontation techniques it is assumed that the patient must accept responsibility for actions and take the consequences for behavior that is counterproductive. The patient is exposed to a surprise or shock stimulus from which there is no escape and to which he or she must respond. Retreats into unreality and evasive defense are cut off. The patient is invited to explore the reactions with the aid of the therapist. He or she must justify aspects of

verbalizations and behavior that the therapist believes are significant. There are some people who learn best by being subjected to such psychological assault. This acts as an aversive stimulus to force a different mode of thinking and behavior, to doubt habitual coping devices, and to reach for new adaptations. The patient may then either be left to ingenuity to find alternative patterns, or possible solutions may be suggested in the hope the patient will grapple onto one of them. The effectiveness of this intervention will depend on the acceptance of the therapist as an authority whose injunctions must be incorporated at face value, as well as readiness for and ability to change. The timing of confrontation is important. We are all aware of how frequently the challenging of pathological character traits merely makes them more rigid. Careful empathic interpretation may have to precede forceful confrontation.

The selection of a proper area for confrontation will depend on the perceptiveness and diagnostic skill of the therapist. There are some therapists who, wedded to a special way of thinking about dynamics, impose this on the patient. Thus if therapists believe that masochism is a universal liability and at the bottom of all pathology, they will interpret the symptoms of the patient in this light. Lewin (1970), for example, believes that every symptom serves both self-tormenting purposes as well as a means of provoking others. Even character patterns are interpreted as a masochistic need to suffer and punish people. The patient is helped "to see what he wants to do and what his conscience forces him to do" and how the disparity creates difficulties. The contrast between a healthy conscience that guides while inhibiting destructive actions and the patient's existing sadistic conscience that viciously torments and punishes is pointed out. It becomes essential for the patient to recognize that an intemperate and merciless conscience is the *"common enemy* against which the therapist is his ego's strong ally." No immediate interpretations are made of specific conflicts. "The initial confrontations are confined to the patient's need for self-punishment and his masochistic responses to anger."

The universality of this concept about masochism may be doubtful but sometimes masochism *is* at the basis of an individual's problems. Accident proneness, obsessional self-torment, suicidal tendencies, and hypochondriacal self-torment, suicidal tendencies,

and hypochondriacal preoccupations, for example, may be indications of a generalized masochism. Where this is apparent, an explanation such as the following may be offered: "You feel angry at what your parents did to you as a child. But you also feel guilty for your anger and thoughts. So you punish yourself for these thoughts and feelings. Your symptoms and your behavior seem to me to be the results of your punishing yourself. Now what are you going to do about what you are doing to yourself?" Should these explanations and injunctions fail to produce results, some therapists resort to stronger challenges and confrontations.

While aggressive confrontation under these circumstances may prove profitable in some patients with good ego strength, it may not be applicable to sicker patients unless the confrontations are toned down to a point where they are executed in an empathic reassuring way. Even then it may be necessary to wait until a good working relationship has been established, and then only after it becomes apparent that masochistic maneuvers are obviously being employed by the patient in the interests of resistance—"You seem to be punishing yourself by refusing to get well."

Other explanations than masochism may be offered by therapists trained in specific schools of psychology or psychiatry. One universal basic cause is presented for all types of emotional illness, and this single etiological factor is tortured to fit in with *every* symptom and behavioral manifestation. Thus, the patient may be dazzled by brilliant explanations of the malfunctions of pregenital splitting, or of the Oedipus complex, or of the devalued self-image, or of subversive archetypes, or of conditioned anxiety, or of any of the countless theories around which current psychologically ideologies are organized. While such single explanations may not be accurate, they may be temporarily effective, especially when dogmatically stated. In the long run, however, they will not hold up.

Most therapists who utilize confrontation employ it in the medium of a wide assortment of eclectic methods like role playing, Gestalt therapy, psychodrama, transactional therapy, encounter therapy, existential therapy, and psychoanalytically oriented psychotherapy.

Utilizing a transactional model, Garner (1970) has developed a confrontation technique that "focuses on the patient's conflict between the unconscious or conscious desire to approach a certain goal and the avoidance tendencies." The technique is characterized by interventions in the form of frequent directive statements made to the patient, with the question, "What do you think or feel about what I told you?" The patient's response is studied, whether it be complete compliance, compliance with critical appraisal, or critical appraisal. In this way an attempt is made to probe *reactions* to statements and to avoid the parroting of insight. The challenging question of the therapist requires that the patient explore the role of the therapist and the interactional dynamics of the relationship. It forces the patient also to examine the stereotyped nature of thoughts and behavior. The patient is invited to work out a mutually satisfactory solution to conflicts.

The focus may be limited or may involve the resolution of a core conflict that existed in the early life of the patient. For example, patients with dependency problems or separation anxiety may be confronted with, "Stop believing you are incapable of taking care of yourself," or "You are acting like the most helpless, inept person in the world." After each of these statements there is added, "What do you think or feel about what I have told you?" The latter question acts like a lever to explore compliance or noncompliance tendencies and to engage in problem-solving activities.

The confrontation formulations may be employed adjunctively in any form of insight therapy when a clearly defined conflict is exposed. They may be employed to reinforce a constructive defense or to challenge a neurotic defense, as in peer groups with addicts (Adler, G, & Buie, 1974). Among their uses is testing how thoroughly the patient has understood a point stressed by the therapist. In this way misinterpretations may be immediately corrected. Confrontation may also be used as an adjunct to behavioral and other educational methods as a wedge into cognitive areas. Obviously, sicker patients, such as borderline cases and schizophrenics, do not respond well to the technique.

GESTALT THERAPY

Establishing its position in the Human Potential Movement, Gestalt therapy (see Chapter 11) gets its inspiration from Gestalt psychology, existentialism, psychodrama, and psychoanalysis (particularly character analysis). It stresses the immediacy of experience in the here and now and nonverbal expressiveness (Fagan & Shepherd, 1970). It describes itself as a philosophy of living in the present rather than the past or future, of experiencing rather than imagining, of expressing rather than explaining or justifying, or avoiding the "shoulds" or "oughts," of taking full responsibility for one's actions, feelings, and thoughts, and of surrendering to "being as one is" (Naranjo, 1971).

By observing the patient's positive gestures and bodily movements, Gestalt therapists attempt to discern aspects that reflect unconscious feelings. The therapist points out these tendencies and asks the patient to exaggerate them, to express any feelings associated with them. The object is to expand the patient's awareness of the self, bodily sensations, and the world around one. Gestalt techniques are sometimes employed to catalyze other therapies. (Perls, 1973; Polster & Polster, 1973).

As to the actual techniques, Gestalt therapists have different ways of operating. Many follow the precepts of Fritz Perls (1969), particularly in working in the here and now, eschewing the "why" in favor of the "how." Since it is contended that review of the past cannot change what has happened, the past is avoided, the focus being on the immediate I-Thou therapeutic relationship. There is insistence on the patient taking full responsibility for the choices and decisions he or she makes. Only by self-acceptance, it is avowed, can meaningful contact be made with others. Closely observing ambiguous nonverbal behaviors and confronting the patient with these without analysis or interpretation may open up channels of repressed ideations and feelings. The patient may be asked to repeat or exaggerate unusual movements and amplify or adopt opposing modes of verbalization. "The whisperer experiments with yelling, the yeller experiments with whispering, the intellectual explainer who drowns everyone with words experiments with babbling sounds, enabling new awareness of sharing and holding back" (Kriesgfeld, 1979). An important objective is restoration to one's total being of split-off and dissociated aspects of the self. The person is consequently exposed to a group of

"therapeutic experiments" in order to come to grips with repressed and repressing aspects of oneself. A patient may be requested to hold conversations with various parts of the body that feel tense or painful, or with people and objects in dreams. One may project these parts, people, or objects onto an empty chair and engage in a dialogue with these. A number of texts are available detailing gestalt techniques (Perls, 1969; Smith, 1976).

The patient may be asked to observe things about the therapist's waiting room and to comment on them, particularly to speculate on the kind of a person the therapist is believed to be from this data. If the patient becomes aware of certain bodily sensations like heart beating, deep breathing, neck stiffening, etc., he or she may be asked to talk to the heart, lungs, neck, etc. The projective elements of anything that one says are inquired into by asking the patient to relate comments about others to oneself. The patient is encouraged to do, and even to exaggerate doing things that he or she avoids or is ashamed of, at first in fantasy and then slowly in reality. All aspects of the patient's dreams are considered part of the self, and the patient is asked to play these parts, dramatizing them while verbalizing feelings freely. Many of the Gestalt techniques lend themselves to groups as well as individual therapy. The techniques used for the most usual situations encountered in therapy are summarized here:

1. *Dealing with conflict:* When elements of a conflict are perceived (e.g., dominant desires versus passive impulses; masculine versus feminine, etc.), the patient is asked to play both roles in turn, utilizing the empty chair in which an imagined significant person is seated or the counterpart aspect of the self is seated.

2. *Unresolved feelings:* When detected, the therapist may insist that these be expressed.

3. *Difficulties in self-expression:* A game is often played wherein the patient makes a statement and ends it by saying, "And I take responsibility for it."

4. *Fear of offending others:* In a group the patient goes around expressing attitudes and feelings frankly to each member.

5. *Testing projections:* A patient who believes another individual has a problem or characteristic is asked to play a role as if the problem or characteristic is

one's own.

6. *Challenging reaction formations* (e.g., excessive prudishness): Here the therapist may ask the patient to play the opposite role deliberately (e.g., verbalizing sexual freedom).

7. *Managing anxiety:* The therapist says, "Why not let it build as far as it likes. Don't try to stop it. Emphasize your shaking. Try to bring it on."

8. *Tendencies to detachment and withdrawal:* The patient is asked to focus on the situations or inner feelings that cause withdrawal.

9. *Exploring the meaning of gestures or unusual verbal statements:* When these are noticeable, the patient is asked to exaggerate them and detail associations.

10. *Difficulties in making assertive statements:* The patient is encouraged to say before each statement, "Of course" and "It is certain that."

11. *Use of dreams:* Each aspect of the dream is believed to represent a part of the individual. The patient is asked to identify with each aspect of the dream and act out a role talking to various aspects of oneself.

12. *Dealing with distorted values:* The therapist often tries to act as a model by verbalizing and sharing with the patient his or her personal values and feelings.

HYPNOSIS

Trance phenomena have been utilized as part of religious and healing rituals in all ages and cultures since the earliest of recorded history. The loss of control by the subject in the trance, the bizarre muscular movements, and the vivid imagery that is released have suggested "possession" by spirits and extramundane forces that have led observers to link hypnosis with mysticism and the paranormal. It is only relatively recently that attempts have been made at scientific investigation of hypnosis in the effort to understand how it influences behavior and particularly its therapeutic potentials. Modem uses of hypnosis embrace its employment within the matrix of a number of paradigms, such as social influence, dissonance reduction, indirect metacommunications, employment of paradox,

imagery evocation, double binds and a variety of other interventions. Most recently the dramatic innovative techniques of Milton Erickson have been analyzed (Rossi, 1980; Zeig, 1985a and b) with the object of distilling from them strategies that can enhance the therapeutic process. Some new ideas have emerged from this contemporary work including "neuro-linguistic programming" (Bandler & Grinder, 1975) through which an attempt is made to manipulate unique individual thought processes in order to effectuate changes in behavior and feelings.

Such studies have shown that employed by reasonably trained professionals within the context of a structured therapeutic program, with awareness of limits of its application, hypnosis can make a contribution as an adjunct to any of the manifold branches of psychotherapy, whether these be supportive, reeducative, or psychoanalytic.

Most professionals who are fearful of hypnosis as a therapeutic tool, or exaggerate its virtues, either have never experimented with it for a time sufficient to test the method or else are victims of superstition, prejudices or naive magical expectancy. A number of spokesmen for hypnosis, some writing extensively, help to discredit it by overdramatizing the process, by exaggerating its powers, by participating in and publishing results of poorly conceived experiments, by engaging in naively organized therapeutic schemes, by offering therapeutic formulations that violate the most elementary precepts of dynamic psychology, or by promulgating its presumed dangers for which there is little basis in fact (Wolberg, LR, 1956).

How hypnosis aids in securing therapeutic effects is not entirely clear, but we may postulate two important influences. First, hypnosis rapidly produces a remarkable rapport with the therapist. Irrespective of the fact that this is probably linked to some anachronistic regressive dependency need, a strong impact is registered on the therapeutic working relationship. The placebo influence, a component of all therapies, is strongly enhanced. Suggestion, another universal component of all treatment processes, is so expanded in hypnosis that the patient responds sensitively and with dramatic readiness to both indirect, subtle persuasions by the therapist and to direct commands

and injunctions that are not too anxiety provoking. The relationship with the therapist, in a surprisingly short time, becomes one in which the therapist becomes endowed with noble, protective, and even magical qualities. The ultimate result of these combined forces can be substantive relief from tension, a restoration of homeostasis, and a recapturing of a sense of mastery, which in themselves may restore adaptive defenses and produce a symptomatic cure.

The second influence of hypnosis is upon the intrapsychic processes. Hypnosis promotes an altered state of consciousness. As such, repression may temporarily be lifted with exposure of emotionally charged impulses that have been denied direct expression and that have hitherto partly drained themselves off through substitutive symptomatic channels. This can lead to a release of vivid imagery and emotionally cathartic verbalizations. Such spontaneous outbursts usually occur only in persons who are strongly repressed while nurturing explosive inner conflicts. On the other hand, a therapist utilizing exploratory techniques to probe unconscious ideation may, by direct suggestion or regression and revivification, expose less highly charged but significant fantasies, verbal associations, and memories, thus opening roads to greater self-understanding.

Hypnosis as a relaxing agency has been employed in physical and psychological disturbances that are characterized by stress and tension. Since stress may have a damaging effect on all bodily functions, its amelioration can be important for healing (Wolberg, LR, 1957). Tension relief may, on the basis of suggestion during the trance state, be supplemented perhaps by self-hypnosis (Wolberg, LR, 1965) or by such techniques as autogenic training (Luthe, 1963; Schultz & Luthe, 1959; Luthe et al, 1963).

Where the symptom does not bind too much anxiety or where its pleasure and masochistic values are not too intense, it may be possible to alleviate it by hypnotic suggestion without symptom substitution. Not only may the ensuing relief initiate a better adjustment, but also it may set off a chain reaction that, reverberating through the entire personality structure, influences its other dimensions. Suggestive hypnosis may also be of

value in controlling the ruminations of chronic obsessive-compulsive patients whose preoccupations immerse them in interminable misery. By helping such victims to divert their thinking into more constructive channels, it may initiate relief of anxiety and a better adaptation. With caution hypnosis may be adopted as a suggestive instrument in controlling certain habits, such as overeating, excessive smoking, and insomnia. The phrasing of suggestions here is important.

Some therapists still use hypnosis like a magic wand to dissipate in thin air symptoms that hamper the adjustment of the patient. While symptom removal by hypnosis is justified where the symptom blocks therapy, as in emergencies or where more extensive therapy cannot be applied, one must realize its limitations. For so long as we depend solely upon the authoritarian powers with which the hypnotic situation automatically invests us, our therapeutic effectiveness will be no greater, and often will be less than miraculous healing. Christian Science, and other therapies dependent upon faith, magic, and prayer. Because of the evanescent effects of suggestive hypnosis, hypnotic therapy has historically enjoyed brief spurts of popularity followed by disappointment and abandonment of the method.

Hypnosis may prove itself to be singularly successful in overcoming resistance, exposing segments of the person's inner life that are deeply buried within and which have hitherto evaded detection. In rare instances this exposure of memories and experiences, as well as the related emotions, will result in the relief of a symptom. In my own work I have been able to remove isolated amnesias, motor paralysis, blindness, and anesthesias through the hypnotic revival of some early experience that resulted in these hysterical symptoms. This is what Freud did in his original work at the turn of the century, which resulted in his pioneer psychoanalytical discoveries. Hypnotic removal of symptoms should if possible be followed by further explorations for conflicts that have generated hysterical defenses.

The use of hypnosis in exploratory psychotherapy, such as in the insight approaches, is contingent upon the influence of hypnosis on unconscious resistance that in resolution

helps the individual establish closer contact with repressed needs and conflicts. It may thus be possible to bring to the surface significant memories and repressed impulses that expedite the analytic process. (Wolberg, 1964a; 1986)

Hypnosis is particularly useful in freeing verbalizations, in liberating transference, and in helping the patient to recall dreams. Where anxiety blocks speech, the mere induction of a trance may serve to release a verbal discharge. Moreover, the provocation of transference feelings may bring to the surface painful emotions as well as fantasies that sometimes burst through with intense violence. Where free associations have been blocked for one reason or another, hypnosis may suffice to restore this form of communication. Hypnosis may serve also as a means of stimulating dreams in patients who are unable to remember them or who have "dried up" in their analytic productiveness.

In behavior therapy hypnosis is useful in various ways. First, it establishes in the mind of the patient the authority of the therapist, who will act as the reinforcing agency. Under these circumstances positive counterconditioning, aversive conditioning, extinction, and other tactics will be catalyzed. Second, by promoting relaxation through hypnosis a positive stimulus is supplied that becomes affiliated with the conditioned stimulus and helps to extinguish it. Third, on the basis of suggestion, the objectives of the therapist, once explicitly defined, may be more easily accepted. The patient is encouraged to behave in emotionally constructive ways, in quest of reversing established patterns or correcting behavioral deficits. Thus, in the method of desensitization through reciprocal inhibition anxiety-provoking cues are presented in a climate of relaxation in progressively stronger form.

There is no way of predicting in advance the exact influence hypnosis may have on the patient or problems since each individual will respond uniquely to the phenomenon of hypnosis in line with the special personal meanings. The mental set toward hypnosis, the motivations to be helped, the depth and quality of resistances, the preparation for induction, ideas about the therapist and particularly the image conjured up of the

therapist, the skill of the therapist as a hypnotist, the quality of the suggestions administered, the management of the patient's doubts and oppositional tendencies, and the nature of the transference and countertransference will all enter into the responsive Gestalt.

Potentially, hypnosis may catalyze every aspect of the therapeutic process. Whether or not a therapist will want to employ it will depend largely on how much confidence one has in hypnosis and how well one works with hypnotic techniques.

Hypnosis is an intense emotional experience that may affect both patient and therapist. In the trance a dynamic configuration of many kinds of phenomena are constantly interacting in response to functional psychophysiological changes within the individual and the specific significance of the hypnotic interpersonal relationship. As attention is shifted from the external world toward the inner self, there is an expansion of self-awareness and a lifting of repressions, with exposure of certain repudiated aspects of the psyche. A regressive kind of relationship develops between the subject and operator, the latter being promoted into the post of a kind of magical authoritative figure.

Hypnosis may also release powerful feelings in the therapist, aspects of which, in the form of countertransference, may be inimical to the therapeutic objective. Particularly obstructive are omnipotent, sadistic, and sexual strivings. Only by experimenting with hypnosis can a therapist determine whether one is personally capable of employing it as a therapeutic adjunct. While one may be able to do good psychotherapy with the usual psychotherapeutic techniques, attempts at hypnosis may alter one's manner toward the patient in ways that will prove antitherapeutic. Thus, a therapist may act aggressively toward patients perceived to be in a helpless state. Coordinately, one may become suffused with feelings of grandiosity. Or one may, as a projected Svengali figure, find oneself sexually attracted to a patient whom one regards as passively seductive. Should these feelings arise in spite of measures to control them, it is best to pursue a pattern of caution and refrain from employing hypnosis in practice.

Hypnosis, then, is merely a device to facilitate the psychotherapeutic process rather

than to substitute for it. No problems need be anticipated in the induction of hypnosis, and in the application of hypnotic and hypnoanalytic procedures, if the therapist masters at least one of the standard techniques, applies it confidently, while constantly observing the reactions of the patient and of oneself. Protracted dependency reactions are no more common than in psychotherapy without hypnosis. It goes without saying that hypnosis is no substitute for careful training, extensive experience, and technical competence. It will not make up for lacks in judgment or skill. However, a sophisticated psychotherapist who has learned how to utilize hypnosis has available a most important adjunctive tool.

Induction of Hypnosis

Hypnosis is extremely easy to induce. The object is to bring the patient to a hyper-suggestible state. Toward this end the operator executes a number of maneuvers, the most common one being a state of muscular relaxation and the fixation of attention. Important rules to follow are these:

1. Engage the attention of the patient by assigning a task, (muscle relaxation, hand clasp, hand levitation), descriptions of which will follow.

2. Approach the induction with a confident manner. Any faltering or unsureness in vocal expression will influence the patient negatively. Adopt a persuasive, calm, reassuring tone of voice, droning suggestions rhythmically and monotonously.

3. Employ repetition in suggestions to focus the patient's attention.

4. Excite the imagination of the patient by building word pictures so that the patient practically lives and feels what is suggested. (In children one can engage their attention by asking them to imagine watching a television screen and observing their favorite programs.)

5. Use positive rather than negative suggestions. For example, where pain is to be deadened, do not say, "You will have no pain." Say, "The sensation will change so that instead of feeling what you have been feeling, it will feel dull, numb, and tolerable." If a hypodermic injection is to be given, do not say, "This will not hurt," but rather, "This will be like a tiny mosquito bite."

6. Should the patient at any time open the eyes and insist he or she is not hypnotized, put your fingers on the eyelids to shut them and say, "That doesn't matter, I just want you to relax." Then continue with suggestions.

7. Almost universally, patients, after the first induction, even those who have been deeply hypnotized, will insist they were not in a trance. Reply with, "Of course you weren't asleep or anesthetized. You were in a state of relaxation and this is all that is necessary. You may go deeper next time, but it really doesn't matter." Give the patient a typewritten copy of material describing some phenomena of hypnosis (see [Appendix U](#)).

8. Some operators find it important to tell the patient that all that will be achieved in the first session is not hypnosis but a state of relaxation that will help the patient quiet the symptoms: "If you fall asleep, that is fine; if you feel completely awake, that too is fine. The effect will still be there." To some people the word "hypnosis" has many unfortunate connotations. It often embraces expectations of an immediate miracle cure. When the patient fails to go into the depth of trance imagined he or she should achieve with the "hypnotic" indication, one may become upset, feel hopeless, and lose confidence in the therapist.

A simple technique that I have found valuable, particularly for suggestive-persuasive-reeducative therapy, involves muscle relaxation. This method lends itself to teaching the patient self-hypnosis to carry on suggestions by oneself. It is helpful in this direction to supply the patient with a tape recording (the patient may bring a machine and a recording may be made directly on it; or if the therapist's recorder is compatible with that of the patient, he or she may be given the recorded tape at the end of the session). The patient may be requested to lean back in a chair and shut the eyes (if preferred one can be supine on a couch) and the material below may be dictated, *slowly,* in a persuasive tone (the therapist may have to practice reading the material so that it does not come through in a stereotyped mechanical way). As a preliminary, I tell the patient, "I would like to teach you a simple relaxing technique that should help you." If the patient agrees, I continue.

Making a Relaxing and Ego Building Recording/h3>

Having prepared the recorder, the therapist, prior to dictating into the microphone

says:

All that will happen is that you will be pleasantly relaxed, no sleep, no deep trances, just comfortable. Now just settle back and shut your eyes. *[At this point the therapist may read the following material. If a recording is to be made, start the recording.]* Breathe in deeply but gently through your nostrils or mouth, right down into the pit of your stomach. D-e-e-p-l-y, d-e-e-p-l-y, d-e-e-p-l-y; but not so deeply that you are uncomfortable. Just deeply enough so that you feel the air soaking in. In . . . and out. D-e-e-p-l-y, d-e-e-p-l-y. In . . . and out. And as you feel the air soaking in, you begin to feel yourself getting sleepy and r-e-l-a-x-e-d. Very r-e-l-a-x-e-d. Even d-r-o-w-s-y, d-r-o-w-s-y and relaxed. Drowsy and relaxed.

Now I want you to concentrate on the muscle groups that I point out to you. Loosen them, relax them while visualizing them. You will notice that you may be tense in certain areas and the idea is to relax yourself completely. Concentrate on your forehead. Loosen the muscles around your eyes. Your eyelids relax. Now your face, your face relaxes. And your mouth . . . relax the muscles around your mouth, and even the inside of your mouth. Your chin; let it sag and feel heavy. And as you relax your muscles, your breathing continues r-e-g-u-l-a-r-l-y and d-e-e-p-l-y, deeply within yourself. Now your neck, your neck relaxes. Every muscle, every fiber in your neck relaxes. Your shoulders relax . . . your arms . . . your elbows . . . your forearms . . . your wrists . . . your hands . . . and your fingers relax. Your arms feel loose and limp; heavy and loose and limp. Your whole body begins to feel loose and limp. Your neck muscles relax; the front of your neck, the back muscles. If you wish, wiggle your head if necessary to get all the kinks out. Keep breathing deeply and relax. Now your chest. The front part of your chest relaxes . . . and the back part of your chest relaxes. Your abdomen ... the pit of your stomach, that relaxes. The small of your back, loosen the muscles. Your hips . . . your thighs . . . your knees relax . . . even the muscles in your legs. Your ankles . . . your feet . . . and your toes. Your whole body feels loose and limp. *[Pause.]* And now, as you feel the muscles relaxing, you will notice that you begin to feel relaxed all over. Your body begins to feel v-e-r-y, v-e-r-y relaxed . . . and you are going to feel d-r-o-w-s-i-e-r, and d-r-o-w-s-i-e-r, from the top of your head right down to your toes. Every breath you take is going to soak in deeper and deeper and deeper, and you feel your body getting drowsier and drowsier.

And now, I want you to imagine, to visualize the most relaxed and quiet and pleasant scene imaginable. Visualize a relaxed and pleasant quiet scene. Any scene that is comfortable. *{[The following may be introduced at the first, and perhaps the second induction to give the patient an idea of the kind of imagery that is suitable. Once the patient selects a scene, these suggestions need not be repeated. If a recording is being made, the recorder should be turned off at this point to eliminate the remainder of this paragraph.]* It can be some scene in your past, or a scene you project in the future. It can be nothing more than being at the beach watching the water breaking on the shore. Or a lake with a sailboat floating lazily by. Or merely looking at the sky with one or two billowy clouds moving slowly. Any scene that is quiet and pleasant and makes you feel drowsy. Or a sound like Beethoven's sonata, or any other selection that is soothing.) Drowsier and drowsier and drowsier. You are v-e-r-y weary, and every breath will send you deeper and deeper and deeper. *[The recorder may now be turned on again.]*

As you visualize this quiet scene, I shall count from one to twenty, and when I reach the count of twenty, you will feel yourself in deep. *[The count should be made very slowly.]* One, deeper, deeper, Two, deeper and deeper and deeper. Three . . . drowsier and drowsier. Four, deeper and deeper. Five . . . drowsier and drowsier and drowsier. Six . . . seven, very very, very

relaxed. Eight, deeper and deeper. Nine . . . ten, drowsier and drowsier. Eleven, twelve, thirteen; deeper and deeper. D-r-o-w-s-i-e-r and d-r-o-w-s-i-e-r. Fourteen, drowsier and drowsier and drowsier. Fifteen . . . sixteen . . . seventeen, deeper and deeper. Eighteen . . . nineteen . . . and finally twenty.

The following "ego-building" suggestions of Hartland (1965) may be employed in supportive and some reeducative approaches. They are introduced at this point.

As I talk to you, you will absorb what I say d-e-e-p-l-y into yourself. "Every day . . . you will become physically *STRONGER* and *FITTER.* You will become *MORE ALERT . . . MORE WIDE AWAKE . . . MORE ENERGETIC.* You will become *MUCH LESS EASILY TIRED . . . MUCH LESS EASILY FATIGUED . . . MUCH LESS EASILY DEPRESSED . . . MUCH LESS EASILY DISCOURAGED.* Every day . . . you will become *SO DEEPLY INTERESTED IN WHATEVER YOU ARE DOING . . . SO DEEPLY INTERESTED IN WHATEVER IS GOING ON . . . THAT YOUR MIND WILL BECOME MUCH LESS PREOCCUPIED WITH YOURSELF . . . AND YOU WILL BECOME MUCH LESS CONSCIOUS OF YOURSELF . . . AND YOUR OWN FEELINGS.*

"Every day . . . YOUR NERVES WILL BECOME STRONGER AND STEADIER . . . YOUR MIND WILL BECOME CALMER AND CLEARER . . . MORE COMPOSED . . . MORE PLACID . . . MORE TRANQUIL. You will become MUCH LESS EASILY WORRIED . . . MUCH LESS EASILY AGITATED . . . MUCH LESS FEARFUL AND APPREHENSIVE . . . MUCH LESS EASILY UPSET. You will be able to THINK MORE CLEARLY . . . you will be able to CONCENTRATE MORE EASILY . . . YOUR MEMORY WILL IMPROVE . . . and you will be able to SEE THINGS IN THEIR TRUE PERSPECTIVE . . . WITHOUT MAGNIFYING THEM . . . WITHOUT ALLOWING THEM TO GET OUT OF PROPORTION.*

"Every day . . . you will become EMOTIONALLY MUCH CALMER . . . MUCH MORE SETTLED . . . MUCH LESS EASILY DISTURBED.*

"Every day . . . you will feel a GREATER FEELING OF PERSONAL WELL-BEING . . . A GREATER FEELING OF PERSONAL SAFETY . . . AND SECURITY . . . than you have felt for a long, long time.*

"Every day ... YOU will become . . . and YOU will remain . . . MORE AND MORE COMPLETELY RELAXED . . . AND LESS TENSE EACH DAY . . . BOTH MENTALLY AND PHYSICALLY.*

"And, AS you become . . . and, AS you remain . . . MORE RELAXED . . . AND LESS TENSE EACH DAY . . . SO, you will develop MUCH MORE CONFIDENCE IN YOURSELF.*

"MUCH more confidence in your ability to DO . . . NOT only what you HAVE to do each day, . . . but MUCH more confidence in your ability to do whatever you OUGHT to be able to do . . . WITHOUT FEAR OF CONSEQUENCES . . . WITHOUT UNNECESSARY ANXIETY. . . WITHOUT UNEASINESS. Because of this . . . every day . . . you will feel MORE AND MORE INDEPENDENT . . . MORE ABLE TO STICK UP FOR YOURSELF, . . . TO STAND UPON YOUR OWN FEET . . . TO HOLD YOUR OWN . . . no matter how difficult or trying things may be. And. because all these things WILL begin to happen . . . EXACTLY as I tell you they will happen, you will begin to feel MUCH HAPPIER . . . MUCH MORE CONTENTED . . . MUCH MORE CHEERFUL . . . MUCH MORE OPTIMISTIC . . . MUCH LESS EASILY DISCOURAGED . . . MUCH LESS EASILY DEPRESSED."*

These are broad suggestions that cover most problems. The therapist may interpolate specific suggestions in accord with the special needs of the patient.

> Now relax and rest for a minute or so, going deeper, d-e-e-p-e-r, d-e-e-p-e-r, and in a minute or so I shall talk to you, and you will be more deeply relaxed. *[Pause for one minute.]*

> In summary, there are four things we are going to accomplish as a result of these exercises, the 4 S's: symptom relief, self-confidence, situational control and self-understanding. First, your various symptoms *[enumerate]* are going to be less and less upsetting to you. You will pay less and less attention to them, because they will bother you less and less. You will find that you have a desire to overcome them more and more. As we work at your problem, you will feel that your self-confidence grows and expands. You will feel more assertive and stronger. You will be able to handle yourself better in any situations that come along particularly those that tend to upset you *[enumerate]*. Finally, and most importantly, your understanding of yourself will improve. You will understand better and better what is behind your trouble, how it started and why your symptoms developed. Whenever you feel your symptoms coming on you will be better able to understand what is bringing them about, and you will be able to do something constructive about this, more and more easily. You will continue working on what is behind your problem. *[Pause.]*

> You should play the recording at least twice daily. The time is up to you. Remember it makes no difference if you are just pleasantly relaxed, or in a deep state, or asleep, the suggestions will still be effective. *[Pause.]*

> Relax and rest and, if you wish, give yourself all the necessary suggestions to *yourself* to feel better. Using the word "you." Take as long as you want. Then you can go to sleep or arouse yourself. When you are ready, you will arouse *yourself* no matter when that is, by counting slowly to yourself from one to five. You will be completely out of it then—awake and alert. Remember, the more you practice, the more intense will be your response, the more easily will your resistances give way. Keep on practicing. And now go ahead—relax—and *when* you are ready—wake *yourself* up.

If a recording is being made, the machine may now be turned off. The patient may be able to arouse himself or herself as desired, or, if too long a period transpires, the patient may be aroused by saying:

> Now, when I count to five, you will be awake. Your eyes will open, you will feel alert and well. One . . . *[pause]* . . . two *[pause]* . . . three . . . *[pause*] . . . four . . . *[pause]* . . . five . . . Lift your eyes.

The above induction may prove invaluable in short-term therapy and if it is recorded on an audiotape and given to the patient to talk about the posthypnotic feeling gains made during the active period of therapy. Understandably, as directive as it is, hypnosis will stimulate transference responses, positive and negative. Asking the patient to talk about the posthypnotic feelings may elicit material that can be useful to work productively with

resistances and defenses. A dynamically oriented therapist may ask for dreams and associations and often the reactions of the patient to the hypnotic induction will open up interesting areas for exploration. Suggestions given a patient to dream will usually expedite dream reporting. This is especially helpful in patients who do not remember their dreams. Sometimes a suggestion to redream a forgotten dream during hypnosis may restore the memory; while dreams distorted by secondary elaborations may be corrected, or forgotten fragments reassembled. During hypnosis a patient may be directed to dream about selected subjects such as feelings about certain people, including the therapist.

Other Induction Methods

Other induction techniques may be employed although the foregoing induction method may be all that the therapist needs to use. Elsewhere, detailed accounts of trance induction have been elaborated (Wolberg, LR, 1948, pp. 98-185; 1964a, pp. 31-67). In brief, the required steps are these:

1. Promoting motivations that will lead to hypnosis by associating the desire to get well with cooperation in the hypnotic process.

2. Removing misconceptions and fears about hypnosis by explanation and clarification.

3. Introducing a suggestibility test, like the hand clasp test, to demonstrate that the patient can follow directions.

4. Giving the patient a short preparatory talk to the effect that the patient will not really go to sleep, even though sleep suggestions will help one relax, and that one will not be asked embarrassing questions or forced to do anything one does not want to do.

5. Inducing a trance by any chosen method.

6. Deepening the trance by suggesting more and more complex hypnotic phenomena.

7. Making therapeutic suggestions.

8. Awakening the patient.

9. Discussing with the patient his or her trance experiences.

One of the easiest ways of inducing hypnosis is by means of the suggestibility test of the hand clasp. To do this, the patient is made comfortable in an armchair and asked to relax the body progressively, starting with the muscles in the forehead, then the face, neck, shoulders, arms, back, thighs, and legs. Following this, the patient is enjoined to clasp the hands, a foot or so away from the eyes. With eyes fixed on the hands, the hands are clasped together more and more firmly as the therapist counts from one to five stating that then, it will be difficult or impossible to separate the hands. After the patient has cooperated with this suggestion, the patient is to stare at the hands while the eyes begin to feel tired and the eyelids heavy. The eyelids progressively will get heavier and heavier until the eyelids feel like lead. The eyes will soon close and a pleasant sense of relaxation will sweep over the patient. These suggestions are repeated over and over in a monotonous cadence and in a firm, reassuring tone until the eyes close. The hands are then unclasped with or without the help of the therapist.

An effective way of inducing a deep trance is by means of hand levitation (Wolberg, 1948). This method is more difficult to master than the other techniques and calls for greater effort and persistence on the part of the therapist. With the patient's hands resting lightly on the thighs, the patient is asked to concentrate attention on everything the hands do. Sensations will be noticed, such as the warmth of the palms of the hands against the thighs, the texture of clothing, and perhaps the weight of the hands pressing on the thighs. Then the fingers will wiggle a little. As soon as this happens, the finger that moved first should be raised. Then the patient is commanded to raise the finger that moved first. Thereafter, gazing at the right hand it is anticipated that the fingers will fan out, the spaces between the fingers getting wider and wider. When this happens, suggestions are made that the fingers will slowly lift from the thigh; then the hand will rise as the arm becomes lighter and lighter; the eyes will become tired and the lids heavy. However, much as he or she wants to, the patient is not to fall asleep until the arm rises and the hand touches the face. As one gets more and more relaxed, and the lids get heavier and heavier, the arm and

hand will get lighter and rise higher until it touches one's face. When it touches the face, the patient will be relaxed and drowsy and the eyes will be firmly shut. Suggestions are repeated constantly until they are acted on by the patient. Asking the patient to imagine a string tied around one or both wrists with a balloon at the free end which rises and pulls the hands up until they touch the face, at which point one will fall asleep, is sometimes also effective.

The traditional method of hypnosis through staring at a fixation object continues to be useful. Here a coin, pencil, or shiny object is held above the head, the patient being asked to stare at it while suggestions are made to the effect that one is getting sleepy, that one's eyes begin to water, and one's lids blink until one no longer can keep the eyes open.

As soon as the eyelids close by the use of any of the above methods, the trance may be deepened by suggesting, progressively, heaviness and stiffness of the left arm (limb catalepsy), heaviness of the lids until the patient cannot open them (lid catalepsy), inability to move the extremities or to get out of the chair (inhibition of voluntary movements), hyperesthesia of the hand, anesthesia of the hand, and, perhaps, auditory and visual hallucinations. Some therapists do not go through the formality of deepening hypnosis (the first method of trance induction through muscle relaxation described above illustrates this). However, if probing techniques are to be employed, it is wise to induce as deep hypnosis as possible (see Wolberg 1948, 1964a). As to the actual syndromes helped by hypnosis, many therapists find that is valuable in the following ways:

1. As a means of removing certain conversion symptoms, like paralysis, aphonia, and some psychophysiologic reactions.

2. As a way of controlling the drinking urge in some alcoholic patients.

3. As a vehicle of establishing the authority of the therapist, which the patient does not dare to defy, thus inhibiting acting-out, especially in psychopathic personalities.

4. As a means of bolstering persuasive therapy in obsessive-compulsive reactions.

5. As treatment for certain habit disorders, like smoking, sexual difficulties,

insomnia, overeating, and nail biting.

6. As a mode of reinforcing desensitization and counterconditioning in behavior therapy, as in phobias.

During insight therapy hypnosis may result in the following:

1. Removal of amnesia in post-traumatic stress reactions with release of repressed memories and emotions.

2. Lifting of repression in conversion and dissociative reactions.

3. Resolution of repression in the treatment of other conditions, like anxiety reactions and phobic reactions.

4. Dissipation of certain transference and content resistances.

5. Facilitation of dreams and free associations.

In supportive therapy, where an authoritarian relationship cannot be set up with facility, hypnosis may put the therapist in a sufficiently omnipotent position to produce better results.

There is another use of hypnosis that has not received the attention it deserves, that is, as an experience in relationship. All therapy requires the establishing of a working relationship between therapist and patient. It is impossible, without good rapport, to help the patient to an understanding of the problem and to the resolution of the manifold resistances in utilizing insight in the direction of change. The mere induction of a trance produces a feeling of closeness and trust in a remarkably short time, resolving certain transference resistances and enabling the patient to proceed toward the exploration of anxiety-provoking inner conflicts. In some patients one may employ hypnosis at the start of therapy, and once a relationship has crystallized, one may go on to implement the traditional psychotherapies without hypnosis. This may cut down on the time required for the establishing of a working relationship.

Another technique utilized occasionally during the exploratory phase of therapy is

the training of the patient in self-hypnosis, suggesting that one will investigate spontaneously, through dreams and fantasies in the self-induced trance state, puzzling aspects of the problem and also that one will work out various resistances that may arise. In this way the patient actively participates in the investigative process and time may be saved. The first induction method above may easily be adapted to self-hypnosis. More details may be found elsewhere (Wolberg LR, 1964a). Self-hypnosis may be employed on a maintenance basis where necessary. Qualms about its use need not be felt; addiction to and dependency on self-hypnosis has not occurred in my experience. Appendix V contains an outline for self-relaxation that may be given to the patient. Practice may result in the capacity for self-hypnosis.

Symptom removal through hypnosis should not pose undue risks. The consequences will depend on the way the removal took place and the attitude of the hypnotist. One does not rush into a complex psychiatric picture like a bull in a china shop. Unfortunate aftermaths are usually the product of a disturbed relationship rather than the result of hypnosis. Unsettling reactions to hypnosis do not seem to be greater than untoward responses to any other therapeutic relationship. A study by Litton (1966) of 19 cases of hysterical aphonias was undertaken to test the hypothesis that rapid removal of a symptom will eventuate in substitutive symptoms or in the precipitation of a breakdown in homeostasis. Removal of the symptom through hypnosis was successful in 14 cases and resisted in 5. Follow-up showed no unpleasant sequelae. In 2 cases there was a return of the symptom after 7 months, and in 1 case after 12 months. Readministration of hypnosis rapidly removed the symptom. As explained before, hypnosis provides a dynamic interpersonal situation that evokes processes in the patient that may be productively examined as a biopsy of how the patient responds to an intensive interpersonal relationship. The patient will project into the hypnotic situation his or her basic defenses and demands. Responses to hypnotic induction, and to the trance experience itself, may constitute the material around which the therapeutic work is organized. The specific meaning to the patient of being put into a trance can bring forth various irrational defenses and fears. For instance, a patient with frigidity was referred to me by her psychoanalyst for some hypnotic work. After the third induction, the patient revealed that

she was aware of her need to keep her legs crossed during the entire trance state. So tightly did she squeeze her thighs together that they ached when she emerged from the trance. Prior to the next induction, I instructed her to keep her legs separated. As I proceeded with suggestions, she became flushed, opened her eyes, and exclaimed that she knew what upset her. I reminded her of her grandfather who, on several occasions, when she was a small child, tossed her into bed and held her close to his body. She had felt his erect penis against her body, which both excited her and frightened her. It became apparent that the hypnotic experience constituted for her an episode during which she hoped for and feared a repetition of this sexual seduction, and her leg crossing constituted a defense against these fantasies. Continued trance inductions desensitized her to her fears and were followed by an improved sexual functioning with her husband.

The hypnotic situation may also enable the patient to recall important past experiences. A man of 45 years with a claustrophobic condition of 10 year's duration was referred by an analyst who had treated the patient for several years. While his analysis (four times weekly for *2½* years) had enabled the patient to mature considerably in his relationship with people, the phobic problem remained as an obstinate block to the financial success he potentially could achieve in his business. The phobia made it impossible for him to dine with people, and, whenever he was forced in a situation in which he had to eat with others, he excused himself several times during the meal so that he could go to the bathroom to disgorge his food.

The patient was inducted into a hypnotic state, and the suggestion was made that he would go back to the period in his life when he had first experienced a feeling similar to that in his phobia. After several minutes had gone by, it became apparent from his sweating, bodily movements, and moaning that the patient was undergoing a profound emotional reaction. Asked to talk, he murmured, in a voice scarcely audible:

> I have a peculiar feeling; the chair is narrow and you are closer. I get a good feeling, a secure feeling *[breaks out into crying]'*, my father, I hated him. He rejected me. He was very critical. He never praised me for anything. There was something in him that wouldn't permit him to like me. I hate him. I hate him. *[The patient beats the side of the chair.]* I feel all choked up. I think of my mother. I am little. I see her *[compulsive crying]*.

The patient's recall of his early traumatic incident enabled us to get into other intimacies. An important one was his relationship with his analyst. It became apparent that he had become bogged down in transference resistance. Discussing this appeared to change his feeling toward his analyst, from one of resentment to that of gratitude that he had been helped significantly in many dimensions. Soon he desensitized himself to the phobic situation.

In working with resistances to giving up symptomatic complaints, the way suggestions are made may help avoid precipitating too much anxiety. If the therapist feels the patient is unable to tolerate recovery for the moment, one may say: (1) "Perhaps there is some information you do not wish to tell me at this time. It is all right to hold this back until the next time you see me or whenever you are ready." Or (2) "I wonder how long it will be before you will want to let yourself give up these uncomfortable symptoms. I do not want you to give them up all at once. Try hard to hold on to one bit of your symptom and not to let it disappear for at least a week or so after you feel comfortable."

In reconstructive therapy hypnosis may be employed to expedite free association in patients who are blocked. It may also foster dream recall. A patient came to me for hypnosis to help her recover a dream that kept eluding her, but which she felt was significant. It had first appeared, she claimed, a long time ago during her psychoanalysis, but she had forgotten it. Try as hard as she could, she was not able to bring it back. Years had gone by after she had stopped her analysis, but periodically she had the impression

that the dream returned, only to vanish with daylight. The situation intrigued her and she asked for referral for hypnosis, during which I told her that if she had a spontaneous dream, she would remember it. On awakening she revealed that a most interesting thing had happened to her while she was relaxing. The meaning of the forgotten dream had flashed through her mind.

"All of a sudden I realized that the dream was that I was all alone and I don't want to be alone. I don't want to be alone. I shed copious tears." This experience brought about a "heavy sadness" which haunted the patient for several days. A spontaneous dream followed: "I go over the rooms that we lived in as a child. The rooms are empty. I'm all alone. Where is everybody? My mother, father, sister, brothers, where are they? There is nobody there. Ours was a busy house. Copious tears." Burdened by an even deeper depressive feeling to which she could not associate in the waking state, the patient was rehypnotized and requested to say what was on her mind. She replied: "Please everybody, please everybody, come back, come back. Don't leave me alone again.

What did I do, what did I do that this should happen." In bitter tears she revealed a memory of having as a tiny child been sent to a hospital after burning herself. Separation from her mother for a protracted period had initiated fear that she would be punished and sent away if she did "anything bad." The traumatic incident (which was validated) was followed by separation of her father from her mother when she was 3 years of age, for which the patient blamed herself unfairly. Therapy including teaching the patient self-hypnosis, during which she was enjoined to revive these images, to master the emotions related to them, and to revalue them in her mind. It was through this means that she desensitized herself. Ultimately her depression was resolved. Hypnotically induced dreams may, in this way, where insight is fragmented, serve to weave unrelated mental threads into a meaningful fabric.

A case illustration of how hypnosis may aid in the uncovering process, with a recording of hypnosis through the handclasp method, may be found in Chapter 44.

NARCOTHERAPY (NARCOSYNTHESIS, NARCOCARTHARSIS, NARCOANALYSIS)

The difficulty of inducing hypnosis in certain subjects, the relatively long time required to produce a trance even in susceptible persons, and the inability on the part of some therapists to acquire skill in trance induction, some time ago brought into prominence a simple technique of promoting hypnosis by the intravenous injection of a hypnotic drug, such as, Sodium Amytal (sometimes called the "Amytal interview") or Sodium Pentothal (Horsley, 1936, 1943; Grinker & Spiegel, 1945; Sargant & Shorvon, 1945; Hoch & Polatin, 1952). It was most prominently used for the therapy of traumatic neurosis (Posttraumatic Stress Disorder) during and after World War II.

Injected narcotic substances produce a cortical depression with relaxation and heightened susceptibility to suggestion, reassurance, and persuasion. The name given to this combined use of narcosis and supportive therapy is "narcosuggestion." The psychologic regression in narcosis, as in hypnosis, incites archaic dependency feelings toward the therapist and expedites authoritative supportive procedures. Acute anxiety reactions, some manic and catatonic reactions which constitute emergencies, or assaultive or self-destructive tendencies may sometimes be approached by narcosuggestion as may other conditions that call for supportive measures. In very resistent phobias the patient, in a light state of narcosis, may be exposed to counterconditioning techniques of behavioral therapy, for instance to Wolpe's "reciprocal inhibition" technique (see Chapter 51). As a diagnostic aid narcotherapy is sometimes employed to unmask a schizophrenic tendency that is concealed by defensive reactions in the waking state. This can help in treatment planning.

Releasing of cortical inhibition liberates charges of pent-up emotion that have been kept from awareness by repression. The result is an emotional catharsis. This effect may also be facilitated in narcosis by suggestion, by persistent questioning and probing, and by encouraging the patient to explore painful areas of his or her life. Recollection of repudiated traumatic memories and experiences may remove mental blocks, flurries of anxiety, depression, and psychosomatic symptoms associated with the repression of such harassing foci. These effects have been found helpful in the treatment of certain emotional problems, particularly acute stress reactions, (transportation and industrial accidents,

catastrophes like floods and fire, and war neuroses), and some anxiety and hysterical reactions. In the war neuroses, particularly, beneficial results are possible especially in cases of recent origin treated before rigid defenses have organized themselves. The working through of the repressed or suppressed material in both narcotic and waking states helps to insure the permanency of the "cure." In chronic war and civilian neuroses, however, the patient does not seem to benefit so readily, since the illness has structuralized itself and stubborn resistances block progress. Another effect of drug interviews is to release pleasant positive feelings, which I. Stevenson et al. (1974) have found is conducive to symptomatic improvement. The effect of narcosis consequently can be both emotionally releasing as well as sedating depending on whether exposure is to challenging confrontations or calming suggestions.

While narcotherapy is principally employed for purposes of short-term therapy, it is sometimes introduced during the course of long-term insight psychotherapy where little material is forthcoming or obdurate resistance blocks the exploratory effort. Here one may occasionally save a treatment situation that has come to a stalemate by inducing narcosis and liberating repressive forces through concerted probing. Transference phenomena that have evaded both patient and therapist sometimes become dramatically operative as emotionally charged material is released. An emergency use of narcotherapy is in the sedating of acute uncontrollable anxiety and panic states that occur during the course of long-term therapy. These symptoms may be so severe that they threaten the therapeutic relationship. In obsessional neurosis, for instance, occasional sessions of light narcosis may prevent alarming reactions at phases when defensive forces subside too rapidly. The secret of narcosynthesis in chronic neurosis lies in the facilitated communication that it induces in severely repressed patients.

Where repressed incidents are of relatively recent origin, cathartic release may provide a dramatic improvement or cure. However, in most cases a structuralization of traumatic events has occurred, barricaded by many defenses, including protective character traits, so that the exposure during narcosis (no matter how dramatic the results) seems to do little for the patient. It is essential, therefore, as soon as the patient is

capable of remembering seemingly important events to subject this material to repeated examination in the waking state, particularly probing for associated emotions. During this process periodic sessions with narcosis may be helpful. Should anxiety be strong or repression too interfering, the anxieties and defensive reactions may yield, and the need for narcosis will then be unnecessary.

Another use of narcosis is to expedite the induction of hypnosis in resistant subjects. During narcosis it may be possible to give patients suggestions to the effect that they will be susceptible to hypnosis. Suggestions must be detailed and specific, covering every aspect of the induction process. For example, the patient may be told when shown a fixation object, the eyes will water, lids will get heavy, the breathing will deepen, and sleep will get deeper and deeper. They will be as deeply asleep as at present. These suggestions should be repeated and the patient may be asked if he or she understands what to do. If confusion exists, the suggestions should be repeated when the drug effect is not so pronounced. As soon as the patient understands what is expected, he or she is asked to repeat what will happen at the next session. After the narcotic session, and before the patient is fully awake, he or she is shown the fixation object and given suggestions that the next time the object is presented drowsiness will occur faster and more deeply. Again, before leaving the room, this suggestion is repeated. The technique works best when positive transference phenomena are operative in the narcotic state. It may not succeed in the event the patient does not understand what to do, or if the patient is in a state of hostile resistance.

Induction of Narcosis

The actual technique of inducing narcosis is simple. Most therapists consider amobarbital sodium (Amytal) the drug of choice. There are various techniques of administration. Sodium Amytal is supplied in sterile powder form in ampules. Ampules of sterile water are also available. The 500-mg (74 gr) size of Amytal size is generally utilized, sterile water being added while rotating (not shaking) the ampule to dissolve the drug. It is important to employ fresh solutions (no older than 30 minutes) and to see to it

that they are clear (not cloudy). Rarely some patients require large amounts of the drug, and a second ampule of 7 ½ gr may be necessary. A small gauge intravenous needle attached to a large syringe is used for administration. The injection should be slow, about 1 cc per minute, to avoid depressing the respiration. While the injection takes place, the patient is asked to count backward from 100 to 1. When the patient becomes confused, mumbles, or stops counting, the injection should stop and treatment begun, such as questioning the patient about feelings, attitudes, and memories. Should too great anxiety intervene, more drug is slowly injected. However, in many cases reassurance that one will feel better after talking will alone suffice without the need for further sedation. The patient may be given interpretations and suggestions that one can if one wishes remember any of the material talked about after awakening or forget it until ready to talk about it. The patient may be requested to remember dreams. After the narcotic session he or she may be allowed to rest or sleep. An ampule of methamphetamine or similar stimulant is held in readiness in the event of respiratory embarrassment, and at the termination of the interview it may be introduced to facilitate awakening. Some therapists inject the 20 mg of methamphetamine intravenously at first. Slowly then, through the same needle, sodium Amytal (500 mg in 20 cc sterile water) is injected until drowsiness and dysarthia appear. Or, 500 mg of sodium Amytal in 9 cc sterilized distilled water are combined with a 20 mg ampule of amphetamine and introduced intravenously at the rate of 1 cc per minute.

Various drugs have been employed instead of amobarbital. Pentothal sodium (supplied in sterile vials) and injected at the rate of 2 cc per minute is a common substitute, the dosage (approximately the same as Amytal) varying with individual patients. Methohexital sodium (Brevital), a short-acting barbiturate, is another substitute being supplied in sterile powder in ampules of 500 mg, 2.5 g, and 5 g. It may be utilized as a continuous drip, 500 mg of Brevital being added to 250 cc of sterile isotonic sodium chloride solution. This provides a 0.2 percent solution. For slow intermittent injection a 1 percent solution is used titrating the amount injected against the reaction of the patient. Sometimes methamphetamine is given intravenously following a intravenous drip of Brevital (Green, DO, & Reimer, 1974). Scarborough and Denson (1958) described a

Pentothal-Desoxyn combination similar to that of Rothman and Sward (1956).

Because of the abuse potential, injectable Desoxyn is no longer available. If a substitute amphetamine can be found, this may be employed in proper dosage.

Methylphenidate hydrochloride (Ritalin) has been found helpful in breaking through blocks in the exploration of the problems of alcoholics (Hartert & Browne-Mayers, 1958). Exploratory interviews are carried out after intravenous injection of 20 to 40 mg of the drug. The patients respond by verbalizing freely with greater introspection and critical self-evaluation as well as more intensive involvement in the therapeutic situation. Since Ritalin in injectable form is not now available, oral administration prior to interviews may be considered with caution since Ritalin may be substituted by the alcoholic for alcohol.

In the course of narcotherapy, as has been mentioned previously, drug injections should be halted temporarily if the patient gets excessively incoherent. Should the patient become too alert, more drug is introduced. It goes without saying that adequate preparations must be made for the patient so that one can sleep off the effects of the medication.

In the event psychotic material is brought up during narcosis, giving evidence of a potential disintegrative tendency, therapeutic goals and methods should be reappraised. Where the patient becomes too upset through release of traumatic material, it is best not to let the excitement mount to the point of overtaxing the ego. More drug is injected to put the patient to sleep, which will enable one to overcome the cathartic effects of the narcosis.

The therapist questioning the patient during narcosis may have to utilize a firm authoritative tone. In posttraumatic stress disorders especially, one builds a dramatic word picture that approximates the original traumatic scene: military combat, rape, assault, fire, accident, flood, earthquake, etc. Kolb and Mutalipassi (1932) have introduced an audio tape with battle noises during narcosis which almost immediately may bring the veteran with combat stress back to the traumatic event. Abreaction takes many forms

ranging from controlled talking about the fearsome incident to a violent acting out—muscularly, emotionally, verbally—the anxieties and fantasies that are being repressed. Sufficient time should be set aside to discuss with the patient feelings and memories after one comes out of narcosis. Generally, repeated sessions of narcosis tend to desensitize the patient allowing the repressed incident to be faced with diminished fear. Some therapists make audiotapes and videotapes of the narcotic sessions which they play back to their patients, and this stimulates animated discussions and provides material for interpretation. It goes without saying that individual and group psychotherapy are important following narcosynthesis in order to deal with the personality vulnerabilities that have predisposed the patient to the dissociative reactions displayed following the trauma.

Narcosis should be avoided in patients with manifest or latent porphyria, or who have liver, cardiac, respiratory or kidney disease. It should not be used in persons who are or were addicted to sedatives or hypnotics. Because of the danger of respiratory depression some therapists prefer to have the actual narcosis done by a trained anesthesiologist who can stand by in case of emergencies.

VIDEO RECORDING

Videotape technology has been advancing at a rapid rate and it is being adapted to increasing areas of health and science. Among its many possibilities are self-observation and self-confrontation (Berger MM, 1971; Melnick & Tims, 1974, Roche Report, 1973, 1974a), which have been applied to the teaching and learning situation (Torkelson & Ramano, 1967). The evolvement of video psychiatry has followed in the wake of this. Videotapes are being produced to teach psychopathology, child development, and psychiatric treatment. A cassette entitled "Electronic Textbook of Psychiatry" has been prepared by the New York State Psychiatric Institute's Department of Educational Research. Written linear programmed texts are being arranged with interdigitating videotaped clinical illustrations to enliven the teaching of psychiatry.

The recording of psychotherapy sessions with opportunity for repeated playback

offers patients an unparalleled learning experience that can catalyze the entire therapeutic process. As recorders and cameras have become less and less expensive, the video adjunct has been employed with increasing frequency in clinics and private practice, particularly in group, family, and marital therapy (Alger & Hogan, 1969; Czajkoski, 1968; Danet, 1969; Stoller, 1967, 1969). In behavior therapy (Bernal, 1969; Melnick & Tims, 1974), and in role playing and psychodrama, its employment is proving valuable. In selected cases persons in individual therapy may find self-observation of substantial value (Geertsma & Reivich, 1965; Paredes et al, 1969). An additional dividend is the fact that a therapist may observe one's own therapeutic performance and interpersonal conduct including countertransference, which can enhance one's own development and sharpen one's skills. The objective data issuing from even fragments of a single session can provide material for study and discussion over weeks and months. Progress or regress may also be scrutinized by comparing the productions of successful sessions. The videotape recording may also be utilized for the purpose of supervising a therapist's work, providing more authentic data than can be conveyed orally by the therapist.

The technique is simple. There is no need to conceal the equipment because after going through the preliminary brief anxiety and self-consciousness phases, patients readily make an adaptation to videotaping. For use of the tape in therapy, 10 minutes of the beginning of the session may be recorded and then played back through the monitor, or recording may be started when a significant period of the session is being approached. The patients are instructed to interrupt the playback if they wish to comment on discrepancies of behavior or if they desire to describe the feelings that they had at the time or have now.

Replay of small segments over and over may be rewarding either for the purposes of clarification and discussion or for desensitization where patients manifest a "shock" reaction at their images. Most patients are surprised at how often their appearance and behavior fails to reveal their shyness, anger, fear, distress, and other emotions. They become sensitive to the pervasive contradictory and paradoxical communications from verbal and nonverbal sources. For example, some patients are not aware of how angry,

argumentative, and unpleasant they are in an interpersonal situation until they objectively see and listen to themselves. Opportunities for clarification, heightened awareness, and more constructive reactions are many. Where, as in group, family, or marital therapy, a patient's responses have been maladaptive and the patient realizes this, one may benefit from repeatedly playing back sessions to grasp incongruities of messages. Patients may be asked to try to repeat messages until they communicate clearly. Should resistance develop in therapy or a stalemate have been reached, videotaping may open up dimensions that succeed in breaking through the block. The availability of splitscreen and special-effects generators through which one may obtain video multiimage distortions to elicit repressed material is an interesting new use for this adjunct (Roche Report, 1973). Original and unique ways of employing tapes are being elaborated by researchers and clinicians, and innovations will undoubtedly continue to emerge. These eventually will provide material for scientifically controlled studies to test their utility and validity.

Melnick and Tims (1974) make some excellent suggestions regarding the physical surroundings and equipment for videotaping. The room should be of ample size to accommodate comfortably the patients while providing enough space to operate the camera. It should be well ventilated. Generally a 15 feet by 18 feet size is good for a group of 8 to 10 people. If a group is the subject, the patients are seated in a semicircle with the open end accommodating the camera. Sound-absorbing materials and furniture in the room, such as accoustic tile on the ceiling, carpeting on the floor, draperies on the windows, and cloth covered chairs help the acoustics. As to selection of equipment, various machines are readily available. One-half inch decks and video cameras are available at moderate price and are usually ample for the average psychotherapist. A camera with a zoom lens will require an operator to focus on the entire group and on individuals. The operator can be the therapist, cotherapist, or a group member. Where taping is on the entire group and not on individuals, selecting a camera with a wide-angle lens (12.5 mm) is convenient since once set up it does not need an operator. The best microphone is an omnidirectional dynamic table microphone placed on a table or microphone stand. A monitor for the video and sound signals is the final piece of equipment, and for this purpose an ordinary television set is usually ample. Additional

optional equipment is also available, such as the use of two cameras with a camera switcher, splitscreen apparatus, a special-effects generator, and a second recorder with an electronic editor, where tapes are to be used for educational purposes. The original choice of equipment should allow for expansion with optional items should the latter be contemplated. If one cannot afford or utilize the most sophisticated apparatus, the simple portable one-half-inch deck and an inexpensive camera and microphone are sufficient, and they may well merit an investment.

THE TELEPHONE

Discrete use of the telephone as an adjunctive device is valuable in emergencies that arise in the course of psychotherapy. These fortunately are rare. Therapists may, for their patients' own good and for their own peace of mind, discourage patients calling for anything other than severe problems that cannot await solution until the next treatment session. Should it become apparent that the patient is taking advantage of the privilege of discrete telephoning, the therapist may focus during interviewing on the patient's need for telephone contact. The patient may be reminded that making one's own decisions during therapy is both strengthening and helpful even where such decisions do not turn out well since this provides material for exploration. If the patient is given sanction to telephone at will the flood of inconsequential calls that can result will very likely annoy the therapist and create severe resentments; this annoyance will adversely affect relations with the patient. In addition, if allowed at all, the therapist may be unable to stop the calls without hurting the working relationship.

There are several exceptions, however, to the rule. First, patients with a suicidal tendency do need the assurance of immediate contact when necessary. Here the therapist may have to insist that the patient telephone when too depressed. The lives of many patients have been saved by their ability to communicate with the therapist in crisis situations, and prior to the effective working of prescribed psychotropic drugs. Moreover, should the patient have taken an overdose of drugs, unintentionally or with suicidal design, reporting this will enable the therapist to call an ambulance or the police to bring

the patient to an emergency unit of a hospital for therapy. Second, patients for whom drug therapy has been prescribed should routinely be requested to telephone if they have peculiar or upsetting reactions to the medication. Hypotension, symptoms of blood dyscrasias, and severe dystonic reactions may need immediate medical intervention.

It goes without saying that the telephone is a vital therapeutic instrument for crisis intervention (Lester & Brockopp, 1973; Williams T, 1971). "Hotlines" exist in larger cities where young polydrug abusers, suicidally inclined persons, rape victims, and others seeking help for some misfortune or for general information can make contact with knowledgeable persons for guidance and counseling. There are for some clients advantages in retaining anonymity over the telephone and also in talking to an anonymous person onto whom the client can project fantasies of a helping person suited to one's needs (Lester D, 1974). It is vital where nonprofessional persons staff such services that they be adequately supervised by professionals. The telephone is an important resource, functioning to provide people with a reassuring human contact and a conduit for referral to available agencies in the community.

Telephone therapy also has a place where patients, for one reason or another, are unable for physical reasons to come to treatment in person (Miller WB, 1972; Robertiello, 1972). There are times where ill health, or absence of transportation, or travel away from home makes it impossible for a patient in psychotherapy to keep appointments, and yet a continuity of treatment is vital. Interestingly, a telephone may make it easier for a patient to reveal certain kinds of information than a face-to-face interview, particularly where a transference reaction exists. This may initiate a breakthrough when the patient returns for regular sessions.

PLAY THERAPY

Play therapy provides children with a means of giving vent to conflicts, ideas, and fantasies that they cannot ordinarily verbalize. One may look upon it as a special nonverbal language through which a child communicates. It is, in a certain sense, an acting-out, permitting through varied activities overt, nonverbal expressions to innermost

feelings. "Play therapy does not belong to any specific school of therapy. Each therapist must first learn to understand and to master this particular language of the child, and then integrate the mastery of the therapeutic tool with the particular tenet of one's own therapeutic orientation. The child's play, in and by itself, is no more therapeutic than the patient's free associations and relating of dreams. It is the therapist's skill and sensitivity which helps the adult patient to understand the often meaningless stringing together of seemingly unrelated thoughts in free association. In a similar way the child therapist helps the child to understand the real meaning behind his spontaneous play activities " (Woltman 1959).

Children, in line with their developmental growth, play act and think differently at different age levels. A 3-year-old may be playing with only a single toy, while an 8- or 10-year-old child may build a complicated structure. It must further be recognized that a child will select that kind of play activity which is best suited for the expression of a particular problem. Burning paper, throwing paper airplanes, or playing out elaborate automobile crashes can be properly used in therapy as long as one alerts oneself to the fact that all three activities may constitute an acting-out of aggressive impulses. The specific meanings that play materials and activities have for the child have been described by R. E. Hartley et al. (1952 a & b), who also has summarized play activities of children in terms of year levels (1957). A comprehensive study of children's play activities with miniature life toys has been presented by Lois Murphy (1956). The seminal contributions of schools of therapy to play therapy are found in the writings of Melanie Klein (1935, 1955), Anna Freud (1928), and Virginia Axline (1947), who is a follower of Carl Rogers. Specific play media and activities described many years ago may still be useful in the therapeutic treatment of children (Bender & Woltmann, 1936, 1937; Erickson EH, 1944, 1951; Gondor, 1954; Lowenfeld, 1939; Lyle & Holly, 1941; Trail, 1945; Whiles, 1941; Woltmann, 1940, 1950, 1951, 1952, 1955, 1956). Play group therapy has been described by Ginott (1961). The free play technique of Gitelson (1939) is helpful in some cases. Where it is difficult to create in the child an attitude that is conducive to spontaneous play, or where specific problems or time limitations play a decisive role, the methods described by Conn (1938), D. Levy (1937, 1939), J. C. Solomon (1938, 1940, 1951), Muro (1968),

Nelson (1967), and Nickerson (1973) may be applicable.

The methods of play therapy appear to be particularly suited to the expression of unconscious aggression and to the acting-out of jealousies in relation to a parent or sibling. They are also an excellent media for exploration of sexual and excretory fantasies. The beneficial effects of play therapy in part accrue from the insight patients gain into their drives and problems. More immediately, a child acts out in play, hostile, sexual, excretory, and other fantasies as well as anxiety-provoking life situations. The cathartic effect of play therapy temporarily alleviates tension. This is not as important as the gradual understanding that develops into the nature and effects of unbridled impulses. The noncondemning attitude of the therapist, who neither criticizes nor restricts the patient, but accords the child freedom in expressing overtly impulses and fantasies of a dreaded nature, alleviates guilt feelings, and eventually makes is possible for the child to acknowledge and to tolerate repressed drives. As these are repeatedly acted out in play, the child becomes desensitized to their influence. Understanding and control are developed by the therapist's carefully timed interpretations.

Controversy exists regarding the preferred approach in play therapy. A research study of play therapy some years ago in 298 outpatient child clinics in the United States indicated that 75 percent of the reporting clinics regard their theoretical orientation as psychoanalytic, 17 percent as nondirective, 5 percent as directive, and 3 percent as between directive and nondirective (Filmer & Hillson, 1959). At the same time, the majority of clinics considered Frederick Allen (1942) as the authority most representative of their orientation. Allen, whose concepts, reflecting those of Rank, stressed the relationship fostered through play therapy as the very core of the therapeutic process. This is in contrast with the approach of Melanie Klein (1955 a & b), which bypasses ego defenses and actively and immediately interprets the deep unconscious meanings of the child's play. The less radical approach of Anna Freud (1946) advocates interpretation of unconscious motivation only after a relationship has been established with the child. At the present time there is some shift toward behavioral theory and practice.

The use of artistic media, such as drawing, painting, and finger painting, as ways of exploring and working through unconscious conflict has been advocated by many therapists (Arlow & Kadis, 1946; Bender, 1937; Brick, 1944; Fink et al, 1967; Hartley RE, & Gondor, 1956; Levick, 1973; Mosse, 1940; Napoli, 1946, 1947; Naumburg, 1947, 1953, 1966; Schopbach, 1964; Stern, MM, 1952 a & b). These productions, whatever their nature, serve as means of emotional catharsis and as vehicles for revealing inner problems, wishes, and fears. Art therapy is particularly valuable in patients who find it difficult to talk freely. It is predicated on the principle that fundamental thoughts and feelings, derived from the unconscious, often find expression in images rather than in words (Naumburg, 1966). Through art a method of symbolic communication develops between patient and therapist. Though untrained in art, individuals can often project their conflicts into visual forms, to which they may then expeditiously associate freely. Dreams, fantasies, and childhood memories may also more readily be represented in a pictorial way rather than in speech. Patients who are blocked in verbalizing may find that drawing or painting their dreams and fantasies expedites translation of their thoughts and feelings into words. The function of the art therapist, according to many authorities in the past, is not to interpret, but to encourage the patient to discover for oneself the meaning of productions that provide symbolic ways of representing unconscious phenomena (Lewis NDC, 1928; Griffiths, 1935; Fairbairn, 1938a & b; Pickford, 1938; McIntosh & Pickford, 1943). The patient projects in the creations significant emotional meanings. This is very much similar to what happens in the Rorschach test (Vernonon, 1935). Furthermore, the symbolized content permits of an expression of inner impulses without too many guilt feelings. The art therapist accepts the patient's projections without punitive or judgmental responses. Interpretations are offered to the patient at strategic times. Interpretive approaches to art symbols have been described by Appel (1931), Jung (1934), Pfister (1934), Lisls (1938), Baynes (1939), Harms (1939, 1941), Reitman (1939), Mira (1940), Naumburg (1944, 1950), and E. Kris (1952). Other informative articles are those of Levy (1934), F. J. Curran (1939), Despert (1937), Mosse (1940), and Bychowski (1947). Traditional concepts about art therapy are still currently accepted.

In the actual technique, the patient may draw or paint during the treatment hour, or may work at home and bring the productions to the therapist. Drawing and painting may be employed not only individually, but also in groups (Naumburg & Caldwell, 1959), being especially valuable in therapy with children (Kramer, 1972). Simple, easily manipulate art materials must be made available to patients, particularly if they have never drawn or painted. Semihard pastels and casein or poster paints are to be preferred to oil paints. The therapist may have to instruct and encourage beginners by what is known as the "scribble technique." In this the patient is instructed to draw without a conscious plan by making a continuous line which may assume an irregular pattern as it meanders over the paper in various directions. The patient is then encouraged to search for a design, object, animal or person while holding the paper in different directions. Once the patient has done this, he or she is enjoined to work in art as spontaneously as possible using different materials.

Where a patient appears emotionally blocked or does not express appropriate feeling toward a special person or situation, instruction to construct an image or make a drawing representing the person or situation may release productive emotions and associations. The fact that the patient can control the drawings gives one a feeling of greater leverage over affective life. This is especially important in individuals with weak defenses who in being encouraged to draw have an option of how far they wish to go.

An attempt may be made to influence mood by asking the patient to draw something that depicts a special emotion. Thus, a depressed person may be asked to draw a happy scene, an anxiety-ridden soul to depict a relaxed and peaceful sketch. In a more cathartic vein, a patient may be requested to delineate on paper exactly how he or she feels or one would like to express if one could. The patient may also be encouraged, and perhaps helped, to depict the completion of an action essential for one's well-being on the theory that one may through this means symbolize a breakthrough of the stalemate and then respond behaviorally. Sometimes the psychotherapist may utilize as an adjunctive helper an art therapist. When such a person is used, regular conferences of the two must be held.

In group therapy some therapists find it useful to suggest that patients draw pictures

on a common theme. Comparing the drawings and getting the group members' associations can provide much stimulation and enhance group activity. This technique has also been employed with smaller groups, as in family therapy (Kwiatowska, 1967).

The activity of the therapist in relation to the patient's drawings will vary. One may sit quietly and observe what is being drawn, waiting for the patient's explanations, or may comment on or ask questions about the images, or may interpret what one believes the patient is trying to say. The patient may be encouraged to draw certain items, (i.e., dreams, memories, fantasies, family members, etc.). The therapist may even sketch on the patient's picture or suggest additions or alterations. Questions about the symbols may be asked, and the patient may be encouraged to make associations.

Where a patient responds to images drawn with fear, anger, or detachment, it is likely that he or she has not been able cognitively to integrate what has been produced. This may provide valuable leads for the interview focus. Encouragement to repeat the same theme in drawing may result in therapeutic desensitization and conflict resolution.

There is a tendency among some art therapists to overvalue the medium of communication—the art production—and to confuse the latter with the therapeutic process itself. While therapy may thus be regarded as a constant uncovering phenomenon that brings up interesting material, there may be a denial or minimization of the true therapeutic vehicle—the relationship between patient and therapist. The use of art as an adjunct in therapy is, nevertheless, considered by some analysts as helpful to patients who express themselves better in drawing and in other artistic ways than in free association or dreams. While the content of therapy may be focused on the art expression, the therapeutic process goes through the usual phases of transference and resistance as in any reconstructive form of psychotherapy.

SEX THERAPY

People with sexual problems as their presenting complaint generally are not motivated to seek intensive treatment. What they desire is to function sexually as rapidly

and normally as possible. Catering to this wish is a group of new sex therapies (Kaplan HS, 1974; Leiblum & Pervin, 1980), originated by the research team of Masters and Johnson (1966, 1970), which are short term, behaviorally oriented, and symptomatically effective for most patients. What some of the authors advocated is a short intensive course of instruction and guidance in proper sexual attitudes and techniques administered to the patient and his or her sexual partner by a dual-sex team.

This format is undoubtedly an excellent one. Some therapists combine behavioral methods with exploratory techniques. They encourage their patients to verbalize their fears, guilt feelings, and misgivings and deal with resistances in traditional psychotherapeutic ways. Ideally, therapy following the intensive initial course continues on a weekly basis for a period until the newly acquired patterns are solidly integrated and the patients are able to manage relapses by themselves.

There are obviously advantages to the couples working with the dual-sex therapeutic team since cooperation of both patient members is more easily obtained, resistances can be dealt with directly, misconceptions about sexuality can be effectively brought out in the open, questions about technique are less likely to be distorted, and desensitization of embarrassment and alleviation of guilt feelings are enhanced. In many cases the core problem is that of communication, particularly in relation to mutual sexual feelings. Breaking into the facade that sex is dirty, not to be talked about, practiced in the dark, etc. can release both partners and lead to a more natural and spontaneous functioning.

Practical considerations, however, may make it impossible to utilize a dual-sex team, and the therapist may have to operate without a cotherapist. In some cases it will be impossible to get the patient's spouse or sexual partner to come for interviewing. Then the therapist will have to work with the patient alone, briefing him or her on how to instruct and work with the partner. If both partners are available, a 2-week vacation period to initiate treatment is best since there will be less distractions. Here, too, modifications may be necessary; thus when the couple is ready for sexual exercises, a 3- or 4-day holiday may

be all that is necessary.

A diagnostic assessment of any sexual problem is vital to the choice of treatment (Wasserman et al, 1980). It is important to determine which of four phases of sexual response is implicated. Is the disorder of one of inhibited desire, or inability to maintain excitement and genital tumescence, or to control or achieve orgasm, or to achieve postorgasmic relaxation and well-being? (Kaplan and Moodie, 1984; Lief, 1981). Distinction of these phases of sexual response is important because varying mechanisms and neural pathways are operative in each and different therapeutic interventions may be called for. For example, inhibited sexual desire may be the product of guilt about and repression of sexuality produced by overmoralistic promptings in childhood, with consequent needs for self-punishment, indulgence in rape or bondage phantasies and masochistic practices as a condition for the release of sexual feeling. Conquest of these developmentally inspired sexual inhibitions may provoke the individual to imagine or to act out violent fantasies sadistically (sexual sadism), with antisocial behavior serving to subdue or symbolically destroy one's conscience or the projected representations. Guilt feelings and masochistic self-punishment usually follow these releases, but rarely eliminate them. Treatment when sought will require psychotherapy, preferably dynamically oriented, and only later behavioral approaches should sexual functioning continue to fail. Inhibited sexual desire may also be associated with failing release triggers that open the gates to sexual feeling, such as fetishism, transvestism, zoophilia, pedaphilia, exhibitionism and voyeurism, which must be approached psychotherapeutically although prognosis for recovery in these ailments is guarded. Sexual desire can be deadened by ailments like depression. Finally, the relationship with a marital partner may be pathological (e.g., incestuous) or so steeped in ongoing hostility as to deaden all thoughts of sex. Here marital therapy and dynamic psychotherapy may be essential.

Appropriate treatment for all of these foregoing conditions will therefore require accurate diagnosis. In the case of inhibited sexual excitement with frigidity and impotence, once organic factors (endocrinopathies, diabetes, arteriosclerosis, etc.) and medicinal agents (antihypertensives, beta-adrenergic drugs, alcohol, tranquilizers, etc.) have been

ruled out, behavioral sex therapy may be effective in itself, especially when the onset has been recent or the causes minor. But where personality difficulties exist, or anxieties and phobias are strong, coordinate psychotherapy and behavioral sex therapy may be necessary. The same may be said for inhibited female and male orgasm, premature ejaculation, dyspareunia and functional vaginismus. For the fourth phasic disturbance of inhibited postorgasmic relaxation and well-being, such treatments as cognitive therapy to alter meaning systems, and dynamic psychotherapy to explore conflicts may be useful.

Sexual problems do not occur in isolation. They appear as a manifestation of coordinate physical, marital, interpersonal, or interpsychic difficulties that are overshadowed by the patient's concern with the sexual symptom. The initial successes scored with the traditional behavior approaches consequently have not been as consistently sustained as was originally anticipated (DeAmicis et al, 1984). One difficulty that is now becoming apparent is the symptom of low sexual desire, which is often masked by defective motivation for therapy.

What appear as limited or absent sexual feelings (Kaplan, 1979) are now being recognized as a symptom of emotional disorder. In many cases such sexual inhibitions are the product of repressed fear, anxiety and anger. Application of a probing dynamic approach will usually bring such repressed feelings to the surface. Non-analysts deal with this dimension by what they call "experiential sensory awareness exercises." The object is to recognize that inhibited sexual desires do not exist as a permanent passive state but are actively being promoted by emotions and attitudes that are in need of clarification and correction. Not only is psychoeducation required to rectify misconceptions about the right to experience pleasure and sexuality, but faulty belief systems and self-statements will require interpretation and restructuring. The action phase of the therapeutic process involves behavioral assignments and that concern the patient and a cooperative partner. Where marital problems exist these will have to be worked out, otherwise therapy will be sabotaged by one or both members. It goes without saying that physical causes of sexual disinterest such as diabetes, depression, use of cardiac medications, etc., will have to be considered in addition to working with psychological factors.

The presence of both members is an essential part of the treatment process. They are given an explanation of the number of sessions that will be involved (usually 15 to 25) and the fact that homework with sexual exercises will be employed. Brief mention may be made that all extramarital affairs, if any, must be halted for treatment to be successful. Readings may be suggested such as Heiman et al. (1976) and Zilbergeld (1973). In addition to meeting with the couple, individual sessions may be necessary. A usual form of therapy involves four phases: (1) experiential sensory awareness, (2) insight, (3) cognitive restructuring, and (4) behavioral assignments (Friedman & Hogan, 1985).

Several sessions of history taking and interviewing to gather relevant data and to clarify misconceptions are customary before starting behavioral conditioning. Important too is determination of what medications an individual is currently taking since heart and blood pressure drugs (e.g., beta-blockers, hydrochlorothiazides, anti-anginal pills, psychoactive drugs (e.g., tranquilizers, sedatives, antidepressants, neuroleptics), gastrointestinal drugs (e.g., Tagamet, Librax), hormonal drugs (e.g., estrogen, progesterone) and other drugs (e.g., fenfluramine, metronidazole, phenytoin) may cause loss of libido, impotence, ejaculatory dysfunction, and anorgasmia. Consultation with the patient's internist to see whether alternate medications can be prescribed will be important. There are a number of organic conditions, such as diabetes, hypopituitarism, hypothyroidism, vascular disorders, and neurogenic disturbances that may be implicated and that will require correction. Once these factors are eliminated, preliminary sessions may be started. These are best done individually with the partners since many personal sensitive areas and confidential secrets may be exposed. Where a dual-sex team is used, the male therapist interviews the man and the female therapist interviews the woman. Patients will often ask the therapist not to reveal secrets to their mates. Such material ranges from masturbation to past and present sexual affairs. Some of these confidences are not as dreadful as the patient imagines, and their revelation could clear the air between the couple. However, the therapist must promise (and hold to the promise) not to expose the patient. If it turns out that therapy cannot continue without bringing up the secret, the therapist must ask the patient's permission. But in all likelihood the revelation may not be necessary.

The sexual history should cover the following.

1. The earliest memory of sexual feeling.

2. The kinds of sexual information expounded to the individual as a child.

3. Preparation for and reactions to menstruation in the female and the first ejaculation in the male.

4. The first sexual experience (masturbating or in relation to another person, animal, or object).

5. Sexual feelings toward parents or siblings.

6. Early homosexual or heterosexual activities. (The first sexual experiences are very important and the patient may never have gotten over them).

7. Present sexual behavior and accompanying feelings and fantasies.

8. Sexual dreams.

9. Attitudes toward masturbation.

10. Conditions under which orgasm occurs.

11. If married, the kind of relationship with mate.

12. Tendencies toward promiscuity.

Attitudes toward sexuality should be explored, for example, how the patient feels about kissing of the mouth, breast, body, and genitals, about manual manipulation of the genitals, about mouth-genital contact, and about different sexual positions. What does the patient feel (like, dislike) about the partner? What makes him or her angry? What makes him or her feel sexy? The therapist should look for what positive and pleasurable things are present in the relationship, since these can be reinforced. Often the *way* the patient responds to these questions, the hesitancies, embarrassment, etc., will yield as much information about attitudes as the content of the answers.

The bulk of patients who come for sexual therapy are well motivated. This is very

much in their favor and permits the use of short-term approaches. The great majority of these patients can be helped without too great delving into dynamics. The empathic liberated attitude of the therapist coupled with correcting misinformation about sex may in itself suddenly liberate the patient.

Some of the more common questions plaguing patients are the following, suggested answers being indicated.

Q. What is the normal frequency of intercourse?

A. There is no such thing as "normal" frequency. Sexual needs vary with each person and the desire for pleasuring oneself can range from daily to bimonthly.

Q. Doesn't masturbation take away desire for intercourse?

A. If people learn better ways of pleasuring themselves, they engage in self-manipulation less frequently, although they can still derive pleasure from it.

Q. Isn't genital intercourse the most desirable form?

A. Sex has several forms and genital intercourse is certainly desirable, but at times other variations of pleasuring, like oral-genital contact, are indulged by many.

Q. I feel my penis is too small. Isn't this objectionable to women?

A. This is a common foolish concern of many men. The vagina is a flexible organ, accommodating itself and capable of being pleasured by all sizes. If you stop worrying about size and concentrate on pleasure in love-making, your partner will undoubtedly be more than satisfied.

Perhaps the most important element in the treatment is the manner and attitude of the therapist (or therapeutic team). In working with patients who are seeking to liberate themselves from their sexual fears and inhibitions, the therapist presents as a model of a permissive authority. Therapists have tremendous leverage in working with sexual therapy because they fit into the role of idealized parental figures who can make new rules. An easygoing, non-condemning, matter-of-fact approach is quite therapeutic in its own right. The ideal therapeutic philosophy is that the patient has been temporarily diverted from attaining the true joys of sex and that if there is the desire to do so, it is possible to move toward reaching this goal of enjoyable pleasure without guilt and fear.

This posture is difficult to simulate if the therapist has "hang-ups" about sex or harbors Victorian sentiments that harmonize with the patient's particular ideas or misconceptions. Many therapists falsely regard their own sexual attitudes and behavior as a norm. If these are too restrictive, they will prevent a full release of the patient's potentialities.

In brief sexual therapy, countertransference phenomena can fleetingly occur. One must expect that a patient of the opposite sex will sometimes openly or covertly express sexual transference. This is usually handled by a casual matter-of-fact attitude of nonresponse. Problems occur when the therapist is deliberately or unconsciously seductive with patients.

The following concepts will have to be integrated by the patient, hence they should be accepted by the therapist:

   1. Sex is a normal and natural function.

   2. The primary purpose of sex is pleasure not performance.

   3. People have many different ways of pleasuring themselves. They can derive satisfaction through manual manipulation, oral-genital contacts and genital-genital contacts. Unfortunately, the way we are brought up teaches many of us wrong attitudes about sexuality.

   4. People have a right to liberate themselves from these crippling attitudes.

   5. All people have the potential of enjoying sexuality.

If the therapist has scruples about these concepts, personal inhibitions may be passed on to the patient. Therefore, it may be preferable to refer patients with sexual difficulties to another therapist or team skilled in sexual therapy.

It is important to avoid the words "abnormal" or "pathological" since these may have frightening connotations. It is best to shy away from the word "masturbation" but rather refer to it as "deriving pleasure manually or through fondling the genitals oneself." The term "mutual masturbation" should also be avoided. Instead one may say "pleasuring each

other manually." It is advisable to ask the patient, "Are there thoughts or fantasies or objects that turn you on?" People often have wild fantasies and even covet harmless fetishes, symbolic residues of past conditionings, which help them to release sexual feelings. To ridicule or condemn these when they are revealed will serve merely to discourage the patient. The proper therapeutic stance is casually to emphasize that people have different ways of pleasuring themselves. The therapist may say, "For every lock there is a key, and each person has his own key for the release of sexual feeling. If there is something harmless that turns you on, there is nothing to be afraid of or ashamed of." The reason why it is important not to interfere with sexually releasing fantasies is that removing them too soon, before other more satisfactory sexually releasing stimuli are developed, may result in paralyzing inhibitions or in resentments that will drive the patient away from therapy.

The patient should be asked to have a complete physical examination if one has not been recently obtained. There are some physical conditions as has been mentioned that result in impairment of functioning as well as medications that are inhibiting to libido. It may be necessary to reduce or to substitute drugs that are not so sexually incapacitating.

Where a depression exists, antidepressant medications may be necessary (buprion [Wellbutrin] is a good antidepressant here) and instead of inhibiting sexual feeling they may release it. Loss of libido is one of the first signs of a depression. In the case of excessive tension *mild* tranquilization may help. Buspirone (BuSpar) is an anxiolytic that has a minimal adverse effect on sexual feeling.

After taking a history, joint conference of partners and therapist (or dual-sex team) is held with the object of outlining the problem or problems and of discussing effective ways that the partners can participate in helping each other toward a better adjustment. An idea is given the couple about the roles of each, played in the past, that have produced the difficulty. The therapist also comments on the behavior of the couple to each other. Transferential data especially should be looked for: "The way you treat your wife [husband] it seems to me is how you described your mother [father] treated your father

[mother]." Empathy must be displayed, and it is urgent to set up as good a working relationship as is possible. Reassurance is important. Sometimes women who have had hysterectomies believe that they will not be able to function sexually again. This mistaken notion should be clarified by the therapist, who may point out that the sexual response has nothing to do with the uterus. People with hysterectomies can function normally sexually. In males who have had suprapublic or transurethral prostatectomies any impotence that follows the operation usually disappears. This information can be reassuring to the prostectomized patient.

It may be advisable to use charts or illustrations to clarify the sex anatomy of male and female, even where no ostensible problems appear to exist. It is astonishing how ignorant some people are of their genital makeup. No matter how sophisticated they may imagine themselves to be, a great gap can exist in their education about how they are built.

Misconceptions will also have to be covered such as (1) that erections and orgasm can be brought on by will power, (2) that all sexual play must lead to intercourse, (3) that orgasms must be simultaneous, (4) that a clitoral orgasm is not an orgasm, (5) that orgasm is always essential during sexual contact, (6) that as one gets older desire for sex disappears.

The couple is then enjoined to start a new mode of sexual communication with each other. The therapist may interject these comments:

1. "Don't ask your spouse what he [she] wants in sex. Start every sentence with 'I want' or 'I would like.' "

2. "Express your feelings rather than act on them. If you are angry, say so. The minute you *act* angry with each other something has gone wrong."

3. "There is no reason not to reveal your performance fears to each other." The couple (or patient) should also be told at the start of therapy: "Until I [we] have given you the permission, to do otherwise, you are to limit your sexual activities to getting turned on with each other. There is to be no real intercourse in the meantime." Pressure removed from the male to penetrate with his penis and the female to have an orgasm may almost

immediately lead to penile erections and vaginal lubrication. This can form the basis for fruitful reconditioning of responses.

4. "You will make mistakes, but that is the best way to learn."

5. "You are not to analyze your performance, just let things happen as they will. The goal is pleasure, not how well you are doing."

6. "You don't have to have intercourse to give your partner sexual satisfactions."

The basic first step to be practiced* by the couple is what Masters and Johnson have called "sensate focus." The couple is instructed to begin in privacy the following assignment:

> *Th.* You are, in a comfortably warm room, to get into bed completely undressed. Turn on a soft light.

Some couples have actually never closely looked at each other nude. The partner with the problem, or with the most severe problem, is instructed:

> *Th.* You are to do with him [or her] whatever you always wanted to do, like touching the face, body, thighs, etc. But *not* the breasts or genitals. There is absolutely to be no intercourse. If you do anything that causes discomfort, your partner must tell you. Your partner is to get what he [or she] can get out of it. But the important thing is for you to experience pleasure in what you are doing. Do this for 5 to 15 minutes, no more. Then your partner is to do the same thing with you.

Very often this exercise will mobilize strong sexual feelings. Impotent men will have erections; nonorgasmic women will lubricate: premature ejaculators will maintain an erection.

The couple may also be told that if they get aroused too much, they may pleasure themselves (masturbate) in the presence of each other, but not to the point of orgasm. Couples often lose their guilt and feel released by the therapist giving them "permission" for them to manipulate themselves in the presence of each other.

If the couple is seen only once weekly rather than the intensive 2-week course at the beginning, they may be told to practice "sensate focus" only twice during the week or at

the most three times. They may also utilize a warm body lotion if they desire.

After such practice, the couple, seen together, is asked individually what has happened. The therapist may ask: "Describe how you felt when *you* did it; how did you feel when it was done to you." A good deal of benefit that comes from sexual therapy derives from the emotional catharsis that relieves patients of guilt, fear, and shame as they talk about their preoccupations and feelings. The fact that the therapist is empathic toward and non-condemning of past experiences and current fantasies and compulsions helps them to approach their problems from a less defiant and more objective perspective. They get the impression that there is nothing really "bad" or "evil" about what they are thinking, feeling, or doing; rather they feel that they can move ahead toward areas of greater sexual and emotional freedom and fulfillment. The therapist should search for factors that create anxiety and mutual hostilities. If not corrected, these may neutralize the effects of therapy. Where necessary, the therapist supplies data about physiology, prescribes books, and discusses techniques of symptom control. Useful suggestions may be found in the illustrated book by Helen Kaplan (1974). What went right and what went wrong? The accounts will usually vary. If things did not go well, this should be discussed and the couple sent out to repeat the exercises with the addendum: "Each person is to tell the other what he [or she] likes to have done." A common complaint is being ticklish. If this is the case, the ticklish partner should put his (or her) hands over that of the partner who does the stroking. They may be enjoined, "When you are more relaxed, the tickling will cease." Should the couple complain that there was no sexual feeling, they may be told: "This is not a sexual performance. It is a practice session." Successes should be praised but not analyzed.

As soon as this phase has gone well, the couple may be encouraged to practice genital pleasuring. "You may now gently stroke each others' genitals, directing each other as you go along. It is not necessary to have an orgasm unless you want to and are sufficiently stimulated. But spend not more than 15 minutes from the start." The man may be told: "It is enjoyable for a woman to be touched gently on the clitoris. You can put your forearm on her tummy and let your hand fall over the pubis." The woman is to direct the

man's hand on her own pubis, the lips, and the clitoris, and tell him when to stop. If the woman does not lubricate, lubrication should be employed especially on the clitoris.

Where an intensive 2-week program is utilized, it may be arranged as follows, varying it according to the reported reactions:

First day: History taking.

Second day: Joint session. Educational explanations. Correcting misconceptions about sex. Directions about "sensate focus."

Third day: Round table (therapists and couple) to discuss reactions. Directions to examine each other avoiding genitals and breast.

Fourth day: More sensate focus. If no anxiety, genitals may be included.

Fifth day: Sensate focus with stimulation of genitals, but not to orgasm. Orgasm may be reached by pleasuring self if desired.

Sixth day: If no anxiety is reported, a mutually pleasurable thing is to be done.

Seventh day: No sexual practice.

Eighth day: As desired with or without practice.

Ninth day: Insertion of penis into vagina for pleasure, but no orgasm, is essential. The goal is pleasure, not orgasm, even if the penis goes inside. If there is no erection, the soft penis with KY jelly or other lubrication can still be introduced. It should contact the clitoris if not inserted. "Even the soft penis gives pleasure."

Tenth day: Repetition of ninth day.

If after four or five sensate focus sessions the couple is not responding and moving ahead, they should not be made to feel that they are failures. Some other form of treatment (like psychoanalytically oriented psychotherapy) may be necessary. The failure is not with the couple. It is due to the limitations of this particular kind of therapy. There is a group of patients such as those with inhibited sexual desire whose defenses prevent them from enjoying sex. Often obsessive ideas about performance interfere with the drive,

excitement, and orgasm phases of the sexual act. In some cases the patient may be taught to disregard or bypass obsessive thoughts. In other cases the problem is too invested with unconscious conflict to disappear with simple sex therapy along behavioral lines. A combined dynamic and behavioral approach is best here.

Some special techniques may be necessary for different problems. In *premature ejaculation* the "squeeze" technique may be helpful. Here the man lies on his back. The woman with legs spread faces his pelvis. She strokes his body and then the penis until there is erection. She continues stroking the penis and randomly places thumbs on the raphe under the glans on the underside of the penis and the forefinger on the other side. She squeezes four times in 15 seconds, but not to the point of pain. Then he lies on his back, and she squats over him. She slowly inserts the lubricated penis and stops all movement for a moment. Then she moves slowly at a 45° angle, and he announces when he is getting too much pleasure. He then withdraws the penis, and the squeeze technique is utilized. Modifications of this technique may be used (Tanner BA, 1973). Where the female sexual partner becomes upset and *insists* on a "better performance," the problem of rapid ejaculation is augmented by guilt and conviction of failure. Tension builds up, which exaggerates the symptom. Here dynamic marital therapy along with sexual therapy along behavioral lines is the preferred approach.

A problem that disturbs many women is that of being *nonorgasmic.* Where the patient has sensuous feelings and can achieve orgasm with masturbation, the difficulty is generally not a serious one. Should a block to sensuous feelings exist, it is expedient to explore with the patient further the history of her sexual development from childhood and the store of misinformation that she has retained about sexuality.

The first step is helping the patient to develop greater sensuous feeling by exercises in relaxing, stroking her body, and self-pleasuring (masturbating). A book like *The Sensuous Woman,* by Lyle Huart, may be helpful. The sensate focus technique described above is then taught the couple with the object of pleasuring each other while avoiding intercourse. Pleasure in giving pleasure to the partner is the object while providing

feedback of how they both feel during the exercises.

McCarthy (1973) describes a technique that may be found helpful.

First day: Stroking and kissing various parts of the partner's body with eyes shut and no genital touching.

Second day: Sensate focus, eyes shut and couple guiding each other with no genital touch.

Third day: Sensate focus, guiding each other and eyes open.

Fourth day: Abstinence.

Fifth day: Sensate focus with lotion, no genital touch.

Sixth day: Sensate focus and genital touch with eyes closed.

Seventh day: Guided sensate focus with genital touch, eyes open.

After this greater spontaneity and experiment are encouraged. Some couples may take several days to execute the directions assigned for one day. When the exercises have been completed, once-a-week visits are possible. Teaching the couple sexual positions may be part of the instructions starting with the "no-demand" position. Oral-genital stimulation techniques may also be introduced and feelings aired about this. Should anxiety develop during any of the stages, a return to sensate focus techniques is advocated. Finally, after orgasms are reached by manual and oral-genital techniques, actual intercourse is encouraged. As much as 2 or 3 months of preliminary stimulation may be required before full intercourse is "permitted." Naturally, if full intercourse occurs prior to this, the therapist acts pleased.

Some therapists skilled in hypnosis have been able to bring their female patients to orgasm by training them in fantasy formation while the patients are in a trance. They are told they will have feelings of gentle warmth in the vaginal area and will be able to accept these feelings and feel excited and passionate deeply inside the vagina. Thereafter scenes are suggested of the patient meeting her secret lover and making exciting love with him.

Because repressive barriers are down and the imagination is so vivid in the trance, some patients are able to experience their first orgasm through such training. Posthypnotic suggestions are made to the effect that orgasms will come with intercourse without guilt or fear. The therapist must be a bit of a romantic poet to make such suggestions sound realistic. Should the therapist decide to utilize this technique, it is wise to have a female helper quietly present during and after trance induction for medico-legal reasons.

The use of vibrators should be avoided in nonorgasmic women, since they will probably respond to the intense stimulation and then find the actual sex experience nonstimulating. Moreover, if the vibrators are used too much, they may cause vaginal ulceration.

Where the complaint is *impotence,* we must differentiate between primary and secondary varieties. In *primary impotence,* the patient has never been able to sustain an erection with a partner sufficient for the sexual act. Some individuals here realize their failing, but they ascribe it to moral scruples, which they imagine will be resolved when they get married. Marriage fails to correct the condition and, recognizing that an annulment is imminent, husband and wife usually seek help from a minister or physician who, in turn, may refer the couple to a psychotherapist. Generally, primary impotence is an aspect of a severe personality problem characterized by strong feelings of inadequacy, inferiority, and doubts about one's masculinity. The principal approach here is dynamic psychotherapy with sex therapy as a supplementary, albeit useful, accessory that should involve the patient and his partner.

Secondary impotence is where, following a period of more or less successful intercourse, the male experiences a loss of erection. This may occur when he is fatigued, or physically ill, or excessively tense and anxious about some situational problem, or most frequently when he is feeling hostile toward his partner. Ever since women have come to regard sex as a right rather than a burden, the incidence of secondary impotence has risen. Especially affected are men who regard their partner's expectations as a challenge to their masculinity. Their reaction to "failure" is usually related to their self-image. If they have a

low feeling about themselves, they will overrespond and look forward to the next attempt with a sense of dread. The need to perform becomes more important to them than the desire to achieve pleasure in the sex act. Hypnosis in some cases, may be emminantly successful as a reinforcing intervention in impotency and premature ejaculation (Wolberg, 1948) utilizing suggestions patterned after the directions discussed previously.

Let us assume that we have eliminated physical causes (for example, diabetes, which is sometimes the source of secondary impotence) for the impotence. Therapy will involve restoration of confidence in the ability to function. No more may be required than clarification that impotence can occur temporarily in all males and that it will rectify itself if the person has no stake in maintaining it. The therapist should emphasize and reemphasize, "The best advice to follow is to forget the need for performance and to attempt satisfying yourself to the limit of your capacity without or with an erection." Treatment with sensate focus is generally successful, but cooperation of the partner is mandatory.

We sometimes encounter a situation where a middle-aged man is secondarily impotent with his wife and has become involved in an erotic stimulating situation with a younger woman. He is sexually disinterested in his wife, who he complains is getting obese, is losing her body firmness, developing wrinkles, neglects her grooming, and exposes him to a boring, stereotyped sexual experience. Often the relationship with the wife has deteriorated into one where the man regards her as a maternal substitute. He may come to therapy spontaneously out of guilt and with the hope the therapist will work some miracle and produce an erection even though he may not be interested so much in pleasing himself as in pleasing his wife. Generally, if the man is emotionally involved with the other woman, sex therapy will not work too well and the restoration of adequate sexual functioning will be unsuccessful. At some point it will be necessary to break up the triad. The therapist may under some circumstances, at the start, where the man's motivation to correct the situation is strong, have to tell him that he will need to break up his relationship with the young woman before therapy can be successful. In other cases where the man is deeply entangled in the affair, immediate rupture can be traumatic and

may be strongly resisted. Here, gradually the effort may be made to help the man see the inadequacy of the relationship with his mistress, an effort that may or may not prove successful. Marital therapy is sometimes useful where the relationship between husband and wife has not deteriorated too badly.

Brief periods of *frigidity* in women are normal, the product resulting from temporary physical disability or fleeting anxieties, tensions, and depressions. Frigidity can also occur when there is anger or irritation with a sexual partner. Short-term therapy with reassurance given that there is nothing seriously wrong, while permitting free verbalization of hostility toward the partner, may be all that is required.

Persistent frigidity may be divided into primary and secondary varieties. In *primary frigidity* the woman has never had an orgasm even during sleep or with masturbation, although she may have experienced some sexual arousal. Usually arousal reaches a pitch and then loss of feeling ensues without orgasm. Responsible for this may be fears of loss of control, of rejection, or of acting foolishly. In *secondary frigidity* the person was once orgasmic and then ceased to respond. Here untoward emotions and attitudes are often implicated, like hostility, distrust, disgust, and fear. Sometimes orgasm may be possible with certain fantasies, like being raped or punished, or with some practices, like being treated roughly, tied down, abused, etc. Sometimes masturbation succeeds while intercourse remains distasteful. Sex therapy may enable some women with secondary frigidity to respond satisfactorily. Should a patient require fantasies, the therapist should not disparage these. The patient may be encouraged to substitute thoughts about her present sexual partner at the start of orgasm in an effort to recondition a new way of thinking.

Long-standing primary frigidity, however, does not usually yield to sex therapy, particularly where it is a product of severe personality problems stemming from disturbed family relationships. There may be a fear of functioning like a woman, a repudiation of femininity, a disgust with and desire to renounce the female sexual organs, consciously or unconsciously conceived of as dirty or repulsive. There may be marked

competitiveness and hostility toward men. Long-term psychoanalysis or dynamic psychotherapy offers chances for improvement or cure after reconstructive changes have been brought about.

In *dyspareunia* and *vaginismus* intercourse is so painful that it becomes aversive rather than pleasurably rewarding. Here the patient should be sent to a gynecologist to rule out organic causes. Trauma during the birth of a child, episiotomy, a painful past abortion, a hysterectomy, endometriosis, allergic reactions to birth control sprays and jellies, and other physical factors may be at the root of the problem. In most cases, however, the cause is psychogenic. During vaginismus the muscles go into spasm, a kind of defensive splinting. Penetration is difficult or impossible even for the little finger. Reaction to erotic approaches then sponsors a panicky withdrawal. Sometimes vaginismus is a secondary response to premature ejaculation or impotence in a husband or lover. The woman's reaction frightens and discourages the man and aggravates his problem, which, in turn, creates further symptoms in the woman. The triad of dyspareunia, vaginismus, and impotence are often at the basis of an unconsummated marriage. Couples sometimes shamefacedly seek help for this situation, and sex therapy may be tried.

A useful method of feaiing with these reactions is to recondition the pain response through the use of graduated dilators. These may be obtained in a surgical supply house, one form being known as Young's Dilators. The smallest size, well lubricated, is slowly inserted by the woman, at first in the presence of her husband. She is encouraged to retain it for a while. Then gradually each day a larger size, well lubricated, is introduced. Next the husband slowly inserts the dilators in graduated size. The time dilators are retained in the vagina is increased from 15 minutes to 2 hours. The patient must be reassured that the dilators will not disappear in her body, a fearful misconception of some patients. Success rates are close to 100 percent, assuming no serious psychiatric problem coexists.

BIBLIOTHERAPY

Attempts are sometimes made by therapists to change faulty attitudes and to influence poor motivation in certain patients through the assigned reading of articles,

pamphlets, and books. By these measures the patient is helped to understand how personality is evolved, why adaptation breaks down, the manifestations of collapse in adaptation, and how psychotherapy may help repair the damage. Advice on the handling of specific problems in adjustment, marriage, and child rearing may also be obtained from some reading materials. This therapeutic use of reading (psychoeducation) has been designated as "bibliotherapy."

Bibliotherapy is of value chiefly to persons who have had little contact with psychotherapy and who require more information about emotional illness before they can admit of its existence in themselves or can recognize that beneficial results may be obtained from treatment. It may correct misconceptions about mental health, psychiatry, and psychotherapy. It is sometimes effective in correcting misconceptions through acceptance of written authoritative statements and directives that help the person to suppress inner fears, to gain reassurance, and to adopt socially acceptable attitudes and values. The latter influence makes bibliotherapy a useful adjunctive device in certain patients receiving psychotherapy. Patients may gain from readings a number of methods by means of which they may regulate their life, inspirational formulas that help in the achievement of happiness and success, and devices that permit of a regulation of those conflicts and strivings that are more or less under volitional control.

Bibliotherapeutic approaches to mental health, while praiseworthy, have definite limitations. People often refuse to accept facts due to a complete or partial unawareness of ego-syntonic personality distortions. To tell parents they must accept and love their children in order for the children to grow into healthy adults, does not mean that they will appreciate the significance of these precepts. Indeed, even though children are being rejected, spouses despised, and family life desecrated, the culprits may not consider their behavior in any way unusual. They may even hold themselves up as parental ideals.

In other instances the person may acknowledge one's difficulties but be totally unable to do anything about them. Educational media that warn people of the disasters to children or to society of their reactions may mobilize counterreactions and actually

exaggerate the existing problems.

The manner in which reading materials are prepared and presented is important. If they apprise of the fact that all parents commit errors, that children are resilient and can stand many mistakes if they feel loved and respected, and that youngsters with even severe difficulties can change, readings may create a corrective atmosphere.

On the whole, reading adjuncts will not prove to be remarkably corrective for the patient who is in reconstructive therapy. This is because no intellectual approach is of great service in modifying deeply repressed conflicts or in ameliorating symptoms that have strong defensive virtues for the individual. Indeed, the educational materials may be utilized by the patient as resistance, items being extracted out of context to justify neurotic patterns. The relative ineffectuality of reading materials in severe neurotic difficulties is attested to by the fact that scores of patients come to psychotherapy after having read more extensively from the psychiatric literature than has the therapist.

Nevertheless, bibliotherapy may help certain individuals to break through specific resistances and to gain limited insight, as, for instance, those patients who, unconvinced of the value of psychotherapy, require examples from the experiences of others of how therapy helps. Resistance to working with dreams may sometimes be handled by asking the patient to read books in which the rationale of dream interpretation is explained. A patient who has in therapy resolved crippling sexual inhibitions may be aided in achieving a more complete sexual life by reading appropriate materials dealing with marriage. Or a patient having problems with children may benefit greatly from books on child psychology. Personal involvement in short stories and case histories is also possible, and McKinney (1975) lists a bibliography that can be useful.

As a therapeutic medium, bibliotherapy is utilized in child therapy. Children readily get "caught up" in a story. A child identifies with one or more of the characters and releases emotional energy vicariously. This may result in greater awareness by the child of personal needs, feelings, and motivations (Ciancilo, 1965; Nickerson, 1975). Some of the ways that bibliotherapy is employed are described by Bell and Moore (1972), Chambers

(1970), Dinkmeyer (1970), Gardner (1974), Heimlich (1972), Mulac (1971), My rick and Moni (1972), and J. A. Wagner (1970).

The following is a list of recommended books and pampthlets, should the therapist decide that bibliotherapy is indicated.

Books on General Psychology, Psychiatry, and Psychoanalysis

Berne E: A Layman's Guide to Psychiatry and Psychoanalysis, New York, Ballentine, 1982 (paperback)

Brill AA: Basic Principles of Psychoanalysis. Lanham, MD, University Press of America, 1985

Freud S: Introductory Lectures on Psychoanalysis: A General Introduction to Psychoanalysis. New York, Liveright, 1977. (paperback). Orig. Title: General Introduction to Psychoanalysis.

Grinker RR, Sr.: Psychiatry in Broad Perspective. New York, Behavioral Publications, 1975

Lichtenberg JD: The Talking Cure: A Descriptive Guide to Psychoanalysis. Hillsdale, NJ, Analytic Press, 1985

Wrightsman LS et al: Psychology; a scientific study of human behavior, 5th ed. Monterey, CA, Brooks/Cole, 1979

Books Explaining How Personality Problems Operate

English OS, Pearson GH: Emotional Problems of Living (3rd ed). New York, Norton, 1963

Fromm E: The Sane Society. New York, Fawcett World, 1977 (paperback)

Horney K: The Neurotic Personality of Our Time. New York, Norton, 1937 (paperback)

Menninger K: The Vital Balance: The Life Process in Mental Health and Illness. Mongolia, MA, Peter Smith, 1973.

Wolberg LR, Kildahl JP: The Dynamics of Personality. New York, Grune & Stratton, 1970

Books Explaining How Psychiatry and Psychotherapy Help

Herink R: The Psychotherapy Handbook. New York, New American Library, 1980

Horney K: Are You Considering Psychoanalysis? New York, Norton, 1963 (paperback)

Kovel J: A Complete Guide to Therapy: From Psychoanalysis to Behavior Modification. New York, Pantheon, 1977 (paperback)

Quinnett PG: The Troubled People Book: A Comprehensive Guide to Getting Help. New York, Continuum, 1982

Rubin TI & Rubin E: Not to Worry: The American Family Book of Mental Health. New York, Viking, 1984

Ruitenbeek H: Psychotherapy: What It's All About. New York, Avon, 1976

Pamphlets

Compulsive Gambling (Milt H). PAP (#598), 1981. $1.00

Depression: Causes and Treatment (Irwin R). PAP (#488), 1970 $1.00

Help for Emotional and Mental Problems (Ogg E). PAP (#567), 1987 $1.00

The Psychotherapies Today (Ogg E). PAP (#596), 1981. $1.00

Some Things You Should Know About Mental and Emotional Illness. (NMHA). (n.d.)

Troubled Children, Troubled Families–Techniques in Child and Family Therapy (Ogg E). PAP (#605), 1982. $1.00

What Everyone Should Know About Mental Health (n.d.) CLB

When Things Go Wrong, What Can You Do? (n.d.) NMHA. 300

Who's Who in Mental Health Care. 1981. CLB (Review copy: Free)

Books on Marriage & Alternate Life Styles

Belkin GS & Goodman N: Marriage, Family & Intimate Relationships. Boston, Houghton Mifflin, 1980

Bell RR: Marriage & Family Interaction, (6th ed). Chicago, Dorsey, 1983

Bernard J: The Future of Marriage. New Haven, Yale University Press, 1982

Lederer WJ: Creating a Good Relationship. New York, Norton, 1984

Rogers CR: Becoming Partners: Marriage and its Alternatives. New York, Delacorte, 1973 (also paperback, New York, Dell)

Stuart RB & Jacobson B: Second Marriage. New York, Norton, 1985

Pamphlets

Building a Marriage on Two Altars (Genne E&W). PAP (#466), 1971. $1.00

The Early Years of Marriage (Klemer RH, MG). PAP (#424), 1968. $1.00

Marriage and Love in the Middle Years (Peterson JA). PAP (#456), 1970. $1.00

New Ways to Better Marriages (Ogg E). PAP (#547), 1977. $1.00

One-Parent Families (Ogg E). PAP (#543), 1976. $1.00

Saving Your Marriage (Duvall E, S). PAP (#213), 1954 $1.00

Sexual Adjustment in Marriage (Klemer RH, MG). PAP (#397), 1966. $1.00

Stepfamilies- A Growing Reality (Berman C). PAP (#609), 1982. $1.00

Strengthen Your Marriage Through Better Communication (Bienvenu M Sr). PAP (#642), 1986. $1.00

What Makes a Marriage Happy (Mace DR). PAP (#290), 1959. $1.00

Yours, Mine & Ours: Tips for Stepparents. U.S. GPO (#S/N 017-024-00833-8), 1984. $3.50

Books on Human Sexuality

Barbach LG: For Yourself: The Fulfillment of Female Sexuality. Garden City, NY, Anchor/Doubleday, 1975 (paperback)

Bell AP et al: Sexual Preference: Its Development in Men & Women. Bloomington, Indiana University Press, 1981

Kitzinger S: Women's Experience of Sex. New York, C.P. Putnam's 1983

Marmor J: Homosexual Behavior: A Modern Reappraisal. New York, Basic Books, 1980

Masters W: The Pleasure Bond: A New Look at Sexuality and Commitment. Boston, Little, Brown, 1975

Money J, Tucker P: Sexual Signatures: On Being a Man or a Woman. Boston, Little, Brown, 1975

Pleck JH & Sawyer J (eds): Men and Masculinity. Englewood Cliffs, NJ, Prentice-Hall, 1974

Silverstein C: A Family Matter: A Parent's Guide to Homosexuality. New York, McGraw-Hill, 1978

Zilbergeld B & Ullman J: Male Sexuality. New York, Bantom Books, 1978

Pamphlets

Changing Views of Homosexuality (Ogg E). PAP (#563), 1978. $1.00

Sex Education for Disabled Persons (Dickman IR). PAP (#531), 1975 $1.00

Books on Family Planning

Publications dealing with the subjects of contraception, fertility, or menopausal hormone therapy may not reflect the results of current research. Readers are urged to consult their physicians.

Bromwich PD & Parsons AK: Contraception. York, Oxford University Press, 1984

Calderon MS: Manual of Family Planning & Contraceptive Practice, (2d ed). Melbourne, FL, Krieger, 1977

Goldstein M & Feldberg M: The Vasectomy Book: A Complete Guide to Decision Making. Boston, Houghton Mifflin, 1982

Guttmacher A: Pregnancy, Birth & Family Planning, revised by Irvin H. Kaiser. New York, NAL, 1986 (paperback)

Hatcher RA et al: It's Your Choice: A Personal Guide to Birth Control Methods for Women ... & Men, Too! New York, Irvington Publisher, 1982

Ory HW et al: Making Choices: Evaluating the Health Risks & Benefits of Birth Control Methods. New York, Alan Guttmacher Institute, 1983

Pamphlets

Basics of Birth Control. Rev ed. PPFA, 1982. $.50

A Guide to Birth Control: Seven Accepted Methods of Contraception, PPFA, 1982. $.50

Abortion: Public Issue, Private Decision (Pilpel, HF, Zuckerman, RJ & Ogg E). PAP (#527), 1975. $1.00

Preparing Tomorrow's Parents (rev ed) (Ogg E). PAP (#520A), 1983. $1.00

Books on Pregnancy and Childbirth

Boston Children's Medical Center. Pregnancy, Birth and the Newborn Baby: A Publication for Parents. New York, Delacorte/Seymour Lawrence, 1972

Colman AD, Libby L: Pregnancy: The Psychological Experience. New York, Seabury, 1972

Cook WA: Natural Childbirth: Fact & Fallacy. Chicago, IL, Nelson-Hall, 1982

Guttmacher A: Pregnancy, Birth & Family Planning. New York, New American Library, 1984. (paperback)

Schaefer G, Zisowitz ML: The Expectant Father. New York, Simon & Schuster, 1964

Pamphlets

Childbirth Today: Where and How to Have Your Baby (Jacobson B). PAP (#628), 1984. $1.00

Pregnancy and You (Auerbach AB, Arnstein HS). PAP (#482), 1972 $1.00

A Pregnancy Primer: The Importance of Prenatal Care (Jacobson B). PAP (#636), 1985. $1.00

Prenatal Care, rev., 1983. Administration for Children, Youth, and Families. U.S.G.P.O., S/N 017-091-00237-1. $2.50.

The Very New Baby: The First Days of Life (Schwartz JV, Botts ER). PAP (#553), 1977. $1.00

Books on Men and Women

Bernard J: Women, Wives, Mothers: Values and Options. Chicago, Aldine, 1975

de Beauvoir S: The Second Sex. New York, Random House, 1974 (paperback)

Komarovsky M: Dilemmas of Masculinity: A Study of College Youth. New York, Norton, 1976.

Mead M: Male and Female. New York, Dell, 1984 (paperback)

Pamphlets

Male "Menopause": Crisis in the Middle Years (Irwin T). PAP (#526), 1975. $1.00

Men and Women-What We Know about Love (Lobsenz NM). PAP (#592), 1981. $1.00

Men's Jobs for Women: Toward Occupational Equality (Jaffe N). PAP (#606), 1982. $1.00

Books on Family Problems and Crises

Atkin E, Rubin E: Part-Time Father: A Guide for the Divorced Father. New York, Vanguard, 1976

Ausubel DP: What Every Well-Informed Person Should Know About Drug Addiction. Chicago: Nelson-Hall, 1980

Caine L: Widow. New York, Morrow, 1975

Heilman RO (ed): Early Recognition of Alcoholism & Other Drug Dependence. Center City, MN, Hazelden, 1973

Jones CL & Battjes R: Etiology of Drug Abuse, Implications for Prevention. (NIDA Research Monograph 56). Washington, D.C., Government Printing Office, 1985

Kubler-Ross E: Death: The Final Stage of Growth. New York, Simon & Schuster, 1986

Meryman R: Children of Alcoholism, a Survivor's Manual. Boston, Little, Brown, 1984

Milt H: Alcoholism—Its Causes and Cures. New York, Scribner, 1976

Nida PC & Heller WM: The Teenager's Survival Guide to Moving. New York, Macmillan, 1985

Sandmaier M: The Invisible Alcoholics: Women and Alcohol Abuse in America. New York, McGraw-Hill, 1981

Stuart IR, Abt LE (eds): Children of Separation and Divorce. New York, Grossman, 1981

Pincus L: Death and the Family: The Importance of Mourning. New York, Pantheon, 1976

Seixas J & Youcha G: Children of Alcoholism: A Survivor's Manual. New York, Harper-Row, 1986 (paperback)

Steinmetz SK & Straus MA (eds): Violence in the Family. New York, Harper-Row, 1974

Pamphlets

AIDS: Fears and Facts (Irwin, M). PAP (#639), 1986. $1.00

Assaults on Women: Rape and Wife Beating (Jaffe N). PAP (#579), 1980. $1.00

Caring About Kids: When Parents Divorce. U.S. GPO (#S/N 017-024-01102-9), 1984. $3.25

Children and Drugs (Saltman J). PAP (#584), 1980. $1.00

Dealing with the Crisis of Suicide (Frederick CJ, Lague L). PAP (#406A), 1967. $1.00

A Death in the Family (Ogg E). PAP (#542), 1976. $1.00

Drinking, Drugs and Driving. NCA, 1986. $.10

Drugs-Use, Misuse, Abuse: Guidance for Families (rev ed) (Hill M). PAP (#515A), 1985. $1.00

The Dying Person and the Family (Doyle N). PAP (#485), 1972 $1.00

Help for the Troubled Employee (Brenton M). PAP (#611), 1982. $1.00

Helping Children Face Crises (Barman A). PAP (#541), 1976. $1.00

How Teens Set the Stage for Alcoholism (O'Gorman, P & Stringfield S). NCA, 1978. $.40

How to Cope with Crises (Irwin T). PAP (#464), 1971. $1.00

If One of Your Parents Drinks Too Much What Are Your Problems Going to Be? (Block MA & Heing FV), 1965, AMA. $.20

Incest: Family Problem, Community Concern (Strouse E). PAP (#638), 1985. $1.00

The Many Faces of Family Violence (Saltman J). PAP (#640), 1986. $1.00

The Right to Die with Dignity (rev ed) (Ogg E). PAP (#587A), 1983. $1.00

Single Parent Families. U.S. GPO (#S/N 017-091-00229-1), 1984. $4.50

Teenage Pregnancy-What Can Be Done? (Dickman IR). PAP (#594), 1981. $1.00

To Combat and Prevent Child Abuse and Neglect (Irwin T). PAP (#588), 1980. $1.00

Understanding and Dealing with Alcoholism (Milt H). PAP (#580), 1980. $1.00

Unmarried Teenagers and Their Children (Ogg E). PAP (#537), 1976. $1.00

What to Do When You Lose Your Job (Weinstein GW). PAP (#617), 1983. $1.00

What You Should Know about Drug Abuse (rev ed) (Saltman J). PAP (#550A), 1984. $1.00

Women and Abuse of Prescription Drugs (Brenton M). PAP (#604), 1982. $1.00

When Parents Divorce. U.S. GPO (DHHS #(ADM) 81-1120) 1981. n.p.

When a Family Faces Cancer (Ogg E). PAP (#286), 1959. $1.00

When a Parent Is Mentally Ill: What to Say to Your Child (Armstein HS) JBFCS, 1974; paper) 1974, $1.50

Women and Alcohol-1980. AA, 1979. $.20

Books on Family Living and Adjustment

Amstein HS: Between Mothers-in-Law & Daughters-in-Law: Achieving a Successful & Caring Relationship. New York, Dodd, 1985

Bradley B: Where Do I Belong? A Kids' Guide to Stepfamilies. Reading, Mass, Addison-Wesley, 1984

Denton W & Denton JH: Creative Couples: The Growth Factor in Marriage. Philadelphia, Westminster, 1983

Duvall EM & Miller B: Marriage & Family Development, (6th ed). New York, Harper-Row, 1984

Edwards M & Hoover E: The Challenge of Being Single. New York, New American Library, 1975

Kornhaber A: Between Parents & Grandparents. New York, St. Martin's 1986

Rosenbaum V & Rosenbaum J: Stepparenting. Novato, CA, Chandler & Sharp, 1977

Satir V: Peoplemaking. Palo Alto, CA, Science & Behavior Books, 1972

Spock B: Raising Children in a Difficult Time. New York, Norton, 1985

Pamphlets

Handling Family Money Problems (Weinstein W). PAP (#626), 1984. $1.00

Making Ends Meet (Weinstein GW). PAP (#624). 1984. $1.00

One-Parent Families (Ogg E). PAP (#543), 1976. $1.00

Preparing to Remarry (Berman C). PAP (#647), 1986. $1.00

Stepfamilies-A Growing Reality (Berman C). PAP (#609), 1982. $1.00

You and Your In-laws: Help for Some Common Problems (Brenton M). PAP (#635), 1985. $1.00

Books on General Child Care and Guidance

Chess S et al: Your Child Is a Person: A Psychological Approach to Parenthood Without Guilt. New York, Penguin, 1977

Erikson EH: Childhood and Society (rev ed). New York, Norton, 1964 (also in paperback).

Ginott HG: Between Parent and Child: New Solutions for Old Problems. New York, Macmillan, 1969

Lamb ME: The Father's Role: Applied Perspectives. Somerset, NJ, John Wiley, 1986

Montessori M: From Childhood to Adolescence. New York, Schocken, 1973

Stone LJ, Church J: Childhood and Adolescence: A Psychology of the Growing Person (rev ed). New York, Random House, 1973

Pamphlets

Environmental Hazards to Children (DiPerna P). PAP (#600), 1981. $1.00

Helping Children Face Crises (Barman A). PAP (#541), 1976. $1.00

How to Discipline Your Children (Baruch D). PAP (#154), 1949. $1.00

Immunization-Protection against Childhood Diseases (rev ed) (Saltman J). PAP (#565A), 1983. $1.00

Motivation and Your Child (Barman A). PAP (#523), 1975. $1.00

Playmates: The Importance of Childhood Friendships (Brenton M). PAP (#525), 1975. $1.00

Pressures on Children (Barman A). PAP (#589), 1980. $1.00

Teaching Children about Money (Weinstein GW). PAP (#593), 1981. $1.00

What Should Parents Expect from Children (Archer J, Yahraes DL). PAP (#357), 1964. $1.00

When Your Child is Sick (rev ed) (Seaver J, Schwartz JV). PAP (#441 A), 1978. $1.00

Your Child's Emotional Health (Wolf AWM). PAP (#264), 1958. $1.00

Your Child's Sense of Responsibility (Neisser EG). PAP (#254), 1957. $1.00

Books on Infants and Young Children

Arnstein HS: Billy & Our New Baby. New York, Human Sciences Press, 1973

Fraiberg S: The Magic Years: Understanding and Handling the Problems of Early Childhood. New York, Scribner, 1984

Snyder A: First Step. New American Library, 1976

Spock B: Baby and Child Care (4th ed). New York, Pocket Books, Simon & Schuster, 1983

Pamphlets

Breastfeeding (Riker AP). PAP (#353S), 1964. $1.00

Caring for the New Baby-The First 18 Months (Schwartz JV, Botts ER). PAP (#616), 1983. $1.00

Enjoy Your Child-Ages 1, 2, and 3 (Hymes JL Jr). PAP (#141), 1948. $1.00

The Pocket Guide to Babysitting. U.S. GPO, 1982. S/N 017-091-00236-3

Three to Six: Your Child Starts to School (Hymes JL Jr). PAP (#163), 1950. $1.00

Your Child From One to Six. U.S. GPO, 1984. S/N 017-091-00219-3. $2.00

Your First Months with Your First Baby (Barman A). PAP (#478), 1972. $1.00

Books on Adoption and Foster Care

Cautley RW: New Foster Parents: The First Experience. New York, Human Sciences Press, 1980

Churchill SR et al: No Child Is Unadoptable: A Reader on Adoption of Children with Special Needs. Beverly Hills, CA, Sage, 1979

Curto J: How to Become a Single Parent: A Guide for Single People Considering Adoption or Natural Parenthood Alone. Englewood Cliffs, NJ, Prentice-Hall, 1983

Day D: The Adoption of Black Children. Lexington, MA, Lexington Books, 1979

Festinger T: No One Ever Asked Us: A Postscript to Foster Care. New York, Columbia University Press, 1984

Adopting a Child (Phillips M). PAP (#585), 1980. $1.00

Raising an Adopted Child' (Berman C). PAP (#620), 1983. $1.00

Books on the Child's Middle Years

Elkind D: A Sympathetic Understanding of the Child Six to Sixteen. Boston, Allyn & Bacon, 1978 (also paperback)

LeShan E: What Makes Me Feel This Way: Growing Up with Human Emotions. New York, Macmillan, 1974

Pamphlets

Early Adolescents: Understanding and Nurturing Their Development (Redl F). ACEI (ISBN 0-87173-087-1), 1978. $2.40

How to Help Your Children Achieve in School. U.S.G.P.O., 1983. S/N 065-000-00176-4. (Dept, of Education) $3.75.

Understand Your Child-From 6 to 12 (Lambert C). PAP (#144), 1948. $1.00

Your Child From 6 to 12. U.S.G.P.O., 1984. S/N 017-091-00070-1. $2.75.

Books on How to Understand and Relate to the Adolescent

Ginott H: Between Parent & Teenager. New York, Avon, 1971

Josselyn IM: The Adolescent and His World. New York, Family Service Association, 1952 (paperback)

Mead M: Culture and Commitment. Garden City, NY, Doubleday, 1970

Winship EC: Reaching Your Teenager. Boston, Houghton Mifflin, 1983

Pamphlets

An Adolescent in Your Home. Washington, D.C. U.S. GPO (#S/N 017-091-00202-9), 1984. $3.50

Adolescent Suicide: Mental Health Challenge (Freese AS). PAP (#569), 1979. $1.00

Anorexia Nervosa and Bulimia: Two Severe Eating Disorders (Jacobson B). PAP (#632), 1985. $1.00

Coming of Age: Problems of Teenagers (Landis PH). PAP (#234), 1956. $1.00

Helping the Handicapped Teenager Mature (Ayrault EW). PAP (#504), 1974. $1.00

Marijuana: Current Perspectives (Saltman J). PAP (#539), 1976. $1.00

Parent-Teenager Communication: Bridging the Generation Gap (Bienvenu MJ Sr). PAP (#438), 1969. $1.00

Parents and Teenagers (Hill M). PAP (#490), 1973. $1.00

The Problem with Puberty (Tepper SS). RAJ Publications, 1981. $1.50

Runaway Teenagers (Koestler FA). PAP (#552), 1977. $1.00

Teenagers and Alcohol: Patterns and Dangers (Saltman J). PAP (#612), 1983. $1.00

You and Your Alcoholic Parent (Hornik EL). PAP (#506), 1974. $1.00

Books on How to Explain Sexuality to Children

Bell R et al: Changing Bodies, Changing Lives: A Book for Teens on Sex & Relationships. New York, Random, 1981

Calderone MS & Ramey JW: Child Study Association of America. What to Tell Your Child about Sex. Northvale, NJ, Jason Aronson, 1983

Calderone MS & Johnson EW: The Family Book About Sexuality. New York, Harper-Row, 1981

Pierson JD: Planned Parenthood Federation of America Staff. How to Talk With Your Child about Sexuality: A Parent's Guide. New York, Doubleday, 1986

Pamphlets

How to Tell Your Child about Sex (Hymes JL. Jr). PAP (#149), 1949. $1.00

Schools and Parents-Partners in Sex Education (Gordon S, Dickman IR). PAP (#581), 1980. $1.00

Sex Education: The Parents' Role (Gordon S, Dickman IR). PAP (#549), 1977. $1.00

Sexually Transmitted Diseases-Epidemic among Teenagers (rev ed) (Saltman J). PAP (#517A), 1982. $1.00

Talking to Preteenagers about sex (Hofstein S). PAP (#476), 1972. $1.00

Books about Sexuality to Read to or Be Read by Children

Andry AC & Schepp S: How Babies Are Made. Alexandria, VA, Time-Life Books, 1968

Gordon S & Gordon J: Did the Sun Shine Before You Were Born? A Sex Education Primer. Fayetteville, NY, Ed-U Press, 1982

Gordon S: Girls are Girls and Boys are Boys-So What's the Difference? Fayetteville, NY, Ed-U Press, 1979.

Johnson CB & Johnson E: Love and Sex and Growing Up. New York, Bantam Books, 1979

Johnson E: Love & Sex in Plain Language, (rev ed). New York, Harper-Row, 1985

Madaras L & Madaras A: What's Happening to My Body? A Growing up Guide for Mothers and Daughters. New York, New Market Press, 1983

Pomeroy WB: Boys & Sex, (rev ed). New York, Delacorte, 1981

Pomeroy WB: Girls & Sex, (rev ed). New York, Dell, 1986

Waxman S: Growing Up Feeling Good: A Child's Introduction to Sexuality. Los Angeles, CA, Panjandrum Books, 1979

Pamphlets

How was I Born? (Nilsson L). DEL, 1975. $10.95

It's My Body: A Book to Teach Young Children How to Resist Uncomfortable Touch (Freeman L), PPSC, 1982. $2.95

Books for Adolescents

Betancourt J: Am I Normal? An Illustrated Guide To Your Changing Body. New York, Avon Books, 1983

Betancourt J: Dear Diary: An Illustrated Guide to Your Changing Body. New York, Avon Books, 1983

Burns C: How to Survive Without Feeling Frustrated, Left Out or Wicked. New York, Harper & Row, 1986

Choice: Changes: You and Your Body. Philadelphia, CHOICE, 1978

Gordon S: The Teenage Survival Book: The Complete Revised, Updated Edition of YOU. New York, Times Books, 1981

Hanckel F & Cunningham J: A Way of Love, A Way of Life: A Young Person's Introduction to What it Means to be Gay. New York, William Morrow, 1979

Hunt M: The Young Person's Guide to Love. New York, Farrar Strauss Giroux, 1975

LeShan E: You and Your Feelings. New York, Macmillan, 1975

Lieberman EJ & Peck E: Sex and Birth Control: A Guide for the Young, rev ed. New York, Harper & Row, 1981

Nida RC & Heller WM: The Teenager's Survival Guide to Moving. New York, Macmillan, 1985

Satir V: Self Esteem: A Declaration. Berkeley, CA, Celestial Arts, 1975

What Every Teenager Should Know About Alcohol. CLB, 1981

Books about Exceptional, Handicapped, and Emotionally Ill Children

Blodgett HE: Mentally Retarded Children: What Parents and Others Should Know. Minneapolis, University of Minnesota Press, 1972

Brown DL: Developmental Handicaps in Babies & Young Children: A Guide for Parents. Springfield, IL, Thomas, 1972

Heisler V: Handicapped Child in the Family: A Guide for Parents. Orlando, FL, Grune, 1972

Lowenfeld B: Our Blind Children: Growing and Learning with Them (3rd ed). Springfield, IL, Thomas, 1977

Meyer DJ et al: Living with a Brother or Sister with Special Needs: A Book for Sibs. Seattle, University of Washington Press, 1985

Myklebust HR: Your Deaf Child. Springfield, IL, Thomas, 1979 (paperback)

Pamphlets

Asthma-Episodes and Treatment (Saltman J). PAP (#608), 1982. $1.00

Getting Help for a Disabled Child-Advice from Parents (Dickman IR, Gordon S). PAP (#615), 1983. $1.00

Help for Your Troubled Child (Barman A, Cohen L). PAP (#454), 1970. $1.00

Learning Disabilities: Problems and Progress (Yahraes H). PAP (#578), 1979. $1.00

The Legal Rights of Retarded Persons (Ogg E). PAP (#583), 1980. $1.00

Mental Retardation-A Changing World (Lippman L). PAP (#577), 1979. $1.00

No Easy Answers: The Learning Disabled Child. U.S. GPO, 1984 (National Institute of Mental Health) S/N 017-024-00687-4 $6.50

The Retarded Child Gets Ready for School (rev ed) (Hill M). PAP (#349A), 1982. $1.00

You and Your Alcoholic Parent (Hornik EL). PAP (#506), 1974. $1.00

Books on Self-understanding and Self-help Books

Benson H: The Relaxation Response. New York, Morrow, 1976

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AA: Al-Anon, 1 Park Ave., New York, NY 10016

AMA: American Medical Association, 535 North Dearborn St., Chicago, IL 60610 CLB: Channing L. Bete Company, South Deerfield, MA 01373

DEL: Delacorte Press, 1 Dag Hammarskjold Plaza, New York, NY 10017

JBFCS: Jewish Board of Family & Children's Services, Library, Inc. 120 West 57th Street, New York, NY 10019

NCA: National Council on Alcoholism, 733 Third Avenue, New York, NY 10017

NIMH: National Institute of Mental Health, 5600 Fishers Lane, Rockville, MD 20852

NMHA: National Mental Health Association, 1021 Prince St., Arlington, VA 22314

PPFA: Planned Parenthood Federation of America, 810 7th Avenue, New York, NY 10019

PAP: Public Affairs Pamphlets, 381 Park Avenue South, New York, NY 10016

PPSC: Planned Parenthood of Snohomish County, 2722 Colby, Suite 515, Everett WA 98201 or Parenting Press 7750 31st Ave., NE Seattle, WA 98115

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Short-Term Psychotherapy

Most of the psychotherapeutic treatments given in this country are short-term by the patients' choice. At the Postgraduate Center for Mental Health, one of the largest outpatient clinics in the United States, for example, patients are seen for psychoanalytically oriented psychotherapy with no limit set for the number of sessions to be given. Patients terminate treatment when they have decided they need no more help. Under these circumstances, the average number of sessions given comes to 17, and this is accompanied by an improvement rate of over 80 percent. Even though the Center is a psychoanalytic training unit, and patients are encouraged to remain in long-term therapy, only 15 percent are deemed suitable candidates for protracted treatment focused on reconstructive goals.

Follow-up studies on patients who have improved with short-term therapy have shown that the majority retain their gains and that some continue to progress by themselves once the start has been made during formal treatment. This does not mean that they would not have improved even more with long-term therapy. It merely indicates that short-term therapy is an important cost-effective approach for many psychiatric problems. It also has been shown by the nation's pioneer health maintenance organization to reduce utilization of medical resources. Yet there are still many therapists who are reluctant to accept the value of short-term approaches. Hoyt (1985) has listed the following reasons for this reluctance: (1) the belief that "more is better" and that long-term methods are more penetrative and thorough, (2) the idea that one should not contaminate the "pure gold" of analysis with baser metals of a supportive nature, (3) the therapist's predetermined notion that long-term therapy is indicated in spite of the patient's wishes, (4) the belief that short-term therapy involves an overwhelming investment of work and energy, (5) the subtle economic factor of maintaining a steady rather than fluctuating source of income, (6) countertransference and undue therapist reactions to termination.

A number of studies have appeared that bear out that short-term therapy is a most efficient means of bringing about at least symptomatic improvement or cure. More than 25 years ago, this was proven by an experimental program of Group Health Insurance, Inc., in which 1200 participating psychiatrists treated a large sample of patients suffering from a wide spectrum of emotional problems (Avnet, 1962). At the end of the limited treatment period a 76 percent cure or improvement rate was scored. Follow-up investigation 2.5 years later recorded 81 percent of patients as having achieved recovery or improvement (Avnet, 1965). On the basis of these studies, it was grossly predicted that four of five patients receiving brief forms of treatment would report or feel some kind of improvement, even with current treatment methods executed by long-term oriented therapists.

That depth changes are also possible has been reported by psychoanalytically trained psychotherapists who present evidence that far-reaching and lasting changes may occur even with a limited number of dynamically oriented sessions (Sifneos, 1967, 1972; Davanloo, 1978; Malan, 1964a, 1976; Mann, 1973; Wolberg, 1980). This contention has understandably been subject to challenge. Personality distortions have a long history. They involve habit patterns and conditionings dating to childhood that have become so entrenched that they resist dislodging in a brief period. Repetitively they force the individual into difficulties with oneself and others, and they may persist even after years of therapy with an experienced psychoanalyst have revealed their source, traced their nefarious workings through developmental epochs, and painstakingly explored their present-day consequences. We can hardly expect that the relatively few sessions available for short-term therapy can effectuate the alchemy of extensive reorganization not possible with prolonged treatment. Reconditioning any established habit requires time; and time is of the essence in molding personality change if change is at all possible. *But experience persuades that this time need not be spent in all cases in continuous psychotherapy.* Removing some misconceptions about one's illness and one's background may dislodge the cornerstone, crumble the foundations, and eventually collapse some of the neurotic superstructure. This development may not be apparent until years have passed following a short-term treatment effort. Obviously, this bounty cannot always be realized. We may

hypothesize that the more experienced, highly trained, and flexible the therapist, the more likely it is to occur. Yet the environment in which the individual functions will undoubtedly also have a determining effect on any reconstructive changes that will evolve, since the milieu may sponsor and encourage or vitiate and crush healthy personality growth. But without having had the benefit of therapy, however brief it may have been, even the most propitious environment will have registered little improvement, save for exceptional cases.

There are patients who by themselves have already worked through a considerable bulk of their problems and who need the mere stimulation of a few sessions with a proficient therapist to enable them to proceed to astonishing development. Such an extensive dividend may not come about, nor should they be expected with many patients in short-term treatment, even where the therapist is sufficiently endowed by personality, training, and experience to do good psychotherapy.

Reasonable anticipations of what short-term treatment should accomplish in the average person are (1) relief of symptoms, (2) restoration to the optimal level of functioning that existed prior to the present illness, and (3) an understanding of some of the forces that initiated the immediate upset. When dynamic short-term therapy has been employed, we may, in addition, hope for (1) recognition of some pervasive personality problems that prevent a better life adjustment, (2) at least partial cognizance of their origin in past experiences and childhood conditionings, (3) recognition of the relationship between prevailing personality problems and the current illness, and (4) an identification of remediable measures that can be applied to environmental difficulties and perhaps to aspects of personality distortions as a whole. If treatment is managed well, patients will be given an opportunity to move beyond restoring their customary emotional balances. Should they possess sufficient motivation to propel them toward further development, should neurotic secondary gain elements be minimal, and should their environment be sufficiently accommodating to sponsor their continued movement, deeper alterations may occur. We may accept any reconstructive change as a welcome blessing if it comes, but, should it not, we must be satisfied that the patients have derived something worthwhile,

even though goal limited, out of their sparse sessions. If therapy is interrupted at the peak of the improvement curve, before the idealized relationship projections dissolve in the acid substratum of transference and resistance, and before dependency has had an opportunity to establish a permanent beachhead in the relationship, the rate of improvement can be substantial.

SELECTION OF CASES

While the best patients are undoubtedly those who are adequately motivated for therapy, intellectually capable of grasping immediate interpretations, proficient in working on an important focus in therapy, not too dependent, have had at least one good relationship in the past, and are immediately able to interact well with the therapist, they generally constitute only a small percentage of the population who apply to a clinic or private practitioner for treatment. The challenge is whether patients not so bountifully blessed with therapeutically positive qualities can be treated adequately on a short-term basis with some chance of improving their general modes of problem solving and perhaps of achieving at least a minor degree of personality reconstruction.

In practice one may distinguish at least five classes of patients who seek help. We have categorized them as class 1 through 5. In general, classes 1 to 3 require only short-term therapy. Classes 4 and 5 will need management for a longer period after an initial short-term regimen of therapy.

Class 1 Patients

Until the onset of the current difficulty class 1 patients have made a good or tolerable adjustment. The goal in therapy is to return them to their habitual level of functioning. Among such patients are those whose stability has been temporarily shattered by a catastrophic life event or crisis (death of a loved one, divorce, severe accident, serious physical illness, financial disaster, or other calamity).Some individuals may have been burdened with extensive conflicts as far back as childhood but up to the present illness have been able to marshal sufficient defenses to make a reasonable

adaptation. The imposition of the crisis has destroyed their capacities for coping and has produced a temporary regression and eruption of neurotic mechanisms. The object in therapy for these patients is essentially supportive in the form of *crisis intervention* with the goal of reestablishing the previous equilibrium. Reconstructive effects while not expected are a welcome dividend. Generally, no more than six sessions are necessary.

An example of a class 1 patient is a satisfactorily adjusted woman of 50 years of age who drove a friend's automobile with an expired license and in the process had a severe accident, killing the driver of the car with which she collided and severely injuring two passengers in her own car, which was damaged beyond repair. She herself sustained a concussion and an injured arm and was moved by ambulance to a hospital, where she remained for a week. Charged with driving violations, sued by the owner of the car she borrowed and by the two injured passengers, she developed a dazed, depressed reaction and then periods of severe dizziness. Therapy here consisted of a good deal of support, reassurance, and help in finding a good lawyer, who counseled her successfully through her entangled legal complications.

Sometimes a crisis opens up closed traumatic chapters in one's life. In such cases it may be possible to link past incidents, feelings, and conflicts with the present upsetting circumstances enabling the patient to clarify anxieties and hopefully to influence deeper strata of personality. In the case above, for example, the patient recalled an incident in her childhood when while wheeling her young brother in a carriage, she accidentally upset it, causing a gash in her sibling that required suturing. Shamed, scolded, and spanked, the frightened child harbored the event that powered fear and guilt within herself. The intensity of her feelings surprised her, and their discharge during therapy fostered an assumption of a more objective attitude toward both the past and the immediate crisis event. It may not be possible in all cases, but an astute and empathic therapist may be able to help the patient make important connections between the past and present.

Class 2 Patients

The chief problem for class 2 patients is not a critical situation that has obtruded

itself into their lives, but rather maladaptive patterns of behavior and/or disturbing symptoms. The object here is symptom cure or relief, modification of destructive habits, and evolvement of more adaptive behavioral configurations. Multiform techniques are employed for 8 to 20 sessions following eclectic *supportive-educational* models under the rubric of many terms, such as short-term behavioral therapy, short-term reeducative therapy, and so forth.

A phobia to air travel exemplifies the complaints of a class 2 patient. This was a great handicap for Miss J since job advancement necessitated visits to remote areas. The origin of the patient's anxiety lay in the last flight that she had taken 8 years previously. A disturbance in one of the engines reported to the passengers by the pilot necessitated a return to the point of origin. Since that time Miss J had not dared enter a plane. Therapy consisted of behavioral systematic desensitization, which in eight sessions resulted in a cure of the symptom.

In utilizing the various eclectic techniques, therapists alert themselves to past patterns that act as a paradigm for the present symptom complex, as well as to manifestations of resistance and transference. In a certain number of cases the patient may be helped to overcome resistances through resolution of provocative inner conflicts and in this way achieve results beyond the profits of symptom relief.

Class 3 Patients

Those in whom both symptoms and behavioral difficulties are connected with deep-seated intrapsychic problems that take the form of personality disturbances and inappropriate coping mechanisms make up the class 3 classification. Such patients have functioned at least marginally up to the time of their breakdown, which was perhaps initiated by an immediate precipitating factor. Most of these patients seek help to alleviate their distress or to solve a crisis. Some come specifically to achieve greater personality development. On evaluation either they are deemed unsuitable for long-term treatment, or extensive therapy is believed to be unnecessary, or for sundry other reasons cannot be done. They often possess the desire and capacity of work toward acquiring self-

understanding.

The goal for class 3 patients is personality reconstruction along with symptomatic and behavioral improvement. Techniques are usually psychoanalytically oriented, involving interviewing, confrontation, dream and transference interpretations, and occasionally the use of adjunctive techniques like hypnoanalysis. Some therapists confine the term *dynamic short-term therapy* to this class of patients and often employ a careful selection process to eliminate patients whom they feel would not work too well with their techniques (Buda, 1972; Davanloo, 1978, Malan, 1963; Sifneos, 1972; Ursano & Dressier, 1974).

An example of a class 3 patient is a young mother who brought her son in for consultation because he was getting such low marks in the final year of high school that the chances of his getting into college were minimal. Moreover, he firmly announced his unwillingness to go to college, insisting on finding a job after graduation so that he could buy an automobile and pursue his two hobbies: baseball and girls. During the interview with the boy it was obvious that he had motivation neither for further college education nor for any kind of therapeutic help. It was apparent too that his stubborn refusal to study and to go on to higher learning was a way of fighting off the domination of his mother and stepfather. Accordingly, the mother was advised to stop nagging the boy to continue his schooling. Instead she was urged to permit him to experiment with finding a job so that he could learn the value of a dollar and to discover for himself the kinds of positions he could get with so little education.

The next day the mother telephoned and reported that she had followed the doctor's instructions. However, she asked for an appointment for herself since she was overly tense and suffered from bad backaches that her orthopedist claimed were due to "nerves." What she wanted was to learn self-hypnosis, which her doctor claimed would help her relax. Abiding by her request, she was taught self-hypnosis-not only for relaxation purposes, but also to determine the sources of her tension. Through interviewing aided by induced imagery during hypnosis, she was able to recognize how angry she was at me for

not satisfying her desire to force her son to go to college. Images of attacking her father, who frustrated and dominated her, soon brought out her violent rage. She realized then that her obsequious behavior toward her husband was a cover for her hostility. Acting on this insight, she was soon able to express her anger and to discuss her reactions with her husband and the reasons for her rages. This opened up channels of communication with a dramatic resolution of her symptoms and an improvement in her feelings about herself and her attitudes toward people, confirmed by a 5-year follow-up.

Patients are generally considered unsuited for dynamic short-term psychotherapy if they are not motivated to search for sources of their problems, are unable to withstand the frustration of receiving immediate symptomatic relief, cannot establish a close interpersonal relationship, do not have the ability or ego strength to tolerate anxiety consequent to the challenging and yielding of neurotic patterns of behavior, are not sufficiently "psychologically minded" to be able to reflect on reasons for their maladjustment, or resort habitually to the abuse of tranquilizers, alcohol, or drugs as a way of dealing with tension.

Class 4 Patients

Patients of the class 4 category are those whose problems even an effective therapist may be unable to mediate in a brief span and who will require more prolonged management after the initial short-term period of formal therapy has disclosed what interventions would best be indicated. The word "management" should be stressed because not all long-term modalities need be, and often are not, best aimed at intrapsychic alterations. Among individuals who appear to require help over an extended span are those whose problems are so severe and deep-rooted that all therapy can do for them is to keep them in reasonable reality functioning, which they could not achieve without a prolonged therapeutic resource.

Class 4 patients include the following:

1. Individuals with chronic psychotic reactions and psychoses in remission who

require some supervisory individual or group with whom contact is regularly made over sufficiently spaced intervals to provide some kind of human relationship, however tenuous this may be, to oversee essential psychotropic drug intake, to regulate the milieu, and to subdue the perils of psychotic processes when these are periodically released. Such patients do not usually require formal prolonged psychotherapy or regular sessions with a psychotherapist; they could do as well, or better, with the supportive help of an empathic counselor. Milieu therapy, rehabilitation procedures, and social or group approaches may be useful.

2. Persons with serious character problems with tendencies toward alcoholism and drug addiction who require regular guidance, surveillance, group approaches, and rehabilitative services over an indefinite period.

3. Individuals with uncontrollable tendencies toward acting-out who need controls from without to restrain them from expressing impulses that will get them into difficulties. Examples are those who are occasionally dominated by dangerous perversions, desires for violence, lust for criminal activities, masochistic needs to hurt themselves, accident proneness, self-defeating gambling, and other corruptions. Many such persons recognize that they need curbs on their uncontrollable wayward desires.

4. Persons so traumatized and fixated in their development that they have never overcome infantile and childish needs and defenses that contravene a mature adaptation. For instance, there may be a constant entrapment in relationships with surrogate parental figures, which usually evolve for both subjects and hosts into a sado-masochistic purgatory. Yet such persons cannot function without a dependency prop, and the therapist offers to operate as a more objective and nonpunitive parental agency. Some of these patients may need a dependency support the remainder of their lives.

Many of the patients in this category fall into devastating frustrating dependency relationships during therapy or alternatives to therapy from which they cannot or will not extricate themselves. Realizing the dangers of this contingency, we can, however, plan our strategy accordingly, for example, by providing supportive props outside of the treatment situation if support is needed. Nor need we abandon reconstructive objectives, once we make proper allowances for possible regressive interludes. In follow-up contacts, I was pleased to find, there had been

change after 5,10, and in some cases 15 years in patients who I believed had little chance to achieve personality alterations.

5. Persons with persistent and uncontrollable anxiety reactions powered

(a) by unconscious conflicts of long standing with existing defenses so fragile that the patient is unable to cope with ordinary demands of life or (b) by a noxious and irremediable environment from which the patient cannot escape.

6. Borderline patients balanced precariously on a razor edge of rationality.

7. Intractable obsessive - compulsive persons whose reactions serve as defenses against psychosis.

8. Paranoidal personalities who require an incorruptible authority for reality testing.

9. Individuals with severe long-standing psychosomatic and hypochondriacal conditions, such as ulcerative colitis, or chronic pain syndromes that have resisted ministrations from medical, psychological, and other helping resources. Often these symptoms are manifestations of defenses against psychotic disintegration.

10. People presenting with depressive disorders who are in danger of attempting suicide and require careful regulation of antidepressive medications or electroconvulsive therapy followed by psychotherapy until the risk of a relapse is over.

Class 5 Patients

In class 5 we place those individuals who seek and require extensive reconstructive personality changes and have the finances, time, forbearance, and ego strength to tolerate long-term psychoanalysis or psychoanalytically oriented psychotherapy. In addition, they have had the good fortune of finding a well-trained, experienced, and mature analyst who is capable of dealing with dependent transference and other resistances as well as with one's personal countertransferences. Patients who can benefit more from long-term reconstructive therapy than from dynamically oriented short-term therapy are often burdened by interfering external conditions that may be so strong, or by the press of inner

neurotic needs so intense, that they cannot proceed on their own toward treatment objectives after the short-term therapeutic period has ended. Continued monitoring by a therapist is essential to prevent a relapse. In certain cases the characterologic detachment is so great that the patient is unable to establish close and trusting contact with a therapist in a brief period, and a considerable bulk of time during the short-term sessions may be occupied with establishing a working relationship.

In addition to adults a special group of patients requiring long-term therapy are highly disturbed children and adolescents who have been stunted in the process of personality development and who require a continuing relationship with a therapist who functions as a guiding, educational, benevolent parental figure.

Long-term patients in classes 4 and 5 usually constitute less than one-quarter of the patient load carried by the average psychotherapist. The bulk of one's practice will generally be composed of patients who may adequately be managed by short-term methods.

ESSENTIAL COMPROMISES IN SHORT-TERM THERAPY

Apart from the fact that acceptance of abbreviated goals may be necessary in short-term therapy, a number of other compromises may be essential. Prominent among these are (1) the employment of greater activity than in longer term treatment, (2) the flexible practice of differential therapeutics, (3) the overcoming of prejudices related to the "depth" of therapy, (4) avoiding denigration of short-term as compared with long-term approaches, and (5) utilization of interrupted rather than continuous treatments.

Encouragement of Therapist Activity

Anathema to short-term therapy is passivity in the therapist. Where time is of no object, the therapist can settle back comfortably and let the patient pick his or her way through the lush jungles of the psyche. To apply the same tactics in the few sessions that are available in short-term therapy will usually bring meager rewards. Treatment failures

are often the product of lack of proper activity. It is for this reason that the conventional non-directive, detached attitude is unwise, as are free association and the use of the couch. Focused interviewing in the sitting up position is almost mandatory.

There are some therapists, of course, whose personalities support a passive role. Such practitioners may still be able to make an effort at involving themselves more actively, assuming as their objective a rapid assay of the central problem, dealing with its most obvious aspects. If one concentrates one's fire, one will be able to hit the target with greater certainty. At least the therapist will prevent the patient from steering the course of treatment into unproductive channels.

In short-term therapy, one cannot afford the luxury as in prolonged treatment of permitting the patient to wallow in resistance until he or she somehow muddles through. Resistance will, of course, occur, but it must be dealt with rapidly through an active frontal attack before it paralyzes progress.

One of the most difficult things to teach students aspiring to become short-term therapists is that activity in the relationship, with an involvement of oneself as a real person, and open expressions of interest, sympathy, and encouragement, are permissible. Somehow passivity has become synonymous with doing good psychotherapy with the result that at the end of the prescribed sessions the patient is no further advanced toward resolution of the problem than when therapy first started. Often therapists are not aware of how uninvolved they are until observed working behind a one-way mirror or through videotaping and their passivity is pointed out to them by a supervisor. Whether they can do anything about their impassiveness is another matter, but, in my experience, encouragement to express a more open interest, to engage oneself more vigorously in the interview, to give one's facial expressions a free release, to offer advice where needed, and to make interpretations when necessary may vitalize the therapeutic situation sufficiently to convince that a stoic bearing, a blankness of countenance, and an unresourceful adherence to a phlegmatic role are not necessarily the "scientific" way of doing therapy. This does not mean that therapists will have to revolutionize their personalities in order

to do short-term therapy. Individuals are constituted differently. Some therapists by nature are quiet and reserved; forcefulness is not within their behavioral range. But they will still be able to exercise the essential activity through a communicative and reassuring relationship. Activity means being interested in the patient and immediate life problems; it does not mean being controlling of the patient. Neither does it give the therapist license to cuddle the patient, make the patient's decisions and otherwise rob the patient of the responsibility of doing things for himself or herself.

Use of Differential Therapeutics

Insofar as the use of a differential therapeutics is concerned psychoanalytically trained therapists are particularly fearful of therapeutic contaminants. Mindful of the long struggle for acceptance of analytic covenants, they are reluctant to take what they consider to be a backward step by dignifying nonanalytic techniques. In this attitude they attempt to delay Freud's prediction that it eventually may be necessary to blend the "gold" of psychoanalysis with the "copper" of other therapies.

Short-term therapy requires a combination of procedures from psychiatric, psychoanalytic, psychological, and sociological fields. Sometimes utilized in the same patient are psychotherapeutic techniques, casework, drugs, hypnosis, group therapy, psychodrama, and desensitization and reconditioning procedures. This fusion of methods, in which there are extracted from the different approached tactics of proven merit, promise the most productive results. To implement such an eclectic regimen, a degree of flexibility is required that enables the therapist to step outside the bounds of training biases and to experiment with methods from fields other than habitual ones.

Here we run headlong into prejudices about what will happen to a personally cherished system of psychotherapy if one introduces into it foreign elements. It may reassure therapists to keep reminding themselves that there is nothing sacred about any of our present day modes of doing psychotherapy. They all work in some cases and fail in others. We actually owe it to our patients, as well as to ourselves to experiment with as many techniques as we can in order to learn which of these will be effective and which do

not yield good results. Certain rigidities in the therapist will interfere with the proper experimentation. Eclecticism does not sanction wild therapy. It presupposes a scrupulous empirical attitude, assaying the values of the different methods for the great variety of conditions that challenge the therapist in daily practice.

Overcoming Prejudices About Depth

Important also is the overcoming of prejudices about "depth." Before a therapist is capable of doing effective short-term therapy he or she will need to abandon value judgments about "superficial" versus "deep" therapy. There is a tendency on the part of psychotherapists to put varying significances on levels of depth as they apply to the content of the therapeutic interviews. Material that relates to the past, from the dredgings of the unconscious, and from transferential interactions become emblazoned with special virtue. All else is labeled "superficial" from which little may be expected insofar as real personality change is concerned. Such notions are the product of a misuse of psychoanalytic wisdom that purports that the only true road to cure is through the alleys of the unconscious. This in spite of the fact that clinical experience persuades that the divulgence of unconscious content carries no guarantee that a patient will get well.

Psychotherapy is no mining operation that depends for its yield exclusively on excavated psychic ore. It is human interaction that embraces a variety of dimensions, psychological and social, verbal and nonverbal. Some of these elements are so complex that we can scarcely express them in words. How can we, for example, describe such things as "faith," "hope," "trust," "acquisition of insight," "meaning," "restoration of mastery," "self-realization," and "development of capacity to love." These are aspects of therapy fluctuating within the matrix of change. In the architecture of personality building, no one tissue or girder stands alone. They are all interrelated. Revelation of the unconscious blends into the total therapeutic Gestalt. It does not constitute it.

Even though in short-term therapy we can only deal with the immediate and manifest, we may ultimately influence the total personality in depth, including the unconscious. Human warmth and feeling, experienced by a patient in one session with an

empathic therapist, may achieve more profound alterations than years with a probing, detached therapist intent on wearing out resistance. This does not mean that one should be neglectful of the unconscious. Within a short span of therapy, repressed psychic aspects may still be elicited and handled.

Correcting Misconceptions About Time in Therapy

Rectification of prejudices about the superiority of long-term over short-term therapy is another must. It may be argued that if a few sessions can potentially induce corrective change, would not prolonged treatment do the job even more effectively, enabling the individual to apply to current life situation the kinds of discipline that sponsor a healthy perspective? There is no question that an extended time period permits the therapist to handle resistance that some patients mobilize toward the giving up of their neuroses. There is no question, too, that some patients, for instance, those that are masochistically inclined, gain a subversive gratification out of their neurotic misery and are loathe to yield it too readily. Here the therapist functions as a sentinel, alerting the patient to the presence and particular manifestations of resistance. Such patients would probably do better in prolonged treatment if we could avoid the trap of dependency and could successfully deal with transference elements that unleashed tend to enmesh the patient in the tangled folds of the past.

On the other hand, we may overemphasize the need for long-term treatment in many patients. We may assume that all persons possess healthy and resilient elements in their personality, which given half a chance, will burgeon forth. A brief period of treatment may be all that is required to set into motion a process of growth.

The question of the superiority of long-term over short-term therapy is therefore a rhetorical one. Experience persuades that some patients get nowhere with long-term therapy and do remarkably well with short-term approaches. There are others in whom short-term treatment does not succeed in denting the surface of their problem and who require a prolonged period of therapy before the slightest penetration is made. As has been pointed out the problem of selection of cases is as poignant a one as is the utilization

of proper techniques. It is doubtful that we can always define syndromes that best will respond to either approach. Factors other than symptomatology and diagnosis determine how the patient will progress. Nor is it possible to delineate precisely special tactics that can expedite treatment in all cases. What works with one therapist and patient may not work with others. Each therapist will need to experiment with methods best suited to individual style and personality.

At the present stage of our knowledge, long-term treatment is not always an indulgence. If the patient is so constituted as to be able to take advantage of explorations into the psyche, and if the therapist is equipped to work on a depth level, extended therapy may be a rewarding adventure. Without question the "working-through" of psychological blocks, and the resolution of the manifold facades and obstructions the mind concocts to defeat itself, can in some persons best be accomplished in a prolonged professional relationship. Here the therapist concentratedly and continuously observes the patient, dealing with resistances as they develop, and bringing the patient to an awareness of the basic conflicts that power defensive operations. Given the proper patient with a personality problem of longstanding, who possesses an adequate motivation for change, with an ego structure sufficiently plastic, an environment that is malleable, a social milieu that will accept the patient's new found freedoms, who can afford luxuries of time and finances, and who relates constructively in a treatment experience with a well-trained psychotherapist, long-term therapy will offer the best opportunity for the most extensive personality change.

Moreover, there are certain chronic conditions that respond to no other instrumentality than continuous psychotherapy, no matter how assiduously the therapist is applied toward releasing forces of health within the patient. The situation is akin to diabetes in which the patient survives solely because he or she receives life-giving insulin. In certain problems, dependency is so deep-rooted that the patient can exist only in the medium of a protective relationship in which the patient can receive dosages of support. The patient appears to thrive in therapy and seemingly may be utilizing insights toward a better integration. But this improvement is illusory; the patient constantly needs to

maintain a life-line to the helping authority to whom he or she clings with a desperation that defies all efforts at treatment termination. Such patients obviously will not do well with short-term methods, although long-term approaches may be inadequate also.

From the foregoing one may get the impression that long-term therapy is the preferred treatment where the patient has a severe personality disorder. This is not always the case. There are some risks in employing prolonged treatment in many patients. Dependent individuals who have been managing to get along on their own, albeit on a tenuous independency level, may become more and more helpless, and importune for increasing demonstrations of support with an exaggeration rather than a relief of their symptoms. Individuals with fragile ego structures will tend to develop frightening transference reactions in prolonged treatment, or they may go to pieces in the process of releasing repressions.

Patients who have been found to respond best to short-term therapy are those who possess a resilient repertoire of coping mechanisms, and who, prior to their immediate upset, were functioning with some degree of satisfaction. It is essential here to qualify the finding that acute problems are best suited for short-term approaches. Our frame of reference is the conventional body of techniques that we utilize today. There is no reason to assume that with the refinement of our methodology even severe personality difficulties may not be significantly improved on a short-term basis. This author has personally observed chronic cases treated with short-term methods, including obsessive-compulsive neurosis and borderline schizophrenia, and has noted many gratifying results. Indeed, had I believed that these patients should continue in extended therapy, I am certain that some would have marooned themselves in permanent treatment waters that would have swamped their tiny surviving islands of independence.

The best strategy, in this author's opinion, is to assume that every patient, irrespective of diagnosis, will respond to short-term treatment unless proven refractory to it. If the therapist approaches each patient with the idea of doing as much as reasonably possible within the span of up to 20 treatment sessions, the patient will be given an

opportunity to take advantage of short-term treatment to the limit of potential. If this expediency fails, a resort to prolonged therapy may be taken.

Use of Interrupted Treatments

Realization that therapy is not a close-ended matter with permanent beginning, middle, and end phases has introduced a new model for the delivery of services. This is oriented around the principle that termination of psychotherapy with a successful outcome does not necessarily immunize the individual against future emotional illness. Conditions outside the individual related to career, status, economic stability, marital situation, and social milieu, as well as within the person, e.g., increased vulnerabilities associated with aging, value change, and physical well-being may impose stresses beyond habitual adaptive capacities. Returning for treatment on a short-term basis may be as important for many people as visiting their personal physicians throughout their life for unexpected ailments that periodically develop. The idea that one can discharge a patient and never see the patient again is an erroneous one and should not be encouraged. This means that all therapy is relevant to a time frame, and that patients are seen as "evolving, receptive to and needing different interventions at different times" (Bennett, 1983).

CATEGORIES OF SHORT-TERM THERAPY

A number of attempts have been made to subdivide short-term therapy into a number of distinctive categories. In general these fall into three groupings (1) crisis intervention, (2) supportive-educational short-term therapy, and (3) dynamic short-term therapy. The goals of crisis intervention usually differ from those in the other brief methods. Here, after from 1 to 6 sessions, an attempt is made to restore habitual balances in the existing life situation. Supportive educational approaches, such as behavior therapy, constitute forms of intervention that are undertaken, along with educational indoctrination, to relieve or remove symptoms, to alter faulty habit patterns, and to rectify behavioral deficits. To attain these objectives, a variety of eclectic techniques is implemented, depending on the idiosyncratic needs of the patient and the skills and

methodological preferences of the therapist. The number of sessions varies, ranging from 6 to 25. In some cases less than six sessions may be ample, and occasionally even one session has proven productive (Rockwell & Pinkerton, 1982; Bloom, 1981). In dynamic short-term therapy the thrust is toward achieving or at least starting a process of personality reconstruction. Sessions here may extend to 40 or more.

In crisis intervention, sessions may have to be prolonged, psychotropic medications may have to be employed, family members may have to be actively involved, and a multidisciplinary treatment team may have to be available at times. Less urgent forms of crisis intervention that are being practiced are indistinguishable from the kind of counseling commonly done in social agencies. The focus is on mobilizing positive forces in the individual to cope with the crisis situation, to resolve remediable environmental difficulties as rapidly as possible, utilizing if necessary appropriate resources in the community, and to take whatever steps are essential to forestall future crises of a similar or related nature. No attempt is made at diagnosis or psychodynamic formulation. Other kinds of crisis intervention attempt provisionally to detect underlying intrapsychic issues and past formative experiences and to relate these to current problems. More extensive goals than mere emotional stabilization are sought.

The "social-counseling" forms of crisis intervention are generally employed in walk-in clinics and crisis centers where large numbers of clients apply for help and where there is a need to avoid getting involved too intimately with clients who might get locked into a dependent relationship. Visits are as frequent as can be arranged and are necessary during the first 4 to 6 weeks. The family is often involved in some of the interviews, and home visits may have to be made. The interview focus is on the present situational difficulty and often is concerned with the most adaptive ways of coping with immediate pressing problems. Vigorous educational measures are sometimes exploited to activate the patient. The employment of supportive measures and the use of other helping individuals and agencies is encouraged.

More ambitious, goal-directed forms of crisis intervention are often seen operating

in outpatient clinics and private practice. If the assigned number of sessions has been exhausted and the patient still requires more help, referral to a clinic or private therapist or continued treatment with the same therapist is considered.

Brief supportive-educational approaches have sponsored a variety of techniques, such as traditional interviewing, behavior therapy, relaxation, hypnosis, biofeedback, somatic therapy, Gestalt therapy, sex therapy, group therapy, etc., singly or in combination. The number of sessions will vary according to the individual therapist, who usually anchors the decision on how long it takes to control symptoms and enhance adaptation.

The philosophy that enjoins therapists to employ dynamic short-term treatment is the conviction that many of the derivatives of present behaviors are rooted in needs, conflicts, and defenses that reach into the past, often as far back as early childhood. Some of the most offensive of these components are unconscious, and while they obtrude themselves in officious and often destructive ways, they are usually rationalized and shielded with a tenacity that is frustrating both to the victim and to those around. The preferred way, according to prevailing theories, that one can bring these mischief makers under control is to propel them into consciousness so that the patient realizes what he or she is up against. By studying how the patient utilizes the relationship with the therapist, the latter has an opportunity to detect how these buried aberrations operate, projected as they are into the treatment situation. Dreams, fantasies, verbal associations, nonverbal behavior, and transference manifestations are considered appropriate media for exploration because they embody unconscious needs and conflicts in a symbolic form. By training, therapists believe themselves capable of decoding these symbols. Since important unconscious determinants shape one's everyday behavior, the therapist tries to establish a connection between the patient's present personality in operation, such as temperament, moods, morals, and manners, with early past experiences and conditionings in order to help the patient acquire some insight into how problems originated.

METHODOLOGY

A variety of short-term therapeutic methods have been proposed by different therapists (Barten, 1969, 1971; Beliak, 1968; Beliak & Small, 1965; Castelnuovo-Tedesco, 1971; Davanloo, 1978; Gottschalk et al, 1967; Harris, MR, et al, 1971; Levene et al, 1972; Malan, 1964, 1976; Mann, J, 1973; Patterson, V, et al, 1971; Sifneos, 1967; 1972; Wolberg, LR, 1980). There obviously are differences among therapists in the way that short-term therapy is implemented—for example, the focal areas chosen for attention and exploration, the relative emphasis on current as compared to past issues, the attention paid to transference, the way resistance is handled, the depth of probing, the dealing with unconscious material that surfaces, the precise manner of interpretation, the degree of activity, the amount of advice giving, the kinds of interventions and adjunctive devices employed, and the prescribed number of sessions. Moreover, all therapists have to deal with their own personalities, prejudices, theoretical biases, and skills, all of which will influence the way they work. In spite of such differences, there are certain basic principles that have evolved from the experiences of a wide assortment of therapists working with diverse patient populations that have produced good results. The practitioner may find he or she can adapt at least some of these principles to his or her own style of operation even though continuing to employ methods that have proven themselves to be effective and are not exactly in accord with what other professionals do. While many of the suggestions as to technique discussed in previous chapters are applicable, in the pages that follow 20 techniques are suggested as a general guide for short-term therapy.

The important operations consist of (1) establishing a rapid positive working relationship (therapeutic alliance), (2) dealing with initial resistances, (3) gathering historical data, (4) selecting a focus for therapy, (5) defining precipitating events, (6) evolving a working hypothesis, (7) making a tentative diagnosis, (8) conveying the need for the patient's active participation in the therapeutic process, (9) making a verbal contract, (10) utilizing appropriate techniques in an active and flexible manner, (11) studying the reactions and defenses of the patient to the techniques being employed, (12) relating present-day patterns to patterns that have operated throughout the patient's life, 13) watching for transference reactions, (14) examining possible countertransference feelings, (15) alerting oneself to resistances, (16) assigning homework, (17) accenting the

termination date, (18) terminating therapy, (19) assigning continuing self-help activities, and (20) arranging for further treatment if necessary.

These operations explained below, may be utilized in toto or in part by therapists who can adapt them to their styles of working.

Establish as Rapidly as Possible a Positive Working Relationship (Therapeutic Alliance)

An atmosphere of warmth, understanding, and acceptance is basic to achieving a positive working relationship with a patient. Empathy particularly is an indispensable personality quality that helps to solidify a good therapeutic alliance.

Generally, at the initial interview, the patient is greeted courteously by name, the therapist introducing oneself as in this excerpt:

> *Th.* How do you do, Mr. Roberts. I am Dr. Wolberg. Won't you sit down over there *(pointing to a chair),* and we'll talk things over and I'll see what I can do to help you *(patient gets seated).*
>
> *Pt.* Thank you, doctor, *(pause)*

A detached deadpan professional attitude is particularly fatal. It may, by eliciting powerful feelings of rejection, provoke protective defensive maneuvers that neutralize efforts toward establishing a working relationship.

It is difficult, of course, to delineate exact rules about how a therapeutic alliance may be established rapidly. Each therapist will utilize himself or herself to achieve this end in terms of own techniques and capacities in rapport. Some therapists possess an extraordinary ability even during the first session, as the patient describes the problem and associated feelings, of putting the patient at ease, of mobilizing faith in the effectiveness of methods that will be utilized, and of subduing the patient's doubts and concerns. A confident enthusiastic manner and a conviction of one's ability to help somehow communicates itself nonverbally to the patient. Therapist enthusiasm is an important ingredient in treatment.

The following suggestions may prove helpful.

Verbalize What The Patient May Be Feeling

Putting into words for the patient what he or she must be feeling but is unable to conceptualize is one of the most effective means of establishing contact. "Reading between the lines" of what the patient is talking about will yield interesting clues. Such simple statements as, "You must be very unhappy and upset about what has happened to you" or "I can understand how unhappy and upset you must be under the circumstances" present the therapist as an empathic person.

Encourage The Patient That The Situation Is Not Hopeless

It is sometimes apparent that, despite presenting oneself for help, the patient is convinced that he or she is hopeless and that little will actually be accomplished from therapy. The therapist who suspects this may say "You probably feel that your situation is hopeless because you have already tried various things that haven't been effective. But there *are* things that can be done, that *you can do* about your situation and I shall guide you toward making an effort." Empathizing with the patient may be important: "Putting myself in your position, I can see that you must be very unhappy and upset about what is happening to you."

Sometimes it is useful to define the patient's role in developing and sustaining the problem in a non-accusing way: 'You probably felt you had no other alternative than to do what you did." "What you are doing now seems reasonable to you, but there may be other ways that could create fewer problems for you."

While no promise is made of a cure, the therapist must convey an attitude of conviction and faith in what is being done.

> *Pt.* I feel hopeless about getting well. Do you think I can get over this trouble of mine?
>
> *Th.* Do you really have a desire to get over this trouble? If you really do, this is nine-tenths of the battle. You will want to apply yourself to the job of getting well. I will point out some things you can do, and if you work at them yourself, I see no reason why you can't get better.

Where the patient becomes self-deprecatory and masochistic, the positive aspects of reactions may be stressed. For example, should the patient say that he or she is constantly furious, one might reply, "This indicates that you are capable of feeling strongly about things." If the patient claims detachment and does not feel anything, the answer may be, "This is a sign you are trying to protect yourself from hurting." Comments such as these are intended to be protective in order to preserve the relationship with the therapist. Later when it becomes apparent that the relationship is sufficiently solid, the therapist's comments may be more provocative and challenging. The patient's defenses being threatened, anxiety may be mobilized, but the patient will be sustained by the therapeutic alliance and will begin to utilize it rather than run away from it.

Deal With Initial Resistances

Among the resistances commonly encountered at the first session are lack of motivation and disappointment that the therapist does not fulfill a stereotype. The therapist's age, race, nationality, sex, appearance, professional discipline, and religion may, as emphasized in previous chapters, not correspond with the patient's ideas of someone in whom he or she wants to confide.

> *Th.* I notice that it is difficult for you to tell me about your problem.
>
> *Pt.* (*Obviously in discomfort*) I don't know what to say. I expected that I would see an older person. Have you had much experience with cases like me?
>
> *Th.* What concerns you is a fear that I don't have as much experience as you believe is necessary and that an older person would do a better job. I can understand how you feel, and you *may* do better with an older person. However, supposing you tell me about your problem and then if you wish I will refer you to the best older therapist who can treat the kind of condition you have.

This tactic of accepting the resistance and inviting the patient to tell you more about himself or herself, as stated before, can be applied to other stereotypes besides age. In a well-conducted interview the therapist will reveal as an empathic understanding person, and the patient will want to continue with him or her in therapy.

Another common form of resistance occurs in the person with a psychosomatic

problem who has been referred for psychotherapy and who is not at all convinced that a psychological problem exists. In such cases the therapist may proceed as in this excerpt.

> *Pt.* Dr. Jones sent me here. I have a problem with stomachaches a long time and have been seeing doctors for it for a long time.
>
> *Th.* As you know, I am a psychiatrist. What makes you feel your problem is psychological?
>
> *Pt.* I don't think it is, but Dr. Jones says it might be, and he sent me here.
>
> *Th.* Do you think it is?
>
> *Pt.* No, I can't see how this pain comes from my head.
>
> *Th.* Well, it might be organic, but with someone who has suffered as long as you have the pain will cause a good deal of tension and upset. *[To insist on the idea that the problem is psychological would be a poor tactic. First the therapist may be wrong, and the condition may be organic though undetectable by present day tests and examinations. Second, the patient may need to retain the notion of the symptom's organicity and even to be able to experience attenuated pain from time to time as a defense against overwhelming anxiety or, in certain serious conditions, psychosis.]*
>
> *Pt.* It sure does.
>
> *Th.* And the tension and depression prevent the stomach from healing. Tension interferes with healing of even true physical problems. Now when you reduce tension, it helps the healing. It might help you even if your problem is organic.
>
> *Pt.* I hope so.
>
> *Th.* So what we can do is try to figure out what problems you have that are causing tension, and also lift the tension. This should help your pain.
>
> *Pt.* I would like that. I get tense in my job with the people I work. Some of them are crumbs. *[Patient goes on talking, opening up pockets of anxiety.]*

The object is to accept the physical condition as it is and not label it psychological for the time being. Actually, as has been indicated, it may be an essential adaptational symptom, the patient needing it to maintain an equilibrium. Dealing with areas of tension usually will help relieve the symptom, and as psychotherapy takes hold, it may make it unnecessary to use the symptom to preserve psychological homeostasis.

Motivational lack may obstruct therapy in other situations, as when a patient does not come to treatment on his or her own accord but is sent or brought by relatives or

concerned parties. Additional examples are children or adolescents with behavior problems, people who are addicted (drug, alcohol, food, gambling), and people receiving pensions for physical disabilities. More on handling lack of motivation is detailed elsewhere (p 573).

Gather Historical Material and Other Data

Through "sympathetic listening" the patient is allowed to tell the story with as little interruption as possible, the therapist interpolating questions and comments that indicate a compassionate understanding of the patient's situation. It is hoped that the data gathered in the initial interview permits a tentative diagnosis and a notion of the etiology and possibly the psychodynamics. Should the patient fail to bring up important immediate concerns and problems, the therapist can ask direct questions. Why has the patient come to treatment at this time? What has been done about the problem to date? Has the patient arrived at any idea as to what is causing the difficulty? What does the patient expect or what would he or she like to get from therapy?

It is often advantageous to follow an outline (see Ch. 24) in order to do as complete a history or behavioral analysis as possible during the first session or two. This may necessitate interrupting the patient after the therapist is convinced that he or she has sufficient helpful data about any one topic.

Among the questions to be explored are the following:

1. Have there been previous upsets that resemble the present one?

2. Were the precipitating events of previous upsets in any way similar to the recent ones?

3. What measures aggravated the previous upsets and which alleviated the symptoms?

4. Apart from the most important problem for which help is sought, what other symptoms are being experienced (such as tension, anxiety, depression, physical symptoms, sexual problems, phobias, obsessions, insomnia,

excessive drinking?

5. What tranquilizers, energizers, hypnotics, and other medications are being taken?

Statistical data are rapidly recorded (age, education, occupation, marital status, how long married, and children if any). What was (and is) the patient's mother like? The father? Any problems with brothers or sisters? Were there any problems experienced as a child (at home, at school, with health, in relationships with other children)? Any problems in sexual development, career choice, occupational adjustment? Can the patient remember any dreams, especially nightmarish and repetitive dreams? Were there previous psychological or psychiatric treatments?

To obtain further data, the patient may be exposed to the Rorschach cards, getting a few responses to these unstructured materials without scoring. This is optional, of course. The therapist does not have to be a clinical psychologist to do this, but he or she should have read some material on the Rorschach. The patient may also be given a sheet of paper and a pencil and be asked to draw a picture of a man and a woman. Some therapists prefer showing the patient rapidly the Thematic Apperception Cards. What distortions appear in the patient's responses and drawings? Can one correlate these with what is happening symptomatically? These tests are no substitutes for essential psychological tests where needed, which can best be done by an experienced clinical psychologist. But they can fulfill a useful purpose in picking up gross defects in the thinking process, borderline or schizophrenic potentialities, paranoidal tendencies, depressive manifestations, and so on. No more than 10 or 15 minutes should be utilized for this purpose.

An example of how Rorschach cards can help reveal underlying impulses not brought out by regular interviewing methods is illustrated in a severely depressed man with a controlled, obsessional character whose passivity and inability to express aggression resulted in others taking advantage of him at work and in his marriage. When questioned about feelings of hostility or aggression, he denied these with some pride. The following were his responses to the Rorschach Cards.

1. Two things flying at each other.

2. Something sailing into something.

3. Two figures pulling something apart; two adults pulling two infants apart.

4. Animals' fur spread out. X-ray *(drops card)*

5. Flying insect, surgical instrument forceps.

6. Animal or insect split and flattened out.

7. X-ray fluoroscope of embryo, adolescents looking at each other with their hair whipping up in the wind.

8. Two animals climbing a tree, one on each side; female organs in all of these cards.

9. Fountain that goes up and spilling blood.

10. Underwater scene, fish swimming, crabs. Inside of a woman's body.

The conflicts related to aggression and being torn apart so apparent in the responses became a principal therapeutic focus and brought forth his repressed anger at his mother.

Select the Symptoms, Behavioral Difficulties, or Conflicts that You Feel are Most Amenable for Improvement

The selection with the patient of an important problem area or a disturbing symptom on which to work is for the purpose of avoiding excursions into regions that, while perhaps challenging, will dilute a meaningful effort. Thus, when you have decided on what to concentrate, inquire of the patient if in his or her opinion these are what he or she would like to eliminate or change. Agreement is important that this chosen area is significant to the patient and worthy of concentrated attention. A patient who complains that the selection is too limited should be assured that it is best to move one step at a time. Controlling a simple situation or alleviating a symptom will help strengthen the personality, and permit more extensive progress.

Thus the focal difficulty around which therapy is organized may be depression, anxiety, tension, or somatic manifestations of tension. It may be a situational precipitating factor or a crisis that has imposed itself. It may be a disturbing pattern or some learned aberration. It may be a pervasive difficulty in relating or in functioning. Or it may be a conflict of which the patient is aware or only partially aware.

Once agreement is reached on the area of focus, the therapist may succinctly sum up what is to be done.

> *Th.* Now that we have decided to focus on the problem [*designate*] that upsets you, what we will do is try to understand what it is all about, how it started, what it means, why it continues. Then we'll establish a plan to do something about it.

Example 1. A symptomatic focus

> *Th.* I get the impression that what bothers you most is tension and anxiety that makes it hard for you to get along. Is it your feeling that we should work toward eliminating these?
>
> *Pt.* Yes. Yes, if I could get rid of feeling so upset, I would be more happy. I'm so irritable and jumpy about everything.

Example 2. A focus on a precipitating event

> *Th.* What you are complaining most about is a sense of hopelessness and depression. If we focused on these and worked toward eliminating them, would you agree?
>
> *Pt.* I should say so, but I would also like to see how I could improve my marriage. It's been going downhill fast. The last fight I had with my husband was the limit.
>
> *Th.* Well, suppose we take up the problems you are having with your husband and see how these are connected with your symptoms.
>
> *Pt.* I would like that, doctor.

Example 3. A dynamic focus

Whenever possible the therapist should attempt to link the patient's symptoms and complaints to underlying factors, the connections with which the patient may be only dimly aware. Carefully phrased interpretations will be required. It may not be possible to detect basic conflicts, only secondary or derivative conflicts being apparent. Moreover, the

patient may not have given the therapist all the facts due to resistance, guilt, or anxiety. Or facts may be defensively distorted. It is often helpful (with the permission of the patient) to interview, if possible, the spouse or another individual with whom the patient is related after the first or second interview. The supplementary data obtained may completely change the initial hypothetical assumptions gleaned from the material exclusively revealed by the patient.

Nevertheless, some invaluable observations may be made from the historical data and interview material that will lend themselves to interpretation for defining a focus. Thus a patient presenting great inferiority problems and repetitive difficulties in work situations with supervisors, who as a child fought bitterly with an older sibling, was told the following: "It is possible that your present anxiety while related to how you get along with your boss touches off troubles you've carried around with you for a long time. You told me you always felt inferior to your brother. In many cases this sense of inferiority continues to bother a person in relation to new substitutive older brothers. It wouldn't be mysterious if this were happening to you. What do you think?" This comment started off a productive series of reminiscences regarding his experiences with his brother, a focus on which resulted in considerable understanding and betterment of his current relationships.

More fundamental nuclear conflicts may be revealed in later sessions (for example, in the above patient an almost classical oedipal conflict existed), especially when transference and resistance manifest themselves.

Considering the short span of a session it would be most propitious to concern ourselves exclusively with issues related to a dynamic theme. It is obviously impossible to do this when so many urgent reality issues impose themselves during the alloted time. The duty of the therapist is to sift out issues that truly must be discussed (one cannot concentrate on early love objects when the patient's house is burning down) separating them from issues utilized for defensive resistance or indulgence of transference gratifications. Nevertheless, where our goal is personality reconstruction we must utilize every session to best advantage even when pressing reality matters require attention.

What the therapist readies himself or herself to do is to listen to the patient's legitimate immediate concerns and establish a bridge to dynamic issues in order to show how a basic theme weaves itself through every aspect of the patient's existence including the immediate reality situation and the relationship with the therapist.

Undoubtedly the relationship with the therapist offers the best focus from the standpoint of understanding personality distortions and their maladaptive consequences. In long-term approaches treatment may be considered incomplete unless adequate consideration is given to transference and countertransference issues. In short-term therapy the press of time and the need to deal with the immediate stressful concerns of the patient may tend to push this focus onto the back burner. At the end of the assigned limited number of sessions, transference phenomena may have received hardly any attention. This is all the more reason for sensitizing oneself to any relationship happenings that offer an opportunity for exploration. When such happenings do occur, or when the therapist discerns transferential distortions from dreams and acting-out, proper interpretation may make a deep imprint on the patient. Even in sessions limited to five or ten treatment hours, when one hits upon some transferential propitious happenings and explored them later on, the discussion is often considered by the patient a high point in therapy. Obviously, we can expect no miracles from such a brief interchange, but if the patient's resistance is not too great, it can have an important influence.

Define the Precipitating Events

It is essential that we identify clearly the precipitating factors that led to the patient's present upset or why the patient came to treatment at this time.

> *Th.* It seems as if you were managing to get along without trouble until your daughter told you about the affair she is having with this married man. Do you believe this started you off on the downslide?

> *Pt.* Doctor, I can't tell you the shock this was to me. Janie was such an ideal child and never was a bit of a problem. And then this thing happened. She's completely changed, and I can't understand it.

Sometimes the events are obscured or denied because the patient has an investment

in sustaining situational irritants even while seeking to escape from their effects. Involvement in an unsatisfactory relationship with a disturbed or rejecting person from whom the patient cannot extricate is an example. It may be necessary to encourage continuing conversation about a suspected precipitant, asking pointed questions in the effort to help the patient see the relationship between symptoms and what may have considered unrelated noxious events. Should the patient fail to make the connections, the therapist may spell these out, asking pertinent questions that may help the patient grasp the association.

Evolve a Working Hypothesis

After the first session the therapist should have gathered enough data from the present and past history, from any dreams that are revealed, and from the general attitude and behavior of the patient to put together some formulation about what is going on. This is presented to the patient in simple language, employing concepts with which the patient has some familiarity. This formulation should never be couched in dismal terms to avoid alarming the patient. Rather a concise, restrained, optimistic picture may be painted making this contingent on the patient's cooperation with the therapeutic plan. Aspects of the hypothesis should ideally bracket the immediate precipitating agencies with what has gone on before in the life history and, if possible, how the patient's personality structure has influenced the way the patient has reacted to the precipitating events.

A woman experiencing a severe anxiety attack revealed the precipitating incident of discovering her husband's marital infidelity. As she discussed this, she disclosed the painful episode of her father's abandoning her mother for another woman.

> *Th.* Is it possible that you are afraid your husband will do to you what your father did to your mother?
>
> *Pt. (breaking down in tears)* Oh, it's so terrible I sometimes think I can't stand it.
>
> *Th.* Stand his leaving you or the fact that he had an affair?
>
> *Pt.* If it could end right now, I mean if he would stop, it *(pause).*

Th. You would forget what had happened?

Pt. (pause) Yes—Yes.

Th. How you handle yourself will determine what happens. You can see that your present upset is probably linked with what happened in your home when you were a child. Would you tell me about your love life with your husband?

The focus on therapy was thereafter concerned with the quality of her relationship with her husband. There were evidences that the patient herself promoted what inwardly she believed was an inevitable abandonment.

The therapist in making a tentative thrust at what is behind a problem should present formulations in simple terms that the patient can understand. The explanation should not be so dogmatic, however, as to preclude a revision of the hypothesis at a later date, should further elicited material demand this. The patient may be asked how he or she feels about what the therapist has said. If the patient is hazy about the content, the confusion is explored and clarification continued.

For example, a patient with migraine is presented with the hypothesis that anger is what is creating the symptom. The patient then makes a connection with past resentments and the denial defenses that were erected, which apparently are still operative in the present.

Th. Your headaches are a great problem obviously since they block you in your work. Our aim is to help reduce or eliminate them. From what you tell me, they started way back probably in your childhood. They are apparently connected with certain emotions. For example, upset feelings and tensions are often a basis for headaches, but there may be other things too, like resentments. What we will do is explore what goes on in your emotions to see what connections we can come up with. Often resentments one has in the present are the result of situations similar to troubles a person had in childhood.

Pt. I had great pains and trouble fighting for my rights when I was small—a bossy mother and father who didn't care. I guess I finally gave up.

Th. Did you give up trying to adjust at home or work?

Pt. Not exactly. But fighting never gets anywheres. People just don't listen.

Make a Tentative Diagnosis

Despite the fact that our current nosological systems leave much to be desired, it may be necessary to fit the patient into some diagnostic scheme if for no other reason than to satisfy institutional regulations and insurance requirements. There is a temptation, of course, to coordinate diagnosis with accepted labels for which reimbursement will be made. This is unfortunate since it tends to limit flexibility and to invalidate utilizing case records for purposes of statistical research. Even though clinical diagnosis bears little relationship to preferred therapeutic techniques in some syndromes, in other syndromes it may be helpful toward instituting a rational program.

Convey the Need for the Patient's Active Participation in the Therapeutic Process

Many patients, accustomed to dealing with medical doctors, expect the therapist to prescribe a formula or give advice that will operate automatically to palliate the problem. An explanation of what will be expected of the patient is in order.

> *Th.* There is no magic about getting well. The way we can best accomplish our goals is to work together as a partnership team. I want you to tell me all the important things that are going on with you and I will try to help you understand them. What we want to do is to develop new, healthier patterns. *My* job is to see what is blocking you from achieving this objective by pointing out some things that have and are still blocking you. *Your* job is to *act* to put into practice new patterns we decide are necessary, you telling me about your experiences and feelings. Psychotherapy is like learning a new language. The learner is the one who must practice the language. If the teacher did all the talking, the student would never be able to carry on a conversation. So remember you are going to have to carry the ball, with my help of course.

Make a Verbal Contract With The Patient

There should be an agreement regarding the frequency of appointments, the number of sessions, and the termination date.

> *Example 1. Where Limitation of the Number of Sessions is Deemed Necessary in Advance*

> *Th.* We are going to have a total of 12 sessions. In that time we should have made an impact on your anxiety and depression. Now, let's consult the calendar. We will terminate therapy on October 9, and I'll mark it down here. Can you also make a note of it?

> *Pt.* Will 12 sessions be enough?

Th. Yes. The least it could do is to get you on the road to really working out the problem.

Pt. What happens if I'm not better?

Th. You are an intelligent person and there is no reason why you shouldn't be better in that time.

Should the therapist dally and compromise confidence in the patient's capacity to get well, the patient may in advance cancel the termination in his or her own mind to an indeterminate future one.

Example 2. When the Termination Date is Left Open

Th. It is hard to estimate how many sessions we will require. I like to keep them below 20. So let us begin on the basis of twice a week.

Pt. Anything you say, doctor. If more are necessary, OK.

Th. It is really best to keep the number of sessions as low as possible to avoid getting dependent on them. So we'll play it by ear.

Pt. That's fine.

The appointment times may then be set and the fee discussed.

Utilize Whatever Techniques are Best Suited to Help the Patient with Immediate Problems

After the initial interview, techniques that are acceptable to the patient, and that are within the training range and competence of the therapist, are implemented, bearing in mind the need for activity and flexibility. The techniques may include supportive, educational, and psychoanalytically oriented interventions and a host of adjunctive devices, such as psychotropic drugs, hypnosis, biofeedback, behavioral and group approaches, and so on, in whatever combinations are necessary to satisfy the patient's immediate and future needs. An explanation may be given the patient about what will be done.

Th. At the start, I believe it would be helpful to reduce your tension. This should be beneficial to you in many ways. One of the best ways of doing this is by teaching you some relaxing exercises. What I would like to do for you is to make a relaxing audio recording. Do you have an audio recorder?

Pt. No, I haven't.

Th. You can buy one quite inexpensively. How do you feel about this?

Pt. It sounds great.

Th. OK. Of course, there are other things we will do, but this should help us get off to a good start.

Many therapists practicing dynamic short-term therapy ask their patients to reveal any dreams that occur during therapy. Some patients insist that they rarely or never dream or if they do, that they do not remember their dreams.

Th. It is important to mention any dreams that come to you.

Pt. I can't get hold of them. They slip away.

Th. One thing you can do is, when you retire, tell yourself you will remember your dreams.

Pt. What if I can't remember?

Th. Keep a pad of paper and a pencil near the head of your bed. When you awaken ask yourself if you dreamt. Then write the dream down. Also, if you wake up during the night.

In some patients brief group therapy may be decided on. This is an active, goal oriented a historical, current-life approach, with emphasis on decision making and patient responsibility with modeling, feedback, and stress on behavioral practice (Imber et al. 1979; Marcovitz & Smith, 1983).

Study the Patient's Reaction and Defense Patterns

The utilization of any technique or stratagem will set into motion reactions and defenses that are grist for the therapeutic mill. The patient will display a range of patterns that the therapist can study. This will permit a dramatic demonstration of the patient's defenses and resistances in actual operation rather than as theories. The patient's dreams and fantasies will often reveal more than actions or verbalizations, and the patient should continually be encouraged to talk about these. The skill of the therapist in working with and interpreting the patient's singular patterns will determine whether these will be integrated or will generate further resistance. Generally, a compassionate, tentative type

of interpretation is best, sprinkling it if possible with a casual light humorous attitude. A patient who wanted hypnosis to control smoking appeared restless during induction:

> *Th.* I noticed that when I asked you to lean back in the chair and try relaxing to my suggestions, you were quite uneasy and kept on opening your eyes. What were you thinking about?

> *Pt.* (*emotionally*) My heart started beating. I was afraid I couldn't do it. What you'd think of me. That I'd fail. I guess I'm afraid of doctors. My husband is trying to get me to see a gynecologist.

> *Th.* But you kept opening your eyes.

> *Pt. (pause)* You know, doctor, I'm afraid of losing control, of what might come out. I guess I don't trust anybody.

> *Th.* Afraid of what would happen here, of what I might do if you shut your eyes? (*smiling*)

> *Pt.* (*laughing*) I guess so. Silly. But the thought came to me about something sexual.

While the Focus at ail Times is on the Present, be Sensitive to How Present Patterns Have Roots in the Past

Examination in dynamic short-term therapy of how the patient was reared and the relationship with parents and siblings is particularly revealing. An attempt is made to note established patterns that have operated throughout the patient's life of which the current stress situation is an immediate manifestation. This data is for the therapist's own consumption and should not be too exhaustive, since the patient if encouraged to explore the past may go on endlessly, and there is no time for this. At a propitious moment, when the patient appears to have some awareness of connections of the past with the present, a proper interpretation may be made. At that time a relationship may be cited among genetic determinants, the existing personality patterns, and the symptoms and complaints for which therapy was originally sought.

Watch for Transference Reactions

The immediate reaching for help encourages projection onto the therapist of positive feelings and attitudes related to an idealized authority figure. These should not be interpreted or in any way discouraged since they act in the interest of alleviating tension

and supporting the placebo element. On the other hand, a *negative* transference reaction should be dealt with rapidly and sympathetically since it will interfere with the therapeutic alliance.

> *Th. [noting the patient's hesitant speech]* You seem to be upset about something.
>
> *Pt.* Why, *should* I be upset?
>
> *Th.* You might be if I did something you didn't like.
>
> *Pt. (pause)* No—I'm afraid, just afraid I'm not doing what I should. I've been here six times and I still have that panicky feeling from time to time. Do other patients do better?
>
> *Th.* You seem to be comparing yourself to my other patients.
>
> *Pt.* I—I—I guess so. The young man that came before me. He seems so self-confident and cheerful. I guess I felt inferior, that you would find fault with me.
>
> *Th.* Do you think I like him better than I do you?
>
> *Pt.* Well, wouldn't you, if he was doing better than I was?
>
> *Th.* That's interesting. Tell me more.
>
> *Pt.* I've been that way. My parents, I felt, preferred my older brother. He always came in on top. They were proud of his accomplishments in school.
>
> *Th.* So in a way you feel I should be acting like your parents.
>
> *Pt.* I can't help feeling that way.
>
> *Th.* Don't you think this is a pattern that is really self-defeating? We ought to explore this more.
>
> *Pt. (emotionally)* Well, I really thought today you were going to send me to another doctor because you were sick of me.
>
> *Th.* Actually, the thought never occurred to me to do that. But I'm glad you brought this matter out because we will be able to explore some of your innermost fears about how people feel about you.

Examine Possible Countertransference Feelings

If you notice persistent irritability, boredom, anger, extraordinary interest in or attraction to any patient, ask yourself whether such feelings and attitudes do not call for

self-examination. Their continuance will almost certainly lead to interference with a good working relationship. For example, a therapist is treating an unstable middle-aged female patient whom he regards as a plumpish, sloppy biddy who sticks her nose into other people's affairs. He tries to maintain an impartial therapeutic stance, but periodically he finds himself scolding her and feeling annoyed and enraged. He is always relieved as the session hour comes to an end. He recognizes that his reactions are countertherapeutic, and he asks himself if they are really justified. The image of his own mother then comes to his mind, and he realizes that he had many of the same feelings of exasperation, displeasure, and disgust with his own parent. Recognizing that he may be transferring in part some of these attitudes to his patient whose physical appearance and manner remind him of his mother, he is better able to maintain objectivity. Should self analysis, however, fail to halt his animosity, he may decide to send the patient to another therapist.

Countertransference may also be a sensitive instrument in dynamic psychotherapy toward understanding of projections from the patient of aspects of inner conflict of which the patient may be incompletely aware.

Constantly Look for Resistances That Threaten to Block Progress

Obstructions to successful therapeutic sessions are nurtured by misconceptions about therapy, lack of motivation, needs to maintain certain benefits that accrue from one's illness, and a host of other sources, conscious and unconscious. Where resistances are too stubborn to budge readily or where they operate with little awareness that they exist, the few sessions assigned to short-term therapy may not suffice to resolve them. One way of dealing with resistances once they are recognized is to bring them out openly in a non-condemning manner. This can be done by stating that the patient may hold on to them as defenses, but if this is so, he or she must suffer the consequences. A frank discussion of why the resistances have value for the patient and their effects on treatment is in order. Another technique is to anticipate resistances from the patient's past modes of adaptation, dreams, and the like, presenting the patient with the possibility of their appearance and what could be done about them should they appear. The therapist should

watch for minimum appearances of resistance, however minor they may be, that will serve as psychological obstructions. Merely bringing these to the attention of the patient may help dissipate them.

Pt. I didn't want to come here. Last time I had a terribly severe headache. I felt dizzy in the head, *(pause)*

Th. I wonder why. Did anything happen here that upset you; did I do anything to upset you?

Pt. No, it's funny but it's something I can't understand. I want to come here, and I don't. It's like I'm afraid.

Th. Afraid?

Pt. (Pause; patient flushes.) I can't understand it. People are always trying to change me. As far back as I can remember, at home, at school.

Th. And you resent their trying to change you.

Pt. Yes. I feel they can't leave me alone.

Th. Perhaps you feel I'm trying to change you.

Pt. (angrily) Aren't you?

Th. Only if *you* want to change. In what way do you want to change, if at all?

Pt. I want to get rid of my headaches, and stomachaches, and all the rest of my aches.

Th. But you don't want to change to do this.

Pt. Well, doctor, this isn't true. I want to change the way *I* want to.

Th. Are you sure the way *you* want to change will help you get rid of your symptoms?

Pt. But that's why I'm coming here so you will tell me.

Th. But you resent my making suggestions to you because somehow you put me in the class of everybody else who you believe wants to take your independence away. And then you show resistance to what I am trying to do.

Pt. (laughs) Isn't that silly, I really do trust you.

Th. Then supposing when you begin to feel you are being dominated you tell me, so we can talk it out. I really want to help you and not dominate you.

Pt. Thank you, doctor, I do feel better.

In brief therapy with patients who possess a reasonably strong ego, confrontation and management of the patient's untoward reactions to challenges may be dramatically effective. Managing the patient's reactions will call for a high degree of stamina, sensitivity, and flexibility on the part of the therapist, an ability to cope with outbursts of anger and other disturbing reactions, and knowledge of how to give reassurance without retracting one's interpretations. However, because judgments about what is happening are made on fragmentary data, it is apt to create justifiable anger and resistance where a therapist is wrong about an appraisal of the problem. This is less the case in long-term therapy where the therapist has a firmer relationship with the patient and is more certain about the dynamics.

Give the Patient Homework

Involve the patient with an assignment to work on how the symptoms are related to happenings in the patient's environment, to attitudes, to fallacies in thinking, to disturbed interpersonal relationships, or to conflicts within oneself. Even a bit of insight may be a saving grace. As soon as feasible, moreover, ask the patient to review his or her idea of the evolution of the problem and what the patient can do to control or regulate the circumstances that reinforce the problem or alleviate the symptoms. Practice schedules may be agreed on toward opposing the situations or tendencies that require control. The patient may be enjoined to keep a log regarding incidents that exaggerate the difficulties and what the patient has done to avoid or resolve such incidents. The patient may also be given some cues regarding how one may work on oneself to reverse some basic destructive personality patterns through such measures as acquiring more understanding and insight, rewarding oneself for positive actions, self-hypnosis, and so on. These tactics may be pursued both during therapy and following therapy by oneself.

For example, the following suggestion was made to a patient who came to therapy for help to abate migraine attacks:

> *Th.* What may help you is understanding what triggers off your headaches and makes them worse. Supposing you keep a diary and jot down the frequency of your headaches. Every time you get a headache write down the day and time. Even more important, write down the events

that immediately preceded the onset of the headache or the feelings or thoughts you had that brought it on. If a headache is stopped by anything that has happened, or by anything you think about or figure out, write that down, and bring your diary when you come here so we can talk about what has happened.

Suggestions on homework assignments may be found in Chapter 53.

Keep Accenting the Termination Date if One was Given the Patient

In preparing the patient for termination of therapy, the calendar may be referred to prior to the last three sessions and the patient reminded of the date. In some patients this will activate separation anxiety and negative transference. Such responses will necessitate active interpretation of the patient's past dependency and fears of autonomy. Evidences of past reactions to separation may help the patient acquire an understanding of the underpinnings of present reactions. The therapist should expect a recrudescence of the patient's symptoms as a defense against being on one's own and as an appeal for continuing treatment. These manifestations are dealt with by further interpretation. *Do not promise* to continue therapy even if the patient predicts failure.

> *Pt.* I know we're supposed to have only one more session. But I get scared not having you around.

> *Th.* One of our aims is to make you stronger so you won't need a crutch. You know enough about yourself now to take some steps on your own. This is part of getting well. So I want you to give yourself a chance.

Many patients will resent termination of therapy after the designated number of sessions have ended. At the middle point of therapy, therefore, the therapist may bring up this possibility. The therapist should search for incidents in the past where separations have created untoward reactions in the patient. Individuals who were separated from their parents at an early age, who had school phobias produced by inability to break ties with the mother, and who are excessively dependent are particularly vulnerable and apt to respond to termination with anxiety, fear, anger, and depression. The termination process here may constitute a prime focus in therapy and a means of enhancing individuation.

> *Th.* We have five more sessions, as you know, and then we will terminate.

Pt. I realize it, but I always have trouble breaking away. My wife calls me a holder-oner.

Th. Yes, that's exactly what we want to avoid, the dependency. You are likely to resent ending treatment for that reason. What do you think?

Pt. (*laughing*) I'll try not to.

Th. Well, keep thinking about it and if you have any bad reactions let's talk about it. It's important not to make treatment a way of life. By the end of the five sessions, you should be able to carry on.

Pt. But supposing I don't make it?

Th. There you go, see, anticipating failure. This is a gesture to hold on.

Pt. Well, doctor, I know you are right. I'll keep working on it.

Terminate Therapy on the Agreed-upon Date

While some therapists do not consider it wise to invite the patient who has progressed satisfactorily to return, others find it a helpful and reassuring aid for most patients to do so at the final session. I generally tell the patient to write to me sometime to let me know things are coming along. In the event problems develop that one cannot manage by oneself, the patient should call for an appointment. Rarely is this invitation abused and if the patient does return the difficulty can be rapidly handled, eventuating in reinforcement of one's understanding.

Th. This is, as you know, our last session. I want you now to try things out on your own. Keep practicing the things I taught you—the relaxation exercises *[where these have been used],* the figuring out what brings on your symptoms and takes them away, and so forth. You should continue to get better. But setbacks may occur from time to time. Don't let that upset you. That's normal and you'll get over the setback. In fact, it may help you figure out better what your symptoms are all about. Now, if in the future you find you need a little more help, don't hesitate to call me and I'll try to arrange an appointment.

Actually relatively few patients will take advantage of this invitation, but they will feel reassured to go out on their own knowing they will not be abandoned. Should they return for an appointment, only a few sessions will be needed to bring the patient to an equilibrium and to help learn about what produced the relapse.

Stress the Need for Continuing Work on Oneself

The matter of continuing work on oneself after termination is very much underutilized. Patients will generally return to an environment that continues to sponsor maladaptive reactions. The patient will need some constant reminder that old neurotic patterns latently await revival and that one must alert oneself to signals of their awakening. In my practice I have found that making a relaxing tape (a technique detailed on p. 1019) sprinkled with positive suggestions of an ego-building nature serves the interest of continued growth. In the event the patient has done well with homework during the active therapy period, the same processes may continue. Institution of a proper philosophical outlook may also be in order prior to discharge. Such attitudes may be encouraged as the need to isolate the past from the present, the realization that a certain amount of tension and anxiety are normal, the need to adjust to handicaps and realistic irremediable conditions, the urgency to work at correcting remediable elements in one's environment, the recognition of the forces that trigger one's problems and the importance of rectifying these, and the wisdom of stopping regretting the past and of avoiding anticipating disaster in the future. It must be recognized that while the immediate accomplishments of short-term therapy may be modest, the continued application of the methods the patient has learned during therapy will help bring about more substantial changes.

Arrange for Further Treatment if Necessary

The question may be asked regarding what to do with the patient who at termination shows little or no improvement. Certain patients will require long-term therapy. In this reference there are some patients who will need help for a prolonged period of time; some require only an occasional contact the remainder of their lives. The contact does not have to be intensive or frequent. Persons with an extreme dependency character disorder, borderline cases, and schizophrenics often do well with short visits (15 to 20 minutes) every 2 weeks or longer. The idea that a supportive person is available may be all that the patient demands to keep him or her in homeostasis. Introducing the patient into a group may also be helpful, multiple transferences diluting the hostile transference that so often occurs in individual therapy. A social group may even suffice to

provide the patient with some means of a human relationship. Some patients will need referral to another therapist who specializes in a different technique, for example, to someone who does biofeedback, behavioral therapy, hypnosis, psychopharmacology, or another modality.

> *Th.* Now, we have completed the number of sessions we agreed on. How do you feel about matters now?

> *Pt.* Better, doctor, but not well. I still have my insomnia and feel discouraged and depressed.

> *Th.* That should get better as time goes on. I should like to have you continue with me in a group.

> *Pt.* You mean with other people? I've heard of it. It scares me, but I'd like to do it.

Where the patient is to be referred to another therapist, he or she may be told:

> *Th.* You have gotten a certain amount of help in coming here, but the kind of problems you have will be helped more by a specialist who deals with such problems. I have someone in mind for you who I believe will be able to help you. If you agree, I shall telephone him to make sure he has time for you.

> *Pt.* I'd like that. Who is the doctor?

> *Th.* Dr.____ If he hasn't time, I'll get someone else.

CRISIS INTERVENTION

Every individual alive is a potential candidate for a breakdown in the adaptive equilibrium if the stressful pressures are sufficiently severe. A crisis may precipitate around any incident that overwhelms one's coping capacities. The crisis stimulus itself bears little relationship to the intensity of the victim's reaction. Some persons can tolerate with equanimity tremendous hardships and adversity. Others will show a catastrophic response to what seems like a minor mishap. A specifically important event, like abandonment by a love object, can touch off an explosive reaction in one who would respond much less drastically to bombings, hurricanes, cataclysmic floods, shipwreck, disastrous reverses of economic fortune, and major accidents. The two important variables are, first, the *meaning* to the individual of the calamity and, second, the *flexibility of one's defenses,* that is, the prevailing ego strength.

The immediate response to a situation that is interpreted as cataclysmic, such as the sudden death of a loved one, a violent accident, or an irretrievable shattering of security, is a dazed shock reaction. As if to safeguard oneself, a peculiar denial mechanism intervenes accompanied by numbness and detachment. This defensive maneuver, however, does not prevent the intrusion of upsetting fantasies or frightening nightmares from breaking through-periodically. When this happens, denial and detachment may again intervene to reestablish a tenuous equilibrium, only to be followed by a repetition of fearsome ruminations. It is as if the individual is both denying and then trying somehow to acquire understanding and to resolve anxiety and guilt. Various reactions to and defenses against anxiety may precipitate self-accusations, aggression, phobias, and excessive indulgence in alcohol or tranquilizers. Moreover, dormant past conflicts may be aroused, marshalling neurotic symptomatic and distorted characterologic displays. At the core of this confounding cycle of denial and twisted repetitive remembering is, first, the mind's attempt to protect itself by repressing what had happened and, second, to heal itself by reprocessing and working through the traumatic experience in order to reconcile it with the present reality situation. In an individual with good ego strength this struggle usually terminates in a successful resolution of the crisis event. Thus, following a crisis situation, most people are capable after a period of 4 to 6 weeks of picking up the pieces, putting themselves together, and resuming their lives along lines similar to before. People who come to a clinic or to a private practitioner are those who have failed to achieve resolution of stressful life events.

In some of these less fortunate individuals the outcome is dubious, eventuating in prolonged and even permanent crippling of functioning. To shorten the struggle and to bolster success in those who otherwise would be destined to a failing adaptation, psychotherapy offers the individual an excellent opportunity to deal constructively with the crisis.

In the psychotherapeutic treatment of crisis situations (crisis therapy) the goal is rapid emotional relief—and not basic personality modification. This does not mean that we neglect opportunities to effectuate personality change. Since such alterations will

require time to provide for resolution of inner conflicts and the reshuffling of the intrapsychic structure, the most we can hope for is to bring the patient to some *awareness* of how underlying problems are related to the immediate crisis. It is gratifying how some patients will grasp the significance of this association and in the posttherapy period work toward a betterment of fundamental characterologic distortions. Obviously, where more than the usual six-session limit of crisis-oriented therapy can be offered, the greater will be the possibility of demonstrating the operative dynamics. Yet where the patient possesses a motivation for change—and the existing crisis often stimulates such a motivation—even six sessions may register a significant impact on the psychological status quo.

Crisis Therapy

Selection of techniques in crisis therapy are geared to four variables (Wolberg, 1972). The first variable we must consider relates to *catastrophic symptoms that require immediate handling.* The most common emergencies are severe depressions with strong suicidal tendencies, acute psychotic upsets with aggressive or bizarre behavior, intense anxiety and panic states, excited hysterical reactions, and drug and alcoholic intoxications. Occasionally, symptoms are sufficiently severe to constitute a portentous threat to the individual or others, under which circumstances it is essential to consider immediate hospitalization. Conferences with responsible relatives or friends will then be essential in order to make provision for the most adequate resource. Fortunately, this contingency is not now employed as frequently as before because of modern somatic therapy. Consultations with a psychiatrist skilled in the administration of somatic treatments will, of course, be in order. Electroconvulsive therapy may be necessary to interrupt suicidal depression or excitement. Acute psychotic attacks usually yield to a regimen of the neuroleptics in the medium of a supportive and sympathetic relationship. It may require almost superhuman forbearance to listen attentively to the patient's concerns, with minimal expressions of censure or incredulity for delusional or hallucinatory content. Panic reactions in the patient require not only fortitude on the part of the therapist, but also the ability to communicate compassion blended with hope. In an emergency room in

a hospital it may be difficult to provide the quiet objective atmosphere that is needed, but an attentive sympathetic doctor or nurse can do much to reassure the patient. Later, frequent visits, even daily, do much to reassure a frightened patient who feels himself or herself to be out of control.

Less catastrophic symptoms are handled in accordance with the prevailing emotional state. Thus during the first stages of denial and detachment, techniques of confrontation and active interpretation of resistances may help to get the patient talking. Where there is extreme repression, hypnotic probing and narcoanalysis may be useful. On the other hand, where the patient is flooded by anxiety, tension, guilt, and ruminations concerning the stressful events, attempts are made to reestablish controls through relaxation methods (like meditation, autogenic training, relaxing hypnotherapy, and biofeedback), or by pharmacological tranquilization (diazepam, Xanax), or by rest, diversions (like social activities, hobbies, and occupational therapy), or by behavioral desensitization and reassurance.

Once troublesome symptoms are brought under reasonable restraint, attention can be focused on the second important variable in the crisis reaction, *the nature of the precipitating agency.* This is usually in the form of some environmental episode that threatens the individual's security or damages the self-esteem. A developmental crisis, broken love affair, rejection by or death of a love object, violent marital discord, persisting delinquent behavior and drug consumption by important family members, transportation or industrial and other accidents, development of an incapacitating or life-threatening illness, calamitous financial reverses, and many other provocative events may be the triggers that set off a crisis. It is rare that the external precipitants that the patient holds responsible for the present troubles are entirely or even most importantly the cause.

Indeed, the therapist will usually find that the patient participates actively in initiating and sustaining many of the environmental misfortunes that presumably are to blame. Yet respectful listening and questioning will give the therapist data regarding the character structure of the patient, the need for upsetting involvements, projective

tendencies, and the legitimate hardships to which the patient is inescapably exposed. An assay of the existing and potential inner strengths in relation to the unavoidable stresses that must be endured and identification of remediable problem areas will enable the therapist better to focus the therapeutic efforts. Crucial is some kind of cognitive reprocessing that is most effectively accomplished by interpretation. The object is to help the patient find a different meaning for the upsetting events and to evolve more adequate ways of coping.

The third variable, *the impact on the patient of the family system,* is especially important in children and adolescents as well as in those living in a closely knit family system. The impact of the family may not be immediately apparent, but a crisis frequently indicates a collapsing family system, the end result of which is a breakdown in the identified patient's capacities for adaptation. Crisis theory assumes that the family is the basic unit and that an emotional illness in any family member connotes a disruption in the family homeostasis. Such a disruption is not altogether bad because through it opportunities are opened up for change with potential benefit to each member. Traditional psychotherapy attempts to treat the individual patient and often relieves the family of responsibility for what is going on with the patient. Crisis theory, on the other hand, insists that change must involve more than the patient. The most frequently used modality, consequently, is family therapy, the object of which is the harnessing and expansion of the constructive elements in the family situation. The therapist does not attempt to halt the crisis by reassurance but rather to utilize the crisis as an instrument of change. During a crisis a family in distress may be willing to let a therapist enter into the picture, recognizing that it cannot by itself cope with the existing emergency. The boundaries are at the start fluid enough so that new consolidations become possible. The family system prior to the crisis and after the crisis usually seals off all points of entry. During the crisis, before new and perhaps even more destructive decisions have been made, a point is reached where we may introduce some new perspectives. This point may exist for only a short period of time; therefore it is vital that there be no delay in rendering service.

Thus a crisis will permit intervention that would not be acceptable before nor subsequent to the crisis explosion. One deterrent frequently is the family's insistence on hospitalization, no longer being able to cope with the identified patient's upsetting behavior. Alternatives to hospitalization will present themselves to an astute therapist who establishes contact with the family. Some of the operative dynamics may become startlingly apparent by listening to the interchanges of the patient and the family.

The most important responsibility of the therapist is to get the family to understand what is going on with the patient in the existing setting and to determine why the crisis has occurred now. There is a understandable history to the crisis and a variety of solutions may have been tried. The therapist may be curious as to why these measures were attempted and why they failed, or at least why they have not succeeded sufficiently. The family should be involved in solutions to be utilized and should have an idea as to the reasons for this. Assignment of tasks for each member is an excellent method of getting people to work together and such assignments may be quite arbitrary ones. The important thing is to get every member involved in some way. This will bring out certain resistances which may have to be negotiated. Trades may be made with the object of securing better cooperation. Since crisis intervention is a short-term process, it should be made clear that visits are limited. This is to avoid dependencies and resentments about termination.

The fourth variable is often the crucial factor in having initiated the crisis situation and consists of *unresolved and demanding childhood needs, defenses and conflicts* that obtrude themselves on adult adjustment, and compulsively dragoon the patient into activities that are bound to end in disaster. These would seem to invite explorations that a therapist, trained in dynamic psychotherapeutic methodology, may be able to implement. The ability to relate the patient's outmoded and neurotic modes of behaving, and the circumstances of their development in early conditionings, as well as the recognition of how personality difficulties have brought about the crisis, would be highly desirable probably constituting the difference between merely palliating the present problem and providing some permanent solution for it. Since the goals of crisis intervention are limited, however, to reestablishing the precrisis equilibrium, and the time allotted to therapy is

circumscribed to the mere achievement of this goal, one may not be able to do much more than to merely point out the areas for further work and exploration. Because crisis therapy is goal limited, there is a tendency to veer away from insight therapies organized around psychodynamic models toward more active behavioral-learning techniques, which are directed at reinforcing appropriate and discouraging maladaptive behavior. The effort has been directed toward the treatment of couples, of entire families, and of groups of non-related people as primary therapeutic instruments. The basic therapeutic thrust is, as has been mentioned, on such practical areas as the immediate disturbing environmental situation and the patient's disruptive symptoms, employing a combination of active procedures like drug therapy and milieu therapy. The few sessions devoted to treatment in crisis intervention certainly prevent any extensive concern with the operations of unconscious conflict. Yet a great deal of data may be obtained by talking to the patient and by studying the interactions of the family, both in family therapy and through the observations of a psychiatric nurse, caseworker, or psychiatric team who visit the home. Such data will be helpful in crisis therapy planning or in a continuing therapeutic program.

In organizing a continuing program the therapist must recognize, without minimizing the value of depth approaches, that not all persons, assuming that they can afford long-term therapy, are sufficiently well motivated, introspective, and possessed by qualities of sufficient ego strength to permit the use of other than expedient, workable, and goal-limited methods aimed at crisis resolution and symptom relief.

Techniques in Crisis Intervention

The following is a summation of practical points to pursue in the practice of crisis intervention.

> 1. *See the patient within 24 hours of the calling for help* even if it means canceling an appointment. A crisis in the life of an individual is apt to motivate one to seek help from some outside agency that otherwise would be avoided. Should such aid be immediately unavailable, one may in desperation exploit spurious measures and defenses that abate the crisis but compromise an optimal adjustment. More insidiously, the incentive for therapy will vanish with resolution of the emergency. The therapist should, therefore, make every effort to see a person in crisis preferably on the very day that help is requested.

2. At the initial interview *alert yourself to patients at high risk for suicide.* These are (a) persons who have a previous history of attempting suicide, (b) endogenous depression (history of cyclic attacks, early morning awakening, loss of appetite, retardation, loss of energy or sex drive), (c) young drug abusers, (d) alcoholic female patients, (e) middle-aged men recently widowed, divorced, or separated, (f) elderly isolated persons.

3. *Handle immediately any depression in the above patients.* Avoid hospitalization if possible except in deep depressions where attempts at suicide have been made recently or the past or are seriously threatened now. Electroconvulsive therapy is best for dangerous depressions. Institute antidepressant medications (Tofranil, Elavil, Sinequan) in adequate dosage where there is no immediate risk.

4. *Evaluate the stress situation.* Does it seem sufficiently adequate to account for the present crisis? What is the family situation, and how is it related to the patient's upset? What were past modes of dealing with crises, and how successful were they?

5. *Evaluate the existing support systems available to the patient* that you can utilize in the therapeutic plan. How solid and reliable are certain members of the family? What community resources are available? What are the strengths of the family with whom the patient will live?

6. *Estimate the patient's ego resources.* What ego resources does the patient have to depend on, estimated by successes and achievements in the past? Positive coping capacities are of greater importance than the prevailing pathology.

7. *Help the patient to an awareness of the factors involved in the reaction to the crisis.* The patient's interpersonal relations should be reviewed in the hope of understanding and reevaluating attitudes and patterns that get the patient into difficulty.

8. *Provide thoughtful, empathic listening and supportive reassurance.* These are essential to enhance the working relationship and to restore hope. The therapist must communicate awareness of the patient's difficulties. The patient should be helped to realize what problems are stress related and that with guidance one can learn to cope with or resolve.

9. *Utilize tranquilizers only where anxiety is so great that the patient cannot make decisions.* When the patient is so concerned with fighting off anxiety that there is no cooperation with the treatment plan, prescribe an anxiolytic (diazepam, Xanax). This is a temporary expedient only. In the event a schizophrenic patient must continue to live with hostile or disturbed parents who fail to respond to or refuse exposure to family therapy, prescribe a neuroleptic medication and establish a way to see that medications are taken regularly.

10. *Deal with the immediate present and avoid probing of the past.* Our chief concern is the here and now. What is the patient's present life situation? Is trouble impending? The focus is on any immediate disruptive situation responsible for the crisis as well as on the corrective measures to be exploited. Historical material is considered only if it is directly linked to the current problem.

11. *Avoid exploring for dynamic factors.* Time in therapy is too short for this. Therapy must be reality oriented, geared toward problem solving. The goal is restoration of the precrisis stability. But if dynamic factors like transference produce resistance to therapy or to the

therapist, deal rapidly with the resistances in order to dissipate them. Where dynamic material is "thrown" at the therapist, utilize it in treatment planning.

12. *Aim for increasing self-reliance and finding alternative constructive solutions for problems.* It is essential that the patient anticipate future sources of stress, learning how to cope with these by strengthening adaptive skills and eliminating habits and patterns that can lead to trouble.

13. *Always involve the family or significant others in the treatment plan.* A crisis represents both an individual and a family system collapse, and family therapy is helpful to alter the family system. A family member or significant friend should be assigned to supervise drug intake where prescribed and to share responsibility in depressed patients.

14. *Group therapy can also be helpful* both as a therapy in itself and as an adjunct to individual sessions. Contact with peers who are working through their difficulties is reassuring and educational. Some therapists consider short-term group therapy superior to individual therapy for crises.

15. *Terminate therapy within six sessions if possible and in extreme circumstances no later than 3 months after treatment has started to avoid dependency.* The patient is assured of further help in the future if required.

16. *Where the patient needs and is motivated for further help for purposes of greater personality development after the precrisis equilibrium has been restored, institute or refer for dynamically oriented short-term therapy.* In most cases, however, further therapy is not sought and may not be needed. Mastery of a stressful life experience through crisis intervention itself may be followed by new learnings and at least some personality growth.

SUPPORTIVE, BEHAVIORAL AND EDUCATIONAL APPROACHES IN SHORT TERM THERAPY

By far the most common measures utilized in short-term therapy are supportive, behavioral, and educational approaches that aim at symptom relief and problem solving. These are employed without compromising the possibility that some reconstructive personality alterations may serendipitously germinate over time. The therapist assiduously avoids probing for unconscious conflicts or developmental difficulties in childhood, or issues of transference and resistance except where they interfere with the conduct of therapy. A focus on problems in the here-and-now is agreed on by patient and therapist, and the number of sessions may be set in advance. These usually are limited to from 6 to 10, but may sometimes be extended to 25 sessions. Upon agreement the therapist actively pursues the focus with selective inattention to and refusal to be diverted by peripheral aspects no matter how important they may seem. The theme is "get in fast

and get out fast." This usually precludes dealing with extensive dynamic factors. In the few sessions that constitute the treatment plan, all that may be reasonably expected is resolution of a current problem situation and restoration of the patient to a previous optimal level of functioning.

The fact that we have so many different techniques for the same emotional problem can be confusing. What may help is a system approach that considers behavior an integrate of coordinated individual systems that are tied together like links in a chain. I have tried to illustrate this in [Table 57-1](), which can help in the selection of a therapeutic focus and preferred treatment modality. Because of time restrictions one will want to select the one method or combination of methods that is most applicable to the prevailing difficulty. Thus if the patient complains about fatiguability, loss of appetite and weight, listlessness, diminished libido, and insomnia, and it becomes apparent that he or she is suffering from a depressive disorder, one may consider organizing the therapeutic thrust around the biochemical link and supplying an antidepressant medication. This would not preclude working with other links in the behavioral chain if these are implicated. If the patient suffers from a great deal of tension with gastrointestinal irritability and bouts of high blood pressure, the therapist may want to manage the somatic link with relaxation therapy or biofeedback while searching for coordinate etiological factors. A conditioned phobic complaint, e.g., fear of entering elevators or other enclosed spaces, would invite a working with the conditioning link through behavioral approaches such as in vivo desensitization. While recognizing that personality factors associated with intrapsychic conflict are probably present, one would have to bypass the intrapsychic link unless such factors constituted the primary complaint, or if personality problems were operating as resistance to symptom-oriented interventions. In the latter case dynamic therapy would be considered. Should the patient have a severe marital problem one would deal with the interpersonal link through couple therapy. In the event stress could not be eliminated because of intolerable environmental circumstances, the therapist would focus on situational difficulties, and institute the proper therapy associated with the social link. If the assessment of the problem points to the philosophic link because of noxious attitudes and belief systems (which can be as pathogenic as virulent viruses and bacteria), one

would attempt to detoxify thinking patterns through cognitive therapy. Unless this is done, disturbed cognitions can poison relationships with people and vitiate the self-image.

We can console ourselves in a minor way. No matter what technique is employed, if the therapist is skilled in its use, has faith in its validity, and communicates this faith to the patient, and if the patient accepts the technique and absorbs this faith, he or she will be influenced in some positive way. The therapist anticipates that in resolving a difficulty related to one disturbed link in the behavioral chain, this will influence by feedback other links. Thus, if neuroleptics are prescribed for a schizophrenic patient with a disturbing thinking disorder, the impact on the biochemistry will register itself positively in varying degrees on the patient's neurophysiology, general behavior, intrapsychic mechanisms, interpersonal relations, social attitudes, and perhaps even one's philosophical outlook. Applying behavior therapy to a phobia will in its correction influence other aspects from the biochemical factors to spiritual essences. Modifying disturbed interpersonal relations through group or interpersonal therapy, correcting environmental difficulties through therapeutic counseling, and altering belief systems through cognitive therapy will have an effect throughout the behavioral continuum. This global response, however, does not in the least absolve therapists from trying to select the best method within their range of skills that is most attuned both to the patient's immediate concerns and unique learning aptitudes.

Be this as it may, there are some general principles that are applicable to most patients. First, one starts therapy by allowing the patient to unburden verbally, to tell his or her story uninterruptedly, interpolating comments to indicate understanding and empathy and to keep the patient focused on important content. Second, the therapist helps the patient arrive at some preliminary understandings of what the difficulty is all about. Third, a method is selected that is targeted on the link that is creating greatest difficulty for that patient-biochemical, physiological, behavioral, interpersonal, social or philosophic. Fourth, as therapy progresses the therapist tries to show the patient how he or she is not an innocent bystander and that the patient, in a major or minor way may be involved in bringing trouble on him or herself. Fifth, the therapist deals with any

resistances that the patient develops that block an understanding of the problem and the productive use of the techniques employed. Sixth, the therapist tries to acquaint the patient with some of the disturbed attitudes carried around by the patient that can create trouble for him or her in the future, how they developed, how they operate now, and how they may show up after he or she leaves therapy. Seventh, the patient is given homework that is aimed at strengthening oneself enough so that problems may be minimized or prevented from occurring later on. Within this broad framework there are, of course, wide differences on how therapists with varying theoretical orientations will operate. By and large, however, psychotherapists with adequate training should anticipate satisfactory results with the great majority of their patients utilizing this format.

Employing whatever techniques or group of techniques are indicated by the needs of the patient and that are within the scope of one's training and experience, the therapist may be able to achieve the goals agreed on in a rapid and effective way. Where the therapist has become aware of the underlying dynamics, it may be necessary to mention at least some salient aspects and to enjoin the patient to work on these by oneself after treatment has ended. On the other hand, the therapist may not be able to achieve desired goals unless interfering dynamic influences that function as resistance are dealt with during the treatment period because the patient is blocked by such resistance toward making progress.

Dealing with Environmental Factors

In practically every emotional problem an improvement in well-being motivates the individual to alter circumstances of living. This comes about as the patient recognizes that he or she does not have to exist under conditions of stress and deprivation. Demoralized by the inner turmoil, the patient may have hopelessly accepted a bad environmental plight as inevitable. In desperation surcease may be sought through involvement in situations that offer asylum, but the patient then gets into predicaments that turn out to be a greater blight than boon. The patient may even masochistically arrange matters so that he or she can suffer as if to pay penance for pervasive guilt feelings. Over and over we observe the

phenomenon of people, distraught with inner conflict, deliberately attempting to give this objectivity by immersing themselves in outside vexations that consume their attention and concern.

In the course of therapy, it is essential to help the patient break the grip of forces that are hurtful or depriving by identifying them and pointing out their effects. Unless the patient has a basic understanding of the role he or she plays in supporting difficulties of which the patient bitterly complains, wresting from one jam will only result in arranging for another in a very short time.

Generally, it is better for the patient to figure out for oneself what can be done to straighten out his or her life. However, active suggestions may have to be given if the patient cannot devise a plan of action alone, and, toward this end, the therapist may suggest available resources that can aid the patient in this particular need. For instance, a patient who has withdrawn from activities may be encouraged to participate in sports, hobbies, and social recreations, the therapist guiding the patient to groups where such diversions may be found. The patient's economic situation may have to be supplemented through opportune expediencies to supply funds for medical and dental care. A husband, wife or child may be ill, and the pressures on the patient will require alleviation through referral to appropriate clinics or agencies. Better housing may be essential to remedy overcrowding or to remove the patient from neighborhoods where there is exposure to prejudice, threats to life, and crime. A handicapped child may require assignment to a special rehabilitative clinic. A child failing at school may need psychological testing. An aging parent with nothing else to do to occupy his or her time may rule a household with an iron fist and be responsible for an impending break-up of a family. Appropriate outlets may have to be found to consume the oldster's energies. Adoption of a child may be the best solution for a childless couple who are anxious to rear a boy or girl. A patient who has moved from another town may feel alone and estranged and need information about recreational and social facilities in the community. These and countless other situations may require handling in the course of short-term psychotherapy.

The therapist, may, of course, be as puzzled as the patient regarding how to fill an existing need. He or she may not know the suitable resources. The chances are, however, that resources do exist if a proper search is launched. A voluntary family agency, or the family agency of the religious faith of the patient, may be able to act as the initial information source, as may a Council of Social Agencies, Welfare Council, Community Council, local or State health or welfare department or children's agency like a Children's Aid Society. Public health nurses and social workers are often cognizant of immediate instrumentalities in the community, and it may be appropriate to call in a social worker to work adjunctively with the therapist as a consultant.

Perhaps the most pressing problems will concern the patient's relationships with members of the immediate family. Pathological interactions of the various family members are the rule, and the patient may be imprisoned by the family role. Indeed, the patient may not be the person in the family who needs the most help; he or she may be the scapegoat or the member with the weakest defenses. Active assistance may have to be given the patient in resolving family crises. For example, a woman sought help for depressive spells accompanied by sporadic lower abdominal spasms. Although she rationalized her reasons for it, it soon became apparent that she resented deeply a situation that she had brought upon herself. Her sister's son who was getting a Master's degree at college needed his thesis typed. The patient casually offered to help and soon found herself working steadily against a deadline, typing several drafts of a two hundred page manuscript. This she did without compensation and with only minimal appreciation from her sister and nephew. Yet the patient felt obligated to continue since she had promised to complete the thesis. Periodically she would abandon her typewriter when her abdominal cramps became too severe; but her guilt feelings soon drove her back to work. Encouraged by the therapist's appraisal of the unfairness of the situation, the patient was able to discuss with her nephew, with reasonable calmness, her inability to complete his manuscript. This precipitated a crisis with her sister who credited the patient's defection to ill-will. After several sessions were focused on the role she had always played with her exploitative sister, the patient was able to handle her guilt feeling sufficiently to desist from retreating from her stand. A temporary break with her sister was terminated by the

latter who apologetically sought to restore the relationship which assumed a much more wholesome tenor.

It may at times be necessary to see other family members to enlist their cooperation. Patients rarely object to this. For instance, a patient though married was being victimized by an over-concerned and dominating mother who visited her daily and assumed control over the patient's household. It was obvious that the patient's protests masked a desire to maintain a dependent relationship with her mother. She refused to get into a fight with her mother or to offend her by requesting that she stay away. She claimed that her mother never would understand her protest to be left alone; her mother was the one person concerned over the patient's depression and helplessness. This was why she commandeered the role of housekeeper in her daughter's home. The patient was urged to discuss with mother her need to become more independent and to take over increasing responsibility. It was pointed out that some of her depression and helplessness were products of her refusal to accept a mature status. The more she depended on her mother, the more inadequate she felt. This situation sponsored a retreat from self-reliance. It was important to urge her mother to stay away from her apartment. I then suggested to the patient that I have a talk with the mother. The presumed purpose as far as the mother was concerned was to get as much historical data as possible. Her parent readily acquiesced and the interview centered around the patient's great sensitivity as a child and her lack of confidence in herself. Feeling myself to be in rapport with the woman, I pointed out to her how urgent it was to help her daughter grow up. I suggested that it might be difficult to resist her daughter's pleas for help, but that it was vital that she do so in order to stimulate her daughter's independent growth. Nor should she come to her child's rescue when the latter made mistakes. It was important for her daughter to make her own decisions and to take the consequences of her blunders. As a matter of fact the more mistakes she made, the more she would learn. The mother agreed to assist me in helping her daughter, and her cooperation in restricting visits to weekly intervals, as a guest not as a housekeeper, was a principal factor in my being able to bring the patient to a much more self-confident adjustment.

Psychotherapy may have to be prescribed for one or more members of the patient's family in order to alter a family constellation that is creating difficulties for all. In our search for pathology we are apt to overlook the fact that every family unit contains healthy elements which if released can aid each of its constituent members. Instead of or in addition to individual therapy family therapy may best be employed. If family therapy is decided on, sessions may be held with as many of the family group as possible. Each person must be made to see how he or she is deprived and depriving, punished and punishing, and exploited and exploiting. Even a few sessions with this intimate group may serve to release feelings and attitudes that may rejuggle the family equation sufficiently to permit the emergence of healthy trends.

Managing Dependency

Most persons in trouble at the start of therapy feel helpless and want to lean on an idealized parental agency. Being permitted to do so relieves their fear and lessens their anxiety. Whether the therapist realizes it or not he or she will be a target for the patient's dependency yearnings, no matter if one tries to be detached and passive, or actively supportive, reassuring or persuasive. Gratification of dependency needs is hoped to be a temporary measure that is ideally followed by developing independence as mastery is restored. This is accompanied by such signs as a decrease in sensitivity, diminished tendencies to over-react to stimuli, a greater ability to handle criticism, a channeling off into more constructive channels of rage, a better management of feelings of rejection, an avoidance of destructive competition, a reduction of personal overambitiousness, and a correction of distorted ideas about one's world. There are no miracles regarding such developments. They come about as the patient is helped to overcome the symptoms, to solve problems, and to evaluate more rationally an immediate environmental situation that will then enable the patient to make better and less neurotic decisions. Basic personality patterns may not undergo alteration although methods of living around them may be handled more easily. Over time the therapist may hopefully discern some reconstructive changes if the patient has some awareness of underlying personality distortions and has motivation to change these. Engaging in additional dynamic therapy

may expedite these changes.

DYNAMIC SHORT-TERM PSYCHOTHERAPY

Where the therapist has decided to deal with the intrapsychic link in the behavioral chain with the object of reconstructive personality change, one would have to consider that patterns of behavior will generally follow a sequence of conditionings that date back to childhood. Many of the patterns have become firmly fixed, operate automatically, and, while the circumstances that initiated them no longer exist, and the memory traces are firmly embedded in the unconscious, they continue to display themselves often to the dismay of the individual and the consternation of those around him or her. Thus, where defiance in childhood was a prerequisite to expressing assertiveness in relation to overly restrictive and moralistic parents, defiant, recalcitrant, aggressive, or hostile outbursts may be essential before assertiveness can be released. Where self-worth was measured in terms of vanquishing a sibling or parent and proving oneself better than these adversaries, compulsive competitive activities may preoccupy the individual to an extraordinary degree. Where sexual feelings were mobilized by parental provocations, strokings, spankings, enemas, observation of adult sexual activities, or precocious stimulation in varied kinds of sex play, engagement in similar activities, or the exploitation of phantasies about such activities, may be requirements for the release of sexual feeling. These impulses may become organized into perversions. Recrudescence into adult life of unusual behavior is often explicable on the basis of the linkage of adult needs with outmoded anachronistic patterns. Such behavior is usually rationalized when it is manifestly out of keeping with the reality situation.

The individual is, more or less, at the mercy of personality distortions, since the experiences that produced them are sealed off from awareness by repression and are thus not easily available to conscious deliberation or control. The patient is driven by needs, drives and defenses that clash with the demands of society on the one hand and with personal values on the other.

Since the patient carries the burdens of conflict, which impose extraordinary

pressures, he or she will be prone to overreact to stressful circumstances in the environment, particularly when these create insecurity or undermine self-esteem. If one's coping mechanisms falter, one may become overwhelmed by a catastrophic sense of helplessness and by shattering of feelings of mastery. This contingency may bring the frightening experience of anxiety with which one will have to deal with whatever mechanisms of defense can be mustered. Often these revive early defenses, which at one time were employed in childhood, but which are now worthless, since though temporarily allaying anxiety, they foster complications that further tend to disorganize the individual in dealings with life.

One must not underestimate the importance of promptings developed in childhood that have been relegated by repression to the dubious oblivion of the unconscious. These underpinnings of personality—the drives and defenses of childhood—assert themselves throughout the life of the individual.

Thus a man, undermined by an over-protective mother who crushed his autonomy and emerging feelings of masculinity, may have sufficient ego strength to rise as an adult above his devalued self-image, by pushing himself into positions of power and achieving monetary success. To all outward appearances he may appear masterful, strong, and accomplished. Yet his feeble inner promptings to make himself dependent register themselves in passive impulses with homosexual phantasies. He will drive himself into compromising relationships with men, promoting fierce competitiveness, needs for identification with their strength, paranoidal outbursts and perhaps desires for sexual contact when under the influence of alcohol. Understandably, the individual will function under a great hardship being in almost constant conflict, with little awareness of what is going on inside of himself.

Essentially the process of therapy that is rooted in the dynamic theoretical model consists of utilizing the relationship situation with the therapist as a means of helping the patient to gain an understanding of himself in regard to how his current reactions and interpersonal involvements are related to formative experiences in his past. An attempt is

made to bring him to an awareness of unconscious needs, drives and value systems, as well as their origin, significance and contemporary manifestations through special techniques introduced by Freud, such as exploration of dreams. The resistances to unveiling these repressed ingredients are dealt with by interpretation. In the course of working with the patient, the therapist will observe the development of attitudes toward him that reflect early disturbed feelings toward authority (transference). Repeated in the medium of the therapeutic relationship ultimately will be some important incidents that resemble traumatic experiences with past authorities.

It goes without saying that the therapist must have the education, understanding and the personality stability to cope with the patient's projections in order to help the patient gain an awareness of his unconscious maneuvers. The therapist may tend to become frustrated by some patients. He or she may feel enervated by the acting-out, demandingness, hostility, critical attitudes, and unreasonableness of the patient who will watch carefully for the therapist's reactions. Should the therapist respond in ways similar to actions of the parents, the therapeutic process will tend to stop. Actually, the patient will probably engineer the situation so that certain traumatizing experiences can be reenacted with the therapist. If the therapist acts in a therapeutically positive manner the contrast to the past actions of the parents helps the patient gain a different conception of what rational authority is like. The hope is that eventually the patient will, because of new understanding, begin to relate to the therapist in a way different from the habitual responses to authority. Thus, the patient will utilize the therapeutic situation as a vehicle for the evolution of constructive attitudes towards oneself and others. New capacities as a person will develop, as will lessened severity of conscience, greater assertiveness and independence, and an ability to express basic drives in relation to the standards of a group.

The particular way of working will depend on the experience and skill of the therapist. One cannot, as a rule, due to lack of time, employ the time-honored devices of free-association, passivity, and anonymity. Nor should the couch be the preferred position. Transference reactions are dealt with rapidly with the objective of avoiding a transference

neurosis. While the latter may release the deepest conflicts, there is no time available for the essential working-through. If a transference neurosis develops without intention, this must be dissipated as soon as possible because of its interference with therapy. Resistance is managed by active interpretations.

To help the patient gain a better understanding of inner drives, the therapist utilizes focused interviewing, structures a broad picture of the existing dynamics, and encourages the patient to fill in the details through concentrated self-observation. If the therapist knows how to employ them, dreams can be advantageously utilized. For example, a patient in the early part of therapy experienced an unaccountable recrudescence of symptoms that discouraged him greatly. Productions were relatively sterile, and, since there was currently no concentration on depth material, and no explanation for the relapse on the basis of unusual environmental difficulties, I assumed that he was resisting talking about matters that bothered him. He denied having any particular feelings toward me, but, when I specifically inquired about dreams, he recalled the following:

> "I'm in a room where there is a performance going on, like a theatre. But I'm not paying attention to it. A quite heavy, unattractive, chunky man is there carrying a large gun, like a machine gun. This man—he and I are emotionally involved, but there is no connotation of physical sex. He gets up and leaves, and I follow. He said he was told by his doctor that day—I don't know how he put it—that he had a heart attack. He began to cry. It meant the end of everything between us. Life was not absolutely desolate for me. He was losing everything, but I was detached and unconcerned. The heart attack meant I would be free of him. Then later in the night I had a second dream involving you. A law suit is going on, something like a trial. You are the lawyer. You are cross examining people. I am disappointed in your performance, the way you handle the cross examination—jumping around, no logic. *(Patient laughs)* You make a reference to making money. I feel let down. All you want is to make money—calculating.' '

The portion of the session that follows brings out what was bothering the patient—a transference response in which he was equating me with his inadequate greedy father from whom he desired escape.

> *Dr.* You must have had some feelings about me that upset you. *(Pause. Patient laughs)*

> *Pt.* That day you took off on ethics. I felt you were taking off on something I had no desire to talk about. Also when I talked about the law suit I had contemplated and the lawyer handling the case, *(The patient was involved in a minor civil suit)* you said: "You act precipitously." I

felt you misunderstood me because I don't act precipitiously. I nullify action by indecision. You spoke strongly.

Dr. Yes.

Pt. I guess I seek perfection from you, like I do from my girl friend. When you make a grammatical error, I dwell on it all day.

Dr. You seem to have a need for a powerful, accepting, perfect person in whom you can put your trust, and you get infuriated when that person shows any weakness. *(Interpreting the patient's feeling as a response to not finding the idealized authority figure.)*

Pt. I see that, but this doesn't have to be that way.

Dr. Why do you think it *is* that way?

Pt. I don't know, *(pause)*

Dr. What about your ever having had a perfect person around? Have you?

Pt. Jesus, no. I wish I had. My father was cruel and weak. I couldn't depend on him. He left my mother and me. I felt helpless and dependent on my mother. *(The patient's father had abandoned his mother when the patient was a boy.)*

Dr. Maybe you hoped that a strong man would come into your life some day?

Pt. I always wanted one. Even now I get excited when I see such a person.

Dr. Perhaps you felt I was going to be such a person? (*Patient laughs.*)

Pt. This is a false outlook on life. I'm not in bondage. I'm not a slave. This is all a lot of crap.

Dr. What about bondage to me? In the dream you escape when the man claims to be sick.

Pt. I do feel I need you, but seeing you puts me in bondage. But I don't dare let myself feel angry toward you. Only toward my girl friend.

Dr. Perhaps that's why you had a return of your symptoms. The feelings of being trapped with me, in a dependency, with an inadequate father figure at that. (*Interpreting the patient's symptoms as a product of conflict.)*

Pt. Yes, yes, I am sure of it.

It is quite possible that the patient may have been able to work through his transference without the use of dreams. However, I felt that handling his dream short-circuited this process.

There is no substitute for experience in doing dynamic short-term therapy. The seasoned therapist will be able to attune himself or herself sensitively to what is going on, gauging the the manner of making an interpretation, and moving from challenge to support in response to the immediate reactions of the patient. It is difficult to outline specific rules that apply to every case since no two therapists will develop the same relationships with any one patient. And a patient will play different roles with different therapists, depending upon where in his or her characterologic scheme the patient happens to fit the therapist. Almost anything can happen in a therapeutic situation, but if the therapist is flexible, sensitive, and empathic mindful of the basic processes of psychotherapy, and aware of existing neurotic impulses as they are mobilized in a relationship with the patient, one should be able to bring the average patient to some understanding of basic problems within the span of a short-term approach. In long-term therapy, sooner or later, the patient's symptoms, the current precipitating factor, the immediate conflicts activated in the present disorder, the underlying personality structure, deeply repressed conflicts originating in childhood, the relationship with parental agencies, and the defensive mechanisms will slowly become defined and correlated. The working-through process proceeds on all levels of the psychic organization, and no aspect of personality or environment is usually considered unimportant in the painstaking investigative design.

In dynamic short-term therapy, we cannot afford the leisurely pace that so extensive a proceeding requires. It is essential to focus on areas that will yield the highest dividends. Generally these deal with problems of immediate concern to the patient. While aspects that trouble the patient topically may not actually be the most important elements of the disorder, they do engulf the attention. Skill as a therapist is revealed in the ability to establish bridges from the immediate complaints to more basic personality difficulties. Only when a continuity has been affirmed between the immediate stresses and the conflictual reservoirs within the personality, will the patient be able to proceed working on more substantial issues. Focusing on what the patient considers to be mere corollaries to the pain, before having shown the patient that they are actually the responsible mischief makers, will usually turn out to be an unproductive exercise. It would be as if in a

business faced with bankruptcy we were to advise delay in regulating office expenditures in favor of studying the economic picture of the world at large. The perturbations of management could scarcely be allayed with remote objectives when what immediately occupies them is the anxiety of meeting the weekly payroll. Were one to consider the day-to-day survival needs, and tangentially relate current operations to more comprehensive, and ultimately more important, general business factors, greater cooperation would be secured.

The particular problem area to be attacked at first in dynamic short-term therapy is, therefore, more or less of the patient's own choosing. Often this deals with the *precipitating stress situation* an exploration of which may alleviate tension and serve to restore the individual to an adaptive balance. Here an attempt is negotiated to identify the immediate trouble source, and to relate it to the patient's subjective distress. An endeavor is made at working-through, at least partially, of the difficulties liberated by the stress situation. These, derivatives of enduring and fixed underlying core conflicts, are handled as autonomous sources of anxiety. Historical material is considered only when it is bracketed to the current problems. Not only may the patient be brought back to emotional homeostasis rapidly, particularly when seen immediately after the stress situation has set in, but inroads may be made on deeper conflicts.

A bright young man of eighteen applied for therapy on the basis that he was about to fail his last year of high school. What worried him was that he would not receive a certificate and could, therefore, not enter college. His parents were no less disturbed than the patient at his impending educational debacle. While his first three years of high school work had yielded passable grades, these were far below his potential as revealed by an intelligence test. What was even more provoking was that in his college entrance examinations he had scored lowest in his class. He had also been unable to secure a passing grade in his midterm examinations. Embarrassed and manifestly upset, he expressed a futile attitude during the initial interview about better ability to study. What kept happening to him was that his mind wandered. When he forced himself to read his assignments, he could not retain what he read. The prospect of repeating his last year at

school was a severe blow to his pride. He envisaged accepting a position as a general helper at a local gasoline service station.

No comment was made to discourage him from stopping school. Instead my retort dealt with the wisdom of adjusting one's career to one's intellectual capacity. If it were true that he was unable to keep up with his class because of his inferior mental ability, it might be very appropriate to accept a less ambitious career status. Why burden oneself with impossibilities? The patient then spent the remainder of the session trying to convince me that his intelligence quotient was in the upper ten percentile. This was most extraordinary, I admitted. Perhaps there were emotional reasons why he had to fail.

During the next few sessions we feverishly explored his fears of competitiveness, his desire to remain the favorite child in his family, his dependency on his mother, his impulse to frustrate and punish his father for pushing him to satisfy a personal selfish ambitiousness, and his dread to leave home and to pursue an independent life. The meaning of his need to fail soon crystallized in his mind. He realized that it required an effort to avoid educational success, that he was actually trying to fail in order to retain the pleasures of irresponsible childhood.

No moral judgments were expressed as to the virtues of these aims. If he really wanted to be a child, if he desired to hurt himself in order to get back at his parents, if he had the wish to retreat from being as good as any of his colleagues, this was within his rights as a person. However, he had to realize that he was doing this to himself. Angrily he protested that such was not at all the case. He was convinced that his parents did not want him to grow up; they lamented losing their older children when they went to college. They wanted him to be dependent. Why then should he go along with their designs and nefarious intentions; why should he be the "fall guy"? The rage he vented at his parents was followed shortly by a recognition of his own dependency desires and his fear of growing up. As we explored this he discovered that there was a clearing of his mind and a greater dedication to his studies. His successful final examinations were a fitting climax to his fifteen sessions of therapy. Letters that I received from the patient from an out-of-town

college, and a follow-up visit one year later, revealed measures of personality growth hardly consistent with the relatively short period that he stayed in treatment.

Another early focus in therapy is on *distressing symptoms.* The patient is only too eager to talk about these. Their exploration may lead to a discovery of provocative anxieties and conflicts that initiate and sustain them. The importance of giving some meaning to disturbing or mysterious complaints cannot be overemphasized. So long as a symptom remains unidentified, it is like an autonomous and frightening foreign body. To label it, to explain its significance, gives the individual a measure of control helping one to restore one's sense of mastery. This enables one to function better, since, in finding out some reasons for the symptoms, one can utilize one's energies to correct their source.

Generally, the presenting symptom is explored thoroughly in the context of the question: "How is the symptom related to the individual's personality structure as a whole?" For example, a man comes to therapy undermined by uncontrollable bouts of anxiety. The history reveals that the first attack followed a quarrel with his wife. From the character of his relationship with his mother, his Rorschach responses, and his dreams it is apparent that he basically is a dependent individual who is relating disagreeably to his wife. The symptom of anxiety is explicable on the basis of his releasing hostility toward the parental substitute and fearing abandonment and counterhostility. Our focus shifts then from his symptom to his personality structure in operation.

Other areas of focus may present themselves, for instance transference and resistance manifestations which, when they appear, will occupy the therapist's attention to the exclusion of any other concern. But here, too, when such reactions arise, they should be integrated with the general theme of the patient's personality functioning.

All persons possess blind spots in understanding of themselves. Many of these are due to gaps in education; some are distortions promoted by parents and friends; some are perversions of factual data; some are misrepresentations initiated and sustained by misguided education. During therapy some of these falsifications will require greater clarification. In assuming a role geared toward clarification, the therapist disclaims being

an oracle of wisdom, but that there are some facts of which he or she is confident. If the therapist is not sure of the stand, ideas may be offered with some reasonable reservations, since it may turn out that they are wrong.

In short-term therapy, the interpretation of unconscious motives prior to their eruption into awareness is generally avoided. This is because the therapist may not in a brief contact feel sure of one's ground, and because one does not wish to stir up powerful resistances that will negate the therapeutic efforts. Interpretations deal with immediately discernible feelings and personality reactions. However, it is sometimes possible for an extremely experienced psychoanalytically trained therapist, who has established good rapport with a patient, to interpret in depth, albeit in a reassuring way. It may be possible also to utilize confrontation, which in some cases may be very productive with a dramatic impact on the patient. For example, a young man in a state of anxiety with uncomfortable somatic accompaniments reveals great fear of standing next to strong looking men in the subway. His dreams repetitively picture him fleeing from men with destructive weapons. The therapist, on the basis of his experience, and his intuitive feelings about the patient's problem, concludes that the patient is concerned about homosexual impulses. The therapist has, in the first few interviews, won the confidence of the patient. He decides to interpret the patient's inner conflict. The following is from a recording of the interview:

> *Dr.* You know it is very common for a person who has lost confidence in himself to assume he isn't masculine. The next thing that happens is that he gets frightened of being beat up, hurt, attacked and even sexually assaulted by strong men. He begins to feel that he is more feminine than masculine. The next thing he begins to assume is that he is homosexual and this scares the devil out of him. *(pause.)*

> *Pt.* Yes, yes. Isn't he? I mean how does one know?

> *Dr.* I get the impression this is something that is bothering you.

> *Pt.* I get caught in this terrible fear. I feel I'm not a man and that I'll do something terrible.

> *Dr.* You mean like letting yourself get involved sexually with a man?

> *Pt.* Not exactly, but when I have a few drinks, I find myself looking at the men with muscles and it scares the hell out of me.

> *Dr.* When you have a few drinks, you *might* get sexually aroused. This is not uncommon. But what

makes you think you are a homosexual?

Pt. I know I'm attracted to women and I enjoy being with women. But I constantly compare myself to other men and I come out the low man on the totem pole.

Dr. So the problem is your position in relation to other men, and your feelings about yourself. This seems to me to be your real problem. You've probably had a low opinion of yourself as far back as you can remember. What do you feel about what I have said?

Pt. (Obviously flustered) I ... I ... I think you're right (blushes). *(In this interchange the patient has been given an opportunity to face his inner phantasies and to give them another interpretation than that he is a hopeless homosexual. The emotional relief to the patient was manifest even in one interview.)*

Unless the therapist is on firm ground psychodynamically, and has developed a good working relationship, probings in depth are apt to pose a hazard. They may create great anxiety, or they may provoke resentment and resistance. The best rule is to preserve a good relationship with the patient by testing the patient's reactions to a few interpretations in depth that are presented in a casual and tentative manner.

A patient with an obsessive fear of being hurt, injured and cut, and thus of coming to an untimely death, had so gentle and obsequious a manner with people that I was convinced he was concealing profoundly destructive tendencies. On one occasion when he was discussing his fear of death, I said: "A problem like yours may be touched off by a number of things. I had one patient who imagined himself to be a killer. This scared him so that he had to push the idea out of his mind. Instead he substituted fears of being hurt or killed. This happens over and over again. Whether or not the same thing is happening to you, I don't know. But if so there may be reasons for it. In the case of the man I treated, he confused being assertive with being aggressive and murderous."

This initiated an exploration into the patient's childhood. There was little question that he had felt overprotected and thwarted in various ways, particularly in exploratory activities. Quarreling, fighting and even disagreeing with others were considered to be evil and "against God's will." My indirect interpretation was accepted and utilized. Where an interpretation is premature or wrong, or where the patient's ego resources are unable to sustain its implications, one may on the other hand, react badly. The therapist then will

have to retrieve the situation, working toward the reestablishment of a positive relationship.

The interpretation of a transference reaction is especially helpful when correct. An adolescent boy treated his visits with me as a casual incident in his routine, refusing to talk about himself and waiting for me to do something dramatic to remove his facial tic. At one visit I remarked, "You just won't say anything about yourself and your feelings. I get the impression that you don't trust me." The patient's reaction was a startled one. He blushingly revealed that he was embarrassed at his thoughts. He never was able to be frank with his family. Whenever he divulged any secrets to his brothers or his parents, they were immediately revealed to the whole family to his great embarrassment. When I retorted that there must be something about coming to see me that made him feel sheepish, he admitted wanting to ask me for some "sex books" to explain masturbation and sex. Perhaps, I replied, he felt I might get the idea he wanted to stimulate himself pornographically with this literature. He blushed furiously at this, whereupon I reassured him that there was nothing to be ashamed of, that a strong sexual interest at his age was normal, and that I certainly would reveal nothing about our conversations to his parents. After all, what we talked about was between ourselves. This maneuver had the effect of releasing a flood of memories of incidents in which his confidence had been betrayed. Our sessions thereafter took a new direction with the patient participating actively. I repeatedly assured him that his parents or family would never know about the content of our talks.

In some cases, it may be expedient to present the patient with a general outline of personality development, particularly what happens with delayed separation individuation, inviting the patient to see which elements apply to him or her. I have found that this is occasionally helpful where insufficient time is available in therapy to pinpoint the precise pathology. Patients are usually enthusiastic at first at having received some clarification, and they may even acknowledge that segments of the presented outline relate to themselves. They then seem to lose the significance of what has been revealed to them. However, much later on follow-up many have brought up pertinent details of the

outline and have confided that it stimulated thinking about themselves.

For instance, a man whose depression was set off by his losing face at work when a younger colleague was advanced ahead of him, came to therapy in an extremely discouraged state and with little motivation to inquire into his patterns of adjustment. Deep resentments were apparent from the violent responses to the Rorschach cards, and from his dreams, which centered around destruction and killing. When I commented that it would be natural for him to feel angry under the circumstances, he countered with the remark that he had written advancement off years ago, that he bore no resentment toward his victorious colleague, and that he was resigned to getting the "short end of the stick." From childhood on he was the underdog in the family, and he was accustomed to this role. Apparently, I retorted, he was not as resigned as he imagined himself to be, otherwise he would not have reacted to the present situation with such despair. Maybe he had not written himself off as a permanent underdog. Then I sketched an outline that followed along lines that I have used on other patients with minor variations. This deals with derivative conflicts much closer to awareness than the nuclear conflicts from which they come that are too deeply repressed to be available in the short period devoted to therapy. The following is from an audio tape that I made with the patient's consent:

> "I believe I have a fair idea of what is going on with you, but I'd like to start from the beginning. I should like to give you a picture of what happens to the average person in the growing up process. From this picture you may be able to see where you fit and what has happened to you. You see, a child at birth comes into the world helpless and dependent. He or she needs a great deal of affection, care, and stimulation. The child also needs to receive the proper discipline to protect him or her. In this medium of loving and understanding care and discipline, where one is given an opportunity to grow, to develop, to explore, and to express oneself, independence gradually increases and dependence gradually decreases, so that at adulthood there is a healthy balance between factors of dependence and independence. Let us say they are equally balanced in the average adult; a certain amount of dependence being quite normal, but not so much that it cripples the person. Normally the dependence level may temporarily go up when a person gets sick, or insecure, and independence will temporarily recede. But this shift is only within a narrow range. However, as a result of bad or depriving experiences in childhood, and from your history this seems to have happened to you to some extent *(the patient's father, a salesman was away a good deal of the time and his older brother brutally intimidated him.)*, the dependence level never goes down sufficiently and the independence level stays low. Now what happens when a person in adult life has excessive dependency and a low level of independence? Mind you, you may not show all the things that I shall point out to you, but try to figure out which of these

do apply to you.

"Now most people with strong feelings of dependence will attempt to find persons who are stronger than they are, who can do for them what they feel they cannot do for themselves. It is almost as if they are searching for idealized parents, not the same kind of parents they had, but much better ones. What does this do to the individual? First, usually he becomes disappointed in the people he picks out as idealized parental figures, because they never come up to his expectations. He feels cheated. For instance, if a man weds a woman who he expects will be a kind, giving, protective, mother figure, he will become infuriated when she fails him on any count. Second, he finds that when he does relate himself to a person onto whom he projects parental qualities, he begins to feel helpless within himself; he feels trapped; he has a desire to escape from the relationship. Third, the feeling of being dependent, makes him feel passive like a child. This is often associated in his mind with being non-masculine; it creates fears of his becoming homosexual and relating himself passively to other men. This role, in our culture, is more acceptable to women, but they too fear excessive passivity, and they may, in relation to mother figures, feel as if they are breast-seeking and homosexual.

"So here he has a dependency motor that is constantly operating, making him forage around for a parental image who will inevitably disappoint him. *(At this point, the patient interrupted and described how disappointed he was in his wife, how ineffective she was, how unable she proved herself to be in taking care of him. We discussed this for a minute and then I continued.)* In addition to the dependency motor, the person has a second motor running, a resentment motor, which operates constantly on the basis that he is either trapped in dependency, or cannot find an idealized parental figure, or because he feels or acts passive and helpless. This resentment promotes tremendous guilt feelings. After all, in our culture one is not supposed to hate. But the hate feelings sometimes do trickle out in spite of this, and on special occasions they gush out, like when the person drinks a little too much. *(The patient laughs here and says this is exactly what happens to him.)* If the hate feelings do come out, the person may get frightened on the basis that he is losing control. The very idea of hating may be so upsetting to him that he pushes this impulse out of his mind, with resulting tension, depression, physical symptoms of various kinds, and self-hate. The hate impulse having been blocked is turned back on the self. This is what we call masochism, the wearing of a hair shirt, the constant self-punishment as a result of the feedback of resentment. The resentment machine goes on a good deal of the time running alongside the dependency motor.

"As if this weren't enough, a third motor gets going along with the other two. High dependence means low independence. A person with low feelings of independence suffers terribly because he does not feel sufficient unto himself; he does not feel competent. He feels nonmasculine, passive, helpless, dependent. It is hard to live with such feelings, so he tries to compensate by being overly aggressive, overly competitive, and overly masculine. This may create much trouble for the person because he may try to make up for his feelings of loss of masculinity. He may have phantasies of becoming a strong, handsome, overly active sexual male, and, when he sees such a figure, he wants to identify with him. This may create in him desires for and fears of homosexuality which may terrify him because he does not really want to be homosexual. Interestingly, in women a low independence level is compensated for by her competing with men, wanting to be like a man, acting like a

man, and resenting being a woman. Homosexual impulses and fears also may emerge as a result of repudiation of femininity.

"A consequence of low feelings of independence is a devalued self-image with starts the fourth motor going. The person begins to despise himself, to feel he is weak, ugly and contemptible. He will pick out any personal evidence for this that he can find, like stature, complexion, physiognomy, and so on. If he happens to have a slight handicap, like a physical deformity or a small penis, he will focus on this as evidence that he is irretrievably damaged. Feelings of self-devaluation give rise to a host of compensatory drives, like being perfectionistic, overly ambitious and power driven. So long as one can do things perfectly and operate without flaw, he will respect himself. Or, if he is bright enough, and his environment favorable, he may boost himself into a successful position of power, operate like a strong authority and gather around himself a group of sycophants who will worship him as the idealized authority, whom in turn the individual may resent and envy while accepting their plaudits. He will feel exploited by those who elevate him to the position of a high priest. "Why," he may ask himself, "can't I find somebody strong I can depend on?" What he seeks actually is a dependent relationship, but this role entails such conflict for him that he goes into fierce competitiveness with any authority on whom he might want to be dependent. (*The patient nods and keeps saying "Yes, yes."*)

"So here we have our dependency operating first; second, resentment, aggression, guilt, and masochism; third, drives for independence; and, fourth, self-devaluation and maneuvers to overcome this through such techniques as perfectionism, overambitiousness and power strivings, in phantasy or in reality.

"To complicate matters some of these drives get sexualized. In dependency, for instance, when one relates to a person the way a child or infant relates to a parent, there may be experienced a powerful suffusion of good feeling which may bubble over into sexual feeling. There is probably a great deal of sexuality in all infants in a very diffuse form, precursors of adult sexuality. And when a person reverts emotionally back to the dependency of infancy, he may re-experience diffuse sexual feelings toward the parental figure. If a man relates dependently to a woman, he may sustain toward her a kind of incestuous feeling. The sexuality will be not as an adult to an adult, but as an infant to a mother, and the feelings for her may be accompanied by tremendous guilt, fear, and perhaps an inability to function sexually. If the parental figure happens to be a man instead of a woman, the person may still relate to him like toward a mother, and emerging sexual feelings will stimulate fears of homosexuality. (*If the patient is a woman with sexual problems, the parallel situation of a female child with a parental substitute may be brought up: A woman may repeat her emotions of childhood when she sought to be loved and protected by a mother. In body closeness she may experience a desire to fondle and be fondled, which will stir up sexual feelings and homosexual fears.*) In sexualizing drives for independence and aggressiveness, one may identify with and seek out powerful masculine figures with whom to fraternize and affiliate. This may again whip up homosexual impulses. Where aggressive-sadistic and self-punitive masochistic impulses exist, these may, for complicated reasons, also be fused with sexual impulses, masochism becoming a condition for sexual release. So here we have the dependence motor, and the resentment-aggression-guilt-masochism motor, and the independence motor, and the self-devaluation motor, with the various compensations and sexualizations. We have a very busy person on our hands. *(At*

this point the patient revealed that he had become impotent with his wife and had experienced homosexual feelings and fears which were upsetting him because they were so foreign to his morals. What I said was making sense to him.)

"In the face of all this trouble, how do some people gain peace? By a fifth motor, that of detachment. Detachment is a defense one may try to use as a way of escaping life's messy problems. Here one withdraws from relationships, isolates himself, runs away from things. By removing himself from people, the individual tries to heal himself. But this does not usually work because after a while a person gets terrified by his isolation and inability to feel. People cannot function without people. They may succeed for a short time, but then they realize they are drifting away from things; they are depriving themselves of life's prime satisfactions. Compulsively, then, the detached person may try to reenter the living atmosphere by becoming gregarious. He may, in desperation, push himself into a dependency situation with a parental figure as a way out of his dilemma. And this will start the whole neurotic cycle all over again.

"You can see that the person keeps getting caught in a web from which there is no escape. So long as he has enough fuel available to feed his various motors and keep them running, he can go on for a period. But if opportunities are not available to him to satisfy his different drives, and if he cannot readily switch from one to the other, he may become excessively tense and upset. If his tension builds up too much, or if he experiences great trouble in his life situation, or if his self-esteem gets crushed for any reason, he may develop a catastrophic feeling of helplessness and expectations of being hurt. *(The patient here excitedly blurted out that he felt so shamed by his defeat at work that he wanted to atom bomb the world. He became angry and weak and frightened. He wanted to get away from everything and everyone. Yet he felt so helpless he wanted to be taken care of like a child. He then felt hopeless and depressed. I commented that his motors had been thrown out of gear by the incident at work and this had precipitated excessive tension and anxiety.)*

"When tension gets too great, and there seems to be no hope, anxiety may hit. And the person will build up defenses to cope with his anxiety, some of which may succeed and some may not. For instance, excessive drinking may be one way of managing anxiety. Fears, compulsions, physical symptoms are other ways. These defenses often do not work. Some, like phobias, may complicate the person's life and make it more difficult than before. Even though ways are sought to deal with anxiety, these prove to be self-defeating.

"Now we are not sure yet how this general outline applies to you. I am sure some of it does, as you yourself have commented. Some of it may not. What I want you to do is to think about it, observe yourself in your actions and relations to people and see where you fit. While knowing where you fit will not stop the motors from running, at least we will have some idea as to with what we are dealing. Then we'll better be able to figure out a plan concerning what to do."

Self-observation should be encouraged and this will help the "working-through" process without which insight can have little effect. It is important then even though a patient can spend limited time in treatment that he or she gain some awareness of the

source of the problems. This ideally should establish the complaint factor as a parcel of a much broader design, and should point to the fact that self-defeating patterns are operating that are outcroppings of elements rooted in past experiences. Once the patient gets the idea that these troubles are not fortuitous, but are events related to definite causes—perhaps carryovers of childish needs and fears—he or she will be more apt to utilize energies toward resolving difficulties rather than expending them in useless resentment and self-recriminations. Insight may operate primarily as a placebo force at first, but if it enables the individual to relate significant forces in development to day-to-day contemporary functioning, this may enable the patient to establish inhibitory controls, and even to structure life along more meaningful and productive lines.

Because the degree of insight that can be inculcated in the patient in a short period of therapy is understandably limited, some therapists circumscribe the area of inquiry. Sifneos, for example, organizes interpretations around oedipal problems, Mann around issues of development, others around separation and grief. Whatever the focus, resistances will tend to sabotage self-understanding. Though the patient may seek to get rid of anxiety and disturbing symptoms, though possessing incentives to be assertive and independent, though wishing to be fulfilled happily and creatively, he or she is a prisoner of one's conditionings that tend compulsively and confoundingly to repeat. Moreover, there are virtues derived from a perpetuation of neurotic drives: symptoms do tend to give the patient temporary protection from anxiety; secondary gains operate that supply the individual with spurious dividends for the illness; normality poses dangers more disagreeable than being well. To work through resistances toward complete understanding, and to put insight into practice with corrective personality change, is a prolonged procedure that will have to go on outside of therapy, perhaps the remainder of the individual's life.

What will be needed is a form of discipline to approach the task of self-understanding toward liberation from destructive patterns. In order to get well the patient will have to acquire the strength to renounce patterns that have personal values. Even though awareness is gained into the need to renounce certain ways of behaving, the

patient may prefer to hang onto a preferred though neurotic way of life despite the inevitability of suffering. The patient may also become resentful to the therapist for not reconciling irreconcilable objectives of achieving the fruits of victory without bothering to till the soil and plant the seed, and of retaining neurotic patterns while avoiding the accompanying pain.

For example, a female patient seeks love from men at the same time that she is extremely competitive with them. To outdo and outshine them has intense values for her. When she fails to vanquish them, she becomes infuriated; when they stop short of giving her the proper affection, she goes into despair. Her lack of insight into her ambivalence toward men is startling in view of the fact that she is capable of advising her friends in *their* affairs of the heart. From her history it is suspected that her problem stems in part from her competitiveness with an older brother against whom she was pitted by her mother, who herself was in rivalry with her passive husband. Yet the patient loved and admired her brother. What bothers the patient is that she can never hold onto a strong male; only weak and passive men seek her out, for whom she has only contempt.

Within six sessions of therapy the patient became aware of her two antagonistic drives, to give affection and to defeat men. An inkling of her strong competitiveness with men also filtered through. She acknowledged how contradictory her motives were, but this had no effect whatsoever on her behavior. Indeed, she became embittered with and repudiated my suggestion that until a change occurred in her rivalrous attitudes toward men, she could not expect that they would respond to her, nor would she be able to realize the love she desired. She countered with the statement that she was looking for a man with "guts" who could fight back and make her feel like a woman.

Ordinarily, one would anticipate that a problem of this severity could be resolved only in prolonged treatment, preferably with the setting-up and working-through of a transference neurosis. For many reasons long-term therapy was not feasible, and after eighteen sessions treatment was terminated with symptomatic relief, but with no alteration of her patterns with men. What I enjoined her to do was to practice principles of

self-observation, which I encourage in all patients who have a desire to achieve more than symptomatic change. Follow-up visits over a 10-year period have revealed deep and continuing changes with a successful marriage to a man she respects with whom she has enjoyed raising two children.

Post-Therapy Self-Observation

Among the areas around which posttherapy self-observation is organized are the following:

1. *Relating outbursts of tension, anxiety and symptom exaggeration to provocative incidents in the environment and to insecurities within the self.* The patient may be told: "Whenever you get upset, tense or anxious, or whenever your symptoms get disturbing, ask yourself: 'What is going on? What has upset me?' Keep working at it, thinking about matters until you make a connection between your symptoms and what has provoked them." If the patient has gotten clues about the operative dynamics from the treatment experience, he or she will be in a position to pinpoint many of the current upsets. Even if the assigned determinants are not entirely complete, the fact that the patient attempts to identify the sources of trouble will help to overcome helplessness and to alleviate much tension.

2. *Observing circumstances that boost or lower feelings about oneself.* The patient is instructed to watch for incidents and situations that boost morale or that are deflating to the ego relating these, if possible, to operations of inherent personality assets and liabilities. For instance, when first forming a relationship with a person, a feeling of peace and contentment may follow on the assumption that the relationship will magically resolve problems. A realization may then dawn that such inordinate expectation can sponsor a parade of troubles since it is based on neurotic dependency. If, on the other hand, the patient experiences greater self-esteem in doing something constructive through personal efforts, the resulting feeling of independence and self-growth may encourage further efforts in this direction.

3. *Observing one's relationship with people.* The patient is encouraged to ask oneself: "What tensions do I get with people? What kind of people do I like or dislike? Are these tensions with all people or only with certain kinds of people? What do people do to upset me and in what ways to I get

upset? What do I do to upset them or to upset myself when I am with them? What do I do and what do they do that tends to make me angry? What problems do I have with my parents, my mate, my children, my boss, associates at work, authorities, people in general?" Whatever clues are gathered about habitual reaction patterns will serve to consolidate an understanding of one's general personality operations.

4. *Observing daydreams or dreams during sleep.* The patient may be reminded, if during therapy he or she has learned that dreams have a meaning, that one may be able to get some valuable data about oneself from phantasies or dreams. The patient may be instructed: "Make a note of any daydreams or night dreams especially those that repeat themselves. Try to remember them and to figure out what they mean." How valuable this exercise may be is illustrated by the case of a young man with fears about his masculinity who developed stomach pains the evening of a blind date that forced him to cancel his appointment. Unable to understand why his pains disappeared immediately after the cancellation, he asked himself to remember any dreams that night. The dream he recalled was this: "My father had his arm around my mother and kept me from her. I felt guilty." He was so enthusiastic that he had made a connection between the incident of the blind date and his oedipal problem that he telephoned me to say he was going to challenge his putting women into the role of his mother by seeing his date through another evening. This he was able to do. Obviously not all patients will be able to utilize their dreams in self-observational practices.

5. *Observing resistances to putting one's insights into action.* The patient is advised that every time understanding is applied to the challenging of a neurotic pattern, this will tend to strengthen one. "You will eventually get to a point where you will be able to block destructive or self-defeating actions before they get you into trouble. But expect some resistance, tension and fear. When you stall in doing what you are supposed to do, ask yourself why? What are you afraid of? Then deliberately challenge your fear and see if you can overcome it."

By a studied application of the above principles of self-observation, the patient may be able to achieve considerable personality growth after treatment has stopped. Gradually one may become aware of patterns that have to be revised before interpersonal horizons can be expanded. Understandably, this process is slow. First, the individual realizes that

symptoms do not occur at random, but rather are related to life situations and relationships with people which stir up tensions, hostilities, and anxieties. This leads to a questioning of the types of relationships that are habitually being established. It may seem incredible to the patient that other ways of behaving are possible. Even partial acceptance of this premise may spur an inquiry into origins of existing attitudes toward people and toward oneself, A continuity may be established between present personality traits and past conditionings. The "blueprint" of the personality that was tentatively sketched while in treatment becomes more solidly outlined, and essential revisions in it are made. The patient sees more clearly the conditions under which early fears and conflicts originated to paralyze functioning. In the course of this investigation one may recover memories long forgotten, or may revive feelings associated with early recollections that have been repressed. There is an increasing facility to master the anxiety associated with the past. He or she begins to doubt that life need be a repetition of past happenings and becomes increasingly convinced that it is unnecessary to inject past attitudes into present situations. Tenuously, against resistance, the patient tests new responses, which in their reward help gradually to extinguish old reactions. Throughout this reconstructive process, the old patterns keep coming back, particularly when the individual feels insecure or self-esteem becomes undermined. The recognition that one is trying to regress as a security measure assists in reversing the retreat. More and more one expresses a claim to a new life, the right to be more self-expressive. The ego expands; the conscience gets less tyrannical; inner promptings find a more healthy release; relationships with people undergo a change for the better.

There is, of course, no guarantee that these productive developments will take place in all cases. Nor can any estimate be made as to how long a period change will require after therapy has ended. But persistence in the practice of self-observation, and active challenging of neurotic patterns, are prime means of achieving reconstructive results. Where the patient has been taught self-relaxation or self-hypnosis, one may advantageously employ these techniques to catalyze self-observation.

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Handling Emergencies in Psychotherapy

Although emergencies are not common in the practice of the average therapist, preparation for their proper management, should any occur, makes good sense, since mishandling can be destructive to the patient and ruinous to one's reputation, apart from the medico-legal complications that can ensue. Not only will the therapist have to palliate the patient's turmoil, but will also have to cope with the concerns of the patient's family, as well as the anxieties within oneself. To retain objectivity and composure in the face of ominous happenings will tax the resources of the most stable therapist. Responsibility should therefore be shared with a skilled consultant psychiatrist, especially if the therapist is a non-medical person.

Crucial decisions are essential in emergencies. Knowing when to pacify, when to confront, when to enjoin, when to direct, when to order, when to notify relatives or friends, when to hospitalize, when to prescribe medications, how to evaluate existing stress situations, how to appraise useful support systems, how to gauge available ego strengths, how to bring the patient to an awareness of factors that keep the crisis alive, when to involve the family in the treatment plan, and the solution to other troublesome points requires expertise in crisis intervention practiced in the medium of an empathic relationship.

Among such possible emergencies are suicidal attempts; psychotic attacks; excitement, overactivity, and antisocial behavior; panic states; acute alcoholic intoxication; acute barbiturate poisoning; hallucinogenic and other intoxications; severe psychosomatic symptoms; and intercurrent incurable somatic illness.

SUICIDAL ATTEMPTS

Suicide ranks among the 10 most common causes of death among adults and among

the three most common causes among adolescents. Statistics underestimate its true incidence due to flaws in reporting. Most (90 percent) of suicidal attempts are unsuccessful. This is because they are ill conceived and reflect the ambivalence of the perpetrator. Usually they constitute a gesture that communicates a plea for life. About 70 percent of successful suicides are among adults, most occurring in the syndrome of major depression and in alcoholics experiencing periodic depressed states. A disproportionate number of suicides are found among professional persons such as lawyers, physicians, dentists, and military men. The therapist should be alerted to a number of warning signs.

1. Symptoms of severe depression especially in males over the age of 55, social isolation, recent divorce or widowhood, unemployment, alcohol or drug abuse, and physical illness of a chronic or painful nature are predisposing factors.

2. At any age those who have made serious suicidal attempts, or where there is a history of suicide or of affective disorder in the family, these should be considered danger signals.

3. Dysthymia (reactive depression) resulting from broken or unhappy love affairs, disharmony in marriage, serious fights with parents among the young, bereavements in the elderly, and severe physical ailments may initiate a suicidal attempt. Likewise, personality problems of a psychopathic or hysterical nature with poor impulse control and peaks of violence and aggression may register themselves in suicidal gestures or in suicidal equivalents like reckless driving and dangerous sports.

4. Most likely to commit successful suicide are severe depressions during early stages of treatment when retardation and indecisiveness are replaced by a slight release of energy. Here prescribed psychotropic drugs and hypnotics may be massively incorporated.

Even in well-conducted psychotherapy vague suicidal threats may be expressed by some patients to the effect that they would be better off dead but they are too cowardly to try suicide. Where such statements lack the tone of conviction, it is best for the therapist not to subject the patient to concentrated interrogation around the matter of suicide. The therapist's expressed concern may frighten the patient badly resulting in loss of self-confidence. It may be found that the patient is trying to prove something or to hurt

someone with a suicidal threat. Actually, an individual is responsible for his or her own actions, and cannot be watched 24 hours per day to prevent executing a threat if this is what is urgently wanted. The family of the patient may also be helped to resist being blackmailed by suicidal threats.

The following signs, symptoms, and situations, however, do point to a potential suicidal risk in a patient:

1. Loss of appetite, severe weight loss, insomnia, listlessness, apathy, persistent expressions of discouragement and hopelessness, loss of sexual desire, extreme constipation, hypochondriac ideas, continuous weeping, and general motor retardation which are present at the start or appear in the course of therapy.

2. Irrespective of diagnosis, any patient who has made a suicidal attempt in the past, or who has a history of severe depression, or who is taking antihypertensive and other medications and drugs that are having a depressive effect.

3. A patient who, during therapy, insistently threatens suicide.

4. Dreams of death, mutilation, and funerals.

Where during treatment, the patient talks *openly and seriously* about a desire to "end it all," it is important not to change the topic or to reassure the patient unduly. Rather, a frank talk about the reasons why the patient feels that suicide is the best recourse gives the patient an opportunity to investigate hidden feelings. This will enable the therapist to determine whether the threat is real, whether it is casually made as a dramatic gesture, whether it is a hostile stab at the therapist, or whether it constitutes an appeal for reassurance. Under no circumstances should the therapist minimize the importance of the threat, cajole the patient, or administer a verbal attack. Arguing with the patient is generally useless. Where the threat seems ominous, the therapist might make helpful statements to the effect that suicide *seems* to be a way out of difficulty, but it actually accomplishes nothing; that there may be other solutions than suicide that are not now apparent; and that suicide is a final act that cannot be undone and that it could always be

resorted to later on if the patient so wishes. The attitudes conveyed to the patient in such statements are respect for one's right to self-determination and a reminder that one is not giving oneself an opportunity to explore more constructive actions. Talking frankly about suicide often serves to rob it of its awesome or appealing quality. Where suicide seems imminent in spite of anything the therapist can do or where an abortive attempt is actually made, there is no alternative than to advise responsible relatives to get the patient hospitalized immediately in a closed ward of a psychiatric hospital.

Suicide prevention centers do exist in the larger cities, and they have been used by depressed individuals and their families in crises. How effective these centers are in preventing suicide has not been evaluated adequately. Their impact may be minimal because individuals intent on suicide do not generally call in. Suicide centers do, however, serve a purpose if no more than to act as a referral source.

Hysterical Personalities

Suicidal attempts in hysterical personalities are common and consist of histrionic gestures calculated to impress, frighten, or force persons with whom the patient is in contact to yield attention and favors. Such attempts are incited by motives for display rather then by genuine desires to take one's life. Dramatic performances of an ingenious nature are indulged, during which there is a superficial slashing of the wrists, or feigned unconsciousness with stertorous breathing while placing an empty bottle of sleeping pills alongside the bed, or the gulping of tincture of iodine, or the impetuous opening of gas jets. Feverish demonstrations of suffering and martyrdom continue after the patient is restrained or "revived," until convinced of having emphasized protests sufficiently. The danger of these pseudo-suicidal maneuvers is that the patient's judgment may not be too good during dramatic overacting and one may accidentally go too far and commit suicide even though this was not the original intent.

In treating hysterical cases with suicidal threatenings, we must demonstrate to the patient that we are neither intimidated by nor angry at the actions of the patient. Interpretation of the purpose of the patient's frenzied behavior should be made in terms

of the broader neurotic patterns.

Psychopathic Personality

Of a related but more serious nature are the suicidal attempts of the psychopathic personality. During episodes of excitement, violence, deep remorse, excessive drinking, or temporary psychotic outbreaks, the psychopaths may slash the wrists or take an overdose of sleeping pills. The desire for self-punishment and death are genuine, though temporary. When their attempt has been aborted and they have been hospitalized, such patients recover rapidly, evidence no further suicidal impulses, and express great remorse at their folly. Yet, a short time later, under propitious circumstances, the attempt will be repeated, with further contrition and promises of abstention. Interpretation of the episode is essential, but it usually fails to act as a deterrent to the patient's actions. When the suicidal episodes are motivated by disturbed interpersonal relationships, as, for instance, a broken love affair or rejection by a love object, the continued exploration of the patient's feelings and patterns is indicated. In addition, the therapist may have to increase the frequency of visits and insist on being telephoned when the patient is tempted to indulge in suicide.

Where the patient persists in this impulsive suicidal behavior, after seeming to have acquired insight into operative patterns, the therapist may have no other alternative than to tell the patient that treatments will have to be discontinued. It may be suggested that the patient may perhaps want to start treatment with another therapist. This may give enough of a jolt to the patient to ensure insistence on the therapists continuing, based on the promise that all further suicidal attempts will be abandoned. Whether or not the therapist concedes to the patient's wishes to continue treatment will depend on how the therapist feels about the patient. Unfortunately, with some psychopaths the threat of discontinuance of therapy may be the only force that can control their explosive conduct. Even here the effect may be temporary.

Schizophrenia

In some types of schizophrenia suicide is a grave possibility. It is most common in

acute, excited catatonic states, particularly those associated with panic. Hallucinations may drive certain patients to mutilate or kill themselves. Fear of homosexual attack or of being persecuted may also force some paranoidal individuals to suicide. The methods of self-destruction employed in schizophrenia may be bizarre, including such mutilations as disembowelment and genital amputation.

The handling of the suicidally inclined schizophrenic patient is organized around administering ample sedation, communicating with the family so that they may assume some responsibility, and arranging for transportation and admission to a mental hospital. Electric convulsive therapy is often indicated. Chlorpromazine (Thorazine), thioridazine (Mellaril), perphenazine (Trilafon), or haloperidol (Haldol) in ample dosage (see the section on somatic therapy in Chapter 56) are indicated.

Pathologic Depressions

Depressed episodes may occur in people due to loss of security, status, or a love object; however, the depression is rarely of such depth as to inspire a desire to take one's life. Where the depressed state is extreme, suicide is always a possibility. Among the most vulnerable pathologic depressive conditions are major depression, bipolar depression, depressions in alcoholics, involutional depression, senile depression, and depressions in organic brain disease.

To manage a patient with a pathologic depression, certain palliative measures are helpful. The handling of diet with the inclusion of stimulating and appetizing foods and the prescription of tonics and vitamins may be indicated in anorexia. In mild depression, a stimulant like Ritalin may be useful temporarily to activate the patient during the day, while sedation may be required at night for insomnia. Here small amounts of a mild hypnotic like chloral hydrate (Noctec) may be prescribed to prevent the patient from accumulating a lethal quantity. In more severe depressions, the patient's family or a reliable friend should be contacted and acquainted with the potential dangers. Where the patient remains at home while in a deep depression, a trustworthy adult person should be in constant attendance. The patient should not be permitted to lock oneself into a room,

including the bathroom. Sleeping pills, tranquilizers, poisonous drugs, razor blades, rope, and sharp knives and instruments should be removed. Window guards are necessary if there is a chance that the patient may destroy oneself by leaping through a window. Hospitalization on a closed ward with constant supervision by efficient nurses or attendants may be essential. The treatment of choice is electroconvulsive therapy, which may prove to be a lifesaving measure. Antidepressants are second best where the patient refuses ECT, but the patient must be watched carefully since the early "lift" from the medication may give enough energy to try suicide. Psychotherapy during severe depression is generally confined to supportive measures, as insight approaches tend to stir up too much anxiety.

Fear and guilt feelings are common in the therapist who will usually be in a dilemma about hospitalization. It is urgent that a non-medical therapist secure a consultation with a psychiatrist to share responsibility, to prescribe ECT or proper medications, or to arrange for hospitalization should the patient need it and is willing to consider it. Although a desperate patient can terminate life in spite of any safeguards, there is a lesser chance in a hospital setting, particularly when ECT is immediately started. Usually there is little problem in decision making when the patient has made an unsuccessful attempt. Here relatives and neighbors rush the patient to an emergency hospital service, or the police are brought into the picture and arrange for admission and perhaps for transport of the patient.

Difficulties in decision are greater in the event a patient has mildly threatened to take his or her life, but makes no active gesture to do so, and has no history of past suicidal attempts. Under these circumstances the therapist may have to utilize the greatest interviewing skills (Murray, 1972). The patient may be told that the ultimate responsibility for one's life is one's own. "You probably won't believe this, but you *will* get over this depression and will feel better. Right now it is natural for you to imagine your suffering will continue indefinitely. It will not." Here it is assumed that the patient is started on a regime of antidepressant drugs (e.g. Tofranil, Elavil, Sinequan) in adequate dosage (see the section on somatic therapy in Chapter 56). In the great majority of

patients a frank empathic talk will tide them over the crisis.

It is often important to see the patient frequently and to telephone between sessions to maintain as close a tie as possible.

Miscellaneous Suicidal Conditions

Sometimes a therapist is consulted by the parents or friends of a child or adolescent who has made a suicidal attempt. Examination may fail to reveal hysteria, depression, or schizophrenia, especially when the child is non-communicative to the point of mutism. It is possible here that the child is internalizing destructive feelings. Young drug abusers are particularly vulnerable. Because the youth is non-motivated for therapy and resents having been taken to a psychiatrist, it may be difficult to treat the patient. By following the rules outlined in Chapter 32. Dealing with Inadequate Motivation, and by indicating to the patient that he or she seems to be angry at someone, it may be possible to establish rapport.

A 14-year-old girl, for example, who had made a suicidal attempt by swallowing 50 aspirin tablets was brought in for a consultation. Refusing to talk except in monosyllables, it was difficult to carry on an interview. The therapist finally remarked, "You must have been awfully angry at someone to have done this to yourself," The patient blanched, then brought her hands to her face and started compulsive sobbing, which went on for 15 minutes. Intermittent were outbursts in the form of protestations of how "bad" she was for feeling the way she did about her mother. Ventilation of her resentment produced immediate emotional relief and established sufficient contact with the therapist to start psychotherapy.

Should a suicidal attempt have been made, the immediate injuries will have to be treated and artificial respiration instituted if necessary. If concentrated oxygen is available, it should be given. In asphyxiation with gas or from fumes of an automobile 50 cc of 50 percent glucose, injected intravenously, may help prevent cerebral edema. Intramuscular adrenaline (epinephrine), 0.5 to 1.0 cc of 1:1000 concentration, may also be

administered.

If suicide was attempted with poisons or drugs, identification of these will permit selection of the proper antidote. Patients who are not unconscious and who have not taken corrosives or petroleum products may be induced to vomit by tickling the pharynx with a finger or spoon, and by giving them a glass of water containing 1 tablespoonful of salt or 1 teaspoonful of powdered mustard or soap suds. This should be repeated several times if necessary and followed by a gastric lavage with 1 quart of water containing 1 tablespoonful of (a) "universal antidote," or (b) 2 parts burnt toasts to 1 part strong tea and 1 part milk of magnesia, or (c) table salt. Next, a neutralization of the specific poison with the antidote is attempted and demulcents (flour, starch, gelatin in a paste, or 12 beaten eggs mixed with milk) are given. Finally, the poisons remaining in the intestinal tract are removed by administering magnesium sulfate (Epsom salts: 30 g in a glass of water). Suicidal attempts with barbiturates are handled by inducing emesis, administering "universal antidote," and preventing shock with measures to be described in a later part of this chapter, under Acute Barbiturate Poisoning.

The Telephone Threat

Where a patient telephones the therapist and states that he or she is about to take a lethal dose of medication (or engage in another kind of suicidal act) the therapist should try to keep communication going especially around any incident that has inspired the impulse to die. The patient's name should be repeated to firm up the sense of identity and some constructive action may be suggested as well as a reminder that the therapist wants to help as much as possible, and that others care for the patient and want to help. If the patient has already taken the lethal pills or opened a gas jet the address should be obtained while the patient is kept talking on the telephone. Another person should be dispatched (perhaps by a note written by the therapist during an interval when the patient is talking) to call the police, trace the call if the patient refuses to say where he or she is, and immediately send an ambulance to escort the patient to an emergency room.

PSYCHOTIC ATTACKS

In the course of psychotherapy anxiety may be released that is beyond the endurance of certain patients. A psychotic episode occurring during treatment may be the product of too early or too avid an attack on resistances and defenses in a patient with fragile ego strength. It may be the consequence of a transference neurosis that gets out of control. A good psychotherapist is capable of gauging the ego strength of the patient and of introducing supportive measures should signs of shattering appear. Nevertheless, even good psychotherapists may be unable to control the outbreak of psychosis in vulnerable patients. The quality of the working relationship is a crucial factor. Some therapists are capable of operating sensitively and empathetically with potentially psychotic and even overtly psychotic patients. Other therapists, particularly those who are unable to manage their countertransference, may be unable to work with infantile dependent personality disorders, with borderline, or with psychotic patients. They may have to transfer patients who show tendencies toward psychotic outbursts once the treatment process is under way.

Symptoms that lead one to suspect beginning ego disintegration during psychotherapy are feelings of unreality, depersonalization, excessive daydreaming, ideas of reference, paranoidal ideas, bizarre somatic sensations, motor excitement, uncontrollable sexual and hostile impulses, propensity for perversions, heightened interest in toilet activities, compulsive talking, fears of castration, and fleeting hallucinations and delusions. These symptoms may appear individually or in combination. For a while the patient may maintain a good grasp on reality, recognizing the unusual or irrational nature of his or her ideas, impulses, and acts. Later on, distortions of reality may occur in the form of fixed delusions and hallucinations, perhaps accompanied by panic reactions, suicidal tendencies, and violent aggression. The first step is to identify any immediate stress factor that is upsetting the patient. Is it in the current life situation? If so, the patient should be helped to resolve the problem or to extricate satisfactorily from it. Is it a consequence of what is happening in therapy? Transference reactions are extremely common, and in a patient with weak ego strength this may pitch protective defenses

overboard. Such reactions in stronger patients may be concealed and evidence of them manifested only in acting-out or in dreams. Getting the patient to talk about feelings in regard to the therapist, with proper clarification and interpretation, may restore the patient's equilibrium. It may be necessary to increase the patient's visits during a period of emotional turmoil.

Second, if the precipitating factor cannot be identified, an attempt should be made to get the patient to speculate as to some cause for the trouble. The preferred explanation may then be used as a focus around which interviewing is organized to explore the patient's suppositions or to discover more cogent etiologic factors.

Third, where the support offered through psychotherapy does not restore the patient to an equilibrium in a short time, a neuroleptic drug, like Thorazine (chlorpromazine), Haldol (haloperidol), Stelazine (trifluoperazine), or Permitil (fluphenazine), in proper dosage may be prescribed. Too frequently, inadequate doses of medication are used. A non-medical therapist will have to bring a psychiatrist who knows drug therapy into the picture.

Should a psychotic attack take place it may be handled within the therapeutic situation by a therapist who has a warm feeling for the patient, who is not disturbed by the existing symptoms, and who is capable of modifying the approach so as to bring about the restoration of repressive barriers. The fact that a psychosis has precipitated is usually indicative of something having gone amiss in the therapeutic relationship. If one can admit to oneself the possibility of errors in handling and if one is able to restore the patient's feelings of trust and confidence, such a therapist may be capable of bringing the retreat from reality to a halt. In line with this objective it is best to discontinue probing for conflictual areas and to keep the content of the interview focused on current reality problems. The relationship with the therapist should be kept on as positive a level as possible, the therapist assuming a helpful active role. Under no circumstances should the therapist express alarm at or condemnation toward any of the patient's misconceptions. Listening attentively to the patient's productions, the therapist counters with reality,

suggesting that perhaps things seem to be as they are because the patient has been so upset. If disturbing transference is at the basis of the patient's turmoil, measures to lessen transference, described in Chapters 42 and 46 may be invoked. Should the patient require more support, the frequency of interviews may be increased.

Where these practices fail to bring relief to the patient, it is likely that the therapeutic relationship has deteriorated and the patient may have to be referred to another therapist. The referral can be upsetting to the patient, and he or she is apt to consider it a further manifestation of rejection or an indication of failure. The therapist may explain that the patient's specific problem will probably be helped more by another therapist with a slightly different approach. If the patient is incapable of thinking rationally and if the difficulties are potentially dangerous to oneself and others, a reliable family member should be asked to assume some responsibility in the matter of referral. Should the patient object to the therapist's making contact with the family, the therapist may, if the situation is sufficiently dangerous, have to communicate with the family irrespective of the patient's wishes.

Where self-injury, suicide, homicide, violent aggression, ruinous spending, criminality, or other disasters are possible, hospitalization may be mandatory. If the therapist is a non-medical person, a consulting psychiatrist should be called in. Discussion may convince the patient to enter an institution voluntarily. Hospitalization will, however, have to be accomplished against the wishes of the patient where one is dangerous to oneself or others and sees no need for confinement. In the event that one is actively resistant and must be hospitalized, intravenous sodium Amytal to the point of deep sleep will permit transport to an institution without the need for physical restraint. A physician should be in attendance in the ambulance that transports the patient in order to handle such emergencies as respiratory paralysis.

The therapist will have to arrange the details of hospital admission in cooperation with the patient's family and, in addition, may have to explain the reasons for hospitalization to them in a reassuring way. In doing this, the therapist may experience

some guilt and anxiety, as if accountable for the patient's collapse. It is important, however, not to castigate oneself for what has happened nor to confess to failure; rather, the family may be informed that the patient's personality structure has been unable to stand inner tensions and that the patient has temporarily broken down. A period of hospitalization is necessary to restore equilibrium.

The specific treatment rendered in the hospital will depend on the severity and type of psychosis. In acute excitement or depression with exhaustion it will be necessary to sedate the patient adequately, to correct dehydration by injecting fluids and salts parenterally, and to administer electroconvulsive therapy or intensive drug therapy, whichever is indicated. In milder excitements or depressions sedatives and hospitalization alone may suffice to restore the patient's stability. It is important that the person assigned to look after the patient avoid arguing with or "psychoanalyzing" the patient, no matter what the provocation, since this will upset the patient even more.

Postoperative reactions after extensive surgery are not uncommon and probably occur in persons who have been maintaining a tenuous emotional homeostasis. For example, a considerable number of cases of psychosis have been reported following open heart surgery. Even in less major procedures, a temporary massive outbreak of pathology (brief reactive psychoses) may occur in unstable personalities. One sees this in some patients receiving hemodialysis for chronic kidney failure. The clinical picture in postoperative reactions will vary, syndromes may resemble organic brain upsets (confusion, disorientation, memory loss), acute schizophrenia (delusions, hallucinations), or affective disorders (depression, agitation, mania).

EXCITEMENT, OVERACTIVITY, AND ANTISOCIAL BEHAVIOR

States of excitement and overactivity developing during psychotherapy are signs of acting-out or manifestations of ego shattering.

During acting-out the patient may engage in destructive, antisocial, or unusual sexual behavior. In attempting to understand acting-out, one's first suspicion is that the

patient is protecting the self from awareness of transference by projecting it away from the therapist. Hostile or aggressive outbursts, delinquency, criminality, marked promiscuity, and perverse sexuality are often products of hostile and sexual impulses toward the therapist that the patient is unable to acknowledge. It is natural to react emotionally when a patient becomes antagnostic toward the therapist. Counteraggression, even though verbal, will only stir the patient up more. Recognizing one's own fear of violence, as well as the pot of anger one may be trying to control that always seeks some kind of release is vital. One should try to get the patient to verbalize anger and outrage without being judgmental and without trying to justify untenable conditions against which the patient is rebelling. If the patient's reaction is an aspect of negative transference, this may be interpreted, but the patient should not be made to feel guilty for his or her behavior. If the patient is responding to some outside stimulus, one should ask oneself: "How would I feel if I were in the patient's situation?" Since the other side of violence is fear, one should try to find out what frightens or upsets the patient and try to act empathic, supportive and reassuring. A simple statement such as "I don't blame you for being upset," may do much to quiet the patient. By acting composed, the therapist may be able to calm the patient. If fear is shown, this may engender more fear and violence in the patient.

MANAGING DANGEROUS PATIENTS

When a patient is being treated who makes a substantial threat against an identifiable third person, the therapist should first assess the degree of dangerousness and possibilities of acting-out as indicated by past history and present lack of impulse control. Then if violence is felt to be possible, a course of action to protect potential victims should be evolved. Documenting one's decisions in the case record is important. It may be that hospitalization, medication, and intensified psychotherapeutic interventions will eliminate the possibility of actualizing the threat. Non-medical therapists should seek the help of a psychiatrist where a dangerous situation impends. In some cases, confidentiality will have to violated and the intended victim notified. A considerable literature has accumulated around the California Tarasoff case (Appelbaum, 1985; Beck,

1982; Monahan, 1981; Dix 1981; Stone, 1976) that initiated the ferment about dangerousness in patients.

The best way to resolve acting-out is to explore the patient's feelings and attitudes toward the intended victim, to determine which of these are rooted in realities and which are irrational carryovers from the past, and to see if concealed transference is at the basis of the patient's aggression. As long as the patient is unaware of and cannot verbalize proclivities toward the therapist, the patient will continue to "blow off steam" outside of therapy. Skillful use of the interviewing process that brings out verbalizations related to the transference may put a halt to the patient's destructive patterns.

Sometimes it is difficult or impossible to get the patient to analyze transference and in this way to terminate acting-out. The therapist here may attempt to deal with this obstruction by (1) stimulating transference, through devices already described, in order to make its manifestations so obvious that the patient cannot help but talk about his or her feelings, or (2) controlling acting-out by increasing visits to as many as daily sessions and by the assumption of a prohibitive, authoritative role. If these measures fail to help the situation, therapy will have to be terminated with transfer to another therapist.

Excitement and antisocial behavior that occur as a result of ego shattering may be dealt with after identifying the cause of the present difficulty. A struggling patient may have to be restrained and 5 mg of Haldol injected into the nearest available muscle. Rapid neuroleptization may be essential (Schwarcz, 1982). Supportive techniques are generally indicated, and the patient may have to be put on a regimen of Haldol (2-5 mg), Thorazine (25-100 mg), or Valium (10 mg), repeated at intervals until adequate sedation occurs. If the decline continues, the therapist had best transfer the patient to another therapist, since the therapist is probably unable to control the situation. Where a dangerous psychotic condition develops, the patient's family will have to be apprised of it, for hospitalization will in all likelihood be necessary. Where violent rages or excitement continue, an organic cause such as temporal lobe lesions including epilepsy should be ruled out. It is not usual that a dangerously disturbed or assaultive patient will have to be

handled in one's office, but if this is unavoidable common sense dictates that the therapist should be reasonably protected. This means that where a patient is potentially dangerous to oneself or to others, he or she should be sent to a hospital or place where adequate treatment can be given and protection is available if necessary. In emergency units in general hospitals, sufficient personnel should be available to restrain the patient, (at best four accessory persons are needed, one for each limb should restraint be essential) The attitude of the therapist is a most important factor, an easygoing, calm manner being reassuring for a patient. Since most violence is a consequence of fear, a quiet, secure atmosphere surrounding the consulting room is desirable. Angry threats directed at a disturbed patient merely aggravate the fear and create further violence. More can be accomplished with calming demeanor than with drugs, which, of course, also should be administered where necessary. Once communication is established with the patient and the patient has confidence that he or she will not be hurt, psychotherapy may be possible under the usual office conditions.

INTENSE ANXIETY ATTACKS

Severe anxiety sometimes breaks out in the course of psychotherapy. It may become so overwhelming that the patient feels helpless in its grip. One's coping resources have seemingly come to an end, and one can no longer crush the fear of imminent disintegration. Demands on the therapist then may become insistent, and the patient will bid for protection and comfort.

The handling of intense anxiety reactions will require much fortitude on the part of the therapist. By assuming a calm, reassuring manner, the therapist provides the patient with the best medium in which to achieve stability. Accordingly, the therapist will have to tolerate the emotions of the patient, conveying a feeling of warmth, understanding, and protectiveness while respecting the patient's latent strengths that have been smothered by the turmoil. Upbraiding the patient for exhibiting foolish fears and attempting to argue away anxiety serve to stimulate rather than to reduce tension.

The best means of handling acute anxiety is to permit the patient to verbalize freely

in an empathic atmosphere. Helping the patient to arrive at an understanding of the source of the anxiety, whether it be environmentally oriented or rooted in unconscious conflict, transference, resistance, or the too abrupt removal of existing defenses, promises the quickest possibility of relief. The triad of emotional catharsis, insight, and reassurance operates together to permit of a reconstitution of defenses against anxiety.

Where anxiety is intense, it is usually impossible to work with the patient on an insight level. Here, supportive measures will be necessary to restore the habitual defenses. If the patient is living under intolerable environmental circumstances, a change of environment may be indicated to lessen harsh pressures on him. In the event that anxiety has followed intensive mental probing, a holiday from exploration may be necessary, with a focusing on casual or seemingly inconsequential topics. A patient who has spent many sleepless nights tossing about restlessly or, once asleep, has awakened periodically with frightening dreams may benefit from a benzodiazepine like Valium (5 or 10 mg) orally. In highly disturbed patients 10 mg of Valium intramuscularly or intravenously may be given. The use of sedatives during the day is to be minimized, if possible, to forestall the sedative habit. If anxiety continues, the frequency of sessions may be increased and the patient may be assured that he or she can reach the therapist at any time in the event of a real emergency. Referral to an experienced psychiatrist skilled in the somatic therapies may be necessary.

Excessive anxiety in psychoneurotic patients is best handled psychotherapeutically, increasing the frequency of sessions if necessary. Where this fails to bring relief, several sessions devoted to "narcosuggestion." that is, reassurance and suggestion under intravenous Pentothal or Amytal (see Narcotherapy, Chapter 56), may be tried. Oral Librium (25 mg, 3 to 4 times daily) or Valium (10 mg, 3 to 4 times a day) may restore the individual's composure, following which the drugs are diminished, then discontinued. Where anxiety is out of control and constitutes an emergency, 50 to 100 mg of intravenous Librium, repeated in 4 to 6 hours if necessary and followed by oral Librium, may be helpful. Some patients respond better to barbiturates than to tranquilizers. In acute anxiety pentobarbital (Nembutal) ¾ to 1½ gr, or secobarbital (Seconal) ¾ to 1½ gr may

dissipate symptoms in about 30 minutes. Some patients prefer to take ¼ to ½ gr of phenobarbital sodium every 3 or 4 hours. Barbiturate administration is to be halted as soon as possible because of the danger of habituation.

In borderline or psychotic patients it is wise to institute drug treatments immediately. Haldol, Thorazine, or Mellaril in adequate dosage (see Table 56-3) may bring anxiety to a halt.

These measures will rarely fail to control severe anxiety in borderline or psychoneurotic patients. In the rare case where they fail, and especially where a transference neurosis is present and cannot be resolved, the patient may have to be referred to another therapist or a short period of hospitalization may be required.

PANIC STATES

The treatment of panic states is more difficult than the management of anxiety. Here the patient is victimized by a wild, unreasoning fear that plunges one into disorganized thinking and behavior or drives one to the point of immobilization. Suicide is always a grave possibility. Admission to an emergency unit in a hospital may be essential, the therapist giving the admission doctor pertinent information about the patient.

Where a patient in panic is seen for the first time, the therapist will be somewhat in a dilemma. The initial step in the management of a panic state with a strange patient is attempting to promote calm by quiet, empathic listening in a quiet atmosphere. Thereafter prescribed a tricyclic antidepressant or MAO inhibitor may be all that the therapist may want to do at the moment. Reassuring the belligerent individual that one is belligerent because one is frightened may have a dramatic effect. Often lit-tie more will be needed than to display interested attention and to express sympathy at appropriate times. Sorting out the problem in this way will give the therapist clues about appropriate therapeutic steps to take, whether medication or hospitalization necessary (emergency units unfortunately do not usually have a secluded place where quiet interviewing can take place). Where the patient is out of contact with reality, is suicidal, or is aggressively

excited, however, he or she will require rapid sedation or tranquilization and probably hospitalization.

Diagnosis is important. The patient may be psychotic as a result of a functional ailment like schizophrenia. Or the patient may be manifesting a toxic psychosis as a result of taking too many drugs or because of a physical ailment. Giving the patient more medication in the latter instances will merely compound the injury. Information about the patient from relatives or friends is highly desirable, even indispensable, in ruling out drug intoxication or physical ailments, such as cardiovascular illness, diabetes, etc., that may be responsible for delirium.

If drug intoxication is ruled out, drug therapy is the treatment of choice for schizophrenic or manic excitements. Rapid tranquilization is indicated to reduce social consequences of morbidity. Not everybody agrees with this, however. In young schizophrenics who are having a first attack there are some who believe that they should be allowed spontaneously in a protected environment to reach a baseline. Thus, Mosher and Feinsilver (1973) state, "We believe that the inner voyage of the schizophrenic person, which is induced by environmental crisis, has great potential for natural healing and growth, and we therefore do not attempt to abort, rechannel, or quell it before it has run a natural course." Whether one heeds this advice or not will depend on the existing social support systems on which the patient will depend. A congenial hospital regimen with empathic nurses and attendants is helpful. On the other hand, and particularly in older patients or those who have had a previous minimum absence from work and their families, it may be vital to avoid prolonged disability and unemployment which can operate as stress factors after the schizophrenic episode is over.

Restoration to a non-psychotic state is possible within a few hours employing powerful neuroleptic drugs that act on the limbic system and influence the psychotic thinking process. The drug often chosen is haloperidol (Haldol) given intramuscularly. The first dose is 5 mg, then 2-5 mg every 30 minutes until the patient is sedated; the blood pressure should be monitored to avoid hypotension. The objective is to get the maximum

therapeutic impact with a minimum of side effects (dystonia, akithesia, and other Parkinsonian symptoms). If the patient falls asleep after the first 5 mg injection, he or she is probably suffering from a toxic psychosis like drug intoxication (e.g., alcoholism), and Haldol is stopped.

Some therapists still prefer chlorpromazine (Thorazine) which is given intramuscularly in 25 to 75 mg dosage according to the size of the patient and degree of disturbance. If the systolic blood pressure standing is below 95, the Thorazine is discontinued; the patient's head is lowered and the feet elevated. If the blood pressure is maintained satisfactorily, the drug is given every hour until control of the excitement is achieved. The dosage is either increased or decreased depending on how the patient responded to the previous dose. The intramuscular medication is discontinued should the patient fall asleep or quiet down sufficiently. The choice of being subsequently seen on an outpatient basis or immediately hospitalized will depend upon whether the patient is dangerous to oneself or others, the attitude of the family, hospital resources in the community, and the patient's cooperativeness.

What dosage of drug orally for ensuing 24-hour periods will be required can be estimated by multiplying the intramuscular dosage of Thorazine that it has taken to tranquilize the patient by 2⅔ (Ketal, 1975). With Haldol one may give the same dose orally as was given intramuscularly. If the patient is too sedated, this can be reduced. Patients should be seen daily or every other day to make sure that they do not slip back.

Drowsiness and hypotension with Haldol are less than with Thorazine. Extra-pyramidal side effects are more common, however. Where such side effects occur with Haldol or other antipsychotic drugs, 1 to 2 mg of Cogentin by mouth (or intravenously if emergent) or 50 mg of Benadryl by mouth or intravenously may be given. Continuance of the drug for several days is indicated. Reassurance of the patient and the family are important. To avert the pyramidal symptoms, some therapists give Cogentin prophylactically, but others do not recommend this.

Where intramuscular injection is not possible or urgent, oral medications are used.

Here 10 to 20 mg of Haldol may be given in liquid concentrate form for the first day; if no response, this is raised to 40 mg the second day and 60 mg the third day until an effect is achieved. Or Thorazine in liquid concentrate form of 50 to 150 mg dose may be given and regulated according to response.

Intravenous sodium Amytal (up to 15 gr) will put the patient into narcosis. If panic continues following this, the patient may require hospitalization on a closed ward. Electroconvulsive treatments will also often interrupt the excitement. As many as 2 ECTs daily may be needed for a few days, followed by one treatment daily, until equilibrium is established. Where delirium and confusion appear in elderly patients or those with respiratory and cardiovascular disorders, Thorazine may be given for restlessness and paraldehyde or chloral hydrate for insomnia. Should epileptic seizures develop and continue (status epilepticus), intravenous sodium Amytal, phenobarbital sodium parenteral, or diphenyl hydantoin (Dilantin) may be administered.

In hospital settings "sleep therapy" is occasionally instituted, especially in psychotic patients, where panic cannot be arrested through other means (Azima, 1958). Here sleep, which lasts 20 to 24 hours a day, is induced by giving the patient a combination of 100 mg (1.5 gr) Seconal, 100 mg Nembutal, 100 mg sodium Amytal, and 50 mg of Thorazine. The patient is aroused three times daily, and the dosage of medication is regulated according to the degree of wakefulness. Good nursing care is urgent; indeed, without it sleep therapy is hazardous. During the waking period the pulse rate, blood pressure, temperature, and respiration are recorded; the patient is gotten out of bed, washed, and fed. Daily 2000 cc of fluid and at least 1500 calories in food are supplied, while vitamins are administered parenterally. A half-hour prior to meals 5 units of insulin are injected to stimulate the appetite. Milk of magnesia is supplied every other day if necessary, and a colonic irrigation is given should a bowel movement not occur in 2 days. Catherization is performed if the patient does not urinate for 12 hours. The bed position of the patient must be changed every 2 hours, and should the patient's breathing become shallow, oxygen and carbon dioxide are administered. Sometimes ECT is instituted with sleep therapy, either daily during the first waking period or three times weekly. In this way a deep regression is

induced. The average treatment duration is 15 to 20 days. Rehabilitative therapy must follow the sleep-treatment episode.

In manic reactions, after the acute psychotic disturbance is brought under control, lithium therapy may be started. Where panic has occurred as a result of battle conditions or civil catastrophes, a withdrawal from the stressful situation for a few days may be necessary. This should not be prolonged to avoid chronicity in cases where the patient will have to function in an unstable atmosphere.

Once the panic state has subsided psychotherapy is essential to forestall further attacks.

TOXIC DRUG PSYCHOSES

Mixed drug intoxications are common and may constitute important emergencies. It is difficult, if not impossible, to determine what substances the patient has imbibed since even he or she may not know their true nature, purchased as they have been from dubious sources. Knowledge of the local drug scene may be of some help, at least in screening out certain possibilities. The kinds of drugs utilized vary in different parts of the country. They include amphetamine, barbiturates, meprobamate, alcohol, phencyclidine, THC, nonbarbiturate hypnotics (like Doriden, Quaalude), marijuana, morning glory seeds, nutmeg, LSD, mescaline, codeine, DMT, STP, MDA, psylocybin, and a variety of mescaline and amphetamine combination compounds.

In many cases adequate therapy can be administered only in a hospital, which unfortunately may not provide the quiet, relaxed atmosphere that excited patients need. Gastric lavage is limited to instances where the drug was recently taken. After a number of hours it is relatively useless. Hemodialysis is valuable for certain drugs and not for others. In all cases maintenance of an airway, of respiration, and of the cardiovascular apparatus is fundamental.

If the nature of the drug that has been taken is known, for example, from the blood

or urine analysis, it may be possible to prescribe certain antagonistic medicinal agents. Thus, if amphetamine is the culprit, Thorazine or other neuroleptic or antipsychotic drugs can be given. If the patient has taken STP or LSD, antidotes may block some sympathomimetic effects without influencing the hallucinogenic aspects. As yet there is no totally effective antagonist for these hallucinogens. Indeed, Thorazine is contraindicated in STP toxicity because of the hypotensive and convulsive potentiating effect, which can be dangerous. Mildly excited patients may respond to a mild tranquilizer like Valium given parenterally.

Global nystagmus is a frequent symptom in drug psychosis and may serve as a valuable diagnostic indicator. Disorientation, confusion, and hallucinations are common, of course. Because, in the average toxic patient, the kinds of drugs that the patient has been taking are difficult to diagnose, it is best to err on the side of caution in administering antipsychotic drugs. Some of the effects of the substances the individual has been taking, like THC (the pure extract of marijuana), may be reinforced by antipsychotics. After reassuring the patient that recovery will soon occur, he or she may be given 10 to 20 mg of Valium intramuscularly. If there is no improvement in the patient after a few hours and no anticholinergic symptoms, such as a lowering of blood pressure and rapid pulse, a major antipsychotic, such as 5 mg of Haldol or 4 mg of Navane or Trilafon, may be given. These drugs have a marked antipsychotic effect without too great sedation. Where an opiate drug is suspected, an airway is introduced, the heart monitored, fluids introduced intravenously with 50 cc of 50 percent dextrose, 2 mg of naloxone (Narcan) and 100 mg thiamine.

Handling the "Bad Trip"

Individuals experimenting with hallucinogenic drugs, including marijuana and amphetamines, may occasionally experience a frightening journey away from reality and need emergency intervention. In the street vernacular such an experience is referred to as a "bad trip." Hallucinations may be vivid, and there may be an inability to communicate. Such reactions may be inspired by an overdose of drug or may be the consequence of

something frightening that the patient perceives or imagines in the environment or even may occur with small dosage in schizophrenic patients. The atmosphere in which the "bad tripper" is treated is important. It should be as quiet as possible. Sending the person to an emergency hospital unit may induce more panic. The therapist or person managing the patient should be reassuring and gentle and never question the patient about the experience, for this may tend to stir the patient up. One should be asked to concentrate one's attention on something in reality, like an object in the room, in order to shift the focus from one's inner life. Rarely are physical restraints or drugs necessary, except when the patient becomes violent. Valium (10 mg intramuscularly, repeated if necessary) is helpful in the latter instance.

The treatment of severe amphetamine psychosis is similar to that of schizophrenic psychosis, namely, prescribing Thorazine or Haldol intramuscularly. In the case of LSD, psylocybin, or marijuana intake with a psychotic-like response, the therapist should stay with the patient while reassuring that the reactions are temporary and will pass in a few hours. Valium (5-10 mg) or Librium (25-50 mg), or a short-acting barbiturate, may be helpful. Where not successful and panic increases, Thorazine intramuscularly may be utilized with all of the precautions outlined under the section on Panic States. Great caution must rule the use of phenothiazines because of the danger of lowering the blood pressure too much, especially where phencyclidine (PCP) has been ingested. In the event of overdose of sleeping medications containing scopalamine, Thorazine should be avoided. Valium may be utilized as may physostigmine (2-4 mg).

The most frightening consequence of a toxic drug absorption is a status epilepticus, a constant series of seizures without the patient regaining consciousness in between. Here one must establish an adequate airway, particularly being sure that the patient's tongue does not block respiration. Diazepam (Valium) 5 to 10 mg intravenously followed by 200-400 mg of phenobarbital intravenously, or reinjecting Valium alone every 10 to 15 minutes for up to one hour (maximum of 40 mg per hour for adults). Phenobarbital (100-200 mg intramuscularly) is also commonly utilized after a single seizure to prevent status epilepticus. It may be given intravenously (200-400) very slowly. A respirator should be

available in the event respiration stops. Phenobarbital may thereafter be given intramuscularly (100-200 mg) every 2 to 6 hours up to 1 g of the drug in 24 hours. The next day the patient may be started on Dilantin (200 mg intramuscularly).

Acute Alcoholic Intoxication

Pathological intoxication sometimes presents itself as a psychiatric emergency. The reactions range from stupor or coma to excited, destructive, combative, homicidal, or suicidal behavior. Comatose states are best treated in a hospital where a neurological study may be made to rule out other causes of unconsciousness, such as apoplexy, brain concussion, status epilepticus, cerebral embolism or tumor, subdural hematoma, toxic delirium, uremic or diabetic coma, and carbon-monoxide or morphine poisoning. Where alcoholic intoxication exists, a hospital with a 24-hour laboratory service permits of the testing of blood sugar and carbon-dioxide levels required for the administration of insulin and dextrose. Nursing care is important. The patient must be turned from side to side regularly and the head lowered to prevent aspiration pneumonia. The pulse, respiration, and blood pressure are recorded every half hour. Oxygen is given by tent or nasal catheter where respiration is depressed. Intravenous sodium chloride should be injected in amounts of 250 cc every 3 or 4 hours.

Where the patient is conscious and gag reflexes are present, a gastric lavage may be provided, external heat applied, and strong coffee administered by mouth or rectum. Intramuscular caffeine and sodium benzoate (0.5-1.0 g) may be dispensed every hour until the patient is alert. Intravenous dextrose solution (100 cc of 50 percent dextrose) may be introduced and repeated, if necessary, every hour, and 10 to 20 units of insulin may be provided, repeated in 12 hours. Thiamine hydrochloride (100 mg) intravenously is also a useful medicament.

Excited reactions, including acute alcoholic intoxication, alcoholic hallucinosis, and delirium tremens are treated by intramuscular injection of Haldol (5 mg), or Navane or Trilafon (4 mg), or Thorazine (25-50 mg) repeated if necessary. Many psychiatrists use Librium intramuscularly or intravenously (50-100 mg) or Valium (10-20 mg) repeated, if

necessary, in 2 to 4 hours, for alcoholic agitation and impending or active delirium tremens or hallucinosis. Dextrose (100 cc of a 25 percent solution), thiamine hydrochloride (100 mg), and 20 units of insulin are given routinely. Morphine and rapid acting hypnotics (Nembutal, Seconal) are contraindicated; however, sodium Amytal (0.5-1.0 g) is sometimes administered intravenously (1 cc per minute) to quiet a violently disturbed patient. Ample fluids should be given intravenously to combat acidosis and dehydration (approximately 3000 cc daily, containing magnesium and potassium minerals). Other drugs include thiamine hydrochloride (20-50 mg), intramuscularly, and nicotinamide (niacinamide, 100 mg), intravenously, substituted in several days by oral thiamine hydrochloride; vitamin C (100 mg), caffeine and sodium benzoate (0.5 g every 4 to 6 hours for 4 to 6 doses) for stimulation, saline laxatives to promote proper elimination, and Compazine (10 mg intramuscularly) for uncontrollable nausea and vomiting. Milk and eggnog may be offered the patient; if not tolerated, 10 percent dextrose and sodium chloride solution intravenously may be required. The need to protect the patient from convulsions is urgent in delirium tremens and here anticonvulsant therapy (e.g., diphenylhydantoin) may be necessary.

Acute Barbiturate Poisoning

The popularity of barbiturates as sedatives has resulted in a relatively large incidence of barbiturate poisoning. Patients who have developed a sedative habit may accidentally take an overdose of barbiturates, or the drugs may be purposefully incorporated with suicidal intent. Sometimes the patient, having swallowed a lethal dose, will telephone the therapist informing of his or her act. At other times relatives or friends will chance on the patient before respiratory paralysis has set in.

The usual therapy consists of immediate hospitalization, if possible, and the institution of the following measures:

1. Establishing an airway, such as with an endotracheal tube with suction of secretions.

2. Administration of oxygen, or artificial respiration if necessary, using a

mechanical resuscitator.

3. Early gastric lavage carefully administered.

4. Fluids given parenterally (5 percent glucose); in extreme hypotension, plasma injected intravenously.

5. Stimulants—vasopressors like Neosynephrine (2-3 mg) if blood pressure is low or L-norepinephrine (4 mg/L of 5 percent glucose solution).

6. Turning the patient hourly with head slightly lower than feet. (Trendelenburg position)

7. Catherization of the bladder if necessary.

8. Prophylactic antibiotics.

9. Hemodialysis with an artificial kidney, if available, or peritoneal dialysis.

10. Digitalis for heart failure.

11. Avoidance of analeptics.

Clemmesen (1963) has described the treatment of poisoning from barbiturates in Denmark, where the incidence of attempted suicide has always been relatively high. A special intoxication center helps control the clinical condition day and night. The pulse, respiration, temperature, blood pressure, and hemoglobin are monitored every 2 or 4 hours; each day the barbiturate acid content of the blood is determined, as is plasma chloride and bicarbonate, blood urea, and serum protein. The gastric contents are *not* aspirated unless the drug was taken within the past 4 or 5 hours, and the pharyngeal and laryngeal reflexes are present. Gastric lavage is avoided. The Trendelenburg position is maintained during the first few days to prevent aspiration of gastric contents. Patients are moved to a different position in bed every 2 hours. There is intensive slapping of the chest and suction of secretion from the air passages. Procaine penicillin (2 million units x 2) are injected each day as a prophylactic against infections. Fluids of 2-3 L are given parenterally. Shock, if present, is managed by blood transfusion and perhaps by drugs such as norepinephrine. Complications, such as pulmonary edema, pneumonia, and

atalectasis are treated. Stimulation with analeptics is avoided. In the absence of pronounced hypotension, pulmonary edema, and reduced renal function, after the clinical condition is under control, osmotic diuresis and alkalinization by infusions of urea and electrolyte solutions reduce the duration of coma two to four times. Of 92 patients with severe barbiturate poisoning, 85 recovered with this treatment approach.

Poisoning from overdose of nonbarbiturates or tranquilizers like the benzodiazepines, may be managed in essentially the same way, although these drugs are somewhat safer than barbiturates. Amphetamine and pressor amines are contraindicated, although norepinephrine may be given. Should inordinate restlessness or tonic and clonic convulsions follow excessive phenothiazine intake, careful administration of sodium Amytal may be helpful, recognizing the potentiation possibility. Cogentin or Artane may also be valuable.

SEVERE PSYCHOSOMATIC SYMPTOMS

There are a number of psychosomatic symptoms for which the patient initially seeks treatment, or that develop suddenly in therapy, that may be regarded as emergencies. Most of these are hysterical conversion or dissociative reactions, such as blindness, seizures, fugues, vomiting, aphonia, amnesia, paralysis, astasia-abasia, violent contractures, and anorexia nervosa. The patient may be so disabled by the symptom that he or she will be unable to cooperate with any attempted psychotherapeutic endeavor. Immediate removal of the symptom may thus be indicated. Such removal need not block the later use of more ambitious therapeutic measures. In the course of symptom removal, efforts may be made to show the patient that the symptoms are rooted in deeper personality problems, the correction of which will necessitate exploration of conflictual sources.

Hypnosis is an ideal adjunctive technique to expedite the emergency relief of hysterical symptoms. Once symptom removal has been decided upon, it is necessary to determine whether to attempt the removal at one session or whether to extend therapy over a period of several weeks. The severity of the symptom, its duration, the nature of the

patient's personality, and the aptitude for hypnosis have to be considered. The approach is an individual one, and suggestions must be so framed that they will conform with the patient's personality, the type of symptom, and its symbolic significance. It is essential to adapt one's language to the patient's intelligence and education. Many failures in symptom removal are due to the fact that what the hypnotist is trying to convey is not clearly understood by the patient.

If hypnotic removal of the symptom at one session is decided upon, sufficient time must be set aside to devote oneself exclusively to the problem. As many as 2 to 3 hours may be necessary. A new patient may be encouraged to discuss past history and symptoms in order for the therapist to determine the patient's reaction to the illness as well as to gain clues to the patient's attitudes, motivations, and personality structure. Accenting of the patient's protestations of how uncomfortable he or she is, the therapist may emphasize that there is no reason why, if the patient has the motivation, the symptom cannot be overcome.

An optimistic attitude is important because many patients are terrified by their illness and have convinced themselves of the impossibility of cure. However, a cure should not be promised. The patient may be told that hypnosis has helped other people recover and that it can help him or her, too, if one will allow oneself to be helped.

The patient may be informed that it is necessary to test individual responses to suggestion; there is no need to concentrate too hard on what is said because, even though attention wanders, suggestions will get to the subconscious mind and produce desired reactions. An urge to rid oneself of suffering stimulates the desire to relax and follow suggestions. No indication is given the patient at this time that the symptom will be removed in its entirety, since the symptom may have hidden values and resistance may occur if the patient suspects that its immediate loss is at hand.

Hypnosis is then induced, and confidence in the ability to follow suggestions is built up by conducting the patient through light, medium, and, finally, if possible, deep trance states. Where the patient has a symptom that consists of loss of a physical function, it may

be expedient to suggest that the therapist does not want the patient now to use the part. This is done in order to associate malfunction with the hypnotist's command instead of with a personal paralysis.

The next step in treatment is to get the patient, if so desired, to discuss under hypnosis reactions to the illness and what is happening in the immediate life situation.

In some patients active participation is encouraged. A reasonable explanation is given for the suggestions that will be made. The patient may even be encouraged to veto suggestions should there be any suspicion that they are against one's best interests or if there is no real desire to follow them. Active participation is encouraged in patients with relatively good ego strength who shy away from too authoritarian an approach.

Symptom removal by suggestion is far more effective where it is demonstrated to the patient that one has not lost control over one's functions, and hence is not the helpless victim of symptoms that cannot be altered or removed. This is achieved by showing the patient, while in a trance, that it is possible to create on command such symptoms as paralysis, spasticity, and anesthesia. Once the patient responds to these suggestions the important influence that the mind had over the body is stressed. Then a symptom identical with the patient's chief complaint is suggested in some other part of the body. Should the patient respond successfully, a partial removal of the symptom in the original site is attempted. For example, where there is a paralyzed arm, the suggestion is made that the fingers will move ever so little. Then paralysis of the other arm, which has been artificially produced, is increased in intensity, while a strong suggestion is made that the patient will find that function is restored to the ailing part. In the case of a paralyzed arm it is suggested that the hand will move, then the arm, and, finally, that the paralysis will disappear altogether.

The fact that symptoms can be produced and removed so readily on suggestion may influence the patient to accept the fact that one is not powerless and that one can exercise control over the body.

In order to protect the patient, should the symptom have a defensive function, some residual symptom that is less disabling than the original complaint can be suggested. It is hoped that the residual symptom will take over the defensive function. For instance, in the case of a paralyzed arm, paralysis of the little finger may be induced, and a suggestion may be given the patient that the finger paralysis will have the same meaning as the arm paralysis and that the finger paralysis will remain until the patient understands fully the reasons for the original paralysis and no longer needs the paralysis. In the event of an extensive anesthesia, numbness of a limited area may be suggested as a substitute.

Posthypnotic suggestions are next given the patient to the effect that the restored functions will continue in the waking state, except for the induced residual symptom. An activity may then be suggested that brings into use the ailing part; the patient finally being awakened in the midst of this action.

These suggestions are repeated at subsequent visits, and, if desired, the patient is taught the technique of self-hypnosis so that suggestive influences may continue through one's own efforts.

Although removal of the patient's symptom at one sitting may be possible and desirable in certain acute disabling hysterial conditions, it is usually best to extend therapy over a longer period. Suggestions are carried out very much better where the patient is convinced that one has been hypnotized and that hypnosis can have a potent influence on one's functions. It may, therefore, be advisable to delay giving therapeutic suggestions until the patient achieves as deep a trance as possible and gains confidence in the ability to experience the phenomena suggested. The employment of therapeutic suggestions at a time when the patient lacks confidence in his or her ability to comply, and where faith in the therapist is not sufficient may end in failure and add discouragement and anxiety to the patient's other troubles.

A deep trance seems to increase therapeutic effectiveness in most patients. Where only a light trance is possible, the patient may not be able to get to a point where he or she becomes assured of the capacity to control the symptom.

All suggestions must be as specific as possible and should be repeated several times. The therapist should build, as completely as possible, a word picture of what the patient is supposed to feel or to do.

The lighter the trance, the less emphatic should the suggestions be. In extremely superficial hypnotic states the patient may be instructed that there is no need to concentrate too closely on the suggestions of the therapist, but rather to fixate attention on a restful train of thought. This technique is based on the idea that the patient's resistances can be circumvented. A logical explanation may be presented of why suggestions will work, along such lines as that the mind is capable of absorbing and utilizing suggestions even though some resistance is present.

If the patient is in a medium or deep trance, suggestions should be framed as simply as possible. The patient, especially when in deep hypnosis, should repeat the suggestions to be followed. Otherwise the therapist will not know whether the commands have been understood. Somnambules, may be instructed to carry out instructions even though they do not remember that these were formulated by the therapist. It is also a good idea in somnambulistic patients to give them a posthypnotic suggestion to the effect that they will be unresponsive to hypnotic induction by any person except the therapist. This will prevent the patient from being victimized by an amateur hypnotist who may very well undo therapeutic benefits.

If facts important in the understanding of the patient's condition are uncovered in hypnosis, these may or may not be brought to the patient's attention, depending upon their significance and upon the ability of the patient to tolerate their implications. It is best to make interpretations as superficial as possible, utilizing knowledge one has gained in working with the patient to guide him or her into activities of a creative nature that do not stir up too much conflict.

Termination of hypnosis by having the patient sleep for a few minutes before interruption is advantageous. The patient is instructed to continue to sleep for a designated number of minutes, following which he or she may awaken. The period of

sleep may range from 2 to 15 minutes. Where the patient is able to dream on suggestion, this period may profitably be utilized to induce dreams either of a spontaneous sort or of a nature relevant to the particular trends elicited during the trance.

There is no set rule as to how much time to devote to hypnosis during each session. Except for the initial induction period, the trance need not exceed one-half hour. Ample time should be allowed to take up with the patient problems both before and after hypnosis. Reaction to the trance may also be discussed. Prejudice against symptom removal continues in force. On the whole, it is unjustified. Needless to say, more extensive psychotherapeutic measures will be necessary to insure lasting relief.

INTERCURRENT INCURABLE SOMATIC ILLNESS

The incidence of an intercurrent incurable physical illness constitutes an emergency in some patients. Development of certain conditions, such as multiple sclerosis, brain tumor, Hodgkin's disease, cancer, cerebral hemorrhage or thrombosis, or a coronary attack, will make it necessary for the therapist to take stock of the reality situation and perhaps to revise therapeutic goals. Essential also is a dealing with the emotional impact of the intercurrent illness on the individual. Insight therapy may have to be halted, and supportive approaches implemented.

Where the person is suffering from a nonfatal illness and where there is a possibility of a residual disability, as in coronary disease, apoplexy, tuberculosis, and various neurologic disorders, an effort must be made to get the patient to accept the illness. A desensitization technique may be utilized, encouraging the patient to discuss the illness and to ventilate fears concerning it. The need to recognize that this illness does not make one different from others, that all people have problems, some of which are more serious than one's own, that it is not disgraceful to be sick, may be repeatedly emphasized.

Persuasive talks may be given the patient to the effect that the most important thing in the achievement of health is to admit and to accept the limitations imposed on one by one's illness. This need not cause the patient to retire in defeat. One will still be able to

gain sufficient recognition and success if one operates within the framework of the handicap. It is most important for self-respect that one continue to utilize remaining capacities and aptitudes, expanding them in a realistic and reasonable way. Many people suffering from a physical handicap have been able to compensate for a disability in one area by becoming proficient in another.

In patients who tend to regard their disability as justifying a completely passive attitude toward life, an effort must be made to stimulate activity and productiveness. The dangers of passivity and dependency, in terms of what these do to self-respect, are stressed. The person is encouraged to become as self-assertive and independent as the handicap will allow.

Where it is important for the patient to relax and to give up competitive efforts, persuasive or cognitive therapy may be combined with a reassuring, guidance approach aimed at externalizing interests along lines that will be engaging, but not too stimulating. The cultivation of a different philosophy toward life, directed at enjoying leisure and looking with disdain on fierce ambitious striving, will often help the patient to accept this new role.

Tension may be alleviated by Librium, and Valium; nausea, by Compazine; severe pain in dying patients, by regular administration of narcotics such as heroin. Intractable and unbearable pain that does not respond to the usual analgesics and to hypnosis may require psychosurgery (lobotomy). The practice of permitting a terminal patient to die with dignity (passive euthanasia) without being burdened with useless and desperate artificial means and heroic measures is becoming more and more accepted (Fletcher MI, 1974; Jaretzki, 1975). Interesting also is the publication called *A Living Will* (Euthanasia Education Council, 1974). Antidepressant drugs are often valuable for reducing pain as well as depression.

In progressive, incurable, and fatal ailments there may be a temptation to stop therapy on the basis that nothing more can be done for the patient. Actually, the patient may need the therapist more than before the ailment had developed. Where the patient

has no knowledge of the seriousness of the condition, as, for instance, inoperable cancer, the decision of whether or not to reveal fully the calamity is a grave one that will influence the degree of suffering in the remaining days of one's life. In many cases it is unwise to burden one with the full seriousness of the condition. Statements may be made to the effect that a condition exists that the physician has classified as one that will get worse before it gets better. There is an obligation, of course, not to withhold facts from the patient, but honesty can be tempered with optimistic uncertainty. Many persons cling to a straw extended to them by an authority and maintain a positive attitude to the end. This is especially important in an illness such as AIDS where the degree of suffering may be influenced by the hopeful outlook that a cure may eventually be discovered through research.

In other patients it is sometimes practical to inform them, particularly if they already more than suspect it, that they have a progressive ailment. They may be assured that everything will be done to reduce pain and suffering and to keep up their good health as much as possible. Persuasive suggestions to face the remaining months with calmness and courage may be very reassuring. The patient may be told that while one's life span is limited, one may extend and enjoy it by the proper mental attitude. A guidance approach helps reduce the disturbing effect of environmental factors and permits the patient to divert interests toward outlets of a distracting nature. Where the patient is so disposed, he or she may be encouraged to cultivate religious interests in which one may find much solace.

The patient's time may be so arranged so as not to sit in utter desolation waiting for death. One may also be taught the technique of self-hypnosis to induce relaxation, diminish tension, reduce pain, and promote a better mental outlook. Mendell (1965) states that patients respond to his statement: "You are not alone. The struggle is not over. You don't have to worry that what can be done is not being done. 1 am with you and aware of what you are undergoing. I am with the forces that are to help you, and if anything develops, I will bring it to you immediately." An attitude should be inculcated in the patient that one has fulfilled one's task well and that it is now time to let oneself relax.

Such an attitude may permit of the peaceful, even happy, acceptance of the end of life. Actually, few dying patients do not appreciate the imminence of death, even though their psychological defenses tend to deny it. The therapist may keep emphasizing that the patient, through courage, is doing much for his or her family. What the patient needs is someone to understand and to help mobilize existing resources, to listen closely with respect and not pity, to display a compassionate matter-of-factness, and above all to help him overcome the fear of isolation. The greatest problem in working with the dying patient is the therapist's own feeling of helplessness, guilt, and fear of death.

The work of Cicely Saunders, Director of St. Christopher's Hospice (Liegner, 1975) is evidence that for dying patients a great deal can be done toward making their last days comfortable, painless, and free from anxiety. Administration of medications ("polypharmacy") to render the patient symptom-free has been routine at St. Christopher's. Diamorphine (heroin) every 4 hours orally, Thorazine and its derivatives, and other medications that are indicated for special conditions, such as dexamethasone for brain metastases and increased intracranial pressure, may be given during the day and night. The physical atmosphere should be clean, cheerful, and comfortable. The members of the staff must be supportive and participate in working through the stress of separation anxiety. Discussion about incurability and dying are not avoided, and the fact is accented "that death is a continuum of life and is not to be feared." Under these conditions the patients may respond to the passing of another patient with little dread or fear.

If the patient who knows that he or she is dying can be shown that the acceptance of death is a positive achievement rather than resignation to nothingness, much will have been accomplished in making the remaining days more tolerable. Understanding the patient's anxiety, guilt feelings, and depression through empathic listening may be extremely reassuring. Helping members of the patient's family to deal with their hostility and despair may also be an essential part of the therapist's task. Cautioning them on the futile search for expensive and nonexistent cures may, incidentally, be in order. At all times the focus is on relieving the patient's physical pain and distress, on making one comfortable in one's home, and on assuaging mental turmoil. If this is done, peace will

usually follow. A good relationship with the patient's family during the last days will help them to an acceptance of the reality of death and lessen the pain of bereavement.

Where death has occurred, the therapist may be called on to render help to the bereaved. Different members of the family will respond with their distinctive reactions to the incident. The detached and presumably adjusted member may actually need more support than the one who is ostensibly upset and manifestly grief stricken. Since members are bound to respond to the emotional tone of those around them, the manner and mode of communication of the therapist will influence the healing process. Cooperativeness, understanding, sympathetic listening, and an expressed desire to help can inspire friendship and trust in the therapist. As Beachy (1967) has pointed out, it is unwise to whitewash the facts of suffering and death or to try to evade the evolving emotional reactions, however unreasonable they may seem. A completely open, factual manner that is not falsely oversolicitous is best, and where needed, the continued care and attention of a clergyman or other supportive person may be advisable. The value of therapy with groups of terminally ill patients makes this modality one that should be considered in selected cases (Yalom & Greaves, 1977).

Readings on this subject may be found in Aldrich (1963), Cassem (1974), Christ (1961), G.W. Davidson (1975), Eissler (1955), Feifel (1959), J. Fletcher (1972), GAP Symposium (1965), Gerson & Bassuk (1980), Kennedy (1960), Krupp & Kligfeld (1961), Kubler-Ross (1969), Langer (1957), Makadon et al. (1984), Morgenthau (1961), Pack (1961), Reeves (1973), P.S. Rhoads (1965), Rund & Hutzler (1983), Saul (1959), A. Schwartz (1961), Standard & Nathan (J955), Tagge et al. (1974), Wahl (1960), A.F.C. Wallace (1956), Weisman (1985), Worcester (1935), Worden (1982), and Zilboorg (1943).

A common denominator in all mental illness is stress, which is a trigger that can set off many deleterious physical and psychological reactions. It is a potent precipitant of emotional disorders and therefore of vital concern to the psychotherapist.

In the course of daily living a certain amount of stress is unavoidable. To an extent this is constructive since it "oils up" the physiological mechanisms essential to adaptation, much as a machine requires periodic use to prevent the constituent parts from drying up and rusting. People often seek ways of stressing themselves temporarily with some pleasurable excitement like competitive sports and games, or exposing themselves to mildly frightening experiences like horror movies or murder mysteries. This not only helps keep the various body organs and systems in tune, but also enables the fight-or-flight mechanisms of the organism to hold themselves in preparation for some more-than-normal stressful emergency.

What we are concerned with in mental health practice are not these adaptive responses to everyday stress, but the effects on the individual of stressful events to which a proper adaptation cannot be made. Specifically we want to know what to do for the patient who is being victimized by abnormal and incapacitating stress reactions, and more importantly, how to modulate or remove the stressful stimuli that are causing the problems.

PHYSIOLOGICAL CONSEQUENCES OF STRESS

It is estimated that stress reactions are a major factor in the etiology of physical illness like heart disease, stomach ulcers, and even cancer to name a few. Knowledge of the involved physiology may be helpful in understanding how this comes about. Simply put, what stress does, as Selye (1956) has shown, is to activate a massive conditioned non-

specific reaction to prepare for appropriate coping with an actual or anticipated threat. The psychological component of this response is part of our animal heritage having evolved over millions of years as a survival mechanism in the face of danger. Once a situation is *perceived* and *evaluated by* the brain as dangerous, several subcortical centers come into play. Two systems are primarily involved that ordinary operate to regulate the normal functions of the body. Both depend on complex chemical compounds (hormones) in the hypothalamus. One of these hormones, cortisol, is so essential to life that its concentration in the blood must be steadily maintained within narrow limits. Cortisol is vital in preparing the body physically to overcome a threatening stress stimulus. What cortisol does is break down aminoacids from muscle and connective tissue into glucose to supply the body with energy. In addition, it regulates cell metabolism, stabilizes plasma membranes, elevates the mood, and has an antiinflamatory effect. This over a short-term period is helpful in dealing with stress. But if excessive cortisol manufacture continues over an extensive period, which is the case in prolonged and continued stress or chronic intermittent stress, cortisol starts doing damage. It breaks down too much muscle tissue, produces clotting failure, weakens bone structure encouraging fractures, depresses the body's immune reactions causing susceptibility to infection, and sometimes produces bizarre behavior. In recent years it has been discovered that another brain hormone liberated by the same adrenal steroid feedback mechanism responsible for cortisol is beta-endorphin, which has a pain-killing morphine-like action, but that in too great concentration, that is when stress is prolonged, may also have an unwholesome effect.

Additionally important to body function is the second system, the sympathetic nervous system and the catecholamine hormones epinephrine and norepinephrine released by the adrenal medulla. In short-term stress this system is activated to increase cardiac output, help respiration by dilating the bronchioles, distribute blood from the inside of the body to muscles and the heart, lessen fatigue, increase alertness and facilitate energy supplies by liberating glucose from muscles and liver and releasing fatty acids from fat deposits. This is all to the good in dealing with temporary stress, but if this action goes on over an extended period, physiological damage can occur in the form of hypertension, gastric ulcers, cardiac arrhythmia, and other organ malfunctions. Increased

plasma cholesterol and elevated low density lipoprotein may predispose to atherosclerosis and coronary insufficiency.

SOURCES OF STRESS

Sources of stress are legion and it would be an insuperable task to list all of them since they vary with each individual. On an environmental level we need merely to catalogue the kinds of problems social agencies deal with to realize that endless troubles stressfully plague human beings apart from cataclysms of climate, war, accidents, and catastrophic physical illness, which after all are not too common in the lives of most people. Noteworthy for the majority are tensions caused by difficult interpersonal relationships with families, spouses, authorities and peers, bereavements, material or fancied threats to the safety, security, and life of the individual such as violent assaults, rape, serious accidents and illnesses, blows to self-esteem, undermining of autonomy and identity, anger that is blocked in expression, and the inability to fulfill important personality needs which may in susceptible persons become stress sources. The origins of many of these difficulties are rooted in past conditionings. Incomplete separation-individuation, devaluated self-esteem, accumulating hostilities, guilt feelings, and personality drives that interfere with harmonious interactions are a few of the surviving anachronisms and traits that generate troubles.

Belief systems sometimes contribute anomalous sources of stress even though the individual recognizes their irrational source. Authentic cases of death may follow the breaking of a taboo or the spells cast on a victim by shaman, voodooist witch doctor or medicine man. Among civilized people, a deep conviction of hopelessness, with expectation of death may bring on irrecoverable illness with loss of appetite and a wasting away, with a calm acceptance of one's inevitable doom. Years ago Walter Cannon wrote about how supernatural fear can bring about a fatal outcome, and he pointed out the fact that some surgeons refused to do a major operation on a patient who was terrorized by the conviction that he or she would not survive.

There are additionally a plethora of aversive events and factors in daily life that can

have a cumulative stressful effect. The individual may to some extent be aware of the damage these mischief-mongers cause and may force himself or herself to tolerate them, either on the basis that the problems are insoluble and there is no escape, or because one feels destined to endure them. More often there is no awareness of the damage they cause and years may go by before the victim realizes that something is wrong and can no longer go on physically or emotionally.

A good deal of literature has been published on selective areas of stress a most interesting contribution having been made by Holmes and Rahe (1967) who developed a Social Rehabilitation Rating Scale designating areas of stressful changes in one's life situation in hierarchical order, assigning to them "life change units" from 100 to 11. At the top of the list, the first three items are the death of a spouse, divorce, and marital separation. These are followed by a large number of other damaging incidents, with somewhat lesser scores. The authors found that a total of 200 or more life change units in a year was matched by an increased incidence of myocardial disease, infections, peptic ulcer, and assorted psychiatric disorders.

Bereavement as a stress source commonly occurs with the death or permanent departure of a person with whom there has been a close relationship (parent, spouse, child, lover). It may develop with removal from one's home, neighborhood, or work situation as in relocation and retirement. The reaction of grief may appear immediately after the critical separation incident, or manifest itself following weeks or months. The classic investigation of Erich Lindemann (1944) revealed five main reactions: (1) somatic symptoms (physical distress, shortness of breath, muscular weakness, tension, subjective discomfort); (2) preoccupation with the image of the lost object; (3) guilt (self-accusations for the situation); (4) hostile reactions (anger at being abandoned; irritability at people in general); (5) behavioral alterations (restlessness, forcing oneself feverishly into activities; enhancement of dependency, feelings of unreality, imitation of attitudes and behavior of a deceased through identification). Reaction formations such as forced cheerfulness or stoicism may mask some of these symptoms.

Grief that follows a lost home precipitates similar reactions to those resulting from the death or permanent departure of a valued person (Fried, 1963). Clearance of urban slum areas, the devastation caused by tornadoes and floods, invasion, and the massive destruction of war has resulted in forced relocation and massive bereavement and personal suffering. The sense of loss of intimacy with one's surroundings, disruption of customary social networks, absence of familiar groups of people, results in a sense of disorientation, the fragmentation of identity, and a grieving for the lost familiar neighborhood.

Retirement, without adequate preparation or training for post-retirement activities and hobbies can impose stressful burdens on a person whose sense of importance, worth, and self-esteem has been contingent on gainful employment. Lacking methods of restoring feelings of being needed the individual may respond with despair, depression, and a longing for return to the previous status. The sense of grief and bereavement parallel those that follow the loss of an important love object.

Why bereavement and separation have such intense effects on people has engaged the attention of many observers. It is the belief of some that these are tangentially related to the fear of death that exists on some level in all people. No satisfactory formula has ever been evolved to neutralize this death fear in spite of such expediencies as belief in immortality, reincarnation, soul survival, and the like. There are those who contend that fear of dying cannot be avoided since it is a biological and evolutionary phenomenon residing within the structure of man. There are others who believe that such fear is not biological, but rather bound to the peculiarities of human development. At its core is the infant's primitive reaction to object loss precipitated by separation from the mother. No matter how secure the individual may seem, the terror of abandonment-separation-death slumbers ominously in the unconscious and symbolically fastens itself to later separation experiences and to any bereavement contingency that threatens personal physical and emotional security. Obviously the more wholesome the rearing of the child, and the more stable the personality structure, the better the coping tactics in dealing with separation. But even in well adjusted individuals the repressed death obsession may awaken with

severe deprivations and life-threatening crises. In unstable persons, fears of annihilation can appear explosively with minor separations and insignificant losses which are interpreted as threats to one's integrity.

Terminal cancer patients and those experiencing severe myocardial disease may be realistically confronted with the imminence of death; such patients often barricade themselves from the terror of dying by denial mechanisms, a conspiracy entered into by visiting persons who, dealing with their own anxieties of mortality, try to flourish a false facade of hope. Slips of speech and disturbing dreams only too pointedly indicate the patient's distrust of such denial maneuvers.

We cannot dismiss the fact that constitutional factors sometimes enter into the generation of stress through hypersensitive biochemical and neurophysiological systems that fire off excessively with even minor stimuli. Nor can we neglect cultural elements that endow certain events with a portentous meaning. *The meaning the individual imparts to any stimulus, external or internal, will determine its stressful potential.* The most insidious sources of stress issue from unconscious conflicts, the individual attempting to rationalize inner turmoil by attributing it to outside sources. Indeed, disturbing stressful situations may deliberately be created to provide objectivity for one's inner feelings.

REACTIONS TO STRESS

Research on stress has shown, sometimes to the exasperation of the experimentor, that the severity of the stresses bear little relationship to the intensity of the resultant physiological and behavioral disruption, even in the same experimental subject at different times. A number of intervening variables appear to be operative, some of which are confoundingly elusive. What is of primary importance is the cognitive set that imparts special meaning to the stressor. The reaction of any individual to stress is regulated by the sense of one's own vulnerability and the perception of one's capacity to cope with, adjust to, or overcome the source of trouble. Mastery of a stress situation in the past akin to the present one, is a positive factor, while failure is a negative element in determining stress tolerance. Most individuals will react to a life-endangering situation with fear or panic. But

a suicidally inclined soul, intent on self-destruction, or a religious martyr, who expects rewards in heaven, may actually promote a life-terminating event. Highly motivated, well doctrined soldiers exposed to skilled prebattle morale building will enter stressful combat with fierce enthusiasm. Soldiers who do not know what they are fighting for are deplorably handicapped during combat.

Are there any personality measures that can tell us how an individual will react to stress? Coping adequacy is related to flexibility of defenses, one predictive measure being the stability of the individual in the face of previous life crises. Andreasen et al. (1972) studied hospitalized burn patients, and found that patients with adjustment difficulties prior to the burn and those with premorbid psychopathology coped poorly with their injury. In an interesting piece of research on physiological and psychological responses to stress, Katz et al. (1970) have shown that "the ego's defenses are obviously able to buffer the individual from threat with great efficiency" and, even to block expected biochemical reactions. So far no reliable test has been found that can measure defenses and that can predict what an individual will do under certain stressful circumstances. Responses are highly specific. In this author's practice, both amateur and seasoned actors on screen, stage, and TV have been seen whose stage fright prior to the opening night performance approached shock reactions, yet with the arrival of doomsday, before a live audience, performed brilliantly with scarcely a whisper of anxiety. On the other hand, the author has seen composed, self-confident individuals including some veterans, decorated for bravery in battle, fall apart when asked unpreparedly to make a speech before a group. No prior psychological test could have predicted these transformations.

Cultural attitudes often determine reaction patterns. For instance, tolerance of pain and the ability to disregard it stoically may be considered virtuous in some societies, contrasting with the complaining, demanding, groaning, angry responses found in other cultural groups. As Zborowski (1977) has stated, stress in part is "a cultural experience in perception as well as in interpretation, and as such is responded to by behavior and attitudes learned within the culture in which the individual is brought up." Such philosophical defenses as a penchant to accept adversity as inevitable, the endorsing of a

fatalistic attitude that man is destined to suffer pain and discomfort, and confidence in faith and prayer as ultimate means of gaining protection through the divine order can greatly subdue reactions to stressful stimuli. Accordingly, stress is subject to the psychological embellishments of the responder who draws on inherent physiological and psychological sensitivities. In individuals with a tendency to depression, stress often functions as an important precipitant. Controlled studies have shown that stressful life events precede the outbreak of major depressions in predisposed individuals. Other syndromes than depression may be precipitated by stress, and it is a challenging hypothesis that predispositions to a specific response may exist in such persons. Brown and Birley (1968) found that 60 percent of patients suffering from a schizophrenic episode had experienced strong stressful situations some weeks prior to the onset of the illness. Only 19 percent of the control group were similarly affected. Past conditionings also provide a fertile paradigm for behavioral patterns. Thus an individual victimized as a child by the abandonment or death of a parent may respond to mild separations in adult life intensely, even catastrophically.

Where physiological responses to stress continue over a period of time, we may expect complications of physical illness and organ damage (Rahe & Arthur, 1977). What inspires the choice of organ afflicted is still hard to say. On the surface we would assume that the weakest link in the physiological chain would break down under the stressful pounding. This then would be a matter of hereditary weakness of an organ system, or previous damage to the organ wrought by a past illness or pathological assault. Because chronic stress affects immunological reactivity and predisposes to autoimmune reactions, some authorities believe that nonspecific damage can occur, postulating as one example rheumatoid arthritis. However, here too a genetic predisposition cannot be ruled out.

Many authorities believe that variant personality typologies generate different degrees of stress and show different modes of coping with adversity. While most authorities downplay the thesis of Alexander (1950) that the organ disrupted by stress is determined by the basic character structure, there may be some tendency in certain dependent, "orally" disposed individuals whose dependent need is frustrated, to

oversecrete digestive juices as if they seek to incorporate food, which from infantile associations is equated with love. Continued gastric hyperacidity may thus result in peptic ulcer. Special personality constellations are believed to activate selected organ systems. A hard driven, time-hungry, competitive, restless personality, type A personality described by Friedman and Rosenman (1959, 1974), is said to be predisposed to coronary disease. There seems to be some experimental evidence for this. Van Egeren and his coworkers (1983) found that social stresses, like competitive rivalry and goal frustration affected the ventricular myocardium differently in type A than the less driven, calmer type B persons. Computer analysis of the electrocardiograms revealed in type A persons a statistically significant depression of the ST segment and a reduction of T wave and R wave amplitude. There are additional studies that show that type A individuals in comparison with type B individuals have more frequent arrhythmias, and increased sympathetic adrenergic responses (rises in blood pressure, accelerated heart rate, and mobilization of epinephrine and norepinephrine) to stress which provide added evidence for greater liability to cardiac illness in type A individuals.

Attempts have been made to correlate other personality typologies with diabetes, ulcerative colitis, cancer, asthma, migraine, and arthritis. One example is the study of a large group of patients with chronic insomnia in different parts of the country (Kales et al, 1983). A consistent pattern was the handling of stress and conflicts, especially about aggression, by internalizing rather than expressing emotions, which apparently promoted physiological disturbances during sleep.

Important to differentiate in evaluating this complex data are physical manifestations of conversion reactions that fulfill defensive psychological needs and are products of the voluntary sensorimotor system. Here the physical symptom (e.g., paralysis, anesthesia, etc.) constitutes a symbolic communication coached in body language. We are inevitably led to the conclusions that organ choice is multifactorial and must be individually evaluated.

Physiological reactions to stress that result in organ damage are obviously inimical

to adequate coping. Psychological defenses similarly may be maladaptive. The adequacy of the coping method depends on a number of factors, principally whether the defense employed succeeds in halting the deleterious effect of the stress response on the physiological level, and whether, on a psychological level, it compromises the present or future adjustment of the individual. A stressed executive earning a large salary and enjoying tenure in an organization can achieve temporary peace of mind by resigning his or her position, but in the long run may be cutting one's own throat and become even more severely stressed while waiting for the meager unemployment check in line with other job hopefuls. Studies indicate that adequate methods of coping include humor, anticipation, rationalization, and philosophizing (Ford 1975; Vaillant, 1971).

MANAGEMENT OF STRESS

There is enough research evidence[8] to make plausible the following facts about stress: (1) the impact of a stressful event, physical or social-psychological is modulated by the expectations, perception, and the unique meaning given the stressor by the subject; (2) the reaction of any individual to stress is regulated by a sense of one's own vulnerability, and the perception of the capacity to cope with, adjust to, or overcome the source of the trouble. (3) Mastery in the past of a stress situation akin to the present one, is a positive, failure a negative factor in determining stress tolerance; (4) graded exposure to a stressful situation, with mastery of some aspects, tend to desensitize the subject to the effects of the stressor; (5) stressful reactions following failure to cope with a threat, or missing the mark on an assigned task, encourage deterioration of responses at later trials; (6) verbalization about one's feelings, and the presence of people who the individual trusts, increases tolerance of stress, reducing psychological and psychosomatic symptomatology. These research findings, paralleling what common sense would tell us, form the basis around which the management of stress can be organized.

The first step in management is to identify the operative stressors. If they are purely environmental, a counseling approach may do more good than depth-oriented psychotherapy. In most cases, however, it is rare that external stressors are not reinforced

by the motivational connivance of the patient who may even have initiated the troubles and then subversively sustains them. Here attempts to deal with the stressors by counseling and millieu therapy will be blocked by the emotional needs of the patient. Should this happen, the therapist will have to institute an approach focused on rectifying the personality operations of the patient.

Initiation of an effective treatment program will depend on the condition of the patient when first seen. A four-part "stress response syndrome" (Horowitz, 1976) is commonly experienced by persons exposed to an acute traumatic event such as bereavement, surgery, a serious accident, a catastrophic blow to security or self-es-teem, or anything that is interpreted as an irretrievable loss. The first phase is characterized by an initial shock reaction with a dulling of perception and feelings of unreality. Second, there is an attempt at denial in order to push out painful emotions related to the incident. The person may act and talk as if nothing has happened, or there may be a minimization of the incident. Following this, a third phase occurs with gradual intrusive feeding into consciousness of the true significance of the event and an experiencing of previously blocked emotions like pain and deprivation. This may alternate with bouts of emotional withdrawal when anxiety is too strong. Fourth, the change in life status that the traumatic event makes inevitable is accepted. This working-through cognitive processing phase may go on for years. It may never be completed being interrupted by images and phantasies of the lost object or previous stabilizing life situation. Patients react uniquely to each phase in accordance with their personality needs and neurotic defenses.

During the first phase of the reaction, therapy is best focussed on terminating, if possible, any identifiable stressful stimuli. This may necessitate removing the patient physically from the stress source provided such rescue will not complicate matters. Where it is essential to live with and adapt to a stressful environment, the person will need to desensitize to its effects and develop ways of modifying or eliminating its most hurtful elements. A relationship with an empathic, knowledgeable person here is most important and the degree of directiveness, support and empathic reassurance must be titrated against the existing confusion, helplessness, and disorganization. In severe reactions,

psychotherapy may be necessary. Hypnosis and the *temporary* administration of an anxiolytic medication may be helpful. The objective is to bring the patient back to a realistic appraisal of the situation. If possible, one should avoid anxiolytics especially in addictive personalities. Should they have to be prescribed, their use must be terminated as rapidly as possible so that the patient does not become dependent on them.

By the time the patient presents for help to a psychotherapist he or she will undoubtedly have made some attempts at self-regulation and environmental manipulation through control, attack, or escape measures. These will show up in manifestations of denial, detachment, displacement, projection, and rationalization. Such defenses are implemented with the aim of dealing with, neutralizing or removing the perceived threat. An insidious escape measure is the use of mind-altering drugs (sedatives, tranquilizers, alcohol, marijuana, cocaine), which will complicate therapy. As soon as some stabilization occurs and the relationship with the therapist is sufficiently firm, resort to substance use or abuse will need to be terminated and this may require aggressive handling. Other untoward defenses are acting out manifestations, outbursts of anger and violence, masochistic activities, unusual sexual practices, withdrawal, and restless agitation. Complications may have ensued as a result of these responses, which, though disturbing and requiring handling, should not sidetrack the therapist's pursuit of mediating the initiating stress.

If the patient is in the denial phase of the stress reaction, during which an attempt is being made by the patient to blot out the presence of the threat by acting as if it did not exist or by minimizing it as through humor or joking, the therapist will have to alter the approach. Without withholding support and reassurance, denial is countered by continued careful confrontations interpreting the purpose behind the patient's disputative maneuvers. In acute stress reactions denial may be so severe as to practically paralyze the person. Phobias and conversion symptoms may be pressed into service to avoid reminders of the stressful situation. Amnesia, fugue states, delirious attacks, tremors, paralysis, sensory disturbances and paralyzing phobias may develop and constitute the immediate reason why the patient comes to treatment. Repression is never complete and

periodically the repressed stressful experience or conflict will feed back into consciousness stimulating bouts of anxiety. So long as denial exists, this back and forth movement will continue. It is essential here to dose the patient with increments of the disavowed or repressed material through confrontation and interpretation of existing fantasies, dreams, and behavioral distortions. Where denial is extreme, hypnosis and narcosynthesis may be of some help in breaking through the resistance, but will require administration by a professional skilled in their use.

The next phase of therapy may well be the most difficult one since it requires a working through of the insights gained in treatment and putting these into corrective practice. During this phase there will be periods of anxiety and depression as the patient reexperiences the trauma, as well as repressive renunciatory interludes.

Therapy is usually performed under a handicap because of continued stubborn distrust of one's environment and of authority in general. This promotes detachment, easily aroused anger, and reluctance to engage in psychiatric or psychological treatment. Where therapy is attempted, the transference may become so ambivalent as to interfere with treatment.

Enjoining the patient to verbalize feelings, the temporary use of medication, and perhaps exposure to hypnosis may open the way to establishing a relationship with the therapist who is then in a better position to institute counseling, cognitive therapy, or dynamically oriented psychotherapy. Should transference still interfere with treatment, group therapy may be tried which, because transference is split and more diffused, may be better tolerated than individual treatment in these highly stressed individuals.

While less dramatic than acute gross stress reactions, but no less devastating in their effects are *chronic stresses of an intermittent nature.* Stress here is due either to an environment from which the individual cannot or will not escape and to which one responds adversely, or to disturbed relationships with significant others like parents, siblings, spouse, children, employer, etc. Usually personality problems are basic and are subsidized by intrapsychic conflicts which sponsor such defenses as projection, fantasy,

dissociation and obsessive rumination that interfere with adequate coping.

A prime goal in dealing with chronic intermittent stress is evolving defenses aimed at a more constructive adaptation and, if possible, the elimination of the sources of tension. Of vital importance is the shoring up of morale, which has usually become vitiated because of the long period of suffering. Regular relaxing exercises, meditation, or self-hypnosis can help a person avoid resorting to tranquilizers, hypnotics, alcohol and smoking.

Attitudes can influence one's physiological and psychological responses. For example, in physical illness an optimistic outlook, the will to live, faith in one's physician, commitment to achievement and conviction of recovery help stimulate the immunological system, speed healing in surgery, shorten physical illness, and, according to some recent research, even inhibit the growth of cancer cells. On the other hand, abandoning hope, giving up one's claim on life, a belief that one is doomed, apathy, and the unwillingness to fight puts a damper on recovery, heightens tension, and hastens death. Norman Cousins (1976) has written an excellent article on the value of a positive outlook. In all cases of stress some form of cognitive therapy is usually called for, which adds an important dimension to the other interventions being employed. In working with such terminal ailments as AIDS this boosting of morale is especially important.

Attitude change through cognitive therapy may also be helpful in prolonged and obdurate *bereavement reactions* aiding in the resolution of grief. The grief work seems to be essential in liberating the individual from the bondage of the cherished object, preparing for a different outlook, and the development of new relationships. What interferes most with a working through of the separation crisis is denial of one's true feelings in the attempt to insulate oneself from painful stress. It may require a good deal of effort on the part of any helping person to gain the individual's confidence, counter the hostility, and break through the wall of detachment that prevents the victim from enduring the pain essential in coming to grips with the loss.

The development of a relationship with some trusted person or counselor is almost

mandatory to help the individual acknowledge and accept feelings and to begin to move toward other relationships. Discussions of misgivings, guilt feelings, idealizations, and memories encourage emotional catharsis. In most cases improvement will come about within a period of about 6 weeks. Where there is denial of one's feelings of guilt and pain, the somatic symptoms, restlessness, insomnia, and nightmares may go on for a prolonged period. A kind of paranoidal distrust often prevents the individual from getting close to people and it will require a good deal of tactful persuasion to promote resumption of close social contacts. The most extreme reaction to bereavement is precipitation of a deep depression with suicidal ideas or actual attempts to kill oneself. One usually encounters a history of previous depressive incidents in such extreme reactions. Antidepressive medications and, where suicide is a possibility, ECT may be required.

A question often asked is how much social support should be rendered in dealing with the effects of stress? In most cases where the stressful situation overwhelms the coping capacities of the victim, social support bolsters up the reserve of the individual. However, it should be withdrawn as soon as possible lest it reinforce helplessness and dependency. In chronic stress especially one should avoid operating as a good genie taking over responsibilities that should be handled by the patient. Indeed there is evidence, as shown by work with cancer patients that supportive activities for patients not undergoing chemotherapy or radiation treatments may "increase negative mood and decrease self-perceptions of worth, mastery, acceptance of the patient role, and acceptance of death." (Revenson et al, 1983). The very rendering of social supports in some persons acts as a stress source (Dunkel-Schetter & Wortman, 1982; Brickman et al, 1982).

Another question relates to the value of prevention. There is a good deal of evidence that anticipating impending stress may be helpful in dealing with it when it comes. For instance according to a study at the Harvard Medical School retirement is a risk factor in coronary heart disease (Gonzales, 1980). Job-related dissatisfactions are also a risk factor that may lead to a decision to leave one's work as the lesser of two evils. Cultivating proper attitudes toward retirement may prove to be a saving grace. A conception of

retirement as a worthy reward for years of dedicated work helps overcome the stressful conviction that it is a punishment for growing old. Where the individual faces an inevitable loss, behavioral practice sessions with role playing and encouraging the person to verbalize feelings may serve a valuable purpose. On the basis of the theory that people can adapt to any stress if they acquire adequate coping facilities, training in stress management may be a priority item in those in high-risk situations (Meichenbaum et al, 1975; Ford, 1975; Vaillant, 1971). Despite unsubstantiated claims of psychological cures rendered by exercises like running and calisthenics, there is evidence that regular exercise and other measures to improve physical fitness help individuals cope better with a high proportion of life changes like divorce, death of a loved one, and switching jobs (Science News, Vol. 130, August 2, 1986).

If an impending stressful event is anticipated such as subjection to major surgery, the expected death of a spouse or family member suffering from an incurable illness, fearful reactions to forced retirement, etc., there is no substitute for counseling sessions with a respected person who is able to supply realistic information in advance and reassuringly to handle the individual's anxieties and concerns. High morale is an important factor in stress coping, and it is best obtained by proper prior preparation or realistic indoctrination. Excessive fears or denial of concern are both conducive to poor coping. Studies show that "A moderate amount of anticipatory fear about realistic threats is necessary for the development of effective inner defenses for coping with subsequent danger and deprivation." (Janis, 1977). During counseling or psychotherapy, contingencies are assessed, resources and supports assayed, and appropriate options and adaptations reviewed.

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Psychotherapy in Special Conditions

The principles of psychotherapy that have been outlined and the technical procedures that have been delineated apply to all emotional problems and conditions irrespective of clinical diagnosis. It may be possible, with the proper working relationship and the adroit use of appropriate techniques, to approach the goal of some personality reconstruction in any syndrome. Experience, however, has shown that certain conditions make extensive therapeutic objectives difficult to achieve. Experience also indicates that they seem to respond favorably to specific techniques or combinations of methods. In this chapter we shall consider the problems and technical modifications encountered in the treatment of neurotic, psychophysiological, personality, and psychotic disorders.

ANXIETY DISORDERS (ANXIETY NEUROSIS, PHOBIC NEUROSIS, ANXIETY STATES)

Some anxiety is a universal human experience considered by existentialists as basic to the nature of existence. It is common to all physical and emotional ailments in which the problems are conceived of as a threat. Anxiety usually generates a host of defenses marshalled to neutralize its effects. Some defenses, however, contribute to greater maladaptation than the anxiety experience itself, for example, recourse to avoidance behavior, inhibitions of function, or overindulgence in drugs and alcohol; When anxiety becomes excessive, it is regarded as a pathological syndrome to which several labels are applied, such as panic disorder, agoraphobia, generalized anxiety disorder, social phobia, simple phobia, obsessive-compulsive disorder, and posttraumatic stress disorder. Except for the anxiety, the specific features of these syndromes are fashioned by the unique personality and cognitive styles of the patient, by family dynamics, and by variable features in the environment. Although anxiety as a symptom is found in many disorders such as depression, schizophrenia, and organic brain disease, the panic, phobic, obsessive-compulsive, and generalized anxiety disorders constitute a distinctive and discrete assembly of entities (Lesser & Rubin, 1986) that are probably biologically based and affect

only approximately 8 percent of the population.

Panic Disorder Without Agoraphobia (DSM-III-R Code 300.01) Panic Disorder With Agoraphobia (DSM-III-R Code 300.21)

The identifying feature of this disorder is that intensive anxiety and catastrophic feelings of impending doom are apt to erupt unexpectedly or in relation to situations that realistically should not be threatening. Faintness, trembling, dizziness, heart palpitations, sweating, depersonalization, chest pain, and paresthesias overwhelm the individual and cause him or her to seek safety at home or in a doctor's office. If the condition repeats itself under the same conditions, phobic defenses may be organized, leading to anticipation of the attacks and further discomfort. The patient may resort to alcohol and barbiturates. Panic disorder must be differentiated from symptoms of certain physical conditions such as hypoglycemia, hyperthyroidism, and pheachromocytoma and from panicky attacks in patients with depression, schizophrenia, somatization disorder, and organic brain disorder. There is some evidence that early separation anxiety is a precursor to the condition and that a genetic predisposition may exist.

In treating the condition it should be kept in mind that appeals to reason have little effect and that insight will be deluged and rendered worthless by the flood of anxiety that overwhelms the individual. The best therapeutic focus is on the biochemical and conditioning links in the behavioral chain. When panic attacks have diminished or disappeared, cognitive therapy may be valuable, and if unconscious conflictual elements are suspected, psychoanalytically oriented psychotherapy may be attempted.

Drug therapy with antidepressants (see Table 56-1) gives us a choice of three classes of medication: tricyclics, MAO inhibitors, and a benzodiazepine antidepressant, alprazolam. Each has its advantages and disadvantages. Tricyclics, such as imipramine (Tofranil), are the most common medications used, but they may require as long as 8 weeks before a substantial response occurs. Moreover, anticholinergic side effects, such as dry mouth, blurred vision, and rapid heart beat, may upset some patients. Tofranil is started with 10 to 25 mg daily to reduce the patient's fear of side effects. Gradually, over a

2-to-4-week period, the dose is raised to 100 to 200 mg/day. If in 8 to 12 weeks the response is poor, the dose may be increased to 300 mg. Should tachycardia and heart palpitations frighten the patient, a beta blocker such as propranolol (Inderal) may be tried. A MAO inhibitor such as phenelzine (Nardil) requires restrictions of diet and avoidance of certain medicaments that some patients find inconvenient. The beginning dose is 15 mg/day, increased by 15 mg every 3 to 4 days until 60 mg are taken daily. The medication should be given in the morning and at noon to avoid possible insomnia. If after 8 to 12 weeks the effect is not impressive, the dose may be raised to 75 to 100 mg. If a side effect of muscle twitching occurs, 150 to 300 mg of vitamin B_6 should be given. One should never go from a regime of tricyclic therapy (which was not effective) to MAO inhibitors without stopping medication for 2 weeks. Alprazolam (Xanax) works within 1 to 2 weeks but may produce some drowsiness, and, taken over a long period, it can be addictive. It is started with 0.25 or 0.5 mg two or three times daily, increased every 3 days by one pill to 4 mg/day. A combination of Xanax 1-3 mg/day and propanolol (Inderal) 40-160 mg/day has resulted in an almost total relief of both panic attacks and anticipatory anxiety (Sheki & Patterson, 1984). Patients, especially those on tricyclics and MAO inhibitors, should be informed that medications require weeks to take effect. The results will depend on consistency in taking the medications.

Some patients absolutely refuse to take these medications. For these patients, relaxation therapy, systematic desensitization and then in vivo desensitization should be employed. In any case the latter therapies are almost indispensable even when drug therapy has controlled the panic. Moreover, if other links in the behavior chain are pathologically implicated, therapies bracketed to these links may productively be employed (see table 57-1). Thus group, couple, and family therapy are valuable if serious interpersonal problems exist; milieu therapy to resolve environmental difficulties; cognitive therapy for rectification of faulty attitudes, self-statements, and belief systems; and dynamically oriented, psychotherapy for personality difficulties of long standing that act as sources of continuing anxiety. In most cases psychotherapy will be needed, with a focus on interpersonal problems, such as marital conflict.

Generalized Anxiety Disorder (DSM-III-R Code 300.02)

Symptoms of a generalized anxiety reaction include restlessness, jitteriness, sighing, fidgetiness, sweating, heart pounding, sensations of tingling in the extremities, gastrointestinal symptoms, urinary frequency, a lump in the throat, flushing, great apprehensiveness, anticipation of catastrophes, fear of losing control, death fears, edginess, irritability, fatigue, and insomnia. The anticipatory expectations relate to unrealistic events or those in which possibilities are not sufficient to justify the patient's massive emotional response. In this way the anticipated happenings may be distinguished from a fear reaction that is stimulated by realistic threatening circumstances. Fears of death, disease, violence, sexual perversions, and so on are often at the basis of undifferentiated excessive anxiety, which may readily be activated by minimal unfortunate or threatening outside events, for instance, sickness in the family, the discovery on physical examination of a minor organic ailment, or an unfortunate environmental happening. The rapid heartbeat, rise in blood pressure, chest pains, and distress in breathing may convince the victim that he or she is suffering from cardiac illness, initiating persistent visits to practitioners and specialists who may diagnose the condition as "psychosomatic," the functional nature of which the patient usually fails to believe.

Most patients with generalized anxiety are so upset by their symptoms that relief from suffering constitutes their only motivation. Because they feel helpless and frightened, they are apt to demand an authoritative, directive relationship in which they are protected and through which they seek to obtain immediate symptomatic relief. To abide by these demands, the therapist may decide to employ emergency measures, which prove temporarily successful in abating anxiety. Some measures will help bring the individual to a point where the anxiety is reduced and spontaneous reparative forces come into play (see Supportive Therapy, Chapter 9). Such supportive treatment may be all that is needed to eliminate suffering, especially if the basic ego structure is reasonably sound and has broken down under the impact of severe external stress. Palliative measures may alleviate anxiety in these cases even if the problems are internally inspired. Should supportive

tactics prove to be successful, most patients will lose their incentive for further help and be content to function in their symptom-free state, even though it may be impermanent. If treatment is unsuccessful, they may lose confidence in the therapist and go elsewhere in search of relief.

It is important, therefore, to persuade the patient to accept more than supportive therapy. This may prove to be a greater task than the therapist has bargained for. Because repression is a chief defense against sources of anxiety, the patient may be unwilling to challenge habitual coping mechanisms, even though they are inadequate in dealing with the difficulty.

Treatment of pathological anxiety reactions must be adapted to their intensity, the needs and motivations of the patient, and the readiness to accept help. We now have a battery of medications that are successful in dealing with anxiety on a symptomatic level. It is always best to see if one can abate anxiety through psychosocial measures before resorting to medications, because, unless the sources of the anxiety are handled with the object of modifying or removing them, the patient will be tempted to use pills as a way of life. This is particularly important when employing the benzodiazepine drugs, which, though relatively safe and less addictive than barbiturates, are still subject to abuse. Alternatively, we may focus on vulnerable links in the behavioral chain (see Table 57-1) and use interventions that have proven helpful in dealing with these links. For example, we may in interviewing a woman with anxiety recognize that many of the patient's problems are organized around ambivalence toward a spouse. To subdue the patient with drugs, acting as if the marital situation can be bypassed, will not help the patient come to grips with the source of her trouble. Marital therapy would not preclude our dealing with any other pathogenic links in the behavior chain with suitable coordinate interventions. If she was so demoralized by anxiety that she could not use psychosocial treatments effectively, we could add anxiolytics to our therapeutic interventions.

Among the most suitable anxiolytics for achieving symptomatic stabilization in from 1 to 6 weeks are alprazolam (Xanax), 0.75 to 4.0 mg/day, diazepam (Valium), 4.0-40

mg/day, lorazepam (Ativan), 2-6 mg/day, oxazepam (Serax), 30-180 mg/day, and clorazepate (Tranxene), 15-60 mg/day. Elderly patients require a reduced dose. The actual dose is titrated to the patient's response, starting with the smallest dose and working up. We can expect some relief in from 1 to 2 weeks, with optimal effect after 6 weeks.

A new anxiolytic that undoubtedly will receive extensive testing is buspirone (BuSpar). This medication has been found to be as effective as the above drugs and to produce less drowsiness and sedation (Cohn & Wilcox, 1986).

Phobic Disorders (Phobic Neurosis, Anxiety Hysteria)

As a defense designed to control anxiety, the phobic reaction constitutes one of the most common syndromes that the psychotherapist must handle in everyday practice. When we consider the structure of a phobia, we must recognize that a maze of primary and auxiliary phenomena embrace this defense. First, the phobia, apart from the simple conditioned fear reaction, is generally a facade that conceals an underlying, earlier causative factor. Second, it is a manifestation that protects the individual from constant and intense anxiety. Third, a phobia gradually changes in its dimensions by generalizing to stimuli that are more and more remote from the initiating phobic excitant. Fourth, as the phobia spreads and circumscribes the individual's activities, the person feels increasingly undermined, self-confidence is progressively shattered, self-image is more and more devalued, and the individual may become depressed and even phobophobic. Loss of mastery revives regressive defenses and needs, including childish dependency promptings, which, if gratified, further contribute to feelings of helplessness.

Agoraphobia (DSM-III-R Code 300.22)

The most common and paralyzing phobia is agoraphobia, which usually manifests as a fear of being alone or of being adrift and helpless in public places such as shopping centers, transportation vehicles, tunnels, bridges, and elevators. In many cases the phobic reaction follows one or more experiences of severe panic while away from home. Safety is

sought within the confines of one's home, and the individual becomes housebound, venturing out only in the company of a spouse, parent, or other member of the family. There is both great dependency on and hostility toward the protective agent whose own neurotic needs to control may be gratified by the patient's helplessness. In this way a mutual neurosis is nurtured and kept alive amid hypocritical protests on both sides. Therapy for agoraphobia is directed principally at the panic against which the agoraphobia is the defense. In vivo desensitization and other adjuncts, such as the antidepressants described above for panic disorders, are also indicated. If the marital or family relationship is symbiotic, marital and family therapy are indispensable. Experience teaches that unless the family member most intimately involved with the patient is also in therapy, he or she will experience disrupted homeostasis and try to undermine the patient's treatment.

Social Phobia (DSM-III Code 300.23)

Here the individual is fearful of exposing himself or herself to the scrutiny, judgment, and possible condemnation of others. Such people justify avoiding situations where their "nervousness," shyness, weakness, inferiority, or ineptitude will be detected. In the extreme form, patients apply judgmental criteria to themselves and develop a fear of manifesting any failings even when they are alone. A common fear of such individuals is of shaking, spilling food, belching, or showing other peculiarities in behavior while eating with one or more people. Stage fright is a frequent form of social phobia found in countless numbers of people, including experienced performers. Erythrophobia, or fear of blushing, and insistence that people can detect expressions on one's face that will be misinterpreted as a sign of "craziness," nymphomania, or homosexual interest are peculiarly resistant to reasoning even when colored movies display the patient in close-ups with normal facial expressions under varied circumstances. The patient may seem to be close to a paranoidal condition here but lack other symptoms that would justify this diagnosis. Secondary depression sometimes accompanies social phobia, stimulated by the patient's conviction of helplessness in being able to do anything about his or her reaction.

Therapy for social phobia is organized around behavior therapy, particularly desensitization, with repeated exposure to the phobic situation. Too early attempts at in vivo desensitization or flooding are not recommended since the patient may panic and thus reinforce the phobia. Assertiveness training, relaxation therapy, hypnosis, and systematic desensitization using imagery can prepare the individual for exposure to the phobic stimulus that he or she dreads. Cognitive therapy may help deal with attitudinal distortions. Group therapy and psychodrama can also be of great value in giving the individual opportunities for performance desensitization and reality testing. The benzodiazepines (e.g., Valium, Atavan) may sometimes be employed as a preliminary form of treatment. They subdue anxiety, but there is always the danger that they will become a primary shield and lead to habituation. Of value for stage fright is 40 mg of propranolol (Inderal) taken shortly before performance. It helps control the shaking, rapid heart beat, and palpitations but does not dull the mind or interfere with muscular coordination, frequent consequences of tranquilization with anxiolytics. Psychoanalytic therapy has not proven to be of much help in the usual run of social phobias, in part because most patients with social phobias are not motivated to receive such intensive help and are unable to tolerate the anxiety inherent in altering ego-syntonic personality distortions. Analysis of pre-Oedipal stresses, in a more supportive object-relations format, is sometimes successful with motivated patients who have not responded to other therapies.

Simple Phobias (DSM-III-R Code 30029)

Phobias of insects, dogs, mice, bats, snakes, lightning, heights, swimming, closed spaces, air travel, and the like may be conditioned-avoidance responses that are patterned after parental phobias or that followed upon anxiety-provoking experiences with the objects or situations in question (near drowning, air crash, etc.). They may yield to behavior therapy with imagery, desensitization, relaxation exercises, and gradual exposure, first to pictures of the phobic objects and situations, then to imitation objects (toys, insects, mice, etc.), and finally to in vivo desensitation and implosive therapy, perhaps at first in the presence of the therapist. A claustrophobic patient, for example, may lock oneself in a closet in the therapist's office for gradually increasing periods. Group

behavior therapy with participants suffering from the same or similar phobias can accelerate treatment, especially during the phase of in vivo desensitization.

Sometimes, however, simple phobias turn out to be not so simple. In such cases anxiety over one's unconscious dangerous drives have been displaced onto external objects and situations that have become disguised symbols of the repudiated inner drives (Oedipal strivings, perverse sexual cravings, hostility, etc.). For example, a person may avoid knives and other potentially lethal objects as a defense against repressed anger. Because of its apparent protective quality, the phobia may become fixed, the patient manifesting the greatest obstinacy in facing it. The treatment of choice is dynamic psychotherapy, which in the most stubborn cases will necessitate setting up and resolving a transference neurosis using the technique of classical analysis. In some cases hypnoanalysis may expedite therapy, but this requires a subject capable of entering a somnambulistic trance (Wolberg, 1964a).

Obsessive-Compulsive Disorder (DSM-III-R Code 300.30)

In obsessive-compulsive disorders ideas, usually with obscene, violent, necrophobic, or thanatophobic content, flood the mind and liberate aversive feelings of guilt, shame, and anxiety. The phenomenon sometimes takes the form of an inner voice that commands the person to do antisocial acts. Attempts to neutralize these ego-alien thoughts may in some cases provoke certain compulsive movements or rituals, which, seemingly absurd to an observer and even to the patients themselves, temporarily relieve the painful feelings. Attempts to control or resist obsessive ideas and the compulsions they inspire generally are in vain and may even activate the obsessions. Compulsive acts that oppose rational conduct may be executed in secret. Obsessives usually chastise themselves for their weakness and betrayal of common sense. Fears of losing control, of becoming psychotic, and figuratively or literally of being possessed by demons complicate the picture and add to the victim's misery (Nemiah, 1985).

The etiology of the disorder is still obscure. There are indications that a biochemical factor of some kind exists in this illness perhaps related to serotonin imbalances.

Hypothesized also is an affiliation with depression, since many patients exhibit biological markers of an affective disorder. Some authorities postulate that there are anatomical abnormalities in the cingulate gyrus and hippocampus. Though psychological mechanisms in obsessive-compulsive disorders offer themselves luxuriously to psychoanalytic inquiry, psychoanalysis and psychoanalytic therapy have failed to bring about hoped-for results in alleviating obsessive and compulsive symptoms.

Clinically, several types of obsessive patients are commonly seen (Insel, 1983). The largest number are those who fear contamination and who then indulge in washing or scrubbing rituals. Such "washers" may, to their dismay, spend a good deal of their time in the bathroom. A second large group are the "checkers," who have to check repeatedly that they have completed an act because they fear that dereliction may bring harm to themselves or others. A third group are the "stallers," who may take forever to execute a simple task; for example, the completion of normal activities such as dressing or eating may take hours. A fourth group are the "worriers," who are preoccupied with Cassandra-like fears of evil acts and catastrophes that are about to happen; usually patients do not perform rituals to neutralize them. Although each patient exhibits the unique traits of his or her personality structure, obsessive persons demonstrate remarkably similar behaviors in every country the world over.

Many therapies have been unsuccessfully employed to bring relief to these suffering and handicapped individuals. Of all treatments, behavior therapy has scored the greatest successes in controlling obsessive and compulsive symptoms (Rachman et al, 1973; Rachman, 1976; Wilson TG, 1976; Marks et al, 1975; Marks, 1981; Foa et al, 1985). The most effective method (scoring up to 80 percent benefit) is in vivo desensitization with practice sessions of (1) deliberate prolonged exposure (45 minutes to 2 hours) to thoughts, fantasies, and situations that inspire disturbing symptoms; and (2) coordinate blocking of compulsive responses (hand washing, checking, ritualistic behavior) that have temporarily served to neutralize anxiety in the past. In implementing this approach, which consists of 10 to 20 sessions, graded exposure to increasingly intense stimuli from 45 minutes to 2 hours and the absolute blocking of responses for long periods (sometimes for

days) requires a motivated patient willing to endure the anxiety and suffering that such restrictions entail.

Obviously the patient will protest vociferously and express dread of being exposed to dangers. It will require tact, understanding, and great persuasion, utilizing the working relationship skillfully, to convince a patient to try this intervention.

The treatment protocol evolved by Stekete and Foa (1985) for exposure and response prevention details the sequence of treatment and contains useful appendices and a case study that illustrates the application of specific procedures. Approximately 3 to 6 hours are spent in gathering information and in treatment planning. The patient is then given a full explanation as to what to expect. The scenes to be used in imagery (flooding), the situations to be met in in vivo desensitization, and the responses and rituals to be prevented are delineated. A decision is made as to whether the patient's home or a hospital is to be used, and the aides (family members, friends, nurses) to assist the patient in the assignments are chosen. Since massed sessions produce better results, a minimum of 3 sessions weekly are given. The total number of sessions are between 15 and 20. At each session the first few minutes are spent in discussing what has happened since the last visit. Next, the patient is exposed to the target thoughts and fantasies and is enjoined to try to fantasize that he or she is actually in the imagined situation. Every 10 minutes, levels of anxiety are monitored. This exercise, which lasts from 1 to 2 hours, is at first highly anxiety provoking, but eventually the anxiety lessens. In advance of the sessions, a series of five graded upsetting scenes are prepared to be presented in low to high order, and each is used until the anxiety diminishes greatly or is gone. After this exposure, the patient is confronted by the therapist with the situations he or she fears most (touching dirt, being prevented from checking a gas stove, etc.) and the therapist models normal behavior (e.g., touching dirt and refraining from washing). Projected slides, pictures, movies, or video recordings may be used to convey the feared situations (funerals, homosexuality, etc.) if the actual situation cannot be confronted. In the case of "washers," no washing of hands is allowed (sometimes for as long as several days), and only a brief shower is permitted every fifth day. In the last few sessions, the patient is instructed as to

normal modes of behavior. Thus "washers" are enjoined to wash their hands only before meals, after bathroom use, and after handling especially dirty objects. Following the intense treatment period, a self-exposure maintenance program (practiced at least weekly) is prescribed as a preventive measure. When necessary, interpersonal skills training, assertiveness training, marital therapy, and family therapy may be prescribed. A follow-up self-help group may be valuable. Only when absolutely essential should hospitalization be prescribed since many provocative situations are likely to be absent in a hospital setting.

As accessory therapy, relaxation exercises may periodically be employed for tension relief (Jacobson, 1974; Benson, 1974). Another technique that some patients find useful is "thought stoppage" (Wolpe, 1958). Here thoughts to be controlled are identified and deliberately practiced at the same time as one shouts "Stop" and perhaps coordinately bangs one's hand against one's thigh. Or one may wear a rubber band around the wrist and flick it to deliver a painful stimulus. Attention should then be diverted elsewhere. Systematic desensitization (Wolpe, 1958) may also occasionally be effective if tension is high. The patient may be enjoined to engage in regular practice sessions of fantasies, such as being exposed to extremes (often to a most ridiculous degree) of his or her symptoms and perhaps their consequences. The logotherapeutic technique of paradoxical intension *(q.v.)* is a form of this type of therapy. At home the patient may be requested to engage in such varied tension-relieving exercises as keeping a diary record of accomplishments (such as response resistance or blockage) and his or her reactions.

Because depression has been so frequently observed in obsessive patients, a variety of drugs have been tried, including clonidine, loxapine, and the tricyclic antidepressants. The latter class of drugs has proven especially beneficial both for their antidepressant and antiobsessional effects (Mavissakalian et al, 1985). Clomipramine (Anafranil) in particular has proven to be valuable and in many cases has enabled an intractable patient to become cooperative. This medication appears to have a specific antiobsessional effect that is distinct from its antidepressive property (Singh & Sexena, 1977). I have found clomipramine almost indispensable in working with some obsessive-compulsive patients

since by muting symptoms motivation is greatly improved. The initial dose of clomipramine (which is available in Canada, Mexico, and Europe and may soon be released in the United States) is 25 mg three times daily, increased to 150 mg/day as required (maximum dose 200 mg and 300 mg for hospitalized patients). Adolescent and elderly patients should be given 20-30 mg daily, increased by 10 mg daily, if necessary, depending on response and tolerance. A history of glaucoma, liver damage, or blood dyscrasias or pregnancy contraindicates treatment. Use of a MAO inhibitor drug following the use of clomipramine necessitates a delay of 14 days, the same as for any other antidepressant drug. Anticholinergic effects as with other antidepressants, are to be expected. In some cases a combination of clomipramine and clonopin reinforces the beneficial effect. Physical examinations and blood tests should be done periodically. The combination of clomipramine and in vivo desensitization is at this date the best treatment for the symptomatic relief of obsessive-compulsive illness.

Any therapist who believes that the relief of obsessions and compulsions in the obsessive patient is all that is necessary is, however, in for an unpleasant surprise. Although dealing with the biological and conditioning links in the behavioral chain is important, this will not resolve all the problems encountered by the patient any more than relieving painful and distracting hemorrhoids will cure a coordinate sinus condition. Additional implicated links in the behavioral chain (see Table 57-1) require attention since the troubles they cause will sometimes cry out for help. In certain patients, symptom alleviation enhances the chances for a reasonable adjustment, including the usual evasions and compromises essential in our society. Other patients may find their liberated energies merely intensify their interpersonal, environmental, and intrapsychic problems. Here interventions related to these areas of trouble are indicated. Counseling, interpersonal therapy, group therapy, marital therapy, family therapy, and milieu therapy are indicated for dealing with difficulties in special areas. Cognitive and dynamic approaches enable the individual to give a more authentic meaning to his or her symptoms than the misinterpretations usually assigned to them (such as that he or she is destined to psychosis, sexual perversion, cancer, murderous acting-out, etc.). Recognition that fantasies and impulses are manifestations that possess a symbolic significance and that

they do not have to be taken literally can be reassuring to many patients, even if it is not completely curative.

The great problem is not only how to deal with the unexpected outbursts of nascent anxiety, which become particularly pronounced when obsessional ideas periodically break loose, but, more significant, how to manage the hostile, disturbing character structure that is a component of the disorder in many patients.

Obsessive-compulsive neurosis does not respond to insight therapy as well as do other neurotic syndromes. It can be done, of course, but the therapist must be extremely skilled in handling the transference and must have much fortitude to tolerate the vicissitudes that will come up in the course of treatment. Years of futile probing into the unconscious and careful unravelment of the sources and meanings of rituals may accomplish little. The obsessional personality is an expert in "one-upmanship." He or she engages in a verbal tug-of-war, must get in the last word, undermines psychotherapy as a process, and derogates the ability of the therapist to provide help. Yet obsessional patients bitterly complain that they are not being helped. What is important in therapy is to deal with the immediate transactions between therapist and patient and to prevent the patient from entering into gambits through which he or she can conspire to wrest control from the therapist. The therapy for compulsive-obsessive personality disorders must, therefore, take into account the patient's dependence, profoundly hostile impulses toward people, need for detachment, tendency to "isolate" intellect from feeling, and the magical frame of reference in which the patient's ideas operate. Salzman (1966) points out that the obsessive-compulsive defense of persistent doubting, negativism, unwillingness to commit oneself, and striving for perfection, omnipotence, and omniscience are attempts to control the universe and to guarantee one's safety, security, and survival. This defense acts as a block to constructive learning. Free association and concern with past memories are used as a screen behind which the obsessional person conceals his or her coping maneuvers. According to Salzman (1983), what is essential in working with obsessional patients is to be continually aware of their obstructive personality characteristics; their defensiveness, which causes them to reject the therapist's observations; their need for

control; their striving for perfection; and their doubt, ambivalence, and tendency to obfuscate issues. This calls for great activity on the part of the therapist, a focus on the present, a need to deal with the patient's grandiosity, continual reexamination of issues so as to facilitate working-through, and "risk-taking" by the therapist.

Most therapists find working with the patient on an analytic level a most difficult and frustrating experience. Classical analysis is usually ineffective and therapy can become interminable as the patient and therapist become locked into a sadomasochistic relationship, very much like a bad marriage, that can go on for years. This does not mean that one has to cast a dynamic approach to the winds. I have found it helpful with many obsessive cases to work dynamically with derivative rather than nuclear conflicts, showing the patients, how the characterological distortions of dependency, hostility, low feelings of independence, devalued self-esteem, and tendencies toward detachment operate in producing disruptions in their relationships with people and their attitudes toward themselves. Patients must be shown how their personality characteristics inevitably create the stress and generate the anxiety that initiate many of their disruptive defenses. Although a patient may seemingly accept such explanations and interpretations, they will at first have little effect on his or her behavior. The therapist will have to demonstrate the workings of the patient's dynamics in his or her everyday life over and over again until a tiny chink occurs in the patient's defensive armor. Most penetrating will be the elucidation of how the patient's personality problems display themselves in the transference with the therapist. A tremendous amount of dogged perseverance will be necessary which can tax the tolerance of the most empathic therapist. Countertransference must be watched assiduously and used as constructively as the therapist can manage given the undisciplined, resistive, and helter-skelter behavior of the patient. Therapists who have the stamina and forbearance to work with their patients beyond the profits of symptom relief toward alteration of the character structure will have to resign themselves to the battle conditions of tempestuous long-term therapy, which, while unnerving in the beginning, may very well prove worthwhile in the end. Some helpful leads may be found in the section in this chapter on the therapy of personality disorders. The articles by Barnett (1972), E. K. Schwartz (1972), Salzman (1966, 1983),

and Suess (1972) contain interesting pointers.

The prognosis for obsessive-compulsive neuroses will depend upon the severity of the condition and the residual ego strength. It will also depend upon the length of time the patient has been ill. In some cases obsessive-compulsive patterns appear to be of relatively recent duration, the compulsive difficulty having developed as a result of external pressures and problems to which the patient could not adjust. The prognosis for these patients is much more favorable than it is for patients who have been ill since puberty. Some psychiatrists recommend that patients who do not respond to medications, behavior therapy, and psychotherapy and whose anxiety and suffering become unendurable ultimately submit to leucotomy, which, in some cases, will control symptoms when everything else fails. Tippin and Haun (1982) report that more than 69 of 110 obsessive patients who had modified leucotomy operations were symptom-free or improved and needed no further treatment. Understandably, this radical form of therapy will be resisted and should not be used except under extraordinary circumstances.

Posttraumatic Stress Disorder (DSM-III-R Code 309.89)

Under unusually harsh and catastrophic conditions of stress, therapists may confront reactions of great physiological and cognitive severity, beyond what we encounter in the face of such adversities as bereavement, marital conflict, chronic illness, and other calamities (see Chapter 59). These conditions include such natural disasters as earthquakes, floods, hurricanes, famine, transportation and industrial accidents, rape, assault, torture, and bombings. For the most part, posttraumatic stress disorders are mainly consequent to the disasters of war. Especially prominent is combat fatigue among soldiers of the participating armies. The most common reaction is an anxiety state characterized by tension, emotional instability, somatic symptoms, insomnia, and nightmarish battle dreams. Less common are conversion, depressive, and psychophysiological reactions. Acute temporary psychotic-like episodes may also occur.

Knowledge of the dynamics of war neurosis made certain preventive measures possible in World War II. Soldiers who had had training that had made them feel they

could defend themselves under all circumstances, who had been shown that they had adequate weapons of attack, who had confidence in their leaders, and who had obtained sufficient indoctrination and morale building were best prepared to resist a breakdown. An important element in prevention was group identification. Cooperation with others was essential, and the individual had to be made to feel that he was part of a team and that he had enough of an idea of the battle situation and the planned strategy so that he would not be caught by surprise.

The incidence of war neuroses is proportionate to shattered morale and to feelings of isolation from fellow soldiers. An organized body of men fighting for a cause that they consider just can best overcome war stress and hardship.

Adequate information regarding the significance of the conflict, assignment to units with congenial companions, fair discipline, commanding officers who merit respect, periodic relief from duty in the combat zone, and confidence in the assigned weapons all contribute to better morale and greater stress tolerance. Teaching soldiers that fear is normal and that one can function with it may be reassuring. A history of previous emotional disorders, an unstable family situation, and poor socioeconomic conditions in civilian life are usually though not always bad prognostic signs. Some solders maladjusted in civilian life relish the conditions and even dangers of army life. Upon termination of army service, having adjusted adequately up to this time, a certain number of such individuals are unable to adjust to civilian life. A phenomenon that was noted among officers and enlisted personnel in Korea and Vietnam was separation anxiety, which developed when the end of their service was near and the solder had to leave his companions. This occurred even among soldiers in combat units. The group identification which held the individuals together was reluctantly given up.

In spite of preventive attempts, stress reactions of varying degrees of intensity may occur, particularly in response to precarious conditions of combat. A more vulnerable soldier may manifest panicky reactions during which thinking gets disorganized, nonproductive somatic symptoms become pronounced, and behavior tends to become

maladaptive, exposing the individual to even more danger. In combat situations during fierce shelling, for example, the soldier may flee safety areas and run wildly away, exposing himself to shrapnel and gunfire. Overwhelming stress may produce a temporary shock-like reaction followed by what seems to be recovery.

Even the most stable combatants are apt to exhibit a good deal of muscle tension, faintness, giddiness, tachycardia, palpitations, shaking, and tremors during an engagement. The bravest soldier will experience fear, which prevents him from throwing caution to the winds. In many cases gross stress reactions are brought on by killings, fatigue, loss of sleep, hunger, and cold over a prolonged period. Homesickness, uncertainty about the future, physical discomfort, and sexual deprivation may be as traumatic as actual engagement in combat. Reactions will usually follow responses to past situations of acute stress. One of the most important factors in subduing these reactions is good leadership, including thoughtful directing of activities toward maintaining morale.

Experience in treating gross stress reactions in the last war indicated that removing soldiers from forward areas to hospitals in the rear tended to aggravate the difficulty. Good results were obtained when treatment was organized around the expectation of returning to duty. It has been observed that an aversive attitude toward "nervousness" and "weakness" by frontline troops acts as a deterrent to neurotic combat reactions. Expectations that a soldier who "breaks down" will be moved away from the battle zone, released from the army, and perhaps compensated for his disability encourage neurotic symptoms. Group identification tends to reassure the individual and bolster morale. The need to be accepted by the group is one of the most important safeguards against "breaking down." A soldier removed from his unit and sent to a hospital is a candidate for psychological disability, which will stir up guilt feelings and devalued self-esteem. The security of the hospital setting paradoxically prevents him from making a rapid recovery. During the last war, rest outside of a hospital, good food, and the opportunity to verbalize fears and other feelings to a reassuring person proved most successful. Tranquilization, narcosyntheses, and hypnosis in serious cases were employed with rapid success in susceptible subjects. Combat exhaustion, if treated early, did not necessarily result in

neurosis. A moderate anxiety state cleared up in 24 hours with rest, reassurance, and some tranquilization if needed. It was assumed that the soldier would go back to the front. Where there was reluctance to return to battle duty, appeals to patriotism, courage, and "not letting one's buddies down" often built up the person's courage and determination. Encouragement to verbalize fear and disgust was vital, since the soldier in this way released tension and discovered that others shared his anxieties.

The value of respecting the soldier's "gripes" in building morale has long been recognized. The role of the leader is important, too, and an intrepid commanding officer has always been of great service. It is amazing how often a change in attitude in a soldier can prevent neurotic collapse. Under constructive leadership, a soldier has the best chance of pulling himself together and of dealing with his need to protect himself from danger while discharging his duties honorably to preserve acceptance from his peers.

In many cases an incubation period ensues during which what Kolb (1982) has termed "secondary reflective cognitive consequences of the catastrophic experiences" surface in the form of survival guilt, shame, and heightened sensitivity to stimuli directly or remotely resembling the initial stressful assault. Mardi Horowitz (1976), in pointing out this reaction, has emphasized the importance of existential threat as a basic cognitive factor in posttraumatic states.

The posttraumatic reaction may occur within 6 months of the trauma (the acute subtype) or after 6 months and even after several years (the chronic or delayed sub-type). Often it develops after the individual has become stabilized and has resumed habitual functioning. Reactions here draw upon latent personality strengths and on the degree of repression that has sealed off appropriate emotional reactions to the offensive stressor. After the individual has apparently digested the implications of what has happened, he may respond with depression, bouts of anxiety, restlessness, aggression, guilt feelings, obsessions, insomnia, nightmares, fugue states, and amnesia, which may continue indefinitely. In the majority of cases, however, an adaptation is made, even though certain symptoms continue, and, after a period of adjustment, these symptoms may become fixed.

In some instances detachment, aggression, startle reactions to noise, muscle tension, tremors, depression, insomnia, battle nightmares, psychosomatic complaints, and bouts of anxiety may be very difficult to handle. In serious cases, outbursts of violence, detachment, and paranoia may interfere with a constructive social adjustment. Guilt feelings about one's behavior in the army, particularly related to the killings and personal feelings of cowardice, may sponsor a good deal of recrimination and self-punishment.

Therapy for posttraumatic stress disorders may require some time, especially if alcohol or drugs have been employed to quiet the symptoms. Even when these are brought under control, a good deal of working-through of the guilt feelings may be required. Hendon et al. (1983) have evolved a useful questionnaire as a first step, along with an excellent outline for a five-session evaluation of the problem. Most important, a provision should be made for continuing therapy after the initial sessions have opened the door to suppressed feelings. Working through such feelings is important. Otherwise the patient will be left in a more vlunerable state than before. Once a treatment is started, exploration of the meaning of the combat experiences and the devices the veteran uses in covering up his guilt and pain are in order.

Treatment of stress reactions in civilian life (hurricanes, floods, explosions, mass bombings, etc.) should be started as soon as possible, since delay permits the neurosis to become more highly organized and allows the secondary gain element to take hold. First aid helps victims of disasters to return to proper functioning in a short time. Preventive measures are of incalculable value if a disaster is anticipated and potential victims are apprised of dangers as well as suitable protective and ameliorative actions that may be taken. Practice drills under simulated disaster conditions, faithfully repeated, help to establish appropriate patterns if and when emergencies occur.

Responses of people to both unexpected and expected dangers will vary depending on the specific meaning of the danger situation to them and their residual stabilities and habitual coping mechanisms in the face of stress. They will also respond uniquely to any warning signals. Among the gravest dangers to the group are the wildly uncontrolled

panic reactions of a few unstable individuals, which can have a contagious influence on the rest of the group. If the leader knows in advance which members are apt to manifest unrestrained fear, he or she may select them in advance and assign them definite tasks so as to divert their energies.

Even with drills, exercises, and warning signals, the impact of a disaster is bound to provoke immediate reactions of anxiety and confusion. These, however, should soon be replaced by adaptive responses encouraged during the practice sessions. As soon as the violent impact of the disaster has subsided, organized activities will take place. Working together and helping the more physically and emotionally disabled has a profoundly reassuring effect. People who are unable to compose themselves may need special treatment. For example, a person who shows blind panic will require firm restraining by two or three people to avoid spreading panic throughout the group. Drug therapy may be necessary as described in the section on dealing with panic reactions in emergencies (see Chapter 58).

In treating disaster victims whose neurotic or psychotic responses do not subside with the termination of the emergency, the first principle is to permit them to verbalize feelings; the second, to accept their reactions, no matter how unreasonable they may seem. Supportive therapy coupled with sedation or tranquilization will usually suffice to restore the person to his or her previous state. Imagery plays an important part in working through these disorders (Horowitz MJ, 1970, 1976; Brett 1985) and may serve as a productive therapeutic vehicle, especially in hypnosis.

If a patient has a continuing stress reaction that threatens to become chronic, narcotherapy *(q.v.)* and hypnotherapy *(q.v.)* are often effective for purposes of symptom removal. In instances where anxiety is extreme, one may utilize an "uncovering" type of technique. Here hypnosis and narcotherapy are also of help. The recovery of amnesias, and the reliving of the traumatic scene in action or verbalization, may have an ameliorative or curative effect.

While hypnotherapy and narcotherapy accomplish approximately the same results,

the emotions accompanying hypnotherapy are often much more vivid, and the cathartic effect consequently greater, than with narcotherapy. There are other advantages to hypnosis. The induction is usually brought about easily without the complication of injections and without posttherapeutic somnolence. Additionally, hypnotic suggestions are capable of demonstrating to the patient more readily his or her ability to gain mastery of functions. On the other hand, narcotherapy is easier to employ and does not call for any special skills.

If it is essential to remove an amnesia, the patient is encouraged under hypnosis or narcosis to talk about the events immediately preceding the traumatic episode and to lead into the episode slowly, reliving the scene as if it were happening again. Frequently the patient will approach the scene and then block, or he or she may actually awaken. Repeated trance inductions often break through this resistance. Also, it will be noted that the abreactive effect will increase as the patient describes the episode repeatedly. Apparently the powerful emotions that are bound down are subject to greater repression than the actual memories of the event.

Hadfield's (1920) original technique is still useful. The patient is hypnotized and instructed that when the therapist's fingers are placed on the patient's forehead, the patient will picture the experiences that caused the present breakdown. This usually produces a vivid recollection of the traumatic event with emotions of fear, rage, despair, and helplessness. The patient often spontaneously relives the traumatic scene with a tremendous cathartic effect. If the patient hesitates, the therapist must encourage a detailed description of the scenes dominating the patient's mind. This is the first step in therapy and must be repeated for a number of sessions until the restored memory is complete. The second step is the utilization of hypnosis to readjust the patient to the traumatic experience. The experience must be worked through, over and over again, until the patient accepts it during hypnosis and remembers it upon awakening. Persuasive suggestions are also given, directed at increasing assurance and self-confidence. After this the emotional relationship to the therapist is analyzed at a conscious level to prevent continuance of the dependency tie.

Horsley (1943) has mentioned that when the ordinary injunctions to recall a traumatic scene fail, several reinforcing methods can be tried. The first has to do with commanding the patient to remember, insisting that he or she will not leave the room until memory is completely restored for the traumatic events. The second method is that of soothing, coaxing, and encouraging a total recall ("You are about to remember the troubled scenes that will remind you of your experiences.") If this is unsuccessful, the patient is told that although the memory has not yet come through, it will upon awakening reveal itself in any way the patient sees fit. Instruction to recall more details in a dream the same or the next night is given.

Various hypnoanalytic procedures, such as dramatization, regression and revivification, play therapy, automatic writing, and mirror gazing, may be utilized to recover an obstinate amnesia (Wolberg, 1964a). The reaction of patients to the recall of repressed experiences varies. Some patients act out the traumatic scene, getting out of bed, charging about the room, ducking to avoid the attacking objects and people. Other patients live through the traumatic episode without getting out of bed. Some individuals collapse with anxiety; they should be reassured and encouraged to go on. If the patient voices hostility, he or she should be given an opportunity to express grievances and dislikes. Clarification of feelings of injustice may afford considerable relief.

It must be remembered that the object in therapy is to dissipate feelings of helplessness and of being menaced by a world that the patient no longer trusts. The sense of mastery and the ability to readjust oneself to life must be restored. The best reactions to hypnosis are obtained when it is executed as close in time to the trauma as possible. This may prevent organization of the condition into a chronic psychoneurosis. Follow-up therapy is essential, with integration on a waking level of the material brought up during the trance. If the anxieties relating to the disaster have precipitated hysterical, phobic, compulsive, and other reactions characteristic of the ways that the patient has dealt with anxiety in everyday life, long-term insight therapy will usually be required.

In chronic stress reactions, treatment is difficult because of the high degree of

organization that has taken place and because of the strong secondary gain element involving monetary compensation and dependency. The recovery of amnesias should always be attempted, but even where successful, this may not at all influence the outcome. An incentive must be created in the patient to function free of symptoms, even at the expense of forfeiting disability compensations, which in comparison to emotional health may be shown to be diminutive indeed. (See also Chapter 59; Crisis Intervention, Chapter 57; and pertinent parts of Chapter 58 on emergencies.)

DISSOCIATIVE DISORDER (HYSTERICAL NEUROSIS, DISSOCIATIVE TYPE)

Dissociative disorders manifest themselves in disturbances of consciousness, memory, and identity. In *multiple personality disorder (DSM-III-R Code 300.14)* a dramatic interruption of the habitual personality is periodically produced by the intrusion of a seemingly foreign personality or personalities that inspire variant behaviors often at odds with the usual patterns of the individual. In *psychogenic fugue (DSM-III Code 300.13)* the person wanders off away from home with the assumption of a new identity and amnesia for the previous identity. In *psychogenic amnesia (DSM-III Code 300.12)* disturbances in recall are characteristic. These blank spots may occur without identifiable cause or may follow an accident or catastrophic incident. In *depersonalization disorder (or depersonalization neurosis) DSM-III-Code 300.60)* the reality sense is impaired with feelings of detachment from oneself.

The basic defense employed in dissociation reactions is repression. Therapeutic techniques are best organized to resolve the repression and deal with inner conflicts. Transference analysis, especially the working through of a transference neurosis, is ideally suited to therapy of this disorder, but may not be possible for practical reasons and because of patient resistance. When transference analysis cannot be used, a less intensive psychoanalytically oriented psychotherapy may be employed. From the viewpoint of mere handling and removal of symptoms, hypnosis is classically of value. Although hysterical symptoms can often be eliminated in relatively few hypnotic sessions, the dramatic, infantile, and self-dramatizing personality constellation associated with this reaction will

require prolonged psychotherapy, preferably along reconstructive lines. Unfortunately, even though insight therapy is accepted by the patient, a great many impediments will become manifest during the course of treatment in the form of intellectual inhibitions and other devices to reinforce repression.

Whereas insight therapy is the best treatment for this condition, circumstances of obstinate resistance, faulty motivation, and profound secondary gain may prevent any other than a supportive approach.

Symptom removal by authoritative suggestion, with or without hypnosis, is occasionally indicated, particularly where the symptom produces great personal discomfort and interferes with the individual's social and economic adjustment. Some symptoms serve a minimal defensive purpose in binding anxiety. The inconvenience to the patient of such symptoms is an important incentive toward their abandonment. If the symptom constitutes a plea for help, love, and reassurance on the basis of helplessness, the therapist, by ordering cessation of symptoms, virtually assures the patient of support and love without the need to utilize symptoms for this purpose. Should the patient sense that his or her demands are not being fulfilled, a return of symptoms or histrionic acting out may be expected.

Although some symptoms vanish with a strong authoritarian suggestive approach, one must not overestimate the permanency of the apparent cure since the original motivations that sponsored the symptom are not altered in the least and a relapse is always possible. Consequently, whenever the therapist can do so, the patient should be prepared for future therapy by explaining the purposeful nature of the symptom and its source in unconscious conflict.

Since hysteria often represents a reaction to unpleasant circumstances that stimulate inner conflicts, a guidance approach is sometimes utilized in appropriate cases to adjust the patient to environmental demands from which he or she cannot escape and to help the patient modify existing remediable situational difficulties. It may be possible to get a hysterical individual to make compromises with the environment so that he or she

will not be inclined to overreact to current stresses. Here, too, an attempt must be made to acquaint the person with the fact that the symptoms, though inspired by external difficulties, are actually internally sponsored. Once the patient accepts this fact, therapy along insight lines may be possible.

The treatment of hysteria through hypnotic symptom removal and by guidance therapy are least successful if the symptom serves the purpose of providing intense substitutive gratification for sexual and hostile impulses.

Difficulty will also be encountered if the symptom tends to reinforce the repression of a traumatic memory or conflict, as in amnesia. The extent of amnesia varies. It may involve a single painful experience in the past, or it may include a fairly wide segment of life. It may actually spread to a point where the person loses his or her identity and forgets the past completely. Amnesia serves the defensive purpose of shielding the individual from anxiety. The intractability of an amnesia, consequently, is related to the amount of anxiety bound down and to the ego resources that are available for coping with the liberated anxiety. The fear of being overcome by anxiety may be so great that an impenetrable block to recall will exist despite all efforts to reintegrate the person to past memories. Indeed, the fear of uncovering a memory may be so strong that the person will resist trance induction.

When resistance to hypnosis is encountered, a light barbiturate narcosis, either oral or intravenous (see the section on Narcotherapy), may remove the block. A trance, once induced, is deepened, and a posthypnotic suggestion is given the patient that he or she will henceforth be responsive to hypnosis without narcosis.

It must again be emphasized that, although certain hysterical symptoms may be treated rapidly through short-term supportive treatment, the basic personality problems associated with the hysterical disorder require a considerable period of reconstructive therapy.

SOMATOFORM DISORDERS

A number of psychophysiological autonomic and visceral disorders are included in this category, namely, somatization disorder, somatoform pain disorder, hypochondriasis (or hypochondriacal neurosis), body dysmorphic disorder, and conversion disorder (hysterical neurosis, conversion type). In *somatization disorder (DSM-III-R Code 300.81),* the patient presents a variety of somatic complaints resulting in frequent consultations with physicians. Despite batteries of negative tests, and medical reassurance that no organic basis exists for the symptoms, the patient is never fully convinced that this is so. Such "psychosomatic" or "psychophysiological" manifestations are complicated by a depressive and anxiety overlay, which adds to the suffering of the individual. An exaggerated form of this symptomatology is found in *hypochondriasis (or hypochondriacal neurosis) DSM-III-R Code 300.70.* Here the symptoms, though intense, are still not of a delusional nature, and some appeal to reason is possible. A special condition in this category is preoccupation with presumed defects in the appearance of one's face and body in the absence of any real anomaly *(body dysmorphic disorder [dysmorphobia])* that may drive the victim to a succession of plastic surgeons for correction that never comes about. Where pain for over six months constitutes the complaint factor and persists in the absence of organic pathology, we may be dealing with a *somatoform pain disorder (DSM-III-R Code 307.80).* This must be differentiated from a *conversion disorder (or hysterical neurosis, conversion type (DSM-III-R Code 300.11),* which usually takes the form of a neurologic disease (paralysis, aphonia, visual disorder, anesthesia, astasia-abasia, and hysterical contractions) or of such morbidities as persistent vomiting, false pregnancy (pseudocyesis) and other peculiar symptoms that are basically symbolic manifestations of inner conflict. In many conversion syndromes a casual attitude (la belle indifference) accompanies the outwardly alarming symptoms. Somatoform disorders are often rooted in disturbances in the personality organization; some are engendered by defects in the earliest contacts of the infant with the mother. The personality structure of the patient, consequently, contains dependent, hostile, and masochistic elements that tend to obstruct a good working relationship. Because the ego is more or less fragile, anxiety, mobilized by the transference and by interpretation, may be intolerable. Insight therapy may, therefore, have to be delayed in favor of discreet supportive techniques during which the patient is

permitted to relate dependently to the therapist.

The negative elements of the relationship with the therapist must constantly be resolved, and the therapist must be alert to hostile manifestations, which the patient will perhaps try to conceal. Once a good working relationship is established, exploration of inner strivings, needs, and conflicts with cautious interpretations may be attempted. Most patients with somatoform disorders find it difficult or impossible to think abstractly, however, and revelations of conflict seem to do little good. They cannot seem to describe their affects and to relate their fantasies, and they fail to respond to free association and interpretation (Nemiah, 1971). Exaggeration of the patient's physical symptoms is a common sign of resistance. When symptoms increase in intensity, the patient may be tempted to leave therapy. Treatment is generally a long-term proposition, since the deep personality problem associated with the symptoms resolves itself slowly. Essentially, therapy may follow the design for the management of personality disorders (q.v.).

A constant danger during insight therapy is the unleashing of excessive quantities of anxiety, usually the result of too speedy symptom removal or too rapid dissipation of defenses. Often the somatic disturbance represents the most acceptable avenue available to the patient for the discharge of anxiety and hostility. Because the ego has been unable to handle these emotions on a conscious level, the mechanism of repression is invoked. When coping devices are threatened without a coordinate strengthening of the ego and the person becomes prematurely aware of unacceptable conflicts and strivings, there is definite danger of precipitating a crisis. The patient may release such intense anxiety that he or she will employ symptomatic contingencies to bind this emotion. The patient may, for instance, develop depressive or compulsive symptoms or display detachment and other characterological defenses. Anxiety may, nevertheless, get out of hand and shatter the ego in fragile personalities even to the point of precipitating a psychosis. In hysterical conversion disorders symptoms may astonishingly be temporarily dissipated by strong authoritative commands as during hypnosis. Little impact is registered on the underlying personality distortions.

It may be impossible to do more for the patient than to give supportive therapy. For instance, persuasion and guidance may enable the patient to organize his or her life around the defects and liabilities, to avoid situations that arouse conflict and hostility, and to attain, at least in part, a sublimation of basic needs. The object here is to bolster the ego to a point where it can handle damaging emotions more rationally as well as to improve interpersonal relationships so that hostility and other disturbing emotions are not constantly being generated. In some instances such therapies help to liberate the individual from the vicious cycle of neurosis, facilitating externalization of interests, increasing self-confidence, and indicating ways of discharging emotions. Minor tranquilizers, such as Librium and Valium, may be administered periodically if symptoms are especially harsh. Considerable relief from symptoms may be obtained through relaxation exercises, meditation, hypnosis, and biofeedback (see Chapter 56). Behavior therapy works better than dynamic psychotherapy.

The therapeutic relationship is kept at as positive a level as possible, an attempt being made to show the patient that the symptoms are not fortuitous, but that a causal relation exists between symptoms and difficulties in dealing with life. The circumstances under which symptoms become exaggerated are investigated with the objective of determining areas of failure in interpersonal functioning. Once a pattern is discerned, its significance and origin are explored. Finally, the patient is encouraged to put into action the retrained attitudes toward life and people. In some cases sufficient ego strength may be developed to make psychoanalytically oriented psychotherapy possible.

Where the patient is coordinately under the care of an internist, cooperation between the therapist and internist will improve the results.

PERSONALITY DISORDERS

Personality problems plague every human being. They are an inevitable consequence of cultural and family aberrations that cannot help but influence child-rearing practices. The great majority of people manage to live with and around disturbing personality problems and to make a reasonable adjustment to everyday pressures and

responsibilities. When problems become intolerably distressful, however, maladjustment may ensue.

Personality disorders encompass a heterogeneous group of traits, tendencies, and patterns of behavior that impair social and occupational functioning. Some of these disorders have a long history dating back to childhood. In the DSM-IIIR classification a number of syndromes fit this description: (1) Disruptive Behavior Disorders (conduct disorder, attention-deficit hyperactivity, oppositional-defiant disorder), (2) Anxiety Disorders of Childhood (separation anxiety disorders, avoidant disorders of childhood or adolescence, overanxious disorder), (3) Eating Disorders (Anorexia nervosa, bulimia nervosa, pica, rumination disorder of infancy), (4) Gender Identity Disorders (gender identity disorder of childhood, transsexualism, (5) Tic Disorders, (6) Disorders of Elimination, (7) Other Speech Disorders, (8) Other Disorders (reactive attachment disorder, stereotyping/habit disorder, elective mutism, identity disorder). Some of these disorders may in history-taking be identified as early manifestations of the pathology for which the patient now seeks help. In many, perhaps most cases, we have problems in tracing the histories of personality disorders because the individual usually forgets, conceals, distorts, or rationalizes early difficulties.

Urgent, inflexible, "ego-syntonic," and resistive to change, personality disorders interfere drastically with adjustment. There may be some awareness of the nature of the problem but it cannot seem to be controlled.

When a patient presents for therapy, the complaint is generally a disturbing symptom or a stressful event that has upset the habitual equilibrium. Most patients do not see the connection between their personality operations and their symptoms at the beginning of therapy. A too early emphasis on such a connection will tend to be confusing. It is important to consider that personality is the machinery through which the individual regulates his or her relationships with life and people. Individuals regard their traits as integral a part of themselves as their skin, and a premature effort to peel away traits that are disruptive will be staunchly resisted. Why this is so is not difficult to understand.

During development, the individual evolves defenses to cope with stresses brought about by hurtful or depriving circumstances. Such defenses endure as a way of life far beyond their period of usefulness. They become welded into the intrapsychic structure, and the original events that initiated them are repressed and more or less relegated to unconscious oblivion. In adult life, they nevertheless continue to operate insidiously, independent of reality. Individuals may even attempt to create conditions that will justify their reactions, as if they seek to master a challenge and to complete the unfinished business of their past.

Treatment with the goal of some reconstructive change is a long-term proposition. It cannot be completed in 6 or 20 or even 40 sessions. It requires detailed work during which the patient is brought to an awareness of the nature of his or her problem and its investment in past history. Once some insight is achieved, the working-through process slowly takes place, aided by homework away from the therapist's office in the crucible of life experience itself. Permanent change may require several years of dedicated treatment. A sequence of operations usually takes place: (1) the disorder is clearly identified; (2) the consequences of the patient's behavior are delineated; (3) motivation to alter offensive patterns are developed; (4) exploration of the origins and purpose of the disorder may be required; (5) modes of rectification of attitudes and a reconditioning of behavior are designed; and (6) termination of treatment is carefully structured.

In the treatment of a personality disorder, we may accordingly execute the following *baseline interventions:*

1. *The patient is brought to an awareness of the traits he or she pursues that create problems.* Detection of these traits will not be difficult from the case history as revealed by the patient, from reports of informants if these are available, and particularly from the patient's attitudes and behavior toward therapy and the therapist. Some patients are at least partially aware of their maladaptive patterns; some appear to be oblivious to their nature and the effect on themselves and others. One cannot jump in immediately and vigorously confront the patient with his or her self-defeating attitudes and corrosive conduct unless a good working relationship has been established. The patient will either not listen or

will assume he or she is being unfairly attacked and misunderstood. But as soon as the therapist feels that a reasonably sound therapeutic relationship exists, confrontation blended with empathic understanding may be necessary and invaluable. If repression acts like an interfering block of concrete, analysis of dreams, transference, and acting-out may be helpful in expediting awareness. Interpretations must be carefully titrated to the patient's ego strength and level of anxiety.

Interpreting character drives in a way that will be therapeutic is an art because reactions to interpretations of anger, offensiveness, denial, disbelief, or detachment can have a negative effect on the therapeutic alliance.

One way of softening the negative impact of interpretations is to couch them in universal terms. In this way, one hopes to avoid a disintegration of the therapeutic relationship. For example, the following statements were offered patients:

> (Strong dependency traits in a man) "Many people come through a difficult childhood with scars that burden them. Because of an unfulfilled early life, they try to make up for satisfactions they failed to get by looking for and getting dependent on a better, more idealized parent figure. Could it be that you are reaching for a more fulfilling relationship, which you believe your wife is not supplying?"

> (Masochistic tendency) "There is really nothing so unusual in the way you are reacting. People who are angry at what has happened to them often are very guilty and may seek to punish themselves for even feeling angry." (Detachment) "It is only natural that when a person feels hurt there is a need to escape from one's feelings. Sometimes not feeling emotions or physically getting away from people is an effective defensive maneuver. But there are penalties one pays for detachment."

> (Perfectionism) "Doing things perfectionistically is one way people have of protecting themselves. The only trouble is that nobody can ever be perfect, and if perfection is a goal one always has to suffer."

By avoiding confronting the patient directly with a character defect, one may obliquely be able to penetrate defenses. Once the patient acknowledges a problem openly, confrontation can then be more direct and personal. The therapist should watch the patient's reactions to interpretations to see whether the patient is strong enough to tolerate and make use of them. Initial reactions should not be taken at face value. As long as there is evidence that confirm the assumptions of the therapist, interpretations should carefully be woven into questions, continuously presenting these to the patient in the

hope that the patient will eventually make the proper connections.

In the case of a man with untoward aggression, his acting-out patterns were vivid enough so that it required little from me to get him to realize that his behavior was problematic, although he attempted to justify and rationalize it. Interpretations fell on deaf ears, even though explanations were deliberately modulated. It was obvious that he defended against using them in the early phases of treatment.

2. *The aversive consequences of the patient's patterns are reviewed in detail.* These are abundant and usually well-known to the patient, although he or she will ascribe them to being misunderstood or discriminated against. A wealth of excuses, resentments, and recriminations will drown the patient's judgment. The therapist will soon realize that no matter how severe the punishment is that follows untoward behavior, the patient is completely unable to control it. Indeed it may become evident, as happened in my patient, that he or she masochistically seems to welcome punishment.

3. *Detailed determination of the function of the disturbed patterns must be elaborated.* Here dynamic thinking is indispensable since the purpose behind the manifest symptomatology is often not explicable in terms of everyday logic. In our patient under discussion it became apparent through exploration of his dreams, associations, and behavior toward me that he was trying to mask underlying passivity, low feelings of independence, and a nonmasculine image he believed he was displaying to the world. Blustering verbal attacks and an appearance of belligerence served the purpose of presenting a macho front. He had guilt feelings about homosexual fantasies but apparently never acted them out. Interest in women was high, and he enjoyed heterosexuality. He was, however, unable to establish an enduring relationship with any one woman. Discussions about his irrational fantasies created motivation to inquire further into their nature.

4. *In some cases it is important to explore the origins of the personality disorder in past formative relationships.* Memories of early determining experiences are usually blurred and their connection with present-day behavior obscure. As therapy proceeds, some memories and connections become clearer. The transference may reveal significant feelings toward early care-taking agencies that are being projected toward present-day

authorities. The most dramatic revelations will occur when an actual transference neurosis precipitates. A few motivated patients may be susceptible to the classical analytic technique, which will most reliably produce a transference neurosis. Countertransference, if studied assiduously, may also yield data about some of the patient's projected unconscious processes. One occasionally finds that the patient's behavior is molded by identification with a parental figure and that the patient is acting-out the hidden designs of these figures with the therapist, or outside persons (projective identification). In many cases a modified analytic approach, dealing with derivatives of nuclear conflicts, is all that is possible. Presentation of a schema such as outlined in Chapter 44 may enable the patient to reconstruct past experiences and to assign to his or her personality patterns a more significant meaning. This will help establish better controls.

Our patient became aware of his continuing dependency, his futile search for an idealized maternal figure, his delayed separation-individuation, his resentment of women as symbols of the controlling and castrating mother, his feelings of low independence and masculinity, and his compensatory strivings for more effective affirmation of his masculinity through power drives, aggression, and fantasies of penis acquisition via homosexual fantasies. These insights fascinated him but still were not sufficient to cure his personality disorder. It did provide him with motivation to want to halt some expressions of self-defeating aggression.

5. *The acquisition of more constructive modes of reacting to provocative stimuli may be expedited through the employment of cognitive and behavioral techniques.* Here the patient may keep a diary of successes and failures in controlling his or her symptoms under various circumstances. Cognitive therapy helps rectify faulty self statements. Assertiveness training, group therapy, and psychodramatic role playing may aid in the reconditioning process if the patient is unable to achieve greater control through simple homework practice. These adjunctive measures were all employed with our patient because of his continuing resistance. Many patients will not need all of these measures.

6. *As soon as the patient manifests some control over his or her patterns and substitutes more productive behavioral alternatives, termination of therapy is in order, with injunctions given to continue homework practice.* A 5-year follow-up of our patient revealed continuing assertiveness without need for aggression, as well as gratifying signs of personality

maturity.

7. *Severe chronic personality disorders do not lend themselves to a "quick fix."* Reinforcements in the environment keep their patterns alive, and resistances to change interfere with progress. Some cases of personality disorders, antisocial personality disorder, and very severe borderline personality disorder, for example, may require treatment in an institution staffed by personnel sufficiently well trained to deal with encrusted characterological patterns that will not yield to anything other than reconditioning in a therapeutic milieu.

The above outline of therapy for personality disorder is a barren description of treatment that of necessity extends over a long period and that requires innovative management. While treatment focuses ideally on intrapsychic and interpersonal links in the behavioral chain, difficulties related to other links may claim priority and need to be treated with special techniques, as well as the baseline interventions described above (see Table 57-1). Diagnosis of personality disorder is usually made on the basis of the most obnoxious or maladaptive traits that are being exhibited. Blatant and unpalatable, these may mask other less disagreeable but equally important personality distortions. Not uncommonly, two or more diagnostically distinct personality disorders may appear in the same person. The classification of character types into diagnostic entities is convenient but faulty to the extent that traits shift and vary with prevailing needs and existing stresses imposed on the individual. Accordingly, at irregular times, different impulses and demands may appear that will inspire a complex array of defenses and reaction formations and suggest many different classifications. Nevertheless, distinctive diagnostic categories are listed in the DSM classification system.

Paranoid Personality Disorder (DSM-III-R Code 301.00)

Individuals with this disorder, which rarely produces sufficient discomfort to bring an individual to therapy for the personality problem alone, exhibit an unwarranted sensitivity to actions in the environment that they believe are designed to annoy, humiliate, or take advantage of them. Such suspicions are impervious to reason. Most persons with this disorder come to treatment for symptoms such as depression, anxiety,

phobias, and other manifest disturbances. Only when the therapist gains their confidence will they reveal some of their peculiar ideas. When attempts are made to bring logic into the picture to prove the ideas incredulous, the relationship may begin to disintegrate. Indeed, these patients may consider the therapist allied to their enemies. It is difficult to convince them that they are trying to preserve themselves by building an impenetrable wall between themselves and others and that secrecy, guardedness, jealously, lack of humor, and involvement with fantasies of being humiliated and downgraded are symptoms of a disorder.

The best way to manage therapy with the paranoidal individual is to listen respectfully to his or her qualms and not argue about them. When the patient expresses concern about being threatened and humiliated by others, the therapist might say: "Anyone who is going through what you are is bound to be upset." One deals with the patient's emotional turmoil and does not try to ridicule or belittle his or her twisted cognitions.

Because of the vulnerability of the relationship with the therapist, the patient is apt to regard criticism as a blow to his or her self-esteem, initiating depression, rage, or anxiety. Criticism is interpreted as evidence that the therapist does not approve of him or her. The patient is apt to intellectualize the entire therapeutic process, using knowledge either as resistance or as a means of fortifying against change. Despite all logic, the patient strives to wedge therapy into the framework of his or her distorted attitudes toward life. Feelings of rejection and distrust are exhibited, and at the slightest challenge from the therapist, defenses crumble, leaving the patient in a state of anger and despair. The patient may then show a psychic rigidity that refuses to yield to reason or entreaty.

Some therapists attempt to gain the goodwill of paranoidal patients through a form of strategic therapy in which they act as if the patient's ideas are factual and even become a partner in the patient's bizarre schemes. This may work at first to solidify the relationship since the patient may accept the therapist as an exceptional friend who does not ridicule his or her ideas and judgments. Unless the therapist is an excellent actor, the

acutely sensitive patient will detect a fraudulent note in the play-acting maneuvers.

Some patients achieve relief from severe symptoms such as depression with antidepressants, and eventually are able to accept the therapist as a sincere friend who wants to help rather than harm. They may then begin to express some doubts about their suspicions. At this point, one may institute cognitive therapy carefully designed so as not to convey the impression that the patient is peculiar or psychotic.

Dependent Personality Disorder (DSM-III Code 301.60)

The character trait of extreme dependency sponsors relegation of responsibilities to other persons and avoidance of decision making. The individual allows a spouse or parent to arrange the most simple matters and has little incentive to promote action on his or her own. The dependence is actually one manifestation of a widespread deficit in separation-individuation, the product of faulty early development. Inability to transcend the dependency stage of development results in severe damage to the self system, including evolvement of compensations and reaction formations such as those described in Chapter 44. An inability to manage the ordinary stresses of life may result in adaptive breakdowns, with ensuing anxiety, depression, phobias, and other neurotic difficulties.

Treatment poses special problems. Dependent persons often show up for treatment not because they feel a need for change but rather because parents, marital partners, or friends insist that something be done for them. Visits to the therapist in such cases are a mere formality. Such patients expect that no change will occur and will be resistant to any effort to get them to participate in the treatment process. The limit of their cooperativeness is to expose themselves to the therapist during the allotted hour.

Dependent patients seek to establish themselves with the therapist in ways that resemble the infant's imposition on the parents. They do not seem to be interested in developing resources within themselves. Rather, they desire to maneuver the therapist into a position where constant favors will be forthcoming. They will abide by any rules of therapy in order to obtain this objective, even to the apparent absorption of insight. It is

most disconcerting, therefore, to learn that assimilated insights are extremely superficial and that the patients are less interested in knowing what is wrong than in perpetuating the child-parent relationship. They actually seem incapable of reasoning logically, and there is an almost psychotic quality to the persistence of their demands for support and direction. Sometimes the residual hostility is expressed in aggressiveness, which is usually masked by passive maneuvers such as procrastination, obstinacy, recalcitrance, and stubbornness, hence the term "passive-aggressive character disorder."

Interpretations of the patient's dependency are usually regarded as chastisement. He or she will assume that any attempt to put responsibility on his or her shoulders is a form of ill will expressed by the therapist. The patient will demonstrate reactions of disappointment, rage, anxiety, and depression and will repeat these reactions in spite of lip service to the effect that he or she wants to get well.

In treating a dependency reaction, it is essential to recognize that hostility is inevitable in the course of therapy. The demands of dependent people are so insatiable that it is impossible to live up to their expectations. Only when such people begin to experience themselves as people with constructive assertiveness and independence are they able to function with any degree of well-being. This goal, unfortunately, may in some instances never be achieved.

Supportive therapy that propitiates the patient's dependency needs is of extremely temporary effect. It is advisable, where possible, to promote a therapeutic approach in which the individual learns to accept responsibility for his or her own development in the hope that the patient will utilize this opportunity to grow.

There are some individuals, however, whose self-structure has been so crushed that they will resist any attempt to make the therapeutic situation a participating one. Here the treatment program may have to be directed at a limited therapeutic goal. The therapist will then have to become resigned to educating the patient to function with his or her dependency strivings with as little detriment as possible.

Behavior therapy is sometimes very helpful. Conditionings are organized so that the patient is rewarded for making his or her own decisions. It is to be expected that the patient will resent this vigorously, accusing the therapist of refusing to accept responsibility. The therapist may then explain that pandering to the patient's demands for support and making decisions for him or her only tends to infantilize the patient. It would make the patient more dependent and more unable to develop to a point where he or she could fulfill himself or herself productively and creatively. The therapist does not wish to shirk responsibility but withholds directiveness out of respect for the patient's right to develop. Although patients may still resent the therapist's intent, they may finally understand that unless they begin to make their own decisions, they will never get to a point where they are strong within themselves. Behavioral assertive training may prove helpful.

Some patients who seemingly are fixated on a dependent level may, with repeated reinforcements and assertiveness training, finally begin to accept themselves as having the right to make their own choices and to develop their own values. Unflagging persistence, however, is the keynote. In therapy the patient will exploit every opportunity to force the therapist to assume a directive role. Nevertheless, when the patient sees that the therapist has his or her welfare at heart, he or she may be able to develop more independence and assertiveness. The shift in therapy from a directive to a nondirective role calls for considerable skill, and it must be tempered to the patient's incentives and ego strength. Unless such a shift is made at some time, psychotherapy will probably be interminable, and the patient will continue on a dependent level requiring the ever presence of the therapist or some other giving person as a condition to security.

Should it become apparent that one cannot work along participating lines and that the patient's only objective is to become dependent on the therapist, visits may be cut down to 15- to 20-minute sessions once weekly or bimonthly, and/or the patient may be referred to a supportive social or reeducative group with periodic fulltime sessions when required.

Obsessive-Compulsive Personality Disorder (Compulsive Personality) DSM-III-R Code 301.40

Compulsive personalities are obsessed with orderliness, preoccupied with trivia, irritatingly perfectionistic, immovably obstinate, overconscientious, and addicted to work and what they consider demanding daily responsibilities. They have little time for leisure and enjoyment, and their relationships with people are often organized around manipulations for their own ends. Lack of confidence in themselves forces many of these individuals to engage "experts," whose advice they rarely follow, to instruct them in "what to do." Maintenance of control becomes a preoccupation, and every thought and action is measured carefully so they will not be caught off guard. Occasionally, particularly in emergencies and under the impact of great stress, controls may shatter and behavior becomes impulsive and disorganized. It becomes apparent then that forced control at all times is a means of preventing the possibility of being destroyed by unpredictable disasters. Because of the fears of making mistakes, some compulsives ruminate about alternative solutions and find it difficult to arrive at decisions. They then ask for advice, which they question and doubt, and make a nuisance of themselves pillorying people with questions. Feelings of warmth and tenderness are subordinated to cold intellectualizations and formal stiffness in manners. The more adjusted compulsive persons are cautious, conscientious, conservative, and conforming solid citizens, and for this reason are often put in positions where punctilious work is demanded. Too frequently, the joy of living is sacrificed to a sense of responsibility. Certain cultures encourage and reward some compulsive traits that are considered desirable, not abnormal.

Though obsessive compulsive personality disorder seems related to obsessive-compulsive disorder, relatively few persons with compulsive personalities succumb to an actual neurosis. They come to therapy because their controlling defenses have failed to function, resulting in underlying fears of shattering. Symptoms of anxiety and depression constitute the complaint factor. Environmental stresses such as severe financial problems, physical illness, forced retirement, and marital difficulties may have taxed coping capacities.

If the individual has adequately adapted to the compulsive personality most of his or her life and if it has not been responsible for a serious physical ailment (such as cardiac disease in the compulsive Type A personality), the objective in treatment is restitution of the old personality controls. Resolution of identifiable environmental stress (via counseling, environmental manipulation, etc.) and medicinal management of symptoms related to the implicated biological links (anxiolytics, antidepressants, etc.) are instituted when indicated. Relaxation therapy is often of great value, and many of these patients are good subjects for hypnosis and biofeedback. Marital therapy may be employed. Cognitive therapy to change attitudes, as toward forced retirement, may be tried, but the patient's stubborn clinging to established belief systems may be difficult to overcome.

Because many of these patients are intellectually keen, some alteration of stubborn personality traits may be possible through persistent application of the "baseline interventions" described at the beginning of this chapter. Supplying the patient with a chart delineating how personality drives operate may prove helpful since this permits the patient to put his or her patterns into an ordered arrangement that can be studied as assigned homework.

Passive-Aggressive Personality Disorder (DSM-III-R Code 301.84)

Persons who display extraordinary resistance to demands being made on them in their education, work, and social relationships may be suffering from a passive-aggressive personality disorder. This diagnosis is, along with "atypical, mixed, or other personality disorder," a kind of wastebasket into which varied reaction patterns are dumped. One often gets the impression that many passive-aggressive individuals utilize their resistance as a form of aggression. They refuse to allow themselves to be "pushed around." In their way, their "forgetting," inefficiency, procrastination, and oppositional tendencies serve the purpose of supporting a spurious independence.

At the core of these traits is a severe developmental disturbance characterized by incomplete separation-individuation. The high level of dependence may be concealed or masked by projecting it onto a religious deity who is worshipped for hoped-for rewards in

the present (e.g., winning at Lotto) or in the future (e.g., reserving an established seat in heaven). Where it is expressed toward a human target (i.e., parent, spouse, lover, authority, etc.), the individual will usually downgrade the strength, wisdom, and designs of his or her chosen host as failing to achieve the virtues of an idealized parental figure. Patients will project toward this person great though controlled hostility for failing them in their need and additionally will blame them for taking away their independence. Hostility may assume the form of aggression, scapegoating, or sadism toward others; or it may be fed back internally with self-punitive and other masochistic maneuvers. Low independence may produce self-criticism and a devaluated self-image, which may sponsor fantasies of being inferior, physically damaged, or sexually inadequate. Compensations take the form of perfectionism, overambitiousness, grandiosity, and compulsive drives to prove one's strength and power. Resorting to alcohol and drugs to overcome anxiety and depression may complicate the picture.

Therapy of patients with a passive-aggressive personality disorder is difficult because of the strong ego-syntonic nature of the associated traits and the ambivalent transference that is bound to emerge. One may deal with such symptoms as anxiety and depression on a short-term basis, but the basic personality structure will continue to stir up problems for the person. Implementation of the "baseline interventions" (page 1167) is desirable, recognizing that a dynamic long-term approach is essential to make any impression on the individual.

During the course of treatment the patient will seemingly modify attitudes toward the therapist, but in this alteration the therapist must search for areas of resistance. For instance, a submissive, ingratiating attitude, which is often a cover for a fear of abandonment, may, upon interpretation, be replaced by an apparently sincere attempt to search for and to analyze inner problems. The therapist may, if the patient is observed closely, detect in this new attitude a fraudulent attempt to gain security by complying with what the patient feels is expected of him or her. While the patient appears to be analyzing his or her problem, the real motive is to gain security by adjusting to what he or she considers are the demands of the therapist. In this way the process of therapy itself

becomes a means of indulging the neurosis.

In analyzing resistances, their sources in infantile attitudes and conditionings usually become apparent. Eventually it is essential to bring the patient to a realization of how the machinery with which he or she reacts to the world now is rooted in early conceptions and misconceptions about life. The interpretation of passive-aggressive character strivings does not suffice to change their nature, for they are the only way the patient knows of adjusting.

A breakdown of character strivings often brings out in sharp focus the repressed needs and impulses from which the strivings issue. When the patient becomes cognizant of what produces insatiable destructive interpersonal attitudes, he or she has the best chance of taking active steps toward their modification.

In certain cases, particularly if there are time limitations, the only thing that can be accomplished is to compromise with the existing disorder in as painless a manner as possible. Environmental manipulation may be necessary to take pressures off the patient. The patient may be shown how to adjust to the reality situation. For instance, if a woman has a strong striving for perfectionism that drives her incessantly into positions that she cannot handle with her intellectual and physical equipment, she may be shown how she can confine herself to a project that she can master proficiently. Whereas the scope of her operations may be limited, she can indulge her perfectionistic strivings in a circumscribed way, gaining some measure of gratification in this. If she is inordinately dependent on strong people, it may be pointed out that she can maintain a certain freedom of action in spite of the fact that she has to lean on authority. If she has an insatiable need to dominate, avenues for its toned-down exercise may be suggested. This approach, of course, merely panders to the patient's neurosis, but it may be the only practical approach for the time being; in many cases it will make the patient's life immeasurably more tolerable.

Whenever possible, patients should be brought to an awareness of the nature, genesis, and dynamic significance of their passive-aggressive character trends. They should be encouraged to observe how mercilessly they operate in everyday life and to

scrutinize why they cannot change their attitudes toward people. Desirable as this may be, a shift in therapeutic orientation toward insight may stir up a hornet's nest in the relationship with the therapist.

Though character trends in the passive-aggressive person are constantly shifting, they are usually interrelated and the fusion makes for a picture that is unique for each individual. Behavior is not the static product of a group of isolated trends; rather, it is a complex integrate of a number of drives. The product of this intermingling differs from any of the component strivings. That is, if the person is compulsively modest, is fired by perfectionism, is quiet at some times and arrogant and aggressive at others, some of these traits will tend to neutralize and some to reinforce each other. Nevertheless, for treatment purposes, we should consider them part of a conglomerate and not deal with them as isolated and distinctive entities.

Power Patterns

While not listed as a separate personality disorder in DSM-III-R, compensatory power impulses predominate in some individuals. Here all that seems to matter in life is forcefulness and strength. The feelings and rights of other people are disregarded. There is a blind admiration for everything invincible. The person is contemptuous of softness and tenderness, and self-esteem is seemingly dependent on the ability to be dominant. As in dependency, the dynamic force behind the power impulse is a profound sense of helplessness and an inability to cope with life with the available resources. A motive behind the power drive is to coerce people to yield to one's will, which provides bounties of various sorts.

The treatment of power drives is oriented toward building up frustration tolerance and increasing the capacity to withstand tension without resorting to aggression. A reeducative or behavioral approach may be effective in helping these patients develop inner restraints capable of controlling their impulses. It is essential to be firmer in working with this type of pattern than with either dependency or detached reactions. These patients must be constantly reminded that there are limits beyond which they

cannot go and that they must face responsibility for their actions. The dynamic significance of their power drive must be constantly pointed out, particularly its use as a means of shoring up the patient's devalued self-image. Patients should be encouraged to make efforts toward the expansion of their personal resources so as to minimize the need for power ploys.

A man may display unprovoked aggression whenever he tries to assert himself or when he feels deprived. Figuratively, he uses an elephant gun to kill a sparrow. He rationalizes his behavior to the effect that people pay no attention unless one forces them to do so. Behind this attitude is a feeling of helplessness and a fear of being rejected or attacked when one expresses one's rights. Consolidated is the conviction that one must display an image of strength and invulnerability to prevent exploitation. When people back away from his violence, this proves to the patient that they are unwilling to pay attention to his reasonable demands. He then becomes all the more angry, demanding, and forceful. The end result of his obnoxious conduct is that he is rejected and cannot hold a job even though he is intelligent and highly qualified. Depression forces him to seek psychiatric help. In therapy we can deal rapidly with the complaint factor of depression by prescribing an antidepressant medication, which in a few weeks may dissolve his malaise. If this is all he wants from therapy, the patient will then terminate treatment secure in the belief that he is cured and that he can now set off to find a new job. Undoubtedly the pattern will repeat itself because his illness has not been dented, let alone resolved. To go beyond mere symptom relief to correction of personality deficits will entail an extensive carefully planned stretch of psychotherapy.

If dependency and power drives are fused, the individual may be shown how he functions in a dual manner, seeking security from stronger people by shows of helplessness or wresting security from them by force and aggression. The chief resistance the therapist will encounter is transference, which may not be resolvable until the patient connects his reactions to historical developmental data.

Schizoid Personality Disorder (DSM-III-R 301.20)

The schizoid personality disorder is organized around the defense of detachment. The individual is often referred to as a "loner" or "isolate" with whom it is difficult to establish a relationship. There is a consuming flatness of mood with an inability to resonate through the spectrum of normal feelings from happiness to sorrow to anger. People who seek to establish contacts with schizoid personalities complain that they are withdrawn, isolated, and "standoffish" ("I'd like to shake him into reacting and feeling"). Daydreaming and living in fantasy are common. The schizoid personality disorder must be differentiated from the schizotypal personality disorder, which is closer to schizophrenia and in which there are distortions in thinking (ideas of reference and influence, depersonalization, peculiar fantasies, and paranoidal notions), odd manner of speaking, and episodes of eccentric behavior.

Such isolated and detached individuals, who shy away from establishing close interpersonal relationships and yet maintain a good hold on reality, rarely come to therapy for the disorder itself. If, however, the need for a relationship of some kind becomes pressing or, more likely, the individual is caught in a relationship from which there is no escape, anxiety may occur and motivate the victim to seek professional help. The disorder, with its features of coldness, aloofness, and absence of concern with and indifference to the feelings of others, is a protective screen and consequently resists therapeutic alteration.

Detachment may be the means elaborated by the individual to protect himself or herself from intense dependency strivings. A close relationship poses dangers of being overwhelmed, for in it the patient may envisage a complete giving up of his or her independence. Detachment may also be a technique of avoiding injury or destruction that the patient believes will occur when he or she comes close to a person. Finally, it may be a method by which the patient protects himself or herself from fears of attacking and destroying others.

In treating a detached patient, one must anticipate that there will be difficulty for a long time in establishing a close relationship, since this tends to mobilize fears of injury

and inspires the building of a protective wall. Much active work will be required in detecting and dissolving resistances to change. The detached patient often has a tendency to intellectualize the entire therapeutic process. The patient will particularly shy away from expressing feelings because he or she will conceive of them as dangerous.

Great hostility is bound to arise, which may be disconcerting principally because it is usually unexpressed or liberated in explosive outbursts. The therapist must realize that hostility is a defense against interpersonal closeness. It is extremely important that the therapist be as tolerant toward the patient's provocations as possible. The patient will probably attempt to goad the therapist into expressions of counteraggression to justify attitudes toward people as untrustworthy and withdrawal from the world because it is potentially menacing.

Sometimes the patient may be encouraged to participate in social activities, competitive games, and sports. Commanding, restrictive directions should, however, be avoided. With encouragement, detached people may begin to relate to others. In groups they drift cautiously from the periphery to the center as they realize that they will not be injured in a close interpersonal relationship. Group therapy may sometimes be most rewarding in certain detached, schizoid individuals, as long as no pressure is put on them to participate. Social groups with a wide range of activities may be prescribed.

A common reaction in the therapy of schizoid personalities is anxiety, which is manifested by disturbing nightmarish dreams or by actual anxiety attacks. The reaction will usually be found when the patient experiences for the first time real closeness or love toward the therapist. The emotions terrorize the patient and cause him or her to fear injury of an indefinable nature. It is essential to deal with this reaction when it occurs by giving the patient as much reassurance and interpretation as is necessary. Detached patients whose defenses have crumbled may go into a clinging dependent attitude when they realize the full weight of their helplessness. Supportive therapy may have to be given here, in an effort to provide the patient with an experience in which he or she receives help without being domineered or smothered with cloying affection. Should anxiety

become too disturbing, anxiolytic medications may temporarily be prescribed.

Schizotypal Personality Disorder (DSM-III-R Code 301.22)

The schizotypal personality disorder is closer to schizophrenia than the schizoid personality disorder. Emotional instability, peculiarities of ideation, involvement with superstition and magical thinking, and perhaps bizarre preoccupations as with clairvoyance and "out-of-body" experiences convey a feeling of strangeness and a psychotic-like tinge, although a definite psychosis is not present. Ideas of reference, fragmentary illusions, and odd mannerisms may be present. The patient often seeks therapy because of depression, anxiety, and depersonalization that have come on spontaneously or as a result of a stressful experience. Insight into cognitive dysfunctions is lacking, and motivation is confined to achieving freedom from disturbing symptoms. It is futile to reason with or to argue these patients out of their peculiarities of thinking and oddities of behavior. Therapy should be confined to dealing supportively with symptoms while establishing a friendly helping relationship. Anxiolytic, antidepressant, and carefully administered neuroleptic treatment in small doses may be indicated.

Narcissistic Personality Disorder (DSM-III-R Code 301.81)

In recent years an interest in the dynamics and therapy of narcissistic subjects has been revived. Scrutiny of the earliest phases of ego development have led to a number of hypotheses on how the disorder evolves and its influence on treatment (Kohut, 1971). Attempts have been made, with variable results, to differentiate narcissistic reactions from borderline cases and schizophrenia, which are distinctive ailments even though a strong bond exists among these entities. Problems in all three have occurred in the primary stages of separation and individuation. Object relationships, as a result, become distorted and shallow and are oriented around how they can enhance the individual's status and interests. Fusion and dependency are basic themes; love objects are imbued with both terrifying and grandiose qualities. In therapy the transference reaction, which is essentially narcissistic, encourages regressive episodes with fear of the loss of the love object, paranoidal symptoms, and a fear of mutilation. The regression is never as deep in

narcissistic personalities as in borderline or schizophrenic patients.

Therapists experience much difficulty in treating the character disorder of excessive narcissism. Persons with this problem seem to have such a need for personal admiration that they conceive of therapy as a means of making themselves more worthy of praise.

Unlike the mature person who gains security from cooperative endeavors in attitudes of altruism and sympathy, narcissistic individuals concentrate most of their interest on themselves. Self-love may actually become structured into grandiose strivings, omnipotent impulses, and megalomania. Although the image of the individual appears to be bloated, analysis readily reveals how helpless and impoverished he or she actually feels. There is danger here of precipitating depression or excitement by presenting insights prematurely. The shock-absorbing capacity of the ego must always be weighed, and interpretations must be given in proportion to the available ego strength. In markedly immature individuals little development may be expected other than a somewhat better environmental adaptation through guidance techniques.

Many of these patients often band together in Bohemian groups, posturing and posing, displaying a haughty defiance of convention, garbing themselves in outlandish dress, arranging their hair out of keeping with the accepted style as a way of expressing their exaggerated exhibitionistic, omnipotent, sadistic, and masochistic impulses. Language for them serves to release tension and not as a genuine means of communication. As long as they impulsively discharge their tension and anxiety in acting-out, they will not be too uncomfortable. "They are hunting eternally for satisfactory and secure models through which they may save themselves by a narcissistic identification. On the surface it appears later as a scattered, superficial pseudo competitiveness" (Greenacre, 1952). There is little motivation for therapy, which is usually sought not by the person but by a concerned parent or friend who is shocked or frightened by the patient's behavior. Under these circumstances psychotherapy proceeds under a great handicap, the patient generally breaking appointments or manifesting such resistance that the therapist's tolerance is put under the severest test. The only incentive that the patient has for

treatment is to please the parent or referral agency, usually to avoid the catastrophe of having his or her allowance cut off. If the person is unable to release tension because of the absence of or removal from environmental resources, anxiety may then come to the surface. Symptomatic discomfort will then act as a motive for help.

Classical psychoanalysis is disappointing in its results with narcissistic patients, but if a semblance of a relationship can be maintained, a modified analytic approach, perhaps drawing inspiration from object relations theory or self-psychology (see Chapter 11) may be useful. Some guidelines for therapy are found in the section on borderline personality disorder that follows.

Borderline Personality Disorder (DSM-III-R Code 301.83)

From the numbers of papers and books published and the frequency of seminars given, borderline patients have replaced white rats as the prime research subjects in the psychological field. Research has yielded some interesting hypotheses about the origins and the dynamics of borderline personality disorder, but it has not definitively established reliable ways of managing the difficult and fragile groups of patients embraced by this diagnostic category. Characteristic is a fluctuating assembly of symptoms that markedly cause subjective distress and impair social and occupational functioning. These include lack of impulse control leading to patterns of unstable and impulsive behavior that seemingly make no sense and involve the patient in difficulties with authority and peers. There are shifts in mood ranging from feelings of emptiness and boredom to temper outbursts and violent bouts of anger that are inappropriate and occasionally lead to quarreling, fighting, suicidal attempts, and other destructive activities. There may be confusion about one's identity in relation to self-image and gender. Fluid, unexpected changes in attitudes, moral precepts, values, and belief make it difficult to reason with and securely adapt to the person. Sometimes, especially when under great stress, transient, quickly recoverable, psychotic episodes occur. Characterologically, the individual manifests dependency, immaturity, detachment, and a wide variety of shifting traits.

Unlike the mature personality whose coping mechanisms are reality-oriented, the

borderline patient retains and employs the archaic defenses that were evolved during infancy and childhood in relationship to parental agencies. Prominent among these are projection, displacement, withdrawal, autism, dissociative processes (splitting of the ego), denial, and hysterical and obsessive-compulsive maneuvers. These combine with a fragmentary delusional system that is repressed but used as a coping device whenever the patient is under extraordinary stress. The existence of this system may be exposed during narcosynthesis or with the administration of small quantities of the psychotomimetic drugs.

Borderline patients are sometimes falsely classified as schizophrenics. Gunderson et al. (1975) have shown that there is little justification for this, since borderline patients do not exhibit distinguishing schizophrenic symptoms and differ in the quality of the thought disorder. Kernberg (1974) has described the personality organization of the borderline as one in which there is ego weakness with primitive mechanisms of defense, such as splitting, denial, omnipotence, devaluation, and early projective tendencies; a shift toward primary process thinking that may come through only in projective testing; and pathological internalized object relations. Kohut (1971) has expounded on the early traumatic disturbances in the relationship with the archaic idealized self-object and the damage to the maturing personality that continues because of this trauma. Fixation to aspects of archaic objects fashions the regression that occurs during analytic therapy.

The psychotherapy of borderline personality disorder is a long and difficult procedure, largely because of the fragile character of the patient-therapist relationship (Eisenstein VW, 1951; Bychowski, 1950). Borderline patients often seek help on an emergency basis when a crisis occurs or when symptoms such as anxiety and depression become intolerable. Some recognize that their interaction with people is disturbed and that they are unable to make a satisfactory social and occupational adjustment. At the start of therapy the therapist may be regarded as a curative deity who will rapidly dissolve the patient's troubles. This idea rapidly vanishes when immediate cure is not forthcoming. Disturbing transference reactions then interfere with the patient's ability to cooperate with treatment routines. There seems to be a deficit in the quality of the "observing ego,"

that part of the self that can judge one's pathological maneuvers. This interferes with establishing a trustful and realistic therapeutic alliance and encourages disturbing transference. How to deal with these reactions is a matter of controversy. Therapists such as Kernberg (1975) believe that the best method is to attempt reconstructive personality change by encouraging regression, by allowing the transference to build up, and then to interpret it. Others like Zetzel (1971) and H. Friedman (1975) have a dimmer view about the possibilities of reconstructive change in borderline patients and are firm in their belief that all that can be done is to keep transference under control and improve adaptation. Still others try pragmatically to move from one to the other paradigm as required. There are advocates and dissenters who support or ridicule each of these three viewpoints.

Disagreements about the most suitable approach probably occur because borderline disorders are constituted by a wide variety of patients who genetically, constitutionally, developmentally, and experientially are different. Moreover, patients are exposed to therapists whose training, skills, philosophies, and personalities may or may not provide a good match. No hard and fast rules about preferential treatment choice can therefore be made for all cases, but a flexible approach may be rewarding (Katz S, 1982).

Most therapists are dubious about curing patients with borderline pathology. They therefore adopt the course of supporting the defensive structure by avoiding unconscious conflict, minimizing concentration on the past, and providing symptom relief in the medium of a benevolent relationship with as much setting of limits as situations warrant. They will then adopt interventions that deal expediently with remediable pathology related to pathological links in the behavioral chain, for example, psychopharmacology for severe anxiety and depression, relaxation exercises for tension, desensitization techniques for phobias, behavioral therapy for impulsivity and self-destructiveness, environmental manipulation for situational disturbances, and cognitive therapy for distortions in thinking. They will veer from counseling, reassurance, confrontation, education, and concern with dynamics within the limits of their training and as required by the immediate needs of their patients. Therapy is usually conducted on a once- or twice-a-week basis. Modifications in method include the following:

1. Establishing a warm supportive relationship is of paramount importance.

2. Time restrictions in the session must be elastic.

3. A long testing period is to be expected. It may often be very difficult for the patient to make a relationship with the therapist.

4. Environmental manipulation may be inescapable.

5. Working with the patient's family to reduce pressure on the patient is frequently indicated.

6. The interview focus is on reality, the patient's relapse into daydreaming or delusion being interpreted as a reaction to fear or guilt.

7. Avoiding the probing of psychotic-like material is advisable.

8. Active reassurance and advice giving may be necessary.

9. Directive encouragement is given to the patient to participate in occupational therapy, hobbies, and recreations.

10. Neurotic defenses are supported and strengthened.

11. Challenging or disagreeing with the patient's distorted ideas is delayed until a good relationship exists.

12. The patient may at the start of therapy be told what to expect during therapy, especially that at times he or she may be upset with the therapist for not doing more for him or her. The patient may want to quit therapy. If the patient does quit, he or she is welcome to return (Katz, 1982).

13. Therapy may last a long time, perhaps the rest of the patient's life.

The importance of keeping the relationship with the therapist as non-distorted and productive as possible with a minimum of acting-out is paramount. When necessary, there is a search for maladaptive defenses and, when there is evidence of interference with transference, (1) elaboration of how they influence the patient's relations with others, (2) confrontation and interpretation of defenses that sponsor a negative transference, (3) the setting of limits in the therapeutic situation, and (4) the employment of modalities such as

hospitals, and foster homes when needed. Combined individual and group psychotherapy for the borderline patient has special advantages and a specific function. It is at present used widely for borderlines in private offices, clinics, and institutions where insight into the necessity for treatment and an ability to relate to a therapeutic situation remain at least partially intact.

While the one-to-one relationship of individual therapy satisfies dependency needs, the borderline patient also feels threatened by it. Many of these patients profit in a group therapeutic setting where they feel less dependent and the therapist appears less powerful. In the security of the group the members relate to each other and to the "democratic" authority figure of the therapist with more freedom and less anxiety than in any other situation. The group atmosphere facilitates expression of one's feelings. It makes interaction and with it socialization desirable and rewarding. The all-or-none conflict that leads to emotional inhibition and withdrawal out of fear of one's own destructive impulses is worked through under the protective leadership of the therapist and by testing the reality of anticipated dire consequences following expression of one's emotions. In the social situation of the therapy group, with its graded anxiety-releasing potential and the opportunity for reality testing, the borderline patient may find his or her first constructive experience in human relationships and may grasp a glimpse of understanding into the positive sides of socialization.

In working with dynamic vectors, care must be taken to prevent the patient's anxiety from getting too extreme. It is better to deal with the secondary elaborations of nuclear conflicts (derivative conflicts) as reflected in personality interactions (see Chapter 44) than with the nuclear conflicts directly. This may be especially useful if the patient displays evidence of obstructive transference and resistance and has enough of an "observing ego" to handle interpretations. Some of the techniques of A. Wolberg described later in this section may be helpful here. Management of counter-transference is a most vital part of therapy because in trying to understand one's untoward feelings and reactions the therapist can obtain important clues regarding basic conflicts that are being extruded through projective identification.

The prescription of psychotropic drugs may be indicated if the patient urgently requires calming or depression is bogging him or her down. Here one must recognize that the reports by patients of benefit may not coordinate with that of outside observers. Drugs may be poorly tolerated in borderlines, and even minor side effects may tempt the patient to discontinue medications. Haldol (Soloff et al, 1986) and Navane (Serban & Siegal, 1984) in moderate doses may be useful for anxiety and emotional instability as well as for psychotic-like symptoms. MAO inhibitors, such as Nardil, have been recommended for depressions associated with experiences of rejection (Klein DF, 1977). Benzodiazepines (Xanax, Valium, Ativan) may occasionally be useful for strong anxiety, recognizing the potential for abuse and that they may stimulate destructive actions. Tegretol in some cases has lowered tendencies toward impulsivity. Lithium has also been used when emotional instability was extreme (Rifkin et al, 1972).

Psychological testing for borderline patients has its advantages. Frieswyk (1982) believes that testing is especially valuable when manifestations of borderline pathology are subtle. We may detect "potential for acting-out, depressive mood swings, suicide, psychotic decompensation, as well as circumstances most likely to evoke untold reactions." We are helped to estimate the patient's capacities for a therapeutic alliance and "potential responses to different treatment modalities."

Short-term hospitalization may be required during critical phases of adjustment, particularly when the patient encounters rejection in a close relationship, is fired from a job, is involved in an accident, or during family crises. When serious regression has been stirred up by negative transference, an explosive reaction or suicidal gesture may require control in a protective setting. A halfway house sometimes is all that is required. The therapist must guard, however, against the patient's desire to use hospitalization as a repetitive escape device.

Reconstructive Psychotherapy

Borderline patients have traditionally been considered unsuitable candidates for psychoanalysis, but in recent years, inspired by the work of such analysts as Kernberg

(1975), Gunderson et al., (1975), Masterson (1976), Kohut (1971), Rinsley (1980), and others, and under the influence of object relations theory, certain modifications in psychoanalysis have been introduced geared toward the hitherto considered impossible goal of reconstructive change. Unfortunately, the writings of some of the innovators have been vertiginous and difficult to understand. Moreover, there are fundamental disagreements regarding the best way to implement psychoanalytic psychotherapy.

Although true classical psychoanalysis is generally contraindicated, some analysts agree with Kernberg that regression should be promoted in order to activate pathological object and self representations and their projection onto the analyst in the transference. Consequently, the therapist is enjoined to be technically neutral and non-interfering. Primitive transference, which rapidly precipitates, should immediately be interpreted in here-and-now terms. Suggestive and manipulative techniques are best avoided, but the patient's condition may necessitate some structuring of daily routines. The therapist is empathic but must be as non-interfering as possible, activities should be confined to clarification and interpretation and external arrangements left to others. Genetic reconstructions cannot be made early in treatment because self and object representations are too fuzzy and undifferentiated and projective identification and splitting are too imminent. Later in therapy when there is a better differentiation and part-object relations have given way to more mature (whole-object) relations, genetic reconstructions may be effective. This form of treatment is long-term, with session frequency no less than three times weekly. Because primitive transferences may activate psychotic processes, hospitalization may be necessary to protect the patient and others. If the patient's defenses are sufficiently strong to prevent acting-out, therapy may proceed outside of a hospital, perhaps with day-hospital arrangements, and if living with a disturbed family is intolerable, in a foster home. This modified analytic approach, known also as "expressive psychotherapy," may not be possible if the patient's secondary gains through exploitation of the illness are too powerful and milieu distortions are so strong as to necessitate constant environmental manipulation. Social isolation may also be too prominent, ego weakness too intense, and antisocial tendencies too dangerous. In addition, there may be too little motivation, too low economic wherewithal, too poor

psychological mindedness, and too limited capacity for introspection to recommend this kind of treatment. Finally, the therapist may have too little training and sophistication in the use of the requisite techniques and too little confidence in their effectiveness to give the method a fair trial.

A large group of analysts question the value of expressive psychotherapy with its promotion of regression as the principal technique and think that it may pose dangers for the patient. They believe that the therapist must be more active and maintain an openly empathic front and provide a reassuring "holding," limit-setting, structured environment irrespective of the intensity of disturbance of the patient. This group, following the leads of "self-psychology," has evolved an elaborate concept of the "self-object" and of personality development that encourages a conception of the borderline patient as less of a laboratory of pathological strivings that require activation and interpretation in an atmosphere of technical neutrality and more of a creation of faulty conditioning and inadequate development with deficits that must be repaired in a nurturant relationship. The patient is helped to tolerate his or her transference reactions and then to replace destructive and angry feelings that emerge in the transference. Only very much later is interpretation utilized.

A modified analytic approach that has proven effective with some borderline patients is illustrated by the work of Arlene Wolberg (1952, 1959, 1960). She recommends that reconstructive treatment must be slowly and carefully organized because of the ever-present projective frame of reference and the danger of throwing the patient into anxiety that will force the patient to use his or her delusional system as a defense, thus pushing the patient over the border into an active psychosis. Freud's account of his management of the patient described in his paper "An Infantile Neurosis" contains tactics that may be used with borderline patients: "The patient ... remained ... unassailably entrenched behind an attitude of obliging apathy. He listened, understood, and remained unapproachable. His shrinking from an independent existence was so great as to outweigh all the vexations of his illness. Only one way was to be found of overcoming it. I was obliged to wait until his attachment to myself had become strong enough to

counterbalance this shrinking, and then played off this one factor against the other" (*Collected Papers,* Vol. III, pp. 477-478). In view of the degree of sadomasochism in the borderline patient, the treatment process must take into account the severe anxiety to which such patients are constantly subjected, the peculiar composition of the ego, which tends to be organized around oppositional tendencies (sadism), stubborn negativism, the need of the patient to fail in certain situations, the passivity, the projective framework, the psychotic-like transference, and the characteristic failure of the various defensive structures. Special techniques are needed.

The first phase of treatment must involve what A. Wolberg (1960, 1973) has called "projective techniques." These are methods of coping with the sadomasochism of the patient, the acting-out tendencies, the denial and dissociative mechanisms, the autism (fantasy life), and the negativism so that the therapist does not become embroiled with the patient in a sadomasochistic relationship. Three projective techniques are recommended: (1) "the use of the other," (2) "attitude therapy," and (3) "ego construction," i.e., reinforcement of the patient's constructive ego trends.

In the "use of the other" the therapist takes advantage of the tendency of borderline patients to deny their own feelings and ideas and to project them onto others. When they speak of "others," therefore, they are actually talking about themselves in a masked way to avoid anxiety. Should the therapist do what is ordinarily done with neurotic patients, i.e., interpret the projection and confront the patient with the defense, borderline patients will be unable to organize themselves and to utilize the interpretation constructively. Instead they will become more resistive and deny the validity of the interpretation, incorporating the interpretation into their sadomasochistic operations by beating themselves with it and advancing it as another reason to hate themselves or, on the other hand, by becoming paranoid against the therapist and using the interpretations as a rationalization for the distrust. The relationship with the therapist is bound to disintegrate under these circumstances; a transference neurosis may precipitate out abruptly; psychotic manifestations may emerge. For these reasons the therapist must preserve the projective defenses of the patient and always (at least during the early stages of treatment) talk

about the motives and maneuvers of the "others," allowing the patient to make personal connections or to deny them as he or she wishes. Such a method will help cement a positive relationship with the patient. Dreams are handled in the same way, never pointing an accusing finger at the patient. Fantasies that have motivated the acting-out are analyzed in a manner similar to dreams: the therapist does not challenge or confront the patient. One merely explores. One does not justify or reassure the patient, even though one acts empathic.

The "others" in the interpersonal encounters are analyzed by conjecturing as to •why they feel and act as they do and what their motives could possibly be. The therapist does not charge the patient with the fact that he or she is like the "others." Eventually when the working relationship consolidates, the patient will acknowledge this. When the first statements are made by the patient that "this is like me," the therapist simply agrees and does not pursue it further. Each time that the patient says "this is like me," the therapist agrees that is *might* be true. Should the patient repeatedly bring up the consociation, the therapist may suggest that this is a pattern worth exploring. The therapist may query, "How does the pattern operate? It is not too obvious in the sessions. This could be worth exploring."

"Attitude therapy" is a projective device used to point up the patient's patterns of operation within any given interpersonal relationship. Inevitably he or she will bring up details of a personal encounter that are highly prejudiced and contain a paranoidal flavor. Accurate accounts will be resisted since this will reveal the patient's acting-out proclivities that mobilize his or her guilt. The therapist must not be put off by the patient's maneuvers; the therapist keeps asking for details, but not to the point where the patient becomes overly defensive. In such a case the therapist discontinues questioning, indicating that it is causing too much anxiety in the patient. When other incidents are reported, however, questioning is begun again.

Eventually the patient's true attitudes and feelings, which contain fragments of the fantasies motivating the acting-out, will be revealed. The therapist may then say,

"Incidents like this can be very upsetting." As the patient brings up accounts of further encounters, definite patterns will emerge. Eventually the therapist will be able to help the patient consolidate his or her thoughts, attitudes, feelings, and behavior in these situations. The interpretations are in the form of broad statements that in a roundabout way, through focusing, indicate a connection between thoughts, feelings, fantasies, anxieties, and patterns of acting-out behavior. Questions are posed in such a manner that the patient makes the associations. If the therapist offers the patient an interpretation before he or she is ready for it, i.e., before the patient has mentioned the possibility several times, then the therapist may become involved in the patient's obsessive mechanisms. The patient will weave the therapist into the warp and woof of his or her fantasy life and chew on the information instead of using it to work out the problem.

In the technique of "positive ego construction" the therapist is the projective object, taking positive trends in the patient's ego and reflecting them back to the patient as if they were the therapist's own. This is because borderline patients cannot accept good things about themselves or utilize their own constructive thinking without excessive anxiety. Such patients are guilty about their positive trends since they have been taught by their parents to disbelieve them; they have been encouraged to fail in certain ways in order to play the roles consigned to them. Success constitutes a greater threat than failure in specific areas. To reduce their guilt but not to analyze it is one of the purposes of this technique. For instance, if a patient brings in the tale of having applied for a job and having bungled the interview by purposefully saying that he could not qualify because of lack of skills, and if he then reflects back on what happened with the remark, "I should have told him that I know enough about this work to be able to learn the special details rapidly, which is the truth," the therapist may respond in a qualified positive way: "It is definitely *my* opinion that you know enough about this work to able to learn the special details rapidly." Thus the phrases the patient has uttered are repeated as the therapist's own ideas. The phrases may also be reorganized and the same thing said in different words. For example, the patient states: "Probably I feel I don't deserve the job." The therapist does not reply with the conventional, "Why not?" Instead the comment may be, "I've thought of this too. Many people I've worked with feel guilt when a good opportunity

presents itself. They shouldn't have to feel this way, but they do."

Role playing may also be employed to rehearse with the therapist what the patient *might* have said, the patient and therapist interchanging roles of patient and employer. After a certain number of incidents have been "role played," a patient may wonder why he or she acts this way. The therapist then replies, "This is an important thing for us to figure out." The therapist does not give the patient the answers when questioned, "Why?" Rather the therapist indicates that the two must seek answers together; this is a cooperative effort between two people who have come to an agreement on certain points.

After the patient is able to accept responsibility for his or her own actions without developing intense anxiety or manifesting the usual defenses, the treatment may take on a form similar to that of working with a neurotic patient. Should the patient become excessively anxious, projective techniques, as outlined above, should be used.

Avoidant Personality Disorder (DSM-III-R Code 301.82)

The determining feature of avoidant personality disorder is possession of a markedly devaluated self-esteem. This produces a defensive reaction of avoidance of any stimulus that points to this defect. Avoidant individuals safeguard against criticism, rejection, humiliation, failure, and social derogation by withdrawal tendencies and refusal to take chances or to expose themselves to any activities that threaten to bring out their inferiority and personal shortcomings. Ungratified needs for love, acceptance, and recognition sponsor frustration, anger, self-debasement, and other masochistic tendencies. Unlike the schizoid personality, who displays some of the same tendencies, the avoidant personality has not given up desires for success and good social relations, and in fact retains an unquenchable thirst for these bounties.

During psychotherapy, the thrust should be toward encouraging exposure to challenges and to activities that promise self-enhancing rewards. In addition to the baseline interventions, the following are recommended:

    1. Behavioral assertiveness training to enable the patient to accept challenges and

to put his or her best foot forward;

2. In vivo desensitization in situations that are usually avoided;

3. Group therapy and psychodrama to provide a platform for the practice of assertive behavior; and

4. Cognitive therapy to correct false attitudes and inhibiting self-statements.

Histrionic Personality Disorder (DSM-III-R Code 301.50)

The need for histrionic and dramatic displays characterize the histrionic personality disorder. A strong narcissistic tinge colors attitudes and interpersonal relationships. The individual, while evincing a superficial though exaggerated show of affection for and concern with others, is actually self-centered, seeking to impress the immediate audience with his or her charm and talents. Emotional instability with periods of screaming, crying, and explosive carrying-on break out when wishes are not granted or actions are disapproved. The irritability, egocentricity, demandingness, and irresponsibility of such persons result in rejection, which is apt to stimulate retaliatory rage and paranoidal-like recriminations. Such behavior is usually forgiven because of the individual's skilled show of remorse and clever seductiveness, only to be repeated at the next frustrating episode. Dependency patterns are common. The histrionics typically fasten onto hosts whose lives they make a continuing episode of crises. Suicidal threats and abortive attempts at destroying themselves are prominent chapters in the book of theatrical displays.

Therapy is usually sought when a spouse or lover seriously threatens to abandon the person unless the latter begins therapy or analysis. With astonishing rapidity, the therapist becomes the object of the patient's displays, seductiveness, and acting-out, since transference is easily mobilized in these patients. Treatment is usually unsuccessful because motivation to change is shallow and insincere. As long as the patient has another human subject to fasten onto, the referring agency is temporarily relieved of the burden. If a therapeutic relationship can be established and the therapist does not allow countertransference to distort a professional stance, some of these patients may be helped with long-term dynamic psychotherapy.

Antisocial Personality Disorder (DSM-III-R Code 301.70)

Allied to narcissistic character disorders is an antisocial personality manifested by poor frustration tolerance, egocentricity, impulsivity, aggressiveness, antisocial acting-out, an inability to profit from experience, undeveloped capacities for cooperative interpersonal relationships, poorly integrated sexual responses, and urgent pleasure pursuits with an inability to postpone gratification. Many such patients lied, fought, stole, and were truants during childhood and resorted to severe substance abuse during adolescence. Vagrancy, sexual promiscuity, and criminality are hallmarks of the disorder in adults. Because of the indelible warping in ego formation, goals in therapy, as with the narcissistic personality, are geared toward symptomatic relief rather than character change.

Modification of destructive and antisocial behavior is, of course, desirable but usually visionary. Recognition of acting-out, the circumstances and needs that initiate it, and the way that the patient draws other people into his or her maneuvers are not too difficult. Doing something to prevent this behavior is another matter.

Most authorities agree that the management of an antisocial personality is most difficult. All approaches have yielded meager results. In many cases the only thing that can be accomplished is manipulation of the environment to eliminate as many temptations as possible that stimulate the patient into expressing his or her vicarious impulses.

If an antisocial individual can establish a relationship to a person, the latter may be able, as a kind but firm authority, to supervise and somehow restrain the patient's actions. Hypnosis may reinforce this authoritative relationship but the patient will usually continue to test the powers of the therapist who acts as a repressive moral force and as a pillar of support. The patient may get to the point where he or she will turn to the therapist for guidance when temptation threatens. Suggestions are couched in terms so as to convince the patient that he or she is actually wiser and happier for resisting certain activities that, as he or she knows from past experience, are bound to have disastrous results. On the basis of a guidance relationship, the patient may be instructed in the

wisdom of postponing immediate gratifications for those that in the long run will prove more lasting and wholesome. The patient is taught the prudence of tolerating frustration and the need to feel a sense of responsibility and consideration for the rights of others. Not that these lessons will be immediately accepted or acted on, but constant repetition sometimes helps the patient to realize that it is to his or her best interest, ultimately, to observe social amenities and to exercise more self-control.

Experience demonstrates that it is possible to modify to some extent the immature explosive reactions of the patient by an extensive training program, particularly in cooperative group work where the individual participates as a member toward a common objective. Adequate group identifications are lacking in these people, and the realization that ego satisfactions can accrue from group experiences may create a chink in the defensive armor. In cases where the individual comes into conflict with the law and incarceration is necessary, a program organized around building up whatever assets the individual possesses, particularly in a therapeutic community, may, in some instances, bring success. In young patients vocational schools that teach a trade may contribute to self-esteem and provide a means of diverting energies into a profitable channel. Should group therapy be deemed necessary, the constituent members ideally should be antisocial personalities with problems similar to those of the patient. The group leader should ideally be an antisocial personality who has recovered and gained respectability. Even if therapy seems successful, intervals of acting-out are to be expected.

PSYCHOACTIVE SUBSTANCE-INDUCED DISORDERS

Alcoholism (Alcohol Abuse) [DSM-III-R Code 305.00]; Alcohol Dependence [DSM-III-R Code 303.90]

People with alcohol dependence rarely come to psychotherapy because they want to quit drinking of their own accord. They are usually pushed into it because of aversive circumstances that their drunkenness has created. A wife threatens her husband with divorce unless he stops his irresponsible tippling. An employer gives an old employee a last chance to get off the bottle by personally arranging a consultation with a therapist. A

drunken driver is about to lose his license and his lawyer insists that it is a good strategy to be in treatment. A judge suspends sentence on a person who has committed a crime while drunk on the condition that he do something about his alcoholic habit. A physician has frightened the drinker or his family with the announcement that alcoholic liver disease will result in incurable cirrhosis. In many cases the principal reason alcoholics seek help is for symptoms of anxiety, depression, blackouts, and insomnia or for stressful environmental conditions with which they cannot cope even under the influence of alcohol or other abusive substances. Alcoholics will often fail to mention their proclivity to drink until the therapist asks how much they drink. Alcoholics will usually minimize the amount they consume and derogate the idea that they cannot hold their liquor. They do this not because they want to deceive the therapist, but because *they are unable to stop their habit* and want to ensure its continuity without paying the penalty with which they are now confronted. The therapist will then realize that the complaint factor may be a secondary complication and that the basic problem is that the patient is poisoning himself and ruining his life with drink. The therapist will recognize also that unless the alcoholic stops drinking completely psychotherapy will have little effect. If the individual is only psychologically and not physiologically dependent on alcohol, it may be possible with psychotherapeutic help to wean the person from drink. If the pattern has progressed to the point where there is a physical need for alcohol, the problem may be an insuperable one unless motivation is created to achieve complete abstinence. Without this motivation, therapeutic efforts will be useless.

Because motivating drinkers to give up alcohol and other abused substances is so difficult, alcoholism has become, world over, one of the most serious and prevalent problems that threatens society today. The more than 10 million alcoholics in the United States affect the lives of 40 million family members. The economic loss to the nation amounts to $120 billion annually. Alcoholism accounts for a great many illnesses with fatal consequences. It is the fourth leading cause of death. Liver disease, gastritis, an increased risk of acquiring certain cancers, toxic interactions with other drugs, nutritional deficiencies, birth defects, hypertension, sluggishness of the cardiac musculature, interference with hypothalamic and pituitary hormones, and various other calamities

shadow the existence of the indiscreet drinker. In addition, there are the ever-too-abundant psychological ravages that interfere with adaptive functioning which affect work, marriage, family, and social relationships, create accident proneness, and otherwise disrupt one's personal life. These problems are too well known to require elaboration here. In sum, alcoholism is the most commonly abused and most dangerous drug habit today.

The fact that alcoholism has traditionally been regarded as a moral failing rather than a disease with genetic associations has led families to regard it as a stigma and a disgrace. In recent years, however, this attitude has changed. The courageous revelation by First Lady Betty Ford of her struggle with alcoholism has helped enormously to give people a more authentic outlook at this crippling and potentially fatal malady. Recognition that alcoholism can be treated has led to the introduction of a number of regimes that try to approach the illness from a scientific perspective. Acceptance of modern treatments give the alcoholic patient almost a 75 percent chance of returning to productive life. The fact that one-half to three-quarters of all referrals to recently created employee assistance programs are for alcohol misuse has stimulated industry and unions to develop services for alcoholically impaired employees. Many deterrents exist, however, *(JAMA,* 1983). First, there is the matter of confidentiality and the patient's right to privacy. Revealing the nature of the difficulty can threaten advancement if not termination of one's job. Second, follow-up studies on treated alcoholics are thwarted by federal confidentiality regulations. Third, there is difficulty in coordinating the accumulated information so that it can be distributed effectively and utilized in medical curricula and by specialists. Fourth, reliable cost-effective methods of assessing new treatment programs must still be developed.

Aggressive programs, such as one at General Motors Corporation, have proven not only that such programs have economic advantages for a company, but also that they enable the company to retain valued employees and thus minimize staff turnover. Three-to 4-week care in institutions practicing a variety of interventions have proven so popular that freestanding inpatient and residential facilities for alcoholism and substance abuse have multiplied. Medically supervised programs and "Care-Units" now exist that provide

hospital-based medical care, as well as educational and psychological counseling for patients and their families. On some units offering multimodal programs some staff members are themselves recovered alcoholics who, because they have gone through similar experiences and "speak the language" of alcoholics, can often provide better role models than professionals.

A common treatment format includes at the start medical detoxification in a hospital. When the patient is able to do so, he or she attends daily group and individual psychotherapy and counseling sessions as well as recreation therapy. Weekly family seminars with patients and their families are held to discuss mutual problems and to explore changes that are essential in the future. Films are shown, literature distributed, and workshops are held to enrich education about the nature and consequences of alcoholism. An aftercare program acts as a bridge to the community to prepare the individual for the habitual stresses he or she will face without alcohol. These treatment units are located in different parts of the country, and information about them may be obtained from local social service agencies.

Getting off alcohol, it is now recognized, is not the end-all of therapy. It is the beginning. What one must do in addition is maintain sobriety and ideally deal with the sources of the drinking problem. Here we come back to the problem of motivation. It is hard enough to get an alcoholic to want to try to stop drinking and enter a unit that will enable him or her to get off alcohol; it is even more difficult to get the alcoholic to do something about the conditions that have created the drinking problem.

Creating Motivation for Abstinence

As mentioned previously, the first step in therapy is to create a sincere desire to remove from one's life the toxic substances that one uses to subdue anxiety. Initial resistance to the idea of accepting help is common and confounding. It is especially a problem in elderly alcoholics, whose denial mechanisms are abetted by their need to flaunt independence. Motivating an individual to accept that he or she needs to give up alcohol to feel better requires a good deal of patience and skill.

The following points and caveats may be of help:

1. When the average alcoholic applies for therapy, he or she usually expresses or suggests a secret hope of learning to drink normally and to "hold my liquor like anyone else." This may be possible in anxiety drinkers following abatement of their neurosis; it is not possible in the case of real alcoholics.

2. Although some persons believe that alcoholics can be cured by weaning them gradually from the bottle and that they may learn to engage in social drinking without exceeding their capacity, experience has shown that success is possible only where alcohol is completely and absolutely eliminated from an individual's regime. The object in therapy is complete elimination of all alcoholic beverages, including wine and beer.

3. The treatment of alcoholism not only embraces the removal of the desire for alcohol; it also involves restoration of the patient to some adaptational equilibrium. Without such restoration, the person will become pathologically depressed, and tension will drive him or her to drink no matter what pressures are exerted.

4. In the anxiety drinker any attempt to force or shame the person into sobriety will interfere with the therapeutic relationship. A useful rule is not to make the diagnosis of alcoholism for the patient but to give the patient information so that he or she makes the diagnosis or at least genuinely asks for help. It is fruitless to design a treatment program for an alcoholic unless he or she is ready to accept the need for help.

5. Never accuse the patient of being an alcoholic, this will stimulate defiance and denial. The patient will accept any other diagnosis except alcoholism. One may tell the patient that some people are chemically unable to tolerate alcohol and that it acts like a poison to their bodies. Many patients will accept that they are "allergic" to alcohol more easily than that they are psychologically unable to control their drinking.

6. Emphasize that it is difficult to break the habit without professional help because the body has become chemically dependent on alcohol and requires medical and psychological interventions to control the effects of withdrawal.

7. Never pressure a patient into giving up alcohol. Explain its effects on the body

and tell the patient to be the judge of whether he or she wants to try to give it up.

8. If the patient asks what the signs of alcoholic dependency are, one may simply say: "If you can't get through the day without a drink, you may want to do something about it. This indicates that the body is asking for help."

9. Warn the patient that he or she may need some support to stop drinking. The best support is an AA (Alcoholics Anonymous) or similar group. If the patient claims he or she is not an alcoholic and does not see the reason to go to an A A group, tell him or her that people with a wide assortment of problems other than drinking are helped by such groups. Deal with the patient's resistance.

10. You may not be able to do very much with an alcoholic without AA or a similar group as a helping adjunct.

11. Avoid psychoanalytic probing or any other insight therapy until the patient is off alcohol; such treatment will do no good. The triad of confrontation, empathy, and proffered hope is the best technique for breaking down denial mechanisms and other resistances (Whitfield, 1980).

12. A patient may be able to start and continue in psychotherapy without becoming an inpatient in a hospital or treatment unit if he or she has sufficient motivation to join a supportive group such as AA and is able to detoxify himself or herself.

Detoxification

A large number of patients who have no serious physical illness can be detoxified at home or preferably at a local detoxification center, usually without drugs (Whitfield, 1980). A pleasant atmosphere is important. The patient being ambulatory, introductory group sessions are initiated, and distracting group activities are arranged. Drug-free detoxification, if it can be done, has advantages; it is shorter, less expensive, can be executed by non-medical personnel, avoids dependence on drugs, and helps the patient remember the unpleasant withdrawal experience, which acts as an aversive stimulus in the face of temptation. Any medications that are needed except anxiolytics and energizers should be continued. If the patient is uncomfortable, however, benzodiazepines such as

Librium or Ativan may be prescribed during the first few days and then discontinued. A strong multivitamin, 50-100 mg of thiamine, and 1 mg of folate should be given daily. If withdrawal seizures have occurred in the past, 300 mg of phenytoin (Dilantin) should be given daily for 5 days. Where an anxiolytic is deemed necessary for more than a few days BuSpar may be used since this medication produces tranquilization with no apparent abuse liability and no withdrawal syndrome reported at the end of therapy.

Conditioned reflex therapy is not as popular as it was in past years. It requires hospitalization in a special unit when it is used. A popular model is to administer an emetic paired with alcohol. Apomorphine is given for purposes of conditioning if there is no disease of the kidney or liver and the patient has not recently been on Antabuse. The patient then receives several glasses of warm water flavored with his or her favorite alcoholic beverages. Several spasms of vomiting may occur. Suggestions are made that the patient will be able to control his or her drinking by disliking all alcoholic beverages; in this way a person's health is restored. This treatment is repeated on successive or alternate days. Salt should be added to the diet to compensate for the salt lost in vomiting. The conditioning method is expensive, and statistics on its usefulness are still unclear.

Some behavior therapists attempt detoxification by training the patient in behaviors that are incompatible with excessive drinking (Miller, 1977). The patient is taught substitutive behaviors in situations that operate as cues for drinking. Thus assertive training (Alberti & Emmons, 1973) may be instituted to enable the individual to express personal rights and feelings without his or her customary recourse to alcohol. Relaxation training and systematic desensitization teaches the patient to master anxiety-provoking situations that lead to drinking. Because troubled marriages are sometimes at the basis of an alcoholic's drinking, couples may be instructed in the use of mutual positive reinforcing behavior with contingency contracting (Stuart, 1969). A variety of other operant approaches have also been employed (Cohen et al, 1972; Azrin, 1976). "Covert sensitization" utilizes imagery to pair a desire for alcohol with nausea (Elkins, 1980). Hypnosis has also been employed (Katz RC, 1980).

If a patient continues to drink or whatever approach is tried proves only partially effective, he or she should be counseled, best in the presence of the spouse, to take a vacation and go to a treatment unit for help. There are many such units, some good, some not so good. The Yellow Pages of the telephone directory lists them under "Alcohol Information and Treatment," but finding units in this way will require investigating their qualifications. They should be hospital based, state certified, and approved by the Joint Commission for the Accreditation of Hospitals (JCAH). There are more than 100 "care units" around the country. They should have a rounded-out program from detoxification to aftercare. The reason concentrated therapy in a closed unit is necessary is that the alcoholic, despite his or her show of independence, is very dependent and needs people around all the time, as well as activities to divert his or her mind. Boredom easily sends the patient to drink. The alcoholic cannot fill the day with sufficient activities at home or at work. Stresses associated with everyday routines may be too anxiety provoking. A complete change of scene in a well-run unit is needed to get these patients off to a fresh start.

In heavy drinkers, detoxification will precipitate abstinence reactions in 12 to 24 hours. Shaking and agitation may frighten these patients, delirium tremens may kill them unless they get proper treatment. Librium, 50-100 mg intravenously, repeated as necessary in 2 to 4 hours, or Ativan intramuscularly, 0.05 mg/kg up to 4 mg, may be required. Emergency reactions will need special interventions (see Chapter 58, "Handling Emergencies in Psychotherapy"). It usually requires 3 to 5 days to detoxify an alcoholic, and up to 3 weeks if other addictive substances have been taken, which is very common. Coincident with and subsequent to detoxification, a multimodal program of counseling, education, group work, and recreational therapy is implemented. Family counseling and therapy are employed as needed. The patient is prepared to continue in an Alcoholics Anonymous or similar group in the area in which he or she lives, and the spouse and family are referred to Al-Anon (Anthony, 1977). The telephone number for Al-Anon is listed in the telephone directory or may be obtained from Alcoholics Anonymous, also listed in the directory.

A considerable number of alcoholics take abuse substances in addition to alcohol. Among the most popular of these drugs are sedative-hypnotics such as barbiturates (Nembutal, Seconal), nonbarbiturate hypnotics. (Noludar, Placidyl), opiates (heroin, illicit methadone), and stimulants (dexedrine, cocaine). After being detoxified from alcohol, the alcoholic may experience symptoms of withdrawal from the other abused substances, which may also require therapy. In some cases the primary problem was the abuse of substances other than alcohol, and alcohol was taken to reinforce the effects of or to deaden withdrawal symptoms from the drugs. Because of the ease and relatively low cost of alcohol, the drinking continued, resulting in alcoholism.

Not uncommon are manifestations of such syndromes as major or bipolar depression, panic disorder, agoraphobia, impulse control disorder, and psychogenic pain, which appear after detoxification has rendered the patient alcohol free. In many cases the primary problem was the syndrome, whose symptoms the individual has tried to control with alcohol. In such cases corrective interventions will be needed.

Once the patient is free from the mind-befogging effects of alcohol, he or she more easily becomes aware of how drinking has interfered with his or her life and happiness. The patient may still have symptoms of anxiety and depression; stress situations will still exist at home and at work; or a personality problem may continue to interfere with proper adaptation. The patient will continue to need care and psychotherapy for these problems. During the period of hospitalization the therapist will have telephoned the patient once or twice or, better still, if possible, would have visited. In this way, continuity of treatment is maintained.

Post-abstinence Therapy

When the patient returns for psychotherapy, he or she may be able to accept the diagnosis of alcoholism. The patient is told that alcoholism is a treatable disease like diabetes for which one cannot be blamed. However, it must be watched and taken care of the rest of one's life. While the patient is better now, care must be taken not to slip back into old habits. This is best prevented by going regularly to an AA group and by continuing

in psychotherapy. A common question is "Can I ever resume normal drinking?" The answer is a categorical no. Alcoholism like diabetes is a lifelong disease and resuming drinking (even one drink) will activate it again." The patient is told that the recovery rate is high if a person follows a good treatment plan. Doing this is the patient's own responsibility. Nobody else can do it for the patient.

If the patient, in spite of this talk, cannot seem to avoid tippling, he or she should be put on Antabuse (disulfiram) after discussing the urgent need for this helping agent. The average daily dose of the drug is 250 mg (with a range of 125 mg to 500 mg), although sometimes more is needed. The patient must be completely off alcohol when it is started. The patient should be instructed that the drug is harmless unless he or she drinks, and that "going off the wagon" will make him or her violently and even dangerously sick. Antabuse will protect the patient from temptation, so taking it daily is important. Ayerst Laboratories puts out a patient education booklet entitled "Now that You're on Antabuse." After one or two years of abstinence, the patient, in conference with the therapist, spouse, or close family member and A A group leader, may experiment with going off Antabuse, provided the patient is able to cope with life and with crises adequately, is relating well with people, and most important, continues in the AA group. Antabuse is most helpful in older motivated individuals who need to control psychological stressors that invite drinking. Contraindicated for Antabuse use are illnesses such as diabetes, cardiac disease, and cirrhosis of the liver. Antabuse is not suitable for schizophrenics and patients with schizoaffective reactions and markedly unstable impulse disorders. It is best to arrange for a relative or a trusted person at work to supervise the regular and uninterrupted taking of Antabuse to maintain a constant level of the drug in the bloodstream. With too small doses of Antabuse, the patient may be able to override its effect with alcohol resumption.

Psychotherapy

The psychotherapeutic treatment of an alcoholic is vital, since true alcoholics never get over the threat of relapsing into drinking. During the period when they are well, they

become non-drinking alcoholics. For many, attendance at AA is necessary all their lives. Older members eventually become leaders and helpers, ministering to the more vulnerable alcoholics. In this way, by identification, non-drinking alcoholics help themselves. Immediately after detoxification, individual therapy is needed in addition to the supportive AA group experience. The danger of relapse during the first 6 weeks after stopping drinking is real and the patient should be seen as frequently as possible during this period. Vulnerable patients who need supervision may be taken care of in a halfway house.

Designing a treatment program for the non-drinking alcoholic is dependent on what pathogenic links in the patient's behavioral chain require treatment. Basic to any treatment program is, to repeat what has been said before, continuing membership in AA or a similar group. Some alcoholics terminate the group program and are able to remain abstinent. For most, however, a good group is indispensable indefinitely as an anchor to sobriety. Psychotherapy for patients who do not have severe marital, family, or environmental problems can be short term, but group membership should continue without interruption.

Many alcoholics suffer from an underlying depression, which should not be too difficult to diagnose. A major depression may require antidepressant therapy with tricyclics or other drugs. A bipolar depression may need Lithium therapy. A neurotic depression is best helped by cognitive, interpersonal, or other form of verbal therapy. Some borderline cases may need carefully controlled neuroleptic therapy. Panic disorders and agoraphobia should be treated with behavioral approaches and antidepressants; and sedative-hypnotics assiduously avoided. Anxiety and tension are ubiquitous complaints, and the individual may importunately petition for some medications to relieve it. This request should not be treated lightly, but the patient must be reminded that the benzodiazepine drugs may be as harmfully addictive for him or her as alcohol. It is therefore best to use other tension-relieving approaches, such as relaxing exercises (a relaxing tape may be made), biofeedback, hypnosis and meditation, as well as physical exercise. Joining a YMCA or YWCA or other athletic club, running (if it is physically

permissible), and swimming are often helpful. Where an anxiolytic is absolutely necessary, buspirone (BuSpar) may be employed.

Searching out and finding existing causes of stress and anxiety in the patient's work, marital, or family situation will necessitate appropriate interventions. In examining the work situation, a battery of vocational lists may disclose that the patient's interests and aptitudes are in a direction other than the existing work. The patient may then be guided to develop along the lines indicated by the tests. Marital difficulties are best approached with marital therapy and family problems with family therapy. Environmental stress will require counseling and environmental manipulation. Consultations with a social agency for recommendations of suitable resources can save a great deal of time. Any existing remediable elements in the patient's environment that may be creating conflict for the patient should be straightened out with the aid of a social worker if necessary. In spite of expressed optimism, the patient is unable to handle frustration, and any objective source of difficulty may suffice to promote tension that will produce a craving for drink. An inquiry into the patient's daily routine and habits may be expedient. Often one finds a gross defect in the person's diet. Alcoholic overindulgence has been coincident with a depletion in dietary intake and with vitamin deficiency. Bad food habits may persist. Prescribing a well-balanced diet with sufficient calories and with supplementary vitamin B is important. The patient should also be encouraged to appease his or her hunger whenever he or she feels a need for food. Hitherto the patient has propitiated hunger pains by drinking alcohol. He or she may be surprised to observe that eating three square meals a day can remove much of the craving for liquor.

The numerous difficulties a patient has experienced through increasing inability to control drinking, the general condemnation of society, and the disdain of family all contribute toward a depreciation of self-esteem. It is difficult to rebuild self-esteem by reassurance, but an effort must be made to underscore repeatedly that the patient has many residual assets that can be expanded. Because alcoholics become negligent about their appearance, it is essential to rebuild interest in their personal care. Appearing neat and well groomed usually has a bolstering effect upon the person. Alcoholic women may

be directed toward taking care of their complexions and hair by going to a beauty parlor. Whatever interest the patient shows in hobbies or external recreations should be encouraged. Patients must be reminded that they are not hopeless cases and that they have many good qualities that they have neglected. Their guilt may be continuously appeased by showing them that their alcoholic craving is part of an illness and that it will be possible to substitute something much more constructive for it.

Teaching the alcoholic to handle frustration will require considerable effort. The patient must be brought around to a realization that everyone has frustrated feelings and that an important job in life is to exercise control. Because of what has happened, the patient is apt to misinterpret any disappointment as a sign of personal failure. It is mandatory that the patient build up a tolerance of frustration, even though willful effort must be extended in this direction. Behavioral therapy may enable the patient to adjust better to many frustrating situations.

Since frustration is usually accompanied by gastric distress, it may stimulate a desire for drink. The patient, therefore, may be advised to carry, at all times, a piece of chocolate or candy. Whenever he or she feels frustrated or under any circumstances a craving for drink develops, he or she can partake of this nourishment. Hot coffee, cocoa, and milkshakes are also good for the same purpose. As the patient gains more self-respect, greater and greater amounts of frustration may be tolerated.

Many misconceptions and faulty self-statements plague the alcoholic, and clarification, persuasion, as well as cognitive therapy are usually in order. In many cases the basic difficulty is a personality disorder. There is no one predisposing personality problem. The character trait of dependency is often prominent, although the patient may try to conceal it. Dependency makes for a host of difficulties that have been outlined previously. Treating a personality disorder usually necessitates using a modified psychoanalytic approach, which is a long-term procedure (see Personality Disorders). If the patient is motivated and it is done properly, however, the reconstructive effects can be most gratifying.

Other Abused Substances

A miscellaneous group of psychoactive substances other than alcohol are used in all societies for mildly stimulating, tension-relieving, or recreational purposes. Among these are caffeine and tobacco. Only if the incorporation of such substances is beyond the individual's tolerance level, or if they impair social or occupational functioning, or produce abnormal physical and psychological changes, or if habituation upsets the individual or those around the individual, may help be sought from a psychotherapist. When the individual is unable to control the intake of a substance, he or she is suffering from what is commonly called a *substance abuse disorder.* If there is physiological dependence on the drug, it is regarded as a *substance dependence disorder.*

Although noxious substances such as alcohol and tobacco, which are consumed legally by average citizens, can have a pathological impact, minor abuse of these substances is generally disregarded. Serious addictions that lead to lives of crime and other social evils are of much greater concern to society. Prominent disorders encountered other than alcohol abuse and alcohol dependence are cocaine abuse, opioid abuse and opioid dependence, barbiturate and other sedative-hypnotic dependence, amphetamine and other sympathomimetic drug abuse and dependence, hallucinogen abuse (such as with cannabis, phencyclidene, and psychedelic drugs), and tobacco dependence.

The chief objective of this growing stable of substances is to reduce tension, anxiety, and depression and to stimulate feelings of tranquility and euphoria. The search for these rewards has brought forth a host of substances, some of which for years have languished unnoticed in chemical laboratories. Periodically, "revolutionary" drugs appear on the streets which are said to produce heaven on earth. Peace of mind, the ability to love unambivalently, the painless acquisition of deep insights, and other astonishing bounties have never before been promised as they are today. Such a drug was MDMA, dubbed "Ecstacy" by its habitues, who claimed results in minutes never before obtained with other substances. Word travels fast among aspirants looking for lasting euphoria, and before long Ecstacy became the promising gate to a new life. But like other miracle drugs,

disillusionment rode on the wings of reality: changes were short-lived, and episodes of disinhibition and psychosis destroyed the fantasy of harmlessness. Like other hallucinogens, its abuses led to its scientific discreditment and prohibition. Since then, other substances have taken its place. The latest "miracle drug" is "crack," a reincarnation of time-honored cocaine.

Cocaine Abuse (DSM-III-R Code 305.60) and Cocaine Dependence (DSM-III-R Code 304.20)

"The psychic effect of cocaine of .05 to . 1 gram consists of exhilaration and lasting euphoria, which does not differ in any way from the normal euphoria of a healthy person. . . . One senses an increase of self-control and feels more vigorous and more capable of work. . . . One is simply normal and soon finds it difficult to believe that one is under the influence of any drug at all."

These words of Sigmund Freud describe what the founder of psychoanalysis observed during his own dalliance with the champagne of illicit substances, which now has become a public health and safety menace. Cocaine is rapidly becoming the major drug problem in this country because of its intense euphoric impact, ready availability on the street, and ease of administration. Snuffing (snorting) small amounts rapidly produces heightened alertness, feelings of well-being, and self-confidence, which last only a short time. Intravenous injections, ("freebasing") and smoking the concentrated refined drug ("crack") have a strikingly exaggerated effect, but the aftermath of this "high" are uncomfortable physical symptoms. Headache, palpitations, stereotyped movements, confusion, incoherence, rambling, nausea, vomiting, perspiration, chills, tachycardia, skin paresthesias ("insects crawling"), anxiety, trembling, and depression enjoin the addict to dose again. Overactivity, impaired judgment, and other behavioral abnormalities may occur. Recovery within 24 hours is usual unless the individual gets a "fix," initiating a new cycle of exhilaration followed by more unpleasant symptoms. Cocaine addiction is associated with weight loss, insomnia, irritability, and paranoid ideas. It may lead to violent activities and crime. With continued use of large amounts of the drug, psychotic attacks may eventuate, resembling amphetamine psychosis. Serious physical ailments also

intervene, especially when the addict habitually combines cocaine with opiates ("speedballs"). Cardiac abnormalities, brain seizure, and pulmonary dysfunction may be followed by respiratory arrest and even death. The cocaine abuser may try to calm anxiety with Valium, but continued physical suffering soon motivates the addict to search for funds to buy relief, often resulting in thievery. The power of the drug is described by Grinspoon and Bakalar (1985): "Cocaine, along with some amphetamines, is the drug most eagerly self-ad-ministered by experimental animals under restraint; they will kill themselves with voluntary injections." Human beings seem to be no less hedonistic, and cocaine addiction is spreading at an alarming rate. At a national information and treatment referral service, for example, more than 1000 telephone calls (the number is 8OO-COCAINE) are received daily and more than $50 billion for the purchase of cocaine are spent annually by abusers of the drug.

Management of acute symptoms of abstinence is urgent to prevent the individual from dosing again with cocaine. Anxiety and restlessness may yield to 10 to 20 mg of Valium or Librium, repeated as necessary. This, of course, is a temporary measure and as soon as some control is established, more permanent therapeutic measures, including residential care, counseling, and psychotherapy, should be initiated. If an overdose of cocaine has been taken, forced oxygen inhalation and muscle relaxants are given, and for convulsions, sodium pentothal (25-50 mg) is injected intravenously. In the event anxiety and tachycardia are especially strong, 1 mg of Inderal (propanolol) is sometimes injected intravenously every minute for up to 10 times. There is some evidence that bromocriptine (Parlodel), a dopamine agonist, may represent a new adjunctive treatment for cocaine abuse.

Opioid Abuse (DSM-III-R Code 305.50) and Opioid Dependence (DSM-III-R Code 304.00)

An occupational hazard for physicians, and pharmacists because of their easy accessibility, a component of pleasure seeking among psychopaths and sociopaths, a means of proving their masculinity among adolescents belonging to gangs, an unfortunate consequence of their prolonged use for pain or anxiety, opiates (particularly heroin)

constitute a growing menace to the population. Harsh penalties for the possession and sale of these drugs make their cost so high that the average addict must steal and engage in other criminal activities to secure a constant supply. The addict consequently becomes a social menace. Because he or she neglects his or her physical health, the addict suffers from disease and premature aging. Suicide is common as an escape from pain when drugs are not available.

Among the numerous narcotic opioid drugs in use today are heroin, morphine, hydromorphone (Dilaudid), oxycodone (Percodan), nalbuphine (Neubain), meperidine (Demerol), alphaprodine (Nisentil), anileridine (Leritine), methadone (Dolophine), propoxyphene (Darvon), pentazocine (Talwin), propiran (Dirame), levorphanol (Levo-Dromovan) and butorphanol (Stadol). The most frequent abusers of these drugs are teenagers, who are introduced to addiction by their peers.

The action of these drugs mimics the effect of built-in pain relievers released by the brain (endorphins and enkaphalins). Both the artificial and natural analgesics can be neutralized by certain substances such as naloxone, naltrexone, nalorphine, and cyclazocine, which block the effects of the addictive drug.

Generally, narcotic drug addition is not a simple matter of physical dependence. It is a manifestation of a long-standing personality problem that has many forms, addiction being one of the symptoms. It is not only a consequence of social and economic deprivation, although many users of drugs come from areas of poverty and destitution; it also occurs among the wealthier classes. Juvenile drug users are (1) seriously disturbed youngsters with a delinquent orientation to life who, because of a lack of cohesiveness, supervision, and discipline in their homes, drift toward renegade gangs to supply them with a sense of belonging and, through antisocial actions, to bolster up a stunted sense of identity; (2) adolescents in schools, whose peers induce them to experiment or who are depressed, bored, defiant, or simply seeking excitement. Drugs provide them with an answer to the tensions and anxieties of growing up. The pleasure rewards of drug intake followed by the violent discomfort of abstinence make drugs the central interest in the life

of the addict. It requires a good deal of money to satisfy the drug need. This sum is generally obtained through crimes against property and by "pushing" drugs, selling them at profit to other addicts.

The treatment of the drug addict with any of our present methods is frustratingly unsuccessful, principally because the addict traditionally lacks the motivation for cure; the presence of narcissistic, immature, schizoid-like personality patterns that stir up incessant inner conflict and interfere with an adaptation to reality; and the existence of a home environment that imposes burdens for which the addict can find no solution. The following guidelines, nonetheless, may be useful:

1. The treatment of addiction to narcotic drugs is best achieved in a specialized institution where withdrawal symptoms can be handled and there is close supervision to prevent the addict from obtaining drugs. If the financial condition forbids hospitalization in a private institution, it is advisable to ask the patient to apply for voluntary admission or commitment to a U.S. Public Health Service hospital at Lexington, Kentucky, or Forth Worth, Texas (Council on Pharmacy and Chemistry, 1952).

2. Withdrawal or detoxification, which takes 4 to 12 days, is best accomplished with methadone, which may be administered orally (Dole and Nyswander, 1965). According to Fraser and Crider (1953) and H.A. Raskin (1964), 1 mg of methadone is equivalent to 2 mg heroin, 4 mg morphine, 1 mg Dilaudid, 20 to 30 mg Demerol, and 25 mg codeine. The dosage of methadone must be titrated to the tolerance of the patient. Too concentrated a dosage may produce respiratory depression, circulatory depression, shock, and cardiac arrest. Generally, detoxification treatment is administered daily under close supervision, does not exceed 21 days, and may not be repeated earlier than 4 weeks following the preceding course. A single oral dose of 15 to 20 mg of methadone will usually control withdrawal symptoms. This may have to be repeated if symptoms are not suppressed. A usual stabilizing dose is 40 mg per day in single or divided doses. After 2 or 3 days the dosage is decreased at a daily or 2-day interval. Hospitalized patients generally are reduced by 10 to 20 percent each day; ambulatory patients require a slower reduction. In cases of great physical debilitation, a high caloric diet, vitamins, hydrotherapy, massage, and glucose infusions are helpful. It is important

to prevent all visitors and other persons not concerned with treatment from seeing the patient who is hospitalized since drugs may be smuggled in as a result of pitiful pleas to relieve his or her suffering. Patients who have been taking low doses of an opioid and who have a good relationship with the therapist may be given Clonidine, 0.1 to 0.3 mg, three or four times daily for detoxification purposes instead of methadone. Patients must be watched for excessive lowering of blood pressure and for excessive sedation. The relapse rate is high once a patient leaves the hospital. Theoretically, a drug antagonist such as naloxone, cyclazocine, and naltraxone should prevent resumption of the habit. Practically, patients can be induced to start, but they rarely continue on the drug antagonist, and in one study 94 percent gave up the medication within 9 months. Librium, Thorazine, Trilafon, or Sodium Amytal may be taken to alleviate distress. Hypnotherapy has served to make some patients more comfortable. A prolonged period of hospitalization is best. Follow-up studies have shown that a high percentage of addicts released before 4 months become readdicted within 6 months.

3. While many drug addicts do well in a sheltered, drug-free environment, a return to the pressures and conflicts of their everyday world rekindles tensions, escape from which will be sought in drugs. An aftercare program is mandatory. Some authorities advocate legislation to force the addict to obtain aftercare services.

4. Aftercare is best administered in a day-night hospital or halfway house where the addict may spend a good part of his or her time, be exposed to the forces of group dynamics, and obtain a full range of social, rehabilitative, vocational, recreational, and psychotherapeutic services geared to his or her needs. The aftercare of drug-free addicts poses many hazards and disappointments principally because of their immature, hypersensitive personalities, their low level of frustration, and their inability to find adequate ways of dealing with their needs and tensions. A return to drugs is easily initiated by one disturbing experience.

5. An aftercare rehabilitation and guidance center is not enough. Rather, *constant care and supervision* are required, with daily interactions with some person (social worker, minister, rehabilitation worker, or psychotherapist). An adequate drug-control program must be so organized as to meet the individual patient's changing needs. Medical, psychiatric, social, educational, and rehabilitative services are part of this

program; and unless these are closely coordinated, treatment can become both chaotic and ineffective. Methadone maintenance programs by themselves are inadequate without the additional services of counseling, vocational training, and psychotherapy.

Psychotherapy of the opioid addict is usually unsuccessful unless all the measures outlined above supplement the treatment program. In a 12-year follow-up study of addicts who had achieved abstinence, it was found that recovery is possible among delinquent addicts provided there is compulsory supervision and a discovery by the addict of gratifying alternatives to drugs (Vaillant, 1966). Since a considerable number of the patients are borderline or schizophrenic, they must be handled with methods attuned to sicker patients.

Addicts sometimes consult psychiatrists asking that they be given an opiate for renal or gall bladder colic or some other emergent condition that requires temporary narcotic administration. Signs of the addiction include the presence of needle marks on the arms, legs, hands, abdomen, and thighs or physical signs of withdrawal.

Other marks of opioid intoxication are constricted pupils, euphoria, dysphoria, apathy, motor retardation, slurred speech, drowsiness, and memory and attention impairment. Withdrawal symptoms (sweating, diarrhea, tachycardia, insomnia, eye watering, running nose, and yawning) may rapidly be brought on in an addict by injecting naloxone (Narcan) as an antidote to morphine, heroin, and similar narcotics. The presence of an opiate may also be detected from chemical analysis of the urine.

Because it is impractical to treat addition unless the drug intake is completely brought under control, the therapist should insist on hospitalization as a preliminary step in the treatment program. During aftercare, a small number of addicts will have sufficient ego strength to respond to reeducation, behavior therapy, or psychotherapy. But, it must be emphasized, psychotherapy unreinforced by a prolonged, perhaps perpetual program of rehabilitation is, as a rule, unsuccessful. An important deterrent in treating a drug addict by psychological means is countertransferential resentment and strong sympathy with the addict, which interfere with the therapist's capacity to show both tolerance and

firmness when necessary. The addict's acting-out tendencies and low level of frustration will upset the equilibrium of the most stable therapist.

Some authorities, disappointed with the results of all treatment methods, advocate supplying addicts legally with drugs to keep them in balance, in this way eliminating the illegal supply outlets. Other authorities argue against dispensing drugs, saying that the factor of increasing tolerance enjoins the addict to expand the dose required to secure the desired effect. Having obtained the limit prescribed from the physician or clinic, the addict will return to the illegal market and continue to be exploited by drug peddlers, resorting to crime for funds as usual.

For this reason, methadone maintenance therapy has become the most common approach for chronic opioid dependence. Patients come to a methadone maintenance clinic (which is controlled by federal regulations) for their daily (up to 40 mg) methadone and after 3 months are given a supply (100 mg) to take home. Progress is monitored by interviews and urine testing. During the first few months of methadone maintenance some side effects may occur, such as sexual dysfunction, sweating, and constipation. Eventually, tolerance of methadone develops and patients feel more comfortable. We are dealing with a difficult population, however, and violent outbursts may be expected, especially among unstable personalities around such issues as take-home supplies of methadone. Some patients continue to seek opioids in addition to methadone (Maddun & Bowden, 1972; Newman, 1976), and some use alcohol and sedative-hypnotics. But many are helped toward a more productive life; criminality lessens, employability increases, and general adaptation is better (Cushman, 1972; Sharoff, 1966). Even some patients who have complicated psychotic and personality problems are helped with adequate counseling and psychotherapy to stabilize with methadone. A few who are not too ill emotionally may achieve complete abstinence from drugs provided environmental stress can be controlled. The preferred objective, of course, is to render the individual completely free of all abused substances as well as methadone. This may be possible in some cases. In other cases abstinence is obtained by administering an opioid antagonist which the addict continues to take much as some alcoholics rely on Antabuse to help keep

them dry.

Among the newer treatments for heroin control in addition to methadone is methadyl acetate, a synthetic congener of methadone. Methadyl acetate appears to be equal to methadone in its rehabilitative efficacy, but its duration of action is from 48 to 72 hours, so it can be dispensed three times weekly instead of daily. It may be useful for a certain subgroup of the addict population (Senay et al, 1977).

There are some incurable addicts who are "well-adjusted and leading useful, productive and otherwise exemplary lives which would probably be upset by removing their drugs. They are contented with their present states, do not desire treatment and would resist change. The wisdom of disturbing them is to be questioned, for the result socially and economically might be destructive and bad" (NY Academy of Medicine, 1963). This applies also to elderly addicts with healed lesions of various sorts.

Some addicts seem highly motivated to rehabilitate themselves but require a drug other than methadone and a narcotic antagonist to sustain them in resisting narcotics. Neuroleptics are helpful in certain situations, particularly if psychotic symptoms threaten. Roskin (1966) believes that the schizophrenic addict uses narcotics as a tranquilizer in the throes of severe schizophrenic decompensation. The schizophrenic addict, in his opinion, has a better prognosis than the pure acting-out addict. "If a drug addict seeks help on his own volition, it may be suspected that he is a schizophrenic." Neuroleptic drugs, therefore, and the supportive relationship with the therapist are helpful replacements for narcotics in the adjustment of the schizophrenic addict. Patients with primary and bipolar depression will require antidepressants.

As mentioned before, clonidine has been used as a detoxifying agent (Mark et al, 1980; Chamey et al, 1981) to wean addicts completely off opioid substances and methadone. This is followed by administration of a substance like naltrexone (Resnick et al, 1974). Naltrexone (Traxan) is a nonaddicting narcotic antagonist that has fewer side effects than the older cyclazocine (Martin WR et al, 1965; Jaffe and Brill, 1966) and naloxone (Narcan) (Zaks et al, 1971). Blocking the euphoric effects of opioids, naltrexone

acts somewhat in the same way with narcotic addicts as Antabuse does with alcoholics (i.e., by reducing motivation for drugs). The patient must be narcotic free when it is started. After detoxification and the slow reduction of methadone to where it is completely withdrawn and when 7 to 10 days of freedom from all opioids and methadone has been verified (sustained by urine tests), naltraxone (50 mg) is administered daily. Charney et al. (1982) have described use of a combination of naltraxone and clonidine as a "safe, effective, and extremely rapid method for treating the methadone withdrawal syndrome."

Motivated addicts also have been helped in groups by relating themselves to other addicts who have broken the habit. The most successful experiment is that of Synanon under whose care the addict deliberately places him- or herself (Casriel, 1962; Gould, 1965; Walder, 1965). Part of the Synanon idea includes an intensive leaderless form of group therapy—usually three times weekly—during which each member is expected to reveal his or her feelings truthfully, and to lay bare fears and hates. "At Synanon we snatch off all the covers of our dirty little secrets. Then we stand there naked for everybody to see" *(Life Magazine,* 1962). Groups with a leader also exist, ideally consisting of three male and three female addicts and one exaddict ("Synanist"). The Synanist acts as moderator who utilizes insight into himself or herself for interpretations. The Synanist also employs such tactics as ridicule, cross-examination, and hostile attack to stir up involvement and activity. Another device, used with a new addict is the "haircut," in which four of five significant members of the Synanon family structure "take one apart," criticizing actions and performances to date. While the "haircut" may be a verbally brutal experience, it is usually quite effective. "When the word gets around that 'haircuts' are being given, people seem to get in line. . . . Many of the people who have experienced these 'haircuts' reported a change in attitude or a shift in direction almost immediately." Lectures are given daily by one of the more experienced members. The members support each other and come to each other's aid when temptation threatens to disrupt drug abstinence. Each member is also expected to perform household tasks according to ability, which gives the addict a sense of participation. Additionally, "a concerted effort is made by the significant figures of the family structure to implant spiritual concepts and values that will result in self-

reliance. Members are urged to read from the classics and from the great teachers of mankind—Jesus, Lao Tse, Buddha. These efforts have been successful to a rather surprising degree. The concept of an open mind is part of a program to help the addict find himself or herself without the use of drugs" (Dederich, 1958). As soon as the addict is adjusted to the new environment, he or she is encouraged to get a job on the outside, to contribute some salary to the group, and to continue living at the Synanon house. Dropout rates, however, are high.

The Synanon idea, which essentially depends for its force on group dynamics, is being adopted in some correctional institutions. The lack of communication between the inmates of an institution and the authorities who run it has always posed a problem. To circumvent this, the people chosen to work with offenders are themselves ex-offenders who have modified their own deviant behavior. Offenders, alcoholics, and drug addicts seem to respond to a leader who, like themselves, has gone through criminal, alcoholic, or drug addiction experiences, who talks their language, and who, in having achieved resocialization, becomes a model with whom new identifications may be made. Such a leader usually approaches his or her work with an evangelical-like zeal to point out new directions in life from which he or she cannot be outmaneuvered by specious arguments. Another technique that has come into recent use with drug addicts is the "marathon group" of continuous group interaction for 2 or more days with short periods of rest.

Residential treatment centers like Synanon have been developing in different parts of the country. An example is Day-top. Therapeutic communities, such as Odyssey House and Phoenix House (DeLeon et al, 1972; Densen-Gerber, 1973), have provided a refuge for some addicts and beneficial effects are usually maintained for as long as a patient is an active member.

Coincident psychiatric problems found among drug abusers are, in order of frequency, affective disorders, especially major depression; alcoholism; personality disorders, principally antisocial personality; and anxiety disorders. Schizophrenia sometimes may be seen, but paranoidal conditions are more common. Therapy, such as

Doxepin for depression, Antabuse for alcoholism, and neuroleptics for schizophrenia, should be instituted if necessary. About one-quarter of opioid addicts take other substances, such as barbiturates, benzodiazepines, cocaine, cannabis, amphetamines, and alcohol. This accents the need to work with many variables that influence continuance of the drug habit. Therapists looking for an ideal model of therapy should consider detoxification with methadone as a preliminary step toward complete abstinence, the use of an antagonist such as naltrexone as safeguard against resumption of the drug habit, and treatment in therapeutic communities of drug-free day-care centers, with the use of behavioral, cognitive, and, in a few cases, modified analytic therapy according to the needs and aptitudes of the patient.

The following readings on narcotic addiction are recommended: Dole and Nyswander (1965, 1966), A.M. Freedman (1966), A.M. Freedman and Sharoff (1965), Mueller (1964), Nyswander (1956), Ray (1961), Sabath (1964), Seevers (1968), Se-nay (1983), Stimson and Oppenheimer (1982), U.S. Department of Health, Education, and Welfare (nd), Verebey (1982), and Wikler (1980).

Sedative, Hypnotic, or Anxiolytic Dependence (DSM-III-R Code 304.10) and Abuse (DSM-III-R Code 305.40)

Dependence on *barbiturates* was once as serious an addiction problem as dependence on narcotics is now. Barbiturates in overdose are lethal and constitute one of the chief means of suicide. They are especially dangerous when taken with alcohol. Sometimes suicide is unintentional if an individual, because of sluggish thinking or chronic intoxication, forgets he or she took pills and swallows additional ones.

In 1962, a survey by the Food and Drug Administration revealed that more than a million pounds of barbituric acid derivatives were available in the United States (Committee on Alcoholism & Addiction, 1965). This 1-year inventory is enough to supply two dozen 1.5-gm doses to every man, woman, and child in the country. The survey led to the conclusion that "any patient whose psychological dependence on a barbiturate drug has reached a degree sufficient to constitute drug abuse has some form of underlying

psychopathology." He or she is "directly comparable to the opiate-dependent person." There are no specific syndromes involved; practically all diagnostic categories are represented. Since federal restrictions have been placed on the sale of barbiturates, benzodiazepines have largely taken their place.

Short-acting barbiturates (Pentothal, Seconal, Amytal) are particularly addicting "They are as truly addicting as heroin or morphine and give the individual and his physician an even greater problem" (U.S. Department of Health, Education, & Welfare, nd). Like alcohol, they are intoxicating, produce confusion, lack of coordination, and emotional instability. Sudden or complete withdrawal of barbiturates from an addicted person usually results in convulsions and sometimes in a temporary psychosis like delirium tremens. Death may follow.

A sizable class of barbiturate addicts are middle-aged and older people who have been given barbiturates for insomnia and have consumed pills for years. This leads to hazy thinking, poor judgment, memory loss, emotional instability, and diminished motor skills.

The most common barbiturates sold illegitimately are secobarbital (Seconal), known on the street as "reds," pentobarbital (Nembutal), dubbed "yellows" or "nembies," and amobarbital secobarbital (Tuinol), called "double-trouble" or "tooies." Sometimes inveterate addicts, especially alcoholics and amphetamine users ("speed freaks"), inject barbiturates ("downers") intravenously ("pill popping") and use them interchangeably with heroin and amphetamines ("uppers"). Behavior is affected markedly and may include episodes of violent disruptive outbursts.

Any person who has taken an overdose intentionally or unintentionally should be rushed to a hospital for immediate treatment. While waiting for the ambulance, vomiting should be induced and the airways kept clear to prevent strangling. The person should be prevented from slipping into unconsciousness. Withdrawal from the drug is essential, but complete immediate withdrawal is dangerous. The patient must be put back on barbiturates to counteract abstinence symptoms and then phased into withdrawal. No more than 0.1 gm should be withdrawn daily, and physiological signs should be monitored

throughout withdrawal (Ewig, 1966). The daily intake is reduced over a 1- to 3-week period. Librium or Valium may be given temporarily to control agitation, tremor, and insomnia. Supportive restoration of electrolyte balance, vitamins, and intravenous fluids are in order (see Chapter 58 on Emergencies). Hospital admission and proper nursing care are mandatory. Physical dependence on minor tranquilizers (Miltown, Librium, Valium) will also be followed by abstinence symptoms, convulsions, and occasionally even death if withdrawal is abrupt, and emergency measures as for barbiturate overdose should be employed. Continuing aftercare, as with narcotic addiction, will be necessary. Caution in prescribing tranquilizers and sedative drugs with dependence-producing properties is essential in "dependence-prone" persons (Bakewell and Wikler, 1966).

Methaqualone (Quaalude) has had some use in recent years as an agent to counteract insomnia, but it has been abused, especially by young people who take one or two pills, sometimes with wine, to produce relaxation and euphoria. It has a reputation for being an aphrodisiac. Depersonalization and various physical symptoms are common adverse effects. Convulsions, delirium, and death may occur with overdose. Other nonbarbiturates that may be overused are glutethimide (Doriden), ethinamate (Valmid), ethchlorvynol (Placidyl), and methprylon (Noludar). Emergency treatment for overdose is similar to that for barbiturate intoxication. While benzodiazepines (Valium, Librium, Xanax, etc.) are much safer than sedative-hypnotics, addiction can occur when they are taken over an extended period. After a month or so, even therapeutic doses may produce a tolerance. Since withdrawal symptoms are apt to occur, a gradual slow reduction of the medication is necessary. If large doses of benzodiazepines have been taken and withdrawal was abrupt, convulsions are possible and Dilantin (hydantoin) is indicated.

Amphetamine or Similarly Acting Sympathomimetic Abuse (DSM-III-R Code 304.40) and Dependence (DSM-III-R Code 305.70)

Addiction to *amphetamine* and similar-acting sympathomimetic stimulants has been growing in this country. It is used by students to prod them into greater alertness, by pleasure seekers in search of "kicks," and by those who habitually try to suppress their appetites to control overweight. Such addiction results in serious physical effects, the

disorganization of the personality, and can even precipitate outright paranoid psychoses (Lemere, 1966) that resemble paranoid schizophrenia. Other symptoms are impaired judgment, aggressive behavior, and lack of coordination. Tolerance to the drug causes the abuser to increase the dosage for a euphoric effect, sometimes to 20 times the original dose. The intake of large amounts of amphetamine may cause a delirium. Attempts at withdrawal produce a letdown or "crash," with depression, physical symptoms, and aggressive behavior that usually send the addict out for a "fix." Amphetamines have been implicated in increasing numbers of automobile accidents and crimes of violence (Medical Society of the County of New York, 1966). Treatment of the individual who takes only 2 or 3 tablets a day requires quick withdrawal and administration of ammonium chloride to bring the pH to the acid side. Though withdrawal is not as urgent in these cases as in persons who take large amounts, there is always the danger that the intake will be increased. Mandatory withdrawal for persons who consume large quantities of amphetamine substances should be carried out in a hospital. The drug is removed abruptly, and the withdrawal effects are treated with intramuscular neuroleptics such as Haldol and, if necessary, barbiturates at night. These are especially indicated if amphetamine-barbiturate mixtures have been used (Connell, 1966). Depression may need to be treated with antidepressant medication such as tricyclics. Aftercare is as important as it is for narcotic addiction, and psychotherapy may be an essential part of the rehabilitative program.

Cannabis Abuse (DSM-III-R Code 305.20) and Cannabis Dependence (DSM-III-R Code 304.30)

Marijuana (cannabis) continues to be a popular substance, especially among students in school and young people in middle-and upper-income groups. The drug is neither as innocuous as is claimed by its friends nor as destructive as contended by its foes. It is a hallucinogen with varying potentials for toxicity depending on the host and the conditions under which it is taken. Generally, marijuana ("joints," "dope," "pot") is smoked experimentally on only random occasions and the hallucinogenic ingredient is in too low a dose to create any real difficulties. Some authorities say that harmful physical and psychological effects of prolonged marijuana use have not been consistently demonstrated

and are minimal compared with the ravages of alcohol intake. Emotionally disturbed persons will, however, continue to indulge in concentrated efforts to experience euphoria by using the most potent substances such as hashish and purified THC, which can cause greater mischief, including depersonalization, paranoidal ideas, anxiety, depression, tachycardia, and apathy. The abuse potential of marijuana is high. There is, nevertheless, no evidence that the use of marijuana is associated with crimes in the United States (Medical Society of the County of New York, 1966). Nor is there evidence that the drug is a narcotic or that it is truly addicting. Yet, in its usual form, it *is* a mild hallucinogen and may, in some susceptible persons, promote panic and aggressive behavior. Moreover, the impaired judgment under the influence of the drug interferes with skilled activities such as driving. Some people with severely disturbed personality problems may proceed from marijuana intake to a heroin habit, although the exact correlation between marijuana and subsequent heroin addiction has not been established. Pressure to legalize marijuana understandably has brought forth heated debate and controversy. Arguments pro and con related to the harmlessness of marijuana do not suffer from a dearth of misinformation. Research has had little effect on bias and the polarization of opinions.

Phencyclidine (PCP) or Similarly Acting Arycyclohexylamine Abuse (DSM-III-R Code 305.90) and Dependence (DSM-III-R Code 304.50)

Phencyclidine (PCP, "angel dust," "crystal," "Peace Pill") and similar substances such as ketamine (Ketalar) and TCP may be taken orally and intravenously, as well as by smoking and inhalation (Cohen, 1977). Effects are rapid and consist of euphoria, grandiosity, hallucinations of color and sound, and slowing of the time sense. Agitation, vomiting, anxiety, nystagmus, elevated blood pressure, ataxia, muscular twitchings or rigidity, anaesthesia, paranoidal ideas, and other symptoms may follow. Delirium can occur with large doses (20 mg or more). Hospitalization and administration of antipsychotics such as haloperidol (Haldol) may be helpful as an emergency measure.

Indulgence of other hallucinogens has been increasingly reported. The use of dimethyltryptamine, psilocybin, bufotenine, peyote, mescaline, charas, morning glory seeds, and nutmeg sometimes produces variant problems, and glue sniffing among

youngsters of school age can become disturbing (Jacobziner, 1963). LSD, which was popular in the past, was obtained from amateur chemists or from organized criminal groups. Usually 100 to 600 micrograms were ingested by individuals on a sugar cube for the purpose of "taking a trip," which was embarked on once or twice a week. Large doses (more than 700 micrograms) were ingested to produce more intense psychotic experiences. Psychotic episodes persisted for days or weeks and, in schizoid personalities, for months or even years, requiring hospitalization. The use of these hallucinogens has diminished in favor of such drugs as cocaine.

Nicotine Dependence (DSM-III-R Code 305.10)

According to the World Health Organization approximately one million persons die of cigarette-related diseases each year the world over and approximately one-third this number (350,000) in the United States alone. This is not because of misuse or abuse of cigarettes since "no safe use for this product exists; every cigarette smoked is intrinsically harmful to health. . . . even when used normally and as intended" (JAMA, 1986). The National Institute on Drug Abuse has warned that nicotine in tobacco is "a powerful addictive drug. . . . six to eight times more addictive than alcohol." In the United States, medical care and cost productivity associated with cigarette smoking total approximately $65 billion per year.

Promotional advertising linking cigarettes to a healthy and athletic life style nevertheless continue in force. To a large extent, adolescents and children fail to comprehend the dangers of the habit, which they continue as adults. Billions of dollars of profit pour into the coffers of the cigarette companies annually. In the meantime the ravages of cigarette smoking promote heart disease, emphysema, cancer of the lung, cancer of the upper respiratory tract, as well as other debilitating and fatal diseases. These are amply detailed in medical journals, although most of the cigarette-smoking public overlook or minimize medical warnings. But some request help.

Cure of the smoking habit is a difficult task, especially if smoking serves the purpose of alleviating tension. Educational campaigns, psychotherapy, and pharmacological aids

have all yielded limited success (Ford & Ederer, 1965). Mark Twain's comment, "It's easy to quit smoking; I've done it hundreds of times," is tragically the experience of most inveterate smokers who try to force themselves to give up tobacco. Group therapy with smokers, anesthetic lozenges, astringent mouth washes, anticholinergic drugs, vitamins, tranquilizers, stimulants, sensory deprivation, systematic desensitization, aversive conditioning, stimulus control, and lobeline as a nicotine replacement may produce temporary withdrawal from tobacco, but the relapse rate is high—75 to 80 percent. The entire process of smoking becomes for the inveterate user of tobacco an adjustment mechanism serving to satisfy specific needs: appeasing and reducing tension, providing a facade of nonchalance and poise, controlling anger, overcoming embarrassment in upsetting interpersonal situations, providing mouth and oral gratifications, acting as a substitute for overeating. Giving up smoking leaves a hollow in the life of the tobacco addict, mobilizes tension, and deprives the addict of a powerful adaptational tool.

In many cases smokers will openly or indirectly reveal that they are convinced that they will be unable to stop. In one case I was consulted by a professional man with Berger's disease, an illness in which smoking is dangerous. When he was admitted to a hospital for the beginning of gangrene of a toe, he had strapped cigarettes across his back to conceal them from the nurses and attendants, knowing that they would remove any cigarettes on his doctor's orders!

The "I can't" resistance ("I don't have what it takes," "My life is too unsettled now," "I'm not strong enough," etc.) is a means of reducing anxiety stemming from the conflicting desires of wanting to smoke and wanting to maintain one's defensive gratifying prop (Clark R, 1974). The defeatist belief is a way of denying this conflict. In applying for help, there is a forlorn hope that someone other than the patient can control his or her smoking. The resistance if unresolved will defeat any applied therapeutic efforts. The fact that smoking continues in spite of treatment convinces the individual that he or she is hopeless and provides an excuse for continued smoking. The idea that the smoker has exposed himself or herself to therapy appeases the guilt. "I know it's bad for me, but I don't care, it doesn't matter, I'm not going to think about it." In working with any smoker,

therefore, this resistance should be tackled at first. The therapist should verbalize the nature of the resistance and explain its purpose. Smokers should be encouraged to stop pretending that they are doing all they can to overcome the habit. At the same time the therapist should express confidence that they *can* quit smoking if they want to and work toward kindling the patients' faith in themselves.

It is important in treating individuals who want to give up smoking to keep in mind that immediate abstinence is possible with many techniques. As with any other addiction, resumption of the habit will usually follow within the first year unless the needs that led to smoking originally are adequately fulfilled.

The first step in smoking control is to ask the patient why he or she feels he or she should give up tobacco at this time. The patient will probably have been warned by a physician to stop the habit because it is a health risk. Such warning usually has fallen on deaf ears. The habit is compelling and insidious. The patient may be told that he or she, like many others, can succeed by recognizing the *positive* value of abstinence. Some therapists give the patient a typewritten form that says something along the following lines:

Overcoming the tobacco habit may be achieved with a minimal amount of suffering if you follow these principles:

> 1. First, prepare a written or typewritten list of the *benefits* you will gain in giving up tobacco, such as that your health will improve, and that you will feel more vigorous, look better, lose the offensive tobacco odor, save money, and respect yourself more for abandoning a self-destructive habit.

> 2. Choose a time to quit when you are under the least stress or tension. *Then quit completely.* Shred or destroy every cigarette or cigar in your possession. Give away your lighter and ashtrays.

> 3. Discomfort during the next few days is to be expected but will disappear within 2 weeks. Such discomfort may be minimized by (a) reading the list you have prepared once in the morning when you get up and at bedtime and more often if you desire; (b) practicing relaxing exercises at least twice

daily (meditation, self-relaxation, self-hypnosis, listening to a relaxing audiotape); (c) oral substitutes like Nicorette gum or smoke-free cigarettes (Favor) *if you need it* to stop physical reactions. Keep sugarless candies, carrot sticks, and menthol-filled plastic fake cigarettes on hand to take to work or use at social functions; (d) tell your friends that you are quitting smoking for health reasons and ask them, please, if they can, not to smoke in your presence for the next few weeks; (e) during the first 24 hours of abstinence expect to feel some muscle cramps, fatigue, headaches, or nausea as nicotine disappears from your body. Expect periodic cravings for a cigarette. Push your mind away from the thought and busy yourself with some activity; take a long walk, write letters, or do other activities; (f) spend as much time as you can in smokeless surroundings such as libraries and theaters; (g) cultivate a hobby (golf, swimming, tennis, bridge).

4. Your eating habits may need to be changed because in giving up tobacco you are apt to crave sweets and more food. Drink 6 to 8 glasses of water daily; keep water, some fruit juice, or a diet soda near you while watching television and sip it to appease your appetite. Avoid spicy foods, and minimize the intake of alcohol and coffee, which can stimulate a desire for tobacco and increase your appetite. Do not despair if you gain a few pounds; you will lose weight after the craving for cigarettes disappears.

5. In about 2 weeks you will have conquered a good deal of the tobacco desire, but the rest of your life fight off the impulse to take even one puff. When nicotine has completely left your body, the joy and vigor you will feel will more than compensate for the loss of this dangerous habit.

In many cases, these simple suggestions may suffice. If they do not, more extensive measures may be needed. Among the chief methods for getting the smoker off tobacco are behavior modification, hypnosis, and group approaches.

Behavior modification methods are fashioned after the techniques used to overcome overweight and obesity. An investigation is launched into the history of the smoking habit, how many cigarettes are consumed daily and under what circumstances, when the frequency increases, what puffing on a cigarette does for the individual, what efforts have been made to stop in the past, and why the individual wants to give up smoking now. Behavior modification techniques are then devised to replace reaching for a cigarette with

other activities, thus providing a nonsmoking routine for the patient (Bernstein & McAlister, 1976). Holding a sizable sum of money in escrow that is forfeited with the taking of even one puff of a cigarette within 6 months may be effective beyond any other technique.

Therapists acquainted with the hypnotic technique will find hypnosis a useful adjunct. Many ways of employing hypnosis have been described, with varying claims of success (Crasilneck & Hall, 1968; von Dedenroth, 1968; Spiegel H, 1970; Watkins H, 1976). In my own experience I have found that hypnosis can help eliminate sources of tension, especially after the smoking habit has been broken. The initial visits should, if possible, be frequent. Suggestions are made in the trance to the effect that the patient will develop a *desire* to stop smoking and that he or she will grow so strong that neither temptation nor tension, no matter how intense, will deviate him or her from the resolve to give up tobacco. This achievement will be rewarded by a feeling of well-being and strength that will be greater with each day of continued abstinence. It is strongly suggested that the patient will, in relinquishing smoking, be able to control his or her appetite so as not to overeat. Dictated tape recordings, made by the therapist, which the patient plays at home twice daily (see section on Induction of Hypnosis) often help to reinforce suggestions and to reduce tension. They are especially useful if the patient cannot come for frequent reinforcing sessions. Self-hypnosis, facilitated by the recording, will also prove to be of value.

Should the patient inquire about other oral gratifications, such as gum chewing or allowing a hard piece of candy to dissolve in the mouth, "permission" for this may be given if it is not overindulged. Some patients who have a need to defy authority will, rather than return to smoking, engage in these harmless oral activities beyond what they believe is permitted. In this way the tobacco habit may become more readily extinguished. The gum chewing and candy indulgence are gradually given up on their own. Because nicotine addiction drives smokers back into the habit, nicotine in a flavored chewing gum (Nicorette) is sometimes prescribed to ease the physical craving for nicotine. The gum may be helpful during the first few weeks of quitting smoking (Russell et al, 1982). Other

common methods that may be used to get individuals off cigarettes (Schwartz I, 1977) are rapid concentrated smoking inhalation and group approaches (supportive and behavioral). The latter prove especially valuable when behavior modification and self-control methods are combined. Powell and Arnold (1982) have described a multiple-treatment design for coronary-prone men that achieved a 50 percent smoking cessation rate at the end of one year, which is about double the usual reported rate of abstinence. Their "Stop Smoking Program" consisted of four consecutive 1½ hour sessions, Monday through Thursday, composed of highly structured activities along the following lines:

1. Stimulus control (altering the antecedents leading to smoking);

2. Relaxation training (deep breathing with pleasant imagery);

3. Thought stopping to eliminate thoughts about reaching for a cigarette;

4. Eating management (avoiding food and eating situations that stimulate a desire to smoke);

5. Substituting props (such as sugar-free candy);

6. Rehearsal of suitable nonsmoking behaviors;

7. "Cognitive coping" to associate positive thoughts with quitting smoking.

In addition, mild aversive stimulation (pairing smoking with pain stimulation to reduce the appeal of tobacco) was employed in some cases. Three once-weekly meetings were held after the formal 4-day program. A manual containing persuasive "pep" talks was supplied, and a counselor telephoned the patient to inquire about progress and to encourage maintenance of abstinence. At the start of therapy, return of part of the patient's fee is promised (contingency contracting) if abstinence is maintained after three to six months, thus providing further motivation to stop the habit.

Smoking cessation programs have been prepared by the American Cancer Society (1971) and by Dananer and Lichtenstein (1978). An innovative behavior modification program, "Quit-by-Mail," using a home computer has been devised by Schneider (1984).

Participants mail out weekly correspondence detailing their progress and problems, and their questions are addressed in pointed computerized responses. It has shown some promise.

Regardless of the methods employed to produce abstinence, many patients need continuing help to deal with the stress and other factors that promote a craving for cigarettes. The nature of such help will have to be designed for specific problems: environmental factors through environmental manipulation, marital difficulties through marital therapy, family problems through family therapy, faulty attitudes through cognitive therapy, and so on. The continued use of self-relaxation techniques, indulgence in interesting diversions and absorbing hobbies, and graded regular physical exercise are valuable. Should excess tension develop as a result of unusual stress, a minor tranquilizer (Valium, Librium) prescribed for only a short period may be required to ease a patient through the crisis. Patients' feelings of well-being in ridding themselves of the tobacco habit, their enhanced physical stamina as a result of eliminating nicotine from their bodies, and the approval they sense from their therapist and friends for their "courage" will, one hopes, suffice in maintaining abstinence. If smoking persists, more extensive therapy will be needed.

A "nonsmoking kit" of pamphlets written for children, adolescents, and parents m^y be obtained at a small cost from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

Summary of Treatment Approaches in Substance Abuse

The treatment of substance abuse is a difficult task as attested to by the worldwide pessimism about the prognosis for this disorder. Dropouts from therapy are more the rule than the exception, and noncompliance with therapeutic routines tax the patience of the most empathic therapist. The therapist has to be more active in approaching substance abusers than is customary, especially at the start of treatment. In an attempt to deal with resistance, the therapist should call when the patient misses a session. Continued noncompliance with routines that have been set up and failure to execute homework

assignments may require more aggressive tactics (Marlatt & Gordon, 1985). The maintenance of discipline, so important in acquiring essential nondrinking and nondrug-taking skills, requires that therapists refuse to be lied to or manipulated, since these merely reinforce the patient's self-destructive patterns. The patient does not, however, have the substitutive skills to deal with stress at the beginning of therapy, so the therapist will have to tolerate an occasional relapse at the start. Such relapse provides an opportunity to review what has produced it. The manner of its management by the therapist can be important in consolidating the therapeutic relationship.

Treatment outcomes in substance abuse are dependent on the severity of the psychopathology (McLellan et al, 1983; Woody et al, 1984; Woody et al, 1986). Supportive therapy and drug counseling may suffice for patients who are not too psychiatrically disturbed. Those with a moderate degree of pathology may be helped, often substantially, by additional psychotherapy. But severely psychiatrically handicapped individuals will show a poor outcome whatever the intervention.

A growing problem in the treatment of substance abuse is that more and more people are increasingly using combinations of substances for purposes of recreation, relaxation, control of disturbing psychological and physical symptoms, and the ever-constant search for euphoria ("pharmacodynamic elation"). A recent estimate placed the figure of polydrug use at 84 percent of all substance abusers. The choice of alcohol, tranquilizers, sleeping pills, marijuana, cocaine, amphetamines, opioids, and other substances makes for mixtures whose effects are unpredictable and that pose many health hazards. Detoxification programs will have to deal with the fact that polydrug use can lead to dangerous withdrawal reactions. For this reason, detoxification, which is basic to the start of any organized treatment program, should be done in a hospital or residential center that has adequate facilities. The incidence of withdrawal and abstinence reactions makes mandatory the use of staff members in these units who are experienced in emergency treatments, and the management of problems specific to the substances that are being abused.

Temporary administration of substitute narcotics such as methadone in the opioid addiction, and small doses of barbiturates in barbiturate abuse, can prevent convulsions and other dangerous physical reactions. Thereafter, phased slow withdrawal, while monitoring physiological responses, is mandatory. The use of oxygen, neuroleptics, and, if they exist, specific drug antagonists (e.g., naltraxone in opioid addiction) can also be better controlled in an institutional setting. Most important, abused substances must not be made secretly accessible in institutional surroundings.

Once the patient is detoxified, the next step is to keep him or her off alcohol and drugs. Here, psychosocial treatments are instituted. The largest handicap in using such therapies is lack of cooperation. Most addicts or alcoholics are brought to a psychotherapist by frantic parents, spouses, or friends. The patients, despite verbal declarations, are not fully committed to staying off drugs, or, if they have "hit bottom" and suffered the after affects of a "binge," their commitment soon vanishes when they recover. If the therapist can establish a relationship with the patient, confrontation may be possible and some motivation stimulated. Despite considerable skepticism, it has been shown that *properly* conducted treatment for alcohol and drug abuse can be effective along a wide range of parameters, including, in overcoming the habit, finding employment, reducing criminal behavior, and enhancing psychological functioning (McLellan et al, 1982).

In formulating a proper treatment plan, the therapist should be aware of a number of essential factors:

1. The patient's enthusiasm for therapy, however, sincere, may be short-lived, giving way sooner or later to what seem to be self-destructive impulses. Extreme physical dependence is inescapable with habitual use of opiates, barbiturates, and alcohol. There is some physical dependence and considerable psychological dependence with the long-term use of amphetamines. Psychological dependence is present with marijuana, tobacco, and hallucinogens, but only moderate physical dependence unless dosage has been high. Great tolerance is soon established with opiates, amphetamines, and hallucinogens; somewhat lesser tolerance with the barbiturates, alcohol, and tobacco.

2. The addict is convinced that drug indulgence, better than anything else, enables

him or her to overcome despair, dissatisfaction, depression, and anxiety.

3. Drug abstinence achieved outside of an addict's habitual environment may not last long after the addict returns to his or her customary surroundings.

4. Since single addictions are rare, removal of one substance does not lessen the craving for others. Indeed, it may provoke the addict to try new experiments with other potentially exciting or calming materials.

5. Detoxification and "cure" of the desire for drugs has little effect on underlying pathological personality problems, only one manifestation of which is the thrust toward drug intake. Other manifestations will require psychosocial interventions. These may yield meager results, and prolonged care (1-2 years) in a therapeutic community like Synanon and Phoenix House may be needed to achieve a social adjustment.

6. A support group (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) of some kind will be necessary, sometimes for the remainder of the individual's life, as a source of reassurance, education, and companionship and as a "port in the storm" when troubles at home or at work brew or the inevitable cravings for a "fix" or drink return. The best support groups are patterned around the precepts of groups that have proven valuable, such as Alcoholics Anonymous or Synanon, and are composed of peers with similar substance abuse problems. Preferably, some of the leaders have suffered from and conquered similar problems. A professional person should be available for supervision and consultation. Periodic urine and serum drug screens should be employed if possible to detect early defection from abstinence. The choice of a proper group cannot be overemphasized because bad leadership and the presence of too disturbed or offensive members can negate the positive benefits of group participation. In large cities, resources for finding good groups are usually ample. In smaller communities, groups in neighboring towns may need to be explored. The therapist may enlist the assistance of social agencies for this purpose. Other community reinforcement resources—social, athletic, and so on—may be available to provide leisure-time positive reinforcements. Caution is needed in their selection, however, since social (or heavier-than-social) drinking may be the norm in some of these groups. One cannot protect the patient from the presence of alcohol. It is everywhere, being consumed freely in and out of homes. The patient must be able to resist any goading and encouragement to "have a short one." Most patients learn to cope with

this pressure by restricting themselves to plain soda and lime or soft drinks.

7. Marital therapy and family therapy are usually conjunctively needed for marital and family problems, and stress factors in the environment will call for counseling and environmental manipulation.

8. Nondrug management of tension and stress are important because the use of any anxiolytics or hypnotic-sedatives after the first week following detoxification is contraindicated. Here, relaxing exercises, self-hypnosis, and meditation may be taught individually and in groups. Cognitive therapy should be employed to rectify faulty philosophies and attitudes. Proper physical exercise daily and instructions regarding diet to overcome and prevent nutritional deficiencies are necessary. Education in self-care may be needed if there is a pattern of habitual neglect.

9. Depression is one of the most common symptoms of substance abuse, and if it is intense may require antidepressants, such as amitriptyline (Elavil) or sinequan (Doxepin). Psychotic ideation and behavior may necessitate antipsychotic drugs such as haloperidol (Haldol), trifluoperazine (Stelazine), or thiothixene (Navane). Some alcoholics need Antabuse, and some opioid addicts off methadone do well with naltrexone (Trexan) to offset impulsive drug use.

10. Once abstinence is sustained by faithful attendance at a support group, and environmental stresses have been mediated through counseling, the therapist should consider whether individual psychotherapy would be valuable. Depth therapy, focused on unconscious conflict and the acquisition of insight into early conditionings, has failed notoriously with this class of patients. Some analysts believe that this is because substance abusers possess an arrested personality and are so handicapped by infantile omnipotence that they cannot make a proper transference to the therapist. Any transferences that do develop are bound to reflect distortions that developed in the original family that are now ego-syntonically indelible. Their revival will prove antitherapeutic. Treatment programs that have proven successful have taken into account the patient's disturbed character structure but have dealt with it in ways other than through insight. They have approached the need on the part of the patient to engage masochistically in unrewarding behaviors by reconditioning responses through a social learning paradigm. The model of treatment described below (12 to 15) can be adapted to both alcohol

and substance abuse (McGrady 1983, 1985; Miller WR et al, 1980; Miller PM, 1982).

11. Preaching the evils of drug and alcohol intake, and its effects on oneself or one's family, does not work. What the patient must achieve is the conviction that he or she can be happier over a longer period without the abused substances than with them. One hopes that through positive reinforcements the patient will acquire this conviction during the early stages of abstinence. Every satisfactory experience of social and vocational adjustment should be rewarded by praise or other reinforcer to encourage a better life style. Designed programs will vary because of differences in personal needs and environmental opportunities, as well as specific responses to reinforcers. What is universally important is a job, occupation, or diversion to engross the individual a good part of the day; boredom is a leading source of stress. If the patient is unemployed, involvement in a hobby (music, art work, occupational therapy, etc.) or organized work-adjustment or volunteer program may have to precede finding paid work. Some substance abusers, especially adolescents, turn with vigor to religion or esoteric philosophies (Zen, Yoga, etc.), which supply them with a meaning for existence that they have sought through spurious chemically induced "insights." This should not be discouraged unless it is overdone and counterproductive.

12. The actual treatment process starts with identification of the stimuli that initiate alcohol or drug intake. This necessitates consideration of all the disturbing factors in the patient's personal, marital, family, and social life. Elements that further reinforce or that punish the drinking or drug response in the present situation are examined. This intensive study of external and internal stimuli that inspire the taking of drugs or alcohol is done with the object of determining ways of modifying or eliminating these stimuli or of finding better modes of dealing with them, cognitively, emotionally, and behaviorally. The treatment interventions that will be used will depend on the resources available, the readiness of the patient to accept them, and the skill of the therapist in implementing them.

13. Vital to the success of any program is motivation to stop the bad habit of resorting to the abused substance. If the patient does not have adequate coping skills, the best resolve will go down the drain as soon as he or she experiences strong anxieties or stress. Further, depression may have been masked by alcohol or drug intake. Insidious also are the ubiquitous desires for pleasure, and need to escape from responsibilities in living

and from the pressures of inner conflicts. Because the patient minimizes the bad consequences of his or her habit and exaggerates his or her ability to control it, efforts toward abstinence may be minimal. The therapist may work on the patient's false assumptions through cognitive therapy, by providing reasons why the patient will be better off dealing with pressures and problems in more suitable ways. Some therapists hand the patient a list of the negative consequences of drinking that the patient has previously identified and ask the patient to read the list several times a day as homework. Training in self-relaxation techniques and a relaxing ego-building audio cassette tape may be valuable. Some patients will require assertiveness training over a period of many months.

14. The therapist must keep searching for stimuli that provoke the patient. Dealing with such mischief mongers directly is an important part of treatment. A prime source of stress here is a family member or spouse who nags, attacks, criticizes, and acts-out his or her problems through the medium of the patient. Counseling of the spouse on an individual or group basis may be important. Marital therapy or family therapy may be indicated, and self-help organizations such as Al-Anon should be sought out. Family members who have been battered by the patient's substance abuse may discover in these group settings better ways of dealing with the patient's difficulties.

Help in the acquisition of new stress-resolving skills and strategies is an important part of the therapy program. The patient is enjoined to search for "triggers" that initiate drinking or drug taking (e.g., an invitation to have a drink, fatigue, stressful events, receiving bad news, perceiving good news, engaging in "happy hour," etc.) and to explore nonalcoholic and nondrug responses to these triggers. The effects of a drink or other substances are then discussed in depth: talking too much, acting foolishly or brashly, guilt, self-disgust, feeling bad physically, a hangover, and so on. Instead of stopping the desire for drugs or drink, these aversive consequences may be shown to act as stressful triggers that initiate more substance abuse. So a chain reaction ties the patient into his or her destructive habit. One strategy to break the chain is to teach the patient to think *immediately* of the negative consequences the moment an impulse, invitation, or other trigger brings up the desire for a drug or drink. Some therapists ask the patient to prepare and carry around a card for each day of the week and to write down the cues that stimulate a desire for indulgence as well as what the patient did about it. Honesty in

recording is stressed, and if a slip occurs the exact amount of drug or drink that was taken must be written down.

Alternative ways of dealing with triggers are encouraged. Insofar as doing something about the environments that tempt the habit, two ways of management are possible. The first consists of reducing environmental temptation, such as avoiding parties where conviviality demands imbibing alcohol, marijuana, or cocaine for good cheer. The second way is deliberate exposure, necessitating in vivo desensitization practice in some situations. Actually, alcohol and recreational drug taking are so much a part of the subculture that one cannot avoid exposure. Patients are constantly confronted with temptation, and it is best to deal with such challenges while in therapy.

Even with all the skills, the therapist will need dedication and concern to deal with substance abusers. Some patients will fail to achieve complete abstinence. Recourse to alcohol and drugs may constitute a preferred way of life. There seems to be little one can do with these patients to stimulate the motivation essential for sobriety or drug abstinence. In these cases, the therapist can perhaps act as a good friend and counselor who is available when the patient needs help with a crisis, to arrange for detoxification if necessary, and to get the patient back to work and acceptable functioning. The therapist need not consider himself or herself a failure in such cases but instead recognize that for some patients neither God nor man can do more than the patient wills.

15. It may be possible with a certain number of patients who have been off abused substances for a while to approach underlying personality conflicts, being aware that such probings may produce untoward transference reactions that will serve as stress stimuli. There are, however, a few patients who have the curiosity and the residual ego strength needed to reach for reconstructive goals.

16. The following self-help groups may be contacted:

Narcotics Anonymous World Service Office, Inc. P.O. Box 622 Sun Valley, CA 91352

World Service Office, Inc. 16155 Wyandotte St. Van Nuys's CA 91406-3423

Nar-Anon Family Group Headquarters, Inc. P.O. Box 2562 Palos Verdes

Peninsula, CA

Families Anonymous P.O. Box 344 Torrance, CA 90501 Telephone: 213-775-3211

Pills Anonymous P.O. Box 473 Ansonia Station New York, NY 10023

SEXUAL DISORDERS

A complex aggregate of physiological, psychological, and environmental factors enter into the sexual reaction. The capacity or incapacity for responsiveness to sexual needs and the distorted or perverted forms of their expression are largely products of past conditionings. Interfering emotions may relate to defects in early training and education (e.g., prohibition of masturbation), to transferential projections (e.g., incestuous feelings toward parental figures), to carryovers of later childhood experiences (e.g., fearsome and humiliating seductions), and to unsatisfactory adult human relationships (e.g., a hostile or nonresponsive partner). Resulting anger and fear are anathema to proper sexual functioning. These affects are not always clearly perceived by the individual suffering from sexual difficulties. Indeed, their existence may be completely denied, and even if the early initiating circumstances are remembered, the emotions relating to them may be shielded under a coat of non-feelingness. This anesthesia influences sexual behavior, distorting the perception of sexual stimuli or altering the manifestations of the sexual drive. Joining this conspiracy are defects in the self-image prompted by disturbances in personality development and by prolonged exposure to humiliating happenings.

The most common phenomena influencing sexual behavior are premature ejaculation and impotence in the male and non-orgasmic response, frigidity, dyspareunia, vaginismus, and conflicts about infertility in the female (Practitioners Conference, 1957; Kleegman, 1959; Geijerstam, 1960; Hastings DW, 1960; Mann EC, 1960; Nichols, 1961). The degree of failure of response may range from total disinterest in sex and inability to derive any sensation from autoerotic stimulation, to prurience under special circumstances (e.g., singular dreams, fantasies, and fetishes), to orgasmic response to

certain acts (e.g., rape, "bondage," humiliation, pain, or sadistic acting-out), to selective reaction to the embraces of a specific love object, to excited behavior with a variety of sexual objects, to constant preoccupation with sexuality (e.g., nymphomania and satyriasis). People are "turned on" by a host of stimuli that are unique to their personalities and early conditioning experiences. Objects and circumstances accompanying the first sexual arousal may be indelibly imprinted and may motivate actual or symbolic revival for sexual feeling thereafter. Later sexual expression may host consequences dependent on the significance of guilt-ridden experiences (e.g., relaxation and exhilaration or self-punitive mechanisms, like anxiety, migraine, and gastrointestinal symptoms). It is understandable that with the complex array of operative contingencies, a vast assortment of patterns will be displayed by different people and at different times prior to, during, and after the sexual act. The degree of orgasmic reaction will also vary individually, from mild release to violent, ecstatic excitement and even unconsciousness.

Sexual Dysfunctions (DSM-III-R Codes for Hypoactive Sexual Desire, 302.71; Sexual Aversion Disorder, 302.79; Female Sexual Arousal Disorder, 302.72; Male Erectile Disorder, 302.72; Inhibited Female Orgasm, 302.73; Inhibited Male Orgasm, 302.74; Premature Ejaculation, 302.75; Dyspareunia, 302.76; Vaginismus, 306.51)

A diagnostic assessment of any sexual problem is vital to determine what kind of treatment is necessary. It is important to determine which of four phases of sexual response is implicated. Is the disorder one of inhibited desire or inability to maintain excitement and genital tumescence, to control or achieve orgasm, or to achieve postorgasmic relaxation and well-being? (Kaplan & Moodie, 1984; Lief 1981). Distinguishing these phases of sexual response is important because different mechanisms and neural pathways are operative in each and different therapeutic interventions may be called for. For example, inhibited sexual desire may be the product of guilt about and repression of sexuality produced by over-moralistic promptings in childhood with consequent fantasies or needs for self-punishment, indulgence in rape or bondage fantasies, and sexual masochism as a condition for the release of sexual feeling. Conquest of these developmentally sexual inhibitions may inspire the individual to imagine or act-out violently and sometimes sadistically (sexual sadism) and to use

antisocial behavior as a way of subduing or symbolically destroying the conscience or projected guilt representations. Guilt feelings and masochistic self-punishment usually follow these releases but rarely eliminate them. Treatment when sought will require psychotherapy, preferably dynamically oriented, and behavioral approaches later should sexual functioning continue to fail. Inhibited sexual desire may also be associated with the release triggers that open the gates to sexual feeling, such as fetishism, transvestism, zoophilia, pedophilia, exhibitionism, and voyeurism, which must be approached psychotherapeutically, although prognosis for recovery in these ailments is guarded. Sexual desire can be deadened by ailments such as depression, as well as by antihypertensive, antidepressant, tranquilizing and other medications. These interferences require specific correction. Finally, one's relationship with a marital partner may be pathological (e.g., incestuous) or so seeped in ongoing hostility as to deaden all thoughts of sex. Here marital therapy and dynamic psychotherapy may be essential. Appropriate treatment for all these conditions requires accurate diagnosis. In the case of inhibited sexual excitement with frigidity and impotence, once organic (endo-crinopathics, diabetes, arteriosclerosis, etc.) and medical factors (antihypertensive and beta-adrenergic drugs, alcohol, tranquilizers, etc.) have been ruled out, behavioral sex therapy may be effective in itself, especially if the onset of the dysfunction has been recent or the causes minor. If personality difficulties exist or anxieties and phobias are strong, however, coordinate psychotherapy may be necessary. The same may be said for inhibited female and male orgasm, premature ejaculation, dyspareunia, and functional vaginismus. If postorgasmic relaxation and well-being are a concern, such treatment as cognitive therapy to alter meaning systems and dynamic psychotherapy to explore conflicts may be useful (Wasserman et al, 1980). If an antidepressant is found necessary for depression, bupropion (Wellbutron) has been found less associated with sexual dysfunction than other antidepressants.

Unfortunately, there has been a tendency on the part of some professionals to project their own experiences into their opinions of what constitutes "normal" sexuality instead of dealing with it as a broad spectrum of behavioral repertoires that cannot rigidly be circumscribed in terms of "healthy" and "pathological." Thus, there are writers who

insist that oral contacts are abnormal, that manual genital stimulation is immature, and that orgasm derived in any other way than through penetration of the penis in the vagina is aberrant if not perverse. These injunctions reinforce any prevailing misconceptions that a patient may be harboring and add to guilt feelings.

Brief sex therapy may be eminently successful in modifying or curing some milder sexual disturbances. In an inspired setting, away from everyday problems and pressures, a couple has the best opportunity for loosening up their inhibitions, relaxing their defenses, and under the prompting of new permissive authorities acquiring better habits of sexual response. Interpersonal hostilities are quietly subdued under these circumstances, and new and more constructive communicative patterns are set up. After therapy is terminated, the real test occurs. Can the improved functioning be sustained in the couple's habitual setting? There is always a possibility that reinstitution of customary pressures and responsibilities may restore tensions and break down the new communication patterns. It would, therefore, seem vital to continue to see the couple after the instruction period is over to help resolve developing problems.

The key to successful sexual therapy is the therapist. One's personality, one's casualness, one's flexibility, one's empathy, one's understanding, one's sense of humor, and one's capacity to communicate all influence the techniques. In many couples the strong defenses and resistances to the directives of the therapeutic authority are apt to create frustration and anger in the therapist. The therapist has to know how to deal with the patient's reactions in an easy-going way without taking offense. The therapist actually needs the skills of a good communicator. It is not possible to adopt a passive analytic stance with this type of treatment.

The short period of therapy can provide a biopsy of the prevailing pathology between the two people. If the pathology is not too severe, if healthy defenses are present, if reasonable flexibility of adaptation prevails, new sexual habits may be maintained. On the other hand, if the sexual difficulty is a reflection of a personality problem, there may still be some improvement sexually but the personality difficulties will have to be dealt

with by more intensive methods.

For example, an impotent single man comes to therapy harboring deep hostile feelings toward women, stemming from a high level of dependency that one may historically trace to his being overprotected by a dominant mother figure—by no means an uncommon condition in problems of impotency. The immediate precipitating factor for the impotency in our present patient, let us imagine, was sexual association with a dominant, demanding woman who somehow undermined his confidence in himself. Let us also hypothesize that, through behavior therapy and in relationship with a cooperative and non-dominant woman, the patient is restored to potency. Lacking recognition of his inner drives and needs, however, he may soon lose interest in what he would consider "uninteresting weak females" and seek out domineering women with whom he could act out his dependency and hostility. Without speculating too much, we would probably witness in a new relationship with a controlling woman a revival of his symptom. A thorough understanding of the problem, however, may help him not only to try to desensitize himself to domineering women, but also to manage more assertively their specific domineering traits. By seeing that he was projecting attitudes toward his mother into his contemporary relationships, he might better be able to deal with "strong" women. The evolvement of firmer controls may enable him to relate even to manipulating women without fear. Or, realizing his choice of women as a weakness he must overcome, he may decide to restrict his sexual contacts to more passive types, while handling his impulse to goad them into domineering roles.

A complicating factor in many patients is that the sexual function in the human being is often employed as a vehicle for the expression of varied strivings, interpersonal attitudes, and needs. Thus, sexual behavior may embrace, among other things, impulses to hurt or to be hurt, to humiliate or to be humiliated, and to display or to mutilate oneself.

When impotence results from vascular surgical procedures, an implant or a recently developed surgical procedure may be effective (Zorgniotti, 1987).

Paraphilias (DSM-III-R Codes for Exhibitionism, 302.40; Pedophilia, 302.20; Sexual

Masochism, 302.83; Sexual Sadism, 302.84; Transvestist Fetishism, 302.81; Voyeurism, 302.82)

Among the more serious and less prevalent sexual disorders are those that relate to gender identity and the paraphilias. An assorted group of problems are embraced under the term *transsexualism.* Here there is conflict about one's anatomic sex and a desire to exchange it for genitals of the opposite sex. Assumption of a role consonant with the desired sex identity are compelling, and occasionally submission to surgery to amputate the undesired sex organs is yielded to. The cross-dressing here is distinguished from transvestism in that in the latter there is no desire to rid oneself of one's genitals. The cross-dressing appears to act as a stimulus for sexual excitement, which in most cases is expressed heterosexually. A *gender disorder of childhood* is characterized by a repudiation of one's sexual identity and a frantic need to act like a member of the opposite sex. The little boy plays with dolls and desires to dress like a girl; the little girl engages in male activities and may deny not having a penis. In the paraphilias there is a compulsive need to utilize imagery or to engage in unusual acts in order to stimulate sexual desire, such as specific items of clothing *(fetishism)* or animals (*zoophilia*); to be humiliated, bound, and beaten (*sexual masochism)-,* to inflict pain or humiliation on the sexual object (*sexual sadism*); to exhibit one's genitals to strangers (*exhibitionism*); to spy upon and observe people in situations of undress or intercourse (*voyeurism*); and to engage in sex (usually mingled with aggression) with a child *(pedophilia).* Neurotic and personality disorders often coexist with these sexual distortions.

These conditions are among the most difficult of all syndromes to treat. Because of the intense pleasure values inherent in the exercise of the perversions and the fact that they fulfill deep needs other than sexual, the patient is usually reluctant to give them up. Although there may be a desire to overcome certain disagreeable symptoms, such as anxiety or tension, the motivation to abandon the coveted sexual expression may be lacking. Because of the lack of incentive, resistance often becomes so intense as to interfere with the therapeutic process.

There is, nevertheless, a growing conviction that sexual deviations are pathological

conditions that sometimes may be helped by psychotherapy. The specific approach to perversions will vary with the theoretical orientation of the therapist (Bieber I, 1962; Bychowski, 1961; Deutsch H, 1965; Fried, 1962, Lorand, 1956; Marmor, 1965; Nunberg, 1955; Ovesey, 1954, 1955a & b; Ovesey et al, 1963; Saul & Beck, 1961; Stark, 1963).

Some authorities speculate that a genetic defect complicated by conditionings in childhood makes certain preliminary fantasies or acts mandatory for sexual feeling and performance in adult life. The origin of many of these conditionings are forgotten, repudiated, and repressed, although the individual is mercilessly bound to special stimuli (fetishistic, masochistic, sadistic, etc.) to release his or her sexuality. In many instances the sexual disturbance reflects improper identity. If normal masculine identification is lacking (an overly possessive controlling mother, intimidation by an overwhelming father, passive indulgence by a weak father) tendencies toward effeminacy may develop in a male. Lack of a feminine and motherly mother who can act as a feminine model may divert a girl from female identification. Under these circumstances, the sexual direction may be altered.

Whether all forms of homosexuality should be classified as abnormal is a moot point about which there are differences in opinion among professionals. Under pressure of some groups, the trustees of the American Psychiatric Association (amidst considerable controversy) officially ruled that the term "homosexuality" be replaced in the Statistical Manual of Mental Disorders by the phrase "ego-syntonic homosexuality" to avoid the stigma of being classified as a disorder. Ego-dystonic homosexuality was a diagnosis applied only to those homosexuals who were in conflict with their sexuality. In justification of this move, we do find many homosexuals who are happy and adjusted, and some studies reveal that symptoms and behavioral disorders among this group are no more frequent than among heterosexuals.

Under these circumstances, it is argued, homosexuality might for some individuals be regarded as a manifestation of a preferred normal life style rather than as a distortion of sexuality. On the other hand, there are those who continue to accent the point that analysis of even so-called well-adjusted homosexuals indicates without question that they

have a developmental block in the evolution of the sexual drive. In appraising the pathological nature of homosexuality, we do have to consider the fact that many homosexuals suffer from the abuse and discrimination heaped on them by society, without which they would probably be able to make a better adjustment.

Homosexuals who apply for therapy are in a special category when they are ostensibly disturbed and upset about their sexual behavior. They may seek therapy for their symptoms, but they may not be motivated to change their sexual orientation. A therapist's forceful attempts to induce change under these circumstances will usually fail. If there are strong conflicts about homosexuality and a sustained and powerful desire for heterosexuality, dynamic psychotherapy or psychoanalysis may succeed in a certain number of cases (Bieber I, 1962) in changing their sexual orientation. Adolescents disturbed about homosexuality may well benefit from some brief counseling along the lines suggested by Gadpaille (1973), which may help lessen their identity problems.

Sometimes homosexual preoccupations in a conflicted individual become so uncontrollably compulsive as to cause the person to act out impulses in a destructive and dangerous manner. Masochistic and sadistic drives are usually operative here. The problem is that the person can easily jeopardize one's safety by becoming involved with psychopathic individuals or by getting into trouble with the law. Such a person may seek from psychotherapy not so much stoppage of homosexual activity as the opportunity to direct one's behavior into less dangerous channels.

Traditional psychotherapy, unfortunately, has had little to offer such applicants; neither insight nor appeals to common sense influence the driving determination to involve themselves in exciting trouble. A form of therapy still in the experimental state is aversive behavioral treatment. Some behavior therapists recommend that if patients are insistent on being forced to stop their behavior, and if sufficiently motivated, they may be able to endure exposure to a series of slides that are sexually stimulating to them but are rewarded with a painful electric shock through electrodes attached to the fingertips (Feldman & MacCulloch, 1965). In a technique evolved by McConaghy (1972) the male

patient selects 10 slides each of a nude adolescent and of young men and women to which he feels some sexual response. At each session three male slides are shown for 10 seconds. A 2-second shock is delivered during the last second of exposure, with the level of shock as unpleasant as the patient can stand. Following this, a slide of a woman is turned on for 20 seconds without accompanying shock. Variable intervals between 3 to 5 minutes pass between showing the three sets of male and female slides. Sessions are given three or more times the first week and are gradually reduced in frequency over the following few months. In female patients the shocks would be delivered with the slides of women, and no shocks would be delivered with the male slides. Again, unless the incentive to control one's homosexual activities is high, this treatment is doomed to failure.

The treatment of sexual perversions, such as sadism, masochism, voyeurism, and exhibitionism, must be organized around removing blocks to personality development in order to correct the immature strivings that are being expressed through the sexual perversion. Fears of adult genitality and of relating intimately and lovingly to persons of the opposite sex must be resolved before adequate sexual functioning is possible. The only rational approach is, therefore, reconstructive in nature. Lack of motivation may, however, inhibit the patient from entering into reconstructive treatment. Additionally, ego weakness and disintegrative tendencies are often present in sexual perversions and act as further blocks to deep therapy. For these reasons the therapeutic objective may have to be confined to the mere control of the perversion and to its possible sublimation. Behavior modification has been utilized here. The therapist may have to function as a supportive, guiding authority who helps the patient to lead a more restrained life.

In treating perversions, the therapist must be prepared for a long struggle. Resistances are, as has been mentioned, usually intense, and the patient will repeatedly relapse into the sexual deviation. The patient should not be blamed, reproved, or made to feel guilty for this. Rather, he or she must be helped to see the purposes served by the perversion and to appreciate why the need to express it becomes more overwhelming at some times than at others. While the ultimate outlook is not as favorable as in some other problems, there is no reason why patients who become motivated for, and who can

tolerate reconstructive therapy, cannot achieve satisfactory results.

SPEECH DISORDERS

(Developmental Articulation Disorder (DSM-III-R Code 315.39), Expressive Language Disorder (DSM-III-R Code 315.31), Receptive Language Disorder (DSM-III-R Code 315.31); Cluttering 307.00; Stuttering, 307.00)

Functional speech problems, which are sometimes arbitrarily called "stuttering" or "stammering," are the consequence of the lack of coordination of various parts of speech wherein the speech rhythm becomes inhibited or interrupted. Associated are vasomotor disturbances, spasm, and incoordination of muscle groups involving other parts of the body. The speech difficulty is initiated and exaggerated by certain social situations, so that the individual is capable of articulating better under some circumstances than others. This is confirmed by the fact that the person is usually able to sing and to talk without difficulty to himself or herself and to animals. Some authorities insist that since there is no actual pathology of the speech apparatus, it may be a grave misnomer to label stuttering a speech disorder. Rather it might be conceived of as a manifestation of total adaptive dysfunction.

Martin F. Schwartz (1974) of Temple University has presented evidence that stuttering is produced by an inappropriate vigorous tightening of the larynx (contraction of the posterior cricoarytenoid) triggered off by subglottal air pressures required for speech. Psychological stress reduces the action of the usual supramedullary inhibiting controls of the involved muscle. To correct this, the patient must place the larynx in an open and relaxed position, which helps keep the air pressure in the voice box low. One-way mirrors and videotape equipment are used to coach the patient. The therapy is still in the experimental stage but a "reasonable expectation of perhaps a 90 percent success rate with stutterers given the proper therapeutic implementation" may be expected within 2 or 3 months (Pellegrino, 1974). Should the therapy prove itself to be this successful, it will undoubtedly replace the traditional treatment methods.

The counseling of parents of a stuttering child is important in the total treatment plan. Generally, parents react with dismay, frustration, and guilt feelings in relation to

their child, many assuming that they are responsible for the problem. At the onset of counseling the parents should be told that we are still unsure of what produces a stuttering child and that worry about complicity in it is not as important as doing something about it. There are, however, things they can do that may help the problem. Constant emphasis on mistakes and subjecting the child to drilling helps aggravate the nonfluency by making the child more self-conscious and aware of his or her failings. The stuttering child requires a great deal of demonstrated love and affection, and the parents must be enjoined to go out of their way to give these. It is essential also that they encourage the child to express feelings openly no matter how badly the child enunciates these and that they control themselves if the child bumbles along in front of friends and relatives. This does not mean that proper discipline should not be imposed, even punitive measures for outrageous behavior, since discipline is an important learning tool for healthy growth. There is in some families a tendency to infantalize and to overprotect a stuttering child. This must be avoided, and the child should be expected to manage whatever responsibilities one of his or her age must assume. The role of the father is important in providing proper guidance and companionship. Since tension in the home contributes to the child's disturbance, it may be necessary to institute marital therapy or family therapy before appreciable improvement can be expected.

Therapy with a child therapist, particularly one experienced in speech difficulties, may have to be prescribed for the manifestly disturbed child or one who has been undermined by the speech problem. These children are exposed to ridicule, teasing, and social ostracism by their classmates. They shy away from talking and presentations in class, resulting in an undermining of self-esteem.

The usual treatment of adult stuttering proceeds on two different levels: correction of the improper speech habit and the handling of the deeper emotional problem that originally initiated and now sustains the difficulty. A guidance approach and social skills training are used toward achieving the first objective (Brady, 1984).

The second goal is obtained through a persuasive, reeducative and, where possible,

reconstructive approach. Therapy involves correcting patent difficulties in the environment that stir up the person's insecurity, and dealing with disturbing inner conflicts. Since the character disturbance in stutterers is usually extensive, therapy is bound to be difficult, prolonged, and, in many cases, unsuccessful insofar as alteration of the underlying personality disorder is concerned. The most that can be done for many stutterers is symptomatic relief in the form of speech correction.

Speech training may do as much harm as good. It is valuable only as a means of building up confidence in the individual's powers to articulate. Unfortunately, it may psychologically have the opposite effect since it overemphasizes will power and control and concentrates the stutterer's attention on the mechanics of speech rather than on what is being said. Instead of becoming less conscious about the speech difficulty, the person becomes more involved with it, thus intensifying the problem. This is not to say that proper exercises in diaphragmatic breathing, phonetics, and articulation are of no value in certain patients. Sometimes, with these methods, a symptomatic recovery may take place in mild cases. In severe cases, however, they are relatively ineffectual, and, especially if the person makes a voluntary effort to stop stuttering, the severity of the speech problem may increase. Rhythmics and eukinetics are sometimes helpful. Training methods, when used, should be employed by a therapist experienced in speech techniques.

In supportive approaches with stuttering adults certain evasions and defenses are sometimes taught to tide the stutterer over situations in which he or she must talk. Drawling, speaking in a rhythmic manner or in a sing-song tone, utilizing distracting sounds like "ah" or a sigh prior to articulation, employing a gesture or engaging in some motor act like pacing or rubbing a watch chain, purposeful pauses, and a variety of other tricks are used. These are entirely palliative and must be considered escapes rather than therapeutic devices.

A persuasive approach is sometimes helpful. The first step in therapy consists of convincing the patient that because of disappointing experiences, he or she has come to overemphasize the speech function. To the stutterer it constitutes an insignia of

aggrandizement and defamation. Self-esteem has become linked with the performance of speech. Because of this the stutterer concentrates attention on the manner of talking more than the content of what is being said. While the speech problem is understandably disturbing, it is probably not regarded with the same emphasis by others. People suffering from stuttering overcome it more easily when they stop running away from acknowledging it. The best tactic is to face the situation and even admit it. As soon as this is done the person will be more at ease and the speech will improve.

A talk such as the following may be indicated:

> *Th.* There is nothing disgraceful about stuttering. Avoiding social situations because of fear of ridicule merely serves to exaggerate the sense of defeat. It is necessary to regard stuttering in the same light as any other physical problem. If you stop being ashamed of it, and do not concern yourself with embarrassing others, people will notice your speech less and less. As you become more unconcerned about *how* you talk, you will concentrate on *what* you say. Keep concentrating on what you say, and pay no attention to how it sounds. Fear and embarrassment exaggerate your speech difficulty, so make yourself act calm and you will feel calm, and your speech will improve.

The next stage of therapy draws on some reeducative techniques and consists of demonstrating to the patient how he or she becomes upset and loses the sense of calmness in some situations. There will be no lack of material since the patient will bring to the therapist's attention many instances in which his or her stuttering becomes exaggerated. Examining the patient's emotional reactions to these situations as well as his or her fantasies give the therapist clues as to the dynamic elements involved in the patient's speech disorder. These may be pointed out to the patient in terms that conform with his or her existing capacities for understanding. The aim is to show the patient that the speech difficulty appears when he or she loses the capacity to remain relaxed and when, for any reason whatsoever, emotional instability develops.

In some cases it will be advisable to refer the patient to a good speech therapist. The therapeutic approach that appears most successful comes from the work of Van Riper (1971), and Wendell Johnson (1946). This aims at the elimination of anxieties about stuttering, which is considered a learned reaction to conscious fears of speech or fluency failure. Patients are enjoined to adopt an "objective attitude" by facing the fact squarely

and, instead of avoiding displaying their stuttering, talking about the speech handicap to others, deliberately meeting all fearful and difficult speaking situations, and articulating in the best way they can, utilizing, if necessary, the evasions, defenses, and tricks that are so often employed by stutterers. Exposure to various speaking challenges while maintaining as objective an attitude as possible is also advised.

Specifically, patients are taught to open up, in as casual and objective and even humorous a way as possible, the speech problem with others, even if the listeners do not know that they have a speech problem. Clearing the atmosphere in this way will put both the listeners and themselves at ease. They are asked to observe how others falter and make mistakes in speaking and by this to realize that normal fluency is imperfect and quite variable. They are requested to observe how certain listeners react to what they say and to check their observation with those of others present. In this way they will discover that they project their personal fears and prejudices onto other people. Most important they are requested to give up running away from fearsome words that cause stuttering and to utter them deliberately, particularly in situations in which they have stumbled over them while remaining emotionally detached and not caring how the listener reacts. Role playing may be used here to prepare the patients for such stints. They are requested to discuss their experiences with the therapist at the next session. The patient is reminded to try to cultivate a calm, unemotional tone of voice. They may practice this with a friend or with members of the family. One-half hour each day is devoted to reading aloud from a book, jotting down those words that are difficult to pronounce. They may then practice enunciating words several times during the day. Some persons find it helpful to talk for a short time daily in front of a mirror, watching their facial movements as they utter sounds. Along with these reconditioning techniques, environmental therapy may be used, geared toward an expansion of the assets of the individuals and a remedying of liabilities in themselves and their situations.

If these techniques do not yield desired results, patients may be taught ways of postponing word attempts, of starting difficult words or of releasing themselves from blockages. They may also be taught a substitutive stuttering pattern, deliberately

prolonging or repeating themselves in an unhurried, tenseless way. For instance, Van Riper's cancellation technique enjoins stutterers to pause immediately after they experience a stuttering block and to ask themselves what they did (pressed their lips together? pushed the tongue against the roof of their mouth? felt panic? diverted their gaze from the listener?). They are then to cancel their failure by "stuttering" on the same word deliberately in a new way with prolonged relaxation, maintaining eye contact with the listener. This starts a reconditioning process so that the stutterers may begin to change their behavior during the fist attempt and then to manipulate preparatory sets prior to the attempt "to facilitate the production of a 'fluent' pattern of stuttering" (Bloodstein, 1966; Van Riper, 1971).

Three important adjuncts in speech therapy are behavior therapy, self-hypnosis, and group therapy. Assertiveness training may be extremely important. Other behavioral approaches can be quite valuable (Brady, 1968) particularly utilizing a metronome. In metronome-conditioned speech retraining (MCSR) a miniaturized electronic metronome is worn behind the ear like a metronome (Brady, 1971, 1972). This may be especially helpful when patients are confronted with a speaking engagement. The metronome allows the speaker to pace the speech. Prior to the use of the ear metronome, the therapist may expose the patients to an ordinary desk metronome, such as used in piano practice. At first as few as 40 beats per minute may have to be used, the patient pronouncing one syllable for each beat. As soon as the patients are fluent in pronouncing several syllables at this speed, the rate is gradually increased to 90 to 100 per minute. A metronome should be procured for practice at home, at first alone, then when feeling confident, with a friend or parent in the room; then with more than one person present. Pauses are introduced to some beats and then more than one word to each beat. What can be helpful is practicing while fantasizing progressively more anxiety-provoking scenes. When reaching a satisfactory fluency, the patients practice with the miniature metronome and then utilize the fluency outside the home, at first in low-stress situations and then in high-stress situations. Should difficulty be experienced under some conditions, they may reduce the speed of the metronome and speak more slowly. Gradually, as the patients gain confidence, they may practice speaking without turning on the metronome, first in low

then higher stress situations.

Another method is to listen to a transistor radio, using earphones while talking to a cassette tape recorder. The radio is played so loudly that one's voice is not heard. At first this is done after practicing relaxation. Then situations of increasing anxiety are imagined. The patient articulates feelings and thoughts at the same time and particularly pronounces his or her name and the words over with which difficulties have been experienced. As the stutterer gains confidence in speaking, he or she may turn the radio off while speaking, turning it back on should nonfluency return.

Persuasive autosuggestions in a self-induced trance reinforce the patient's desires for self-confidence and assertiveness. Group therapy in which the patient comes into contact with other persons suffering from speech problems removes the sense of isolation. The fact that companions experience the same trepidations as the patient does help the patient reevaluate his or her reaction. An opportunity is provided to speak and to recite in a permissive setting. The identification with the group, along with the growing confidence in the ability to speak fluently, may have a most positive .effect on speech performance.

As the patient begins to experience improvement in his or her interpersonal relationships, the speech problem will plague the patient less and less. Utilizing the speech group as a bridge, one may be able to integrate with other groups and to consider oneself on an equal plane with its constituent members. In some cases reconstructive therapy may be possible to deal correctively with the personality disorder (Barbara, 1954, 1957, 1958, 1963). This, however, is associated with many vicissitudes as Glauber (1952) has pointed out.

In situations of strong anxiety, such as speaking before a group, some therapists advise taking 40 mg of Inderal shortly before the assignment, which will cut down on the anxiety without impairing cognition.

SLEEP DISORDERS (DYSSOMIAS)

Among the sleep disorders are the *Dyssomias,* which include primary insomnia, hypersomnias, and sleep-wake schedule disorders, and the *Parasomnias* identified as dream anxiety disorders (nightmare disorder), sleep terror disorder and sleepwalking disorder. By far, Primary Insomnia DSM-III-R Code 307.42 is the most common sleep disorder encountered in practice.

Insomnia is a ubiquitous symptom which more than one-third of the population experiences periodically. In most cases episodic sleeplessness is accepted philosophically, especially if it does not interfere too much with everyday functioning. In some persons, however, it is a persistent phenomenon for which help may be sought. Causes are heterogeneous, ranging from physical ailments, to depression, to environmental crises, to psychiatric stress. Sometimes insomnia is a consequence of prolonged consumption of hypnotics and sedatives, in which case the buildup of tolerance inspires wakefulness.

Patterns of insomnia are individual: (1) some people find it difficult to fall asleep but once slumber occurs do not awake until morning; (2) some fall asleep easily but awake in a few hours, fall asleep again, and go through the sleep-awakening cycle several times during the night; (3) some doze off readily but awaken at 4 to 6 a.m. and then cannot return to sleep; (4) others sleep throughout the day lightly, fitfully, restlessly, and get up in the morning as exhausted and tired as when they went to bed.

In recent years, research in sleep laboratories and clinical experience has yielded important information that is valuable in treatment planning (Kales, 1984). The following points are important to consider:

1. Insomnia is not as ruinous to health as the victim imagines. People can go without sleep for even several days without being damaged physically or becoming psychotic.

2. The amount of sleep required for optimal alertness the next day varies with the individual. Not everybody needs 8 or 9 hours; some persons do well with *4½* or 5 or 6 hours. Aging lowers the requirements to as little as 4 hours in some people, and older people normally sleep lightly.

3. People generally underestimate the hours of true sleep they get. Thus, many subjects on testing in sleep laboratories will show no sleep disturbance yet will complain of insomnia.

4. Insomnia is only a symptom. Its causes can be diverse. In all cases, treating the causes if possible is primary: Physical ailments such as coronary artery disease, which produces nocturnal anginal pain; duodenal ulcer, which stimulates gastric acid especially at night, driving the person to seek antacids; prostatic enlargement, which produces arousal because of the frequency of urination; bronchial asthma; hypothyroidism, sleep apnea, myoclonus, and other physical conditions that cause discomfort and pain requiring proper medical or surgical help. Depression may need antidepressive medications; anxiety reactions often do well with simple relaxation therapy; environmental disturbances may be helped with counseling and milieu therapy; and psychiatric stress necessitates psychotherapy and behavior therapy.

5. Certain medications such as beta blockers and tranquilizers can make a person feel sleepy and fatigued during the day, which may falsely lead a person to think he or she is not getting enough sleep. Other substances may actually cause insomnia. These include Dexedrine, Ritalin, Tenuate, Proludin, and coffee, tea, soft drinks containing caffeine, and alcohol taken late in the day or evening. Steroids, Inderal, and other beta blockers, may also create problems.

6. Once insomnia develops for any reason an added deterrent to sleeping well is anticipating being awake during the night and suffering fatigue and exhaustion as a consequence. This whips the person into a state of self-defeating alertness.

7. Markedly irregular hours of retiring interfere with the bodies built-in time clock. People who go to bed late at night usually, often to their dismay, wake up at their regular morning hour.

8. Hypnotic drugs used over a long period lose their effectiveness and therefore are for short-term (no longer than 3 to 4 weeks) or periodic use. Continued employment creates tolerance and addiction without added benefits. Withdrawal of these drugs, taken over a period, produces a "surge" of dreaming, jitteriness, and more insomnia. Such withdrawal must be done slowly and in some cases may require hospitalization to deal with unpleasant sequelae.

9. Over-the-counter sleep medications contain methapyrilene and/or scopolamine. Prolonged use is neither safe nor effective at current dosage levels.

The treatment of insomnia will depend upon whether or not it is acute, the provocative factors that keep the patient awake, and the degree of addiction to hypnotic drugs.

Acute temporary periods of insomnia produced by situational stress are usually readily handled by reassuring the patient that sleeping less than his or her usual quota will not cause damage, by permitting the patient to verbalize his or her fears and resentments, and perhaps by prescribing a hypnotic substance for 1 to 3 nights if necessary. Short-term insomnia due to work and family problems, bereavement, or illness requires education about insomnia, helping the development of proper sleeping habits, and, if necessary, prescription of a benzodiazepine hypnotic for no more than 3 weeks.

The treatment of chronic insomnia is a more difficult matter, largely because the patient has established faulty habits and has probably incorporated the insomnia into his or her neurotic superstructure. The primary treatment is behavioral (Hauri, 1979), and hypnotics should be avoided if possible.

The therapy for established insomnia starts with exploring its history and manifestations, the patient's attitudes toward it, what he or she has done about it in the past, and what is maintaining it in the present. In many cases the demoralization of the patient will have to be dealt with by supplying scientific facts about insomnia to displace as much as possible unfounded myths and fears. If the patient has not had a good physical examination in the past, he or she should be asked to get one to rule out any organic causes. The patient should also be asked to keep a diary of his or her sleeping habits and working schedule for at least 24 hours, including bedtime routines, use of medications, sleep disruptions, and daytime fatigue, which may or may not yield important clues.

The next procedure is to instruct the patient in proper sleeping habits. These can serve as effective alternatives to drugs. Among measures to be recommended are the

following:

1. Rearranging sleeping habits.

2. Reassuring the patient about sleep needs.

3. Getting the patient to accept insomnia.

4. Teaching the patient relaxing exercises.

5. Treating hypnotic drug dependence.

6. Prescribing medication.

Rearranging Sleeping Habits

(1) The patient should attempt to establish a regular bedtime, avoiding naps during the day. If sleep does not come easily, one may try relaxing exercises (or deep breathing, audiotapes, self-hypnosis, or meditation) or imagery with object counting ("counting sheep"). Should sleep not follow, one should go to another room to read or watch television until drowsiness develops instead of tossing around. (2) excessive smoking and drinking should be eliminated. (3) In some patients a change of mattresses should be made from hard to soft or vice versa, attention being paid to the bedcovers so that the patient is neither over- nor underheated, to the wearing of more comfortable night apparel, and to the regulation of the room temperature. Simple as this may sound, it may be all that is required. (4) A change in position during sleep may be indicated if the patient is in an uncomfortable repose. Superstitions such as that one must not sleep on the left side because the heart may be damaged, should, if this position is a preferred one, be corrected. Patients with asthma or orthopnea are more comfortable propped up in bed rather than lying prone. An elevation of the head and upper trunk is sometimes a preferred position. In married persons a change from a double to twin beds, or the reverse, may be considered. (5) A bedtime snack (warm milk, sandwich, cocoa) is reassuring to some people, as is a glass of beer or ale or a small tumbler of sherry, port, or an aperitif. (6) Tea or coffee should be excluded from the evening meal and not taken before going to bed. (7) Reading in bed concentrates the attention away from inner

concerns. Television programs selected before bedtime should not be too stimulating. (8) Daily exercise and a brisk walk in the evening followed by a hot bath are recommended by some. (9) Should the patient desire to experiment with it, an oscillating mattress is available in "sleep shops" or department stores that rhythmically rocks some people to sleep. (10) Ear plugs, antisnore masks, and eye shades may be used to control situations disturbing to sleep. If necessary, one may sleep in a separate room away from a snoring partner. (11) Making up for lost sleep during weekdays by sleeping longer over weekends or on holidays can be disruptive to establishing proper sleeping patterns. Regular wake-up times should be observed even after a poor night's sleep.

Reassuring the Patient About Sleep Needs

The individual's estimate of how much sleep he or she must have for health reasons is usually far above his or her true physiological requirements. As people get older, sleep needs decrease. A reduction of deep sleep stages (III and IV) is normal. Because lighter stages (I and II) occur, older people get the feeling they do not sleep a wink. They also awaken several times during the night and fall asleep again, which is normal. If the patient can be convinced that merely reposing in bed and not forcing oneself to sleep is not damaging to one's health and if the patient can develop the philosophy "If I sleep, so much the better; if not, it doesn't matter," he or she may be able to stop worrying himself or herself into wakefulness. The patient may be told that merely lying in bed and relaxing are usually sufficient to take care of the physiological needs. If the patient does not sleep as much as he or she believes is necessary, no real harm will befall the patient. Of course, he or she may be driven to distraction by worrying about not sleeping. Worry will actually cause the insomniac more difficulty than not sleeping.

Relaxing Exercises

Progressive muscle relaxation with deep breathing exercises and self-hypnosis are valuable adjuncts in insomnia. The techniques of relaxation and self-hypnosis have been outlined previously in this volume *(q.v.)*. They may advantageously be taught to the patient. Repeated suggestions are made that he or she will be able to "turn one's mind off,"

to focus on a pleasant scene, and to feel himself or herself getting more and more drowsy and relaxed. This may reestablish the sleep rhythm more effectively than any other measure. A useful pamphlet on ways to approach sleep may be prescribed for the patient *(Better Sleep,* 1963). An interesting article called "The science of sleep," by Joan Arehart-Treichel (1977) in *Science News,* may be recommended, as may the book by Coates and Thoresen (1979).

Acceptance of Insomnia

Several unusual methods of controlling sleep have emerged that may be suited for certain patients. One technique deliberately restricts the hours spent in bed fruitlessly attempting to fall asleep. Persons appear to "sleep better if they spend fewer, rather than more hours, in bed" *(JAMA,* 1985). Subjects are enjoined to stay awake later but to arise at their customary times. They are not permitted to nap during the daytime. Another method that has been employed with patients who drive themselves frantic during the day with the fear that they will not be able to sleep that night is paradoxical intention (Ascher and Efran, 1978, Ascher et al. 1980). Here suggestions are given that the person "try to remain awake as long as possible, rather than attempt to fall asleep." A rapid reduction of sleep onset latency can result.

Should insomnia continue to be distressing, referral to a sleep disorder clinic may be considered. Such may be the case in phase-shift sleep-wake (in which the patient seems to be able to sleep only during the daytime and is awake at night). Chronotherapy, a specialized procedure, is best done in such clinics.

Some therapists try to get insomniacs to accept their insomnia as something with which they can learn to live. Indeed, insomniacs may, as Modell (1955) has pointed out, successfully exploit their symptom. Once they are convinced they need less sleep physiologically than their mind dictates, patients may be encouraged to accomplish something useful during their waking hours at night. Instead of tossing about fitfully in bed and brooding about problems, they may read or write in bed. Or they may get up, take a shower, and, for an hour or two, apply themselves to useful work, particularly work that

worries them if it goes undone. They may then return to bed.

Drug Treatment

Prescription of a hypnotic should be given only when behavioral or psychosocial therapy fails to relieve sleeplessness. In cases of depression, antidepressants may eliminate the insomnia. If stress exists, the only logical intervention is to deal with its sources. Hypnotics temporarily given for no more than 3 weeks, and preferably less, may be of great help. If there is a history of alcohol or drug abuse, hypnotics should not be prescribed because the patient will almost invariably refuse to give them up or, worse still, will take them with alcohol or other depressants, which may be fatal. When hypnotics have been used for more than 2 weeks, withdrawal should be gradual to avoid rebound sleeplessness or such neurological symptoms as twitching.

Many substances have been used, abused, and then discarded in humans' quest for a harmless substance that can hasten and sustain sleep. We still do not have such a substance, but currently the benzodiazepines, the least harmful, though still not perfect, solution, have replaced alcohol, bromides, opiates, barbiturates, ethclorvynol, glutethimide, and methaqualone as the most frequently prescribed drug for insomnia. Chloral hydrate is still employed by some as a safe and effective hypnotic.

Taken occasionally when stress distracts the normal sleep tendency, hypnotic benzodiazepines are useful aids. When taken regularly as sleep insurance, all hypnotics eventually betray their purpose by fostering cognitive and psychomotor impairments. Without a pharmacological "straight jacket," the individual anticipates a sleepless night with the feared consequence of not being able to function well or at all the next day. On the other hand, if benzodiazepines are not prescribed, a stressed individual may resort to alcohol or more dangerous drugs that cannot be monitored.

The most popular benzodiazepines employed as hypnotics are the long-acting flurazepam (Dalmane), with a half-life of about 100 hours, the short-acting temazepam (Restoril), with a half-life of 9.5 to 12.5 hours, and the ultra short-acting triazolam

(Halcion), with a half-life of only 1.6 to 5.4 hours. Diazepam (Valium), 2 to 5 mg (and up to 10 mg), is an old standby; it has a half-life of several days. Lorazepam (Ativan), 2 to 4 mg, is also popular and has a shorter half-life of up to 18 hours. Doxepin (Sinequan), 25 to 50 mg, is another choice. It is a dibenzoxepin tricycle compound used in depression and hence less prescribed for insomnia although it may be effective in some cases.

The drug to use will depend on the type of insomnia the patient is suffering. In transient situational stress with a carry over of anxiety during the day, Valium (2 to 5 mg) is a good alternative, especially if one wants its anxiety-reducing effects (with its accompanying slight hangover) to continue through the daytime. Dalmane has its advocates. Its sedative effects continue in the daytime because of its long half-life. Here one starts with a 15-mg dose but informs the patient that it is more effective on the second, third, or fourth night of consecutive use than on the first night. Should 15 mg fail to work after a week, 30 mg may then be given. In severe chronic insomnia one may start initially with the 30-mg dosage. Elderly persons who require daytime alertness and good psychomotor performance are best given 0.125 mg of Halcion, which may be increased to a limit of 0.25 to 0.5 mg. Halcion (0.25 to 0.5 mg) is also valuable for persons with jet lag or who awaken in the middle of the night and need a short boost to fall back to sleep. Restoril (15 to 30 mg) is also tolerated well by young and old and is especially suited to those who anticipate sleep difficulties. For early-morning awakening, doxepin (25 to 50 mg) is sometimes quite effective. The amino acid L-tryptophane has been shown to reduce sleep latency without distortions of psychological sleep (Hartmann, 1977), but it has not been consistently used as a hypnotic because of its mild effect.

Should these medications fail and it is judged that the patient truly needs a stronger temporary hypnotic, the choice of drug will depend upon whether short action is desired (i.e., 3-4 hours), in which case pentobarbital (Nembutal) 1.5 grains (100 mg) is prescribed; intermediate action (i.e., 4-6 hours) will require butabarbital (Butisol); 1.5 grains or long action (i.e., 6-8 hours) for which 1.5 grains of phenobarbital will be necessary. Sometimes a combination drug is used such as Tuinol (1.5 grains), which contains Seconal and Amytal, for short and intermediate action. Should a "hangover" result the next morning,

the doses should be halved. Under no circumstances should a stimulant such as amphetamine be prescribed to alert the patient the next day since a vicious sedating-stimulating habit may be established. The non-barbiturates are also popular. Among these chloral hydrate is preferred (7.5-15 grains). This is available in capsule form (Noctec), which consists of 3 or 7.5 grains of chloral hydrate and is taken in doses of one to two capsules nightly; or in syrup form, which contains 7.5 grains of chloral hydrate per teaspoonful. Other non-barbiturates are also occasionally employed but must be used with caution. These include Placidyl (500 mg), Doriden (500 mg), and Noludar (300 mg).

The use of hypnotics should be confined to at most 3 weeks because beyond this time habituation is likely. If long-term use is anticipated, the patient may be enjoined to skip medication several times during the week. Many patients are comfortable with a hypnotic every 3 days, which enables them to catch up on their desired quota of sleep. In spite of everything that can be done to deal with the causes of insomnia, it may be impossible to stop it. This is especially the case if the patient has an intractable medical condition with pain and debility. In these cases, the therapist may have to prescribe long-term periodic hypnotic medication as adjunctive therapy.

When hypnotic drugs have been used over a long period, they usually become less effective and REM sleep is markedly reduced. Therapy is much more difficult since the patient will resist going off hypnotics. Should drugs be abruptly withdrawn, disturbing rebound insomnia will eventuate. The brief snatches of sleep that do occur are interrupted by a rebound in REM sleep, upsetting dreams, and nightmares. Consequently, slow withdrawal is necessary (a good rule is reducing by one nightly dose every 5 or 6 days). The patient should be warned about the possibility of a temporary increase in insomnia, vivid dreams, and nightmares. Relaxation exercises or self-hypnosis are prescribed or biofeedback employed if the therapist has the apparatus. Other principles outlined above should be followed.

In absolutely refractory insomnia, multidimensional treatment in an inpatient psychiatric unit may be most helpful.

EATING DISORDERS

Overweight and Obesity (Psychological Factors Affecting Physical Condition, DSM-III-R Code 316.00)

The pursuit of thinness has become an obsession, especially in prosperous societies, but often it is a futile gesture. Obesity is a refractory condition whose cure rate is less than for many kinds of cancer. If grossly excessive, overweight leads to many physical disabilities, but even more important to untold hours of self-reproach and suffering on the part of even its less overweight victims. Recent studies have shown that such physiological factors as fat cells that are enlarged in size and number and a low metabolic rate are prominent among some obese persons. These factors, probably genetically determined, make it difficult and for some individuals impossible to lose weight even on a prescribed low-calorie diet. There is also a small group of persons who have serious personality problems dating back to infancy and early childhood associated with an overvaluing of oral activities, in whom overeating becomes a compulsive mechanism that defies all methods of control except long-term psychotherapy (Bruch 1957, 1961, 1973; Caldwell, 1965). Even here the food compulsion may defy correction. Most overweight persons do not fit into these sub-types of obesity, however, and may be helped by modern methods of treatment to lose weight for cosmetic if not health reasons.

The basic therapy that has been commonly employed is behavior modification that takes into consideration the prevailing eating patterns of the patient (Stunkard 1972, 1985, Craighead et al, 1981). Detailed questioning is essential regarding not only the kinds and preparation of foods the patient prefers to eat, but also the time of day when overeating occurs, the availability of the food, the exact circumstances under which the appetite is stimulated, propensity for sweets, late-evening snacking, social pressures, and so on. What is essential is control of environmental eating cues that excite temptation. Once these factors are identified, the patient is instructed in how to rearrange eating routines and given homework assignments to practice the new orientation.

Standard forms of therapy involve (1) following a diet of around 800 to 1000

calories daily, carefully recording the food consumed, (2) keeping a chart, daily or weekly, of one's weight, (3) eating meals preferably at home with no distractions such as radio, television, or reading, (4) chewing each mouthful of food very slowly and spending at least 20 minutes at each meal, (5) forbidding snacking between meals, (6) food shopping from a list of essential items and no more, (7) exercising daily and walking rather than riding, and (8) being rewarded with money or gifts for losing weight and being penalized by a fine for gaining weight. Such programs are often executed in groups for a number of sessions, among which Weight Watchers and Overeaters Anonymous are especially popular.

Except for a small group of physiologically and psychologically handicapped persons, overweight individuals who follow the principles of these programs will lose considerable poundage. The real problem is maintenance, because most people are constantly plagued with temptation and sooner or later will abandon their new eating styles. Fantasies of the good life—the tinkle of beautiful crystal, the feel of fine silver, and the smell and taste of gourmet cooking will haunt the most dedicated soul. And, in an incredibly short time, to the great consternation of the dieter, the old weight has been restored. Anyone who operates under the illusion that weight loss is simply a matter of discipline and diet and that a few behavioral strategies can dissolve fat and ensure permanent weight loss will be subject to disappointment.

For many people, food is a pacifier. It alleviates tension and acts as a means not only of gratifying hunger and securing great pleasure but of quelling anger and restoring one's adaptive equilibrium. The driving impact of hunger is kept alive by inner forces of which the individual may not be entirely aware. This fact has led to a broadening of behavioral strategies to include cognitive elements. We are interested not only in what the patient does but in the thoughts and impulses that stir up the craving for food and especially for those foodstuffs that are fattening.

In some cases, particularly if physiological factors exist and constant dietary attempts have led to failure, the individual should not be forced to reduce. The lesser of two evils is to accept one's body size and try to lessen the overconcern with achieving

thinness. Society does discriminate against overweight people, and even those who are mildly plump get to hate their bodies and to despise themselves for loss of willpower. Psychotherapy may not be able, especially with short-term methods, to get to the provocative psychological factors responsible, and the most we will be able to accomplish is to help people to stop tormenting themselves with their obsessional dieting preoccupations.

If a patient comes to therapy principally for help for emotional and adjustment problems and obesity is a secondary concern, the focus at first will be on the primary complaint factor. In the course of therapy, the patient may bring up the matter of overweight, in which case techniques may be used similar to those used when obesity is the initial complaint. Generally the patients will already have experimented with weight-loss measures on their own. The therapist may inquire about those that have proven temporarily successful. In some cases no more has to be done than to encourage the patient to continue on these diets and to join Weight Watchers, Overeaters Anonymous, or similar groups. Commercial weight-loss clinics must be selected carefully since some employ potentially dangerous drugs, have minimal medical supervision, and neglect essential exercise, which is an important ingredient in a good program. In treating the average adult who is less than 40 percent overweight and who probably does not possess serious psychological problems, some clarification about diets will usually be necessary. Though the patient has been exposed to years of dietary information and may profess to know all about dieting, there are usually large gaps in knowledge that have been filled with old wives' tales about food and feeding as well as faddist whimsies extracted from magazines and newspapers. Information on what constitutes a good dietary regime (7 calories per pound of ideal weight with proper protein, mineral, and vitamin content) that can act as the basis of a living diet to be followed faithfully may have to be supplied. In some patients alcohol, taken to appease tension, constitutes a block to dieting. One ounce of drink of any spirit contains about 135 calories. An average martini has as many calories as three slices of bread! Considering that several highballs or cocktails supply 500 to 750 calories and that the appetite is in addition stimulated by alcohol, food control for the drinker becomes a nonexistent entity. The matter of exercise will also require explanation.

A 250-pound man climbing 20 flights of stairs will lose the equivalent of one slice of bread. Exercise firms up muscles, but it cannot take off sufficient poundage without strict dieting. When suggesting a proper diet, the therapist may have to give the patient a basic nutritional list of essential daily foods. This consists of a helping of fresh fruit twice daily; a small helping of cooked vegetables; a salad; lean broiled meat, fish, or fowl twice daily; a glass of milk or cheese twice daily; 2 to 3 eggs weekly; and little or no alcoholic beverages (Tullis, 1973). Fats, nuts, candy, cake, and all desserts are to be avoided. Low-calorie salad dressings, low-calorie sweeteners, and sugar-free drinks may be permitted.

A report released by researchers in a study supported by the National Institutes of Health has lauded the substitution of fats in the diet with 60 mg of sucrose polyester per day. This reduces caloric intake by 23 percent (*JAMA*, 1982) and contributes to weight loss. Meals should be taken at regular hours with no snacking allowed.

In most cases, however, the lack of success with these routine methods will necessitate an aggressive therapeutic program on either an individual or group basis. Assessment should include an evaluation of the patient's goals. Sometimes these are unrealistic, for example, if the patient expects to lose 20 pounds in 4 weeks. The patient's dietary and eating habits should be recorded as well as any stress factors of which the patient is aware. Many patients believe that they can lose weight by having little or no breakfast and skimping on lunch. In this case, most of the eating occurs at nighttime, when a ravenous appetite is set loose. Some patients desire medications that will act as appetite suppressants. Information should be supplied that experience with these chemical adjuncts has been disappointing. Their effect is temporary at best, and when they are discontinued, the patient is worse off than at the beginning.

An evaluation of social support systems is vital since many tensions are the product of social isolation and lack of family and group contacts. Because the relationship with the spouse is especially important, the spouse should become a vital part of the treatment program from the start. As the patient loses or fails to lose weight, the attitudes of the spouse will influence what happens, and the spouse's relationship with the patient may

change for the better or worse. Not infrequently, the spouse will subtly encourage the patient to go off the diet as body changes in the latter occur. Obesity may be a way of locking the patient into a neurotic relationship that the spouse needs for his or her personal stability. There may be fear that greater physical attractiveness will motivate the patient to abandon the spouse or make the spouse attractive sexually to others or seek activities away from home. Some men find obese wives more sexually stimulative and thus may discourage weight loss in their wives. These additional reasons for sabotage of the patient's therapy make the husband's presence at some of the sessions a desirable part of the treatment program.

It is obvious that motivation to lose weight is crucial to the success of any treatment program for obesity. Certain patients come to therapy with the expectation that some miracle will happen and that their appetites for food will somehow disappear as a result of magical tactics like hypnosis (Krogar, 1970; Stanton, 1975). Because motivation to participate actively in the assigned program is essential, an initial screening process may be used. Patients are told that unless they are ready to follow the routines prescribed, they are not ready for the program. They are then given a few routines to follow during the first and second session, such as keeping a record of their weight and their food intake each week.

Simple tactics such as chewing food very slowly, putting the fork down between bites, sitting in the same place for each meal, and avoiding distractions like television while eating may be advised. Should the patients fail to do these simple things nor be disciplined enough to lose at least 2 pounds during the first 2 weeks of therapy, it is doubtful that the more burdensome tasks that come later will be executed. Such reluctant patients may be told bluntly that they are not yet ready for the program the therapist has to offer. Motivation may sometimes be helped by imposing financial penalties for non-attendance at sessions (Brownell & Foreyt, 1985). At the University of Philadelphia and Baylor College of Medicine, for example, patients are required to deposit $100 in addition to a treatment fee of $200. If the patient attends at least 80 percent of the sessions, the deposit is returned.

Included in the weight-reducing directives are definite instructions regarding routine exercise. Physical exercise is prescribed not so much for its weight-reducing potential, which is low, but for its general effect on the well-being of the patient, which reflects back on the patient's ability to follow a sensible weight-loss maintenance regime. Morever, exercise helps prevent the loss of essential muscle tissue and the lowering of the basal metabolic rate as dieting proceeds. The therapist must be firm about insisting that graded exercises be carried out daily. Most obese patients will resist exercising for many reasons, including shame of exposing their bulky bodies to others and the torpor that excessive poundage imposes on them.

According to some authorities on obesity (Stunkard, 1984; Garrow, 1981), different degrees of obesity call for different approaches. Mildly obese people (30-40 percent overweight) are best helped with behavioral methods. Moderately obese people (40-100 percent overweight) require a very low-calorie diet as well as behavior modification. Severely obese people (more than 100 percent overweight), which is rare, may need an intestinal bypass operation after having failed with a very low-calorie diet and behavior modification. Such intractable cases usually display a combination of basic defects in metabolism and poor motivation, which results in lack of cooperation. A "short-circuit" procedure (ileal bypass) results in a reduction of the length of the small bowel lowering the absorptive surface for nutrients. While weight loss occurs, serious malabsorption, diarrhea, gallstones, and susceptibility to infections may impair health. The operation is consequently done as a last resort.

It is important to remember that weight will rapidly be regained if a reducing diet is markedly different from the diet the individual will return to later. Some nutritionists therefore advise patterning a diet around the patient's customary one but substituting nonfattening for fattening items, eliminating high-calorie foods, and introducing more vegetables, fruits, and cereals. It is essential that the organization of a dietary regime take into account the need for the person to continue to eat healthful foods to maintain his or her ideal weight. How fast one should lose weight is also important. Obese people want to reduce rapidly. They have previously tried to do this with crash diets. This has not worked

because returning to previous food habits nullified their accomplishment. The rate of weight loss during the active period of dieting is best maintained at a low level, perhaps no more than 1 to 1 i pounds weekly, which gives the individual a chance to reorganize food habits. If however, obesity is pronounced, if morale demands it, and especially if the metabolism of the individual is sluggish, a drastic reduction of food intake (to 400 to 700 calories) or outright semistarvation (Genuth et al, 1974) *under medical supervision* may be undertaken to foster the loss of 3 to 5 pounds weekly. Naturally, there is great danger here of rapid return to the original weight once professional supervision if terminated.

In recent years a very low-calorie diet mainly of protein (lean meat, fish and fowl, vitamins and minerals) has been popularized for patients who are at least 40 pounds overweight. Patients have initial physical examinations and are seen regularly by their physicians for checkups and laboratory tests. Supervision is essential, and if the patient adheres to the diet, and in addition receives behavior modification, impressive weight loss is possible in most cases. Unless a continuing maintenance program exists, however, relapses are the rule. Satisfactory maintenance may often be achieved when patients are continuously supervised, preferably in a group setting. An interesting treatment manual describing a behavioral approach to obesity has been prepared by Brownell. Information on it may be obtained by writing to Dr. Kelly D. Brownell, Department of Psychiatry, University of Pennsylvania, 133 South 36th Street, Philadelphia, PA 19104.

Weight-loss maintenance is a key issue and, as has been mentioned, the involvement of a spouse at the point when the patient has lost enough weight to make a difference in appearance may spell the difference between a successful and poor outcome. Most patients will require personal individual or group therapy for a year. Thereafter, some patients do better in a continuing group, but this is not always the case. The patient should be forewarned to contact the therapist should there be danger of slipping back into the old habits. Any stress situations are apt to cause a patient to overeat to appease tensions. Often fantasies of gourmet foods may tempt or upset the patient. Patients who have irreverent thoughts about luscious foods must be taught to correct self-statements that keep undermining their resolve. The emphasis in such a cognitive approach must be on

their strengths not weaknesses. Hunger may be explained as a good sign, indicating that the patient is consuming excess body fat. Mastering hunger then becomes a virtuous act of caring about themselves and safeguarding health, longevity, and appearance.

One should not overlook the damaging psychological consequences of having been overweight. Obese people often have a depreciated self-image and believe their bodies to be misshapen, grotesque, and contemptible. They sustain a loathsome hatred of themselves. This is most often the case in juvenile obesity in which extraordinary efforts may be made to conceal body fat. Some of these residues remain even after weight loss. Or an attractive body may confront the individual with new challenges, for example, coping with sexual gestures from members of the opposite sex which they are not equipped to handle. Continued psychotherapy may then be in order.

Psychoanalysis and psychoanalytic therapy have little impact on the isolated symptom of obesity. Correcting disturbed personality factors may, however, have an impact on overeating patterns. When successful, they can significantly improve the quality of life of their beneficiaries in a broad spectrum of behaviors.

Anorexia Nervosa (DSM-III-R Code 307.10)

Anorexia Nervosa usually invites desperate expediencies. In their anger, anguish, and dismay, patients and therapists may take recourse in such measures as cajolery, bribes, tube feedings, and even electroconvulsive therapy. These may have an immediate ameliorative effect, but since they circumvent the core problems they ultimately aggravate self-starvation. Anorexia nervosa mainly affects young adolescent girls of well-to-do families who defend their avoidance of food with a captious logic that does not yield to common-sense arguments. Even though they are emaciated, they still insist on losing weight by restricting food intake, forcing themselves to vomit, and driving themselves mercilessly in forced exercise. Sometimes obsessive-compulsive behavior takes place. Interludes of binge eating (bulimia) and vomiting are followed by self-hatred. If some motivation exists, behavior therapy by itself sometimes brings temporary benefits (White JG, 1964). Follow-up studies, however, have been discouraging, with relapse and alarming

substitutive symptoms being the rule rather than the exception (Bruch, 1973). The malady appears to be on the increase throughout the world, as the pursuit of thinness remains a chief obsessive concern.

Theories of its cause range from genetic predisposition, to hypothalamic dysregulation, to exaggerated dopamine activity, to an affective disorder, to reaction to psychosexual conflict, to an extraordinary stressful experience. Psychological studies often reveal an erstwhile "perfect" child struggling to maintain her stature with abstemious relentlessness. Basic is the search for identity and a struggle for independence and control. Paradoxically, short-lived bouts of uncontrollable eating binges further undermine the anorexic's self-esteem and incite an exaggerated refusal to eat. A pathological distortion of the body image is universal.

Therapy is thus understandably difficult. It hinges on two objectives: (1) improving nutrition (the use of high-calorie diet is sometimes helpful but must not be forced (Maxmen et al, 1974); and (2) rectifying the instrumental psychological causes. In mild cases, where the family warfare is not too extreme, treatment may be achieved at home. In most instances, separation from the home environment (usually with hospitalization) is mandatory in order to remove the patient from the highly charged family situation and from the aversive entourage surrounding the prevailing eating atmosphere. The relationship with the therapist is primary, with a minimum of pressure employed. Focus on food stuffs and calories is avoided.

Certain medications have a positive effect on anorectic patients. The most important of these is the antidepressant group, such as amitryptiline (Elavil), which is started in a low dose and worked up to 150 mg daily. Another drug with antidepressant qualities is cyproheptadine (Periactin). Chlorpromazine (Thorazine) has also been used with good results in some cases. Behavior modification is used freely to reinforce corrective eating patterns. If family difficulties are prominent, family therapy can be helpful. Psychoanalysis in the classical from has not been found to be too useful, one reason being the lack of motivation for depth therapy. A modified form of dynamic therapy reinforced by family

therapy (Liebman et al, 1974) and supportive measures has yielded the most encouraging results and has helped to rectify identity problems, temper cognitive distortions, and expand autonomy and self-control in relation to eating habits. Continuing psychotherapy with the patient, and perhaps family therapy, is required after hospitalization (Bruch, 1973, 1975).

Bulimia Nervosa (DSM-III-R Code 307.51)

The episodic unrestrained incorporation of large quantities of food, which sometimes occurs along with anorexia nervosa, is also an isolated pattern that is increasingly being encountered in adolescent girls of normal weight. Occasionally it occurs in obese people who seemingly resent the strictures of dietary control, and periodically indulge themselves in compulsive eating. A recent survey of tenth-grade students has also revealed an alarming number of children who engage in binge-purge activities (Killen et al, 1986). The activity is usually followed by guilt feelings, self-recrimination, and forced vomiting. Laxatives and diuretics are taken for the purpose of trying to regulate weight. A good deal of secrecy may accompany the habit, spasms of wild food intake being confined to stealthy visits to the refrigerator or to the privacy of one's room, where sweets and other goodies have been stowed away. Depression accompanies the disorder either as a primary or secondary factor. Indulgence in such substances as barbiturates and amphetamines may sometimes occur. Periods of frantic dieting are often pursued. Concern with one's body and appearance mingled with distortions of the body image make for a peculiar picture, although in all other respects the individual appears normal. Most victims of this illness do not spontaneously seek therapy, but they may be referred by concerned parents or friends.

The association of bulimia and depression is an interesting one. A disproportionate number of bulimics have a positive dexamethasone suppression text, reflecting a relationship between bulimia and major affective disorder (Hudson et al, 1983a). A number of reports have detailed the successful treatment of bulimia with tricyclic antidepressants such as imipramine (Hudson et al, 1983b) and MAO inhibitors, such as

phenelzine (60-90 mg daily) (Walsh et al, 1982).

The fact that binge eating may be controlled by antidepressants does not reduce the impulse to engage in this abnormal food activity. For this reason, individual therapy plus short-term therapy groups should be held with a focus on nutrition, expanding self-esteem, and finding alternatives to binge eating and purging. Indeed, some studies show that a multifaceted group approach produces results equivalent to the taking of antidepressants. Connors et al. (1984) has shown that utilization of a treatment approach incorporating education, self-monitoring, goal setting, assertiveness training, relaxation, and cognitive restructuring can lead to significant attitudinal and behavioral change. Following the initial improvements with antidepressants and with brief group therapy, prolonged dynamic psychotherapy may be needed if personality disorders require restructuring.

HABIT DISORDERS

A number of symptomatic complaints are commonly encountered among patients that serve either as a prime reason for seeking therapy or become so distracting that they obstruct the therapeutic effort. Their resolution consequently will concern the psychotherapist, who, having satisfactorily managed to overcome them, may proceed with any underlying personality problems of which the symptoms are a surface manifestation. Many of the techniques for habit modification come from the behavioral field. The effectiveness of reinforcement therapy has been validated even with chronic psychotic patients (Gottfried & Verdicchio, 1974).

Functional Enuresis (DSM-III-R Code 307.60)

Once urologic or general causes for enuresis (a good physical examination is a necessity) are eliminated (for instance, local irritation around the meatal or urethral area, phimosis, adherent clitoris, balanitis, cystitis, urinary tract infections, pinworms, diabetes, cerebral dysrhythmia, and systemic diseases), its sources in psychological conflict may be explored. If the patient is not mentally defective or of borderline intelligence, the presence

of enuresis probably indicates improper habit training, emotional immaturity, or conflicts related to sexuality or aggression (Bakwin, 1961). Frequently enuresis has positive values for the individual as a masturbatory equivalent. In some instances it represents a form of aggression against the parents or against the world in general. Often it signifies an appeal for dependence on the basis of being a childish, passive, helpless person. In this context, enuresis may symbolize for the boy castration and the achieving of feminity. In girls it may connote aggressive masculinity and symbolic functioning with a penis.

For children a record is kept of dry and wet nights, the former being rewarded by praise and the record marked with a star. Rewards like ice cream may also be used. When the child wets, he or she should be responsible for changing the bed clothes and for seeing that they are washed. One-third of the children presenting with enuresis may be cured by this regimen alone (McGregor HG, 1937).

Strong emotional stress sometimes produces enuresis in persons who are ordinarily continent. This was brought out during World War II when certain soldiers subjected to the rigors of induction or warfare displayed the regressive symptom of bedwetting. Most soldiers who showed this symptom had a history of early bedwetting or of periodic attacks of the disorder prior to induction.

In treating enuretic children, they may first be requested to empty their bladder at bedtime; then awakened 2 hours later and induced to urinate again. This interval may gradually be prolonged, and, if enuresis stops, the evening awakening may be discontinued after 6 months. Positive praise and encouragement are given the children when they control their bladder; however, there should be no scolding or punishment for wetting. Exciting play or activity prior to bedtime is best curtailed, and fluids restricted after four o-clock. Coffee, tea, cocoa, sweets, salts, and spices should be avoided. Sedatives, amphetamine, methyl testosterone, anticonvulsants, belladonna, and other substances have been administered with varying results. Imipramine (Tofranil) has been used (Poussaint & Ditman, 1964; Stewart MA, 1975) one-half hour before bedtime and the results have been promising. The dose is 25 mg for children of 4 to 7 years, 35 mg for

children of 8 to 11 years, and 50 mg for children older than 11 years. Countering improvement are side effects in certain cases. Friedell (1927) obtained an 80 percent cure rate with intramuscular injections of sterile water. W. A. Stewart (1963) described how Zulliger cured a young man of 19 with lifelong enuresis in one session by convincing the patient that he, the therapist, sided with the patient against his father. The fact that so many treatments have yielded positive results indicates the presence of a strong suggestive and placebo element in the management of enuresis (English OS & Pearson, 1937; *Hospital Focus,* 1964).

Enuresis developing in an adult is usually a regressive phenomenon connoting a desire to return to a childish adaptation and a defiance of the adult world.

The treatment of enuresis will depend upon whether one wishes to deal with the symptom as an entity, disregarding the emotional undercurrents, or to work with the intrapsychic structure in hopes that the symptom will eventually resolve itself (Pierce, 1975). Focusing on the symptom as preliminary to working with more fundamental dynamic factors is preferred by many since the symptom is an undermining element that robs the individual of self-confidence and vitiates interest in searching for conflictual sources. Accordingly, concomitant counseling and carefully conducted psychotherapy should, if possible, be employed.

A rapid effective conditioning technique, which, according to the British journal *Lancet* (1964), brings a relief yield of 75 percent, involves a buzzer or bell which sounds off when there is wetting of the bed (Mowrer & Mowrer, 1938). There are advocates and critics of this method. Sidetracking the issue of whether symptom removal is rational or irrational (Winnicott, 1953; Eysenck, 1959) or whether the buzzer treatment is a form of classical or operant conditioning (Lovibond, 1963), this approach to enuresis in controlled studies has been shown to be superior to other therapies (Werry, 1966). While the relapse rate is about 30 percent, relapses respond rapidly to a second course of treatment. There is little evidence that symptom substitution or precipitation of a neurosis develops with the removal of enuresis; on the contrary, the emotional well-being seems benefited (Bailer

& Schalock, 1956; Behrle et al, 1956; Bostock & Schackleton, 1957; Gillison & Skinner, 1958; Lovibond, 1963; Werry, 1966). The apparatus consists of two foil electrodes separated by thin gauze placed under the child. The covering over the electrodes should be as thin as possible. Parents and child are reassured there will be no shock, and the child is to prepare the bed and set the alarm. Should the alarm go off, he or she must get up and go to the bathroom. On return the child is to remake the bed and reset the alarm. Eventually the child will awaken before the alarm goes off. Should the child fail to awaken when the alarm sounds, the parents should awaken the child and see to it that he or she goes to the bathroom. A 90 percent cure is reported in 6 months (Dische, 1971). An improved form of apparatus is the Mozes Detector invented and used in Canada and tested at the Toronto Hospital for Sick Children with impressive results *(Medical World News,* 1972). Another conducting apparatus consists of a moisture pad worn inside the underwear (jockey pants or stretch-type bikini). The reported success rate is more than placebo. It may be obtained through Nite Train'r Enterprises, P.O. Box 282, Newberry, Oregon 97132.

Hypnotherapy is sometimes a useful adjunct (Stanton, 1979). Elsewhere (Wolberg LR, 1948), a full recording of the hypnotic treatment of enuresis is described. Actually, there is no single hypnotic method suitable for all patients; the specific suggestions and stratagems will depend upon the problems and personality characteristics of the patient. One method is to train the patient to enter as deep a trance state as possible. In the trance, an attempt is made to show the patient that he or she is able to produce various phenomena, such as paralysis and muscle spasm, and that he or she can shift or remove these by self-suggestions. Fantasies related to the most pleasurable thing that can happen to a person are obtained for the purpose of reinforcing the conditioning process later on. The patient is then requested to experience a sensation of slight bladder pressure such as occurs immediately prior to urination. As soon as he or she feels this sensation, it will inspire a dream or will make his or her hand rise to the face, which will cause the patient's eyes to open and to awaken. Even though no dream or hand levitation occurs, it is suggested that the patient's eyes will open, nevertheless. At that moment he or she will experience an urgency to get out of bed. Going to the bathroom will be associated with a

feeling similar to that accompanying the fantasy of the best thing that can happen to a person. These suggestions are repeated a number of times.

The next stage in therapy is teaching the patient to control sensations that arise inside the bladder so that urine can be retained without needing to awaken until morning. Suggestions to this effect are given the patient as soon as he or she establishes a habit of getting out of bed and going to the bathroom. The positive relationship with the therapist may be utilized as a reinforcing agent in reconditioning, praise and reassurance being offered when suggestions are followed.

In patients who have expressed a willingness to undergo dynamic psychotherapy, conditioning procedures may be delayed until they are deemed absolutely necessary. This is because the symptom may disappear as the origins of bedwetting are explored, and the unconscious fantasies associated with it clarified. There is, however, no reason why psychotherapy cannot be combined with a conditioning approach.

Nail Biting and Hair Plucking

Nail biting and finger sucking are common outlets for tension in preadolescence and adolescence and may persist as a neurotic symptom into adult life. Among other things,, nail biting serves as a substitutive release for masochistic, sadistic, and repressed masturbatory needs. If no other serious emotional problems coexist, the treatment may be symptomatic (Pierce, 1975), or therapy may be focused on outer emotional factors that generate tension, particularly environmental family problems. Most nail biters have little motivation for real psychotherapy, seeking mere measures of control because of embarrassment about their habit. They are usually unaware that the nail-biting symptom has a meaning, and they are often puzzled by the persistence of the urge to chew their fingertips.

If psychotherapy is resisted, the therapist may have no alternative but to treat the symptom. Hypnosis may be useful here. In hypnosis, strong authoritarian suggestions are made to the effect that the patient will have a desire that grows stronger and stronger to

give up the childish habit of nail biting. Patients who put their fingers into their mouths will discover that their fingernails taste disgustingly bitter. They may even develop nausea with the mere desire to bite the nails. Daily hypnotic sessions are best, but since this is usually impractical, a tape recording may be made that the patient may use twice daily (see Induction of Hypnosis, Chapter 56). Some therapists teach the parents of nail biters to activate the machine while the child is asleep to reinforce suggestions through sleep conditioning. Self-hypnosis may be employed in an adult. If these tactics fail, aversive conditioning *(q.v.),* a small shocking apparatus or a heavy rubber band around the wrist that can be painfully snapped may be tried (Bucher, 1968). A strong desire to control the symptom must be expressed by the patient and cooperation secured.

An assessment of the patient's problems will determine whether further reeducative or reconstructive therapy is indicated after the nail biting is brought under control.

Hair plucking (trichotillomania) (DSM-III-R Code 312.39) of the head, eyelashes, eyebrows is often a manifestation of a severe personality problem, often of an obsessive-compulsive or schizoid nature. It may serve as an outlet for revenge and self-punishment, and it is often accompanied by frustration, guilt feelings, and remorse. Psychotherapy is notoriously ineffective in dealing with this symptom. Hypnosis and particularly aversive conditioning may score some successes.

AFFECTIVE DISORDERS (MOOD DISORDERS)

BIPOLAR DISORDERS: bipolar disorder manic [296.4X]; bipolar disorder depressed [296.5X]; bipolar disorder mixed [296.6X]; cyclothymia [301.13]; DEPRESSIVE DISORDERS: major depression, single episode (296.2X); major depression recurrent [296.3X]; dysthymia *[or depressive neurosis]* 300.40; Atypical Disorders: *Bipolar Disorder* not otherwise specified [296.70]; Depressive disorder not otherwise specified [311.00]).

Depression is a generic term that embraces a variety of syndromes ranging from normal grief at the passing of a loved one, to reactions of prolonged distress out of proportion to the intensity of the traumatic stimulus, to paralyzing inhibition and retardation arising spontaneously from endogenous sources, to psychotic manifestations

with intense melancholia and nihilistic, somatic, or paranoid delusions or hallucinations. A number of syndromes are classified under the category of affective disorders. At the top of the scale in intensity are *major depressive disorder* and *bipolar disorder.* The latter is characterized by alternating moods of elation and depression and is constituted by three subtypes: (1) *bipolar disorder, manic,* in which expansiveness and overactivity are dominant; (2) *bipolar disorder, depressed,* in which sadness and retardation are prominent; and (3) *bipolar disorder, mixed,* in which one or the other mood occurs within a short span. *Cyclothymic disorder* is a mixed affective disorder of lesser intensity. Depressive reactions that often follow psychosocial stress and promote sleep disturbance, fatiguability, social withdrawal, and ahedonia are classified as *dysthymic disorder* (depressive neuroses, reactive depression). Atypical features of a mixed reaction merit the diagnosis of *atypical bipolar disorder;* or if the mood is primarily depression without the usual characteristics of a major depression or dysthymic disorder, they are regarded as signs of an *atypical depression.* Shadings of depression with schizophrenic symptoms have been called *schizoaffective disorder.*

According to some researchers, bipolar and unipolar disorders are two distinct entities. There is some controversy about the precipitating factors that activate a bipolar disorder. In some cases, stress seems to initiate an attack. In other cases, endogenous causes are implicated that appear to have little relation to environmental or inner conflictual sources. Typical of the manic phase are euphoria, irritability, grandiosity, hyperactivity, pressure of speech, and flight of ideas. After recovery and a varying interval of relative calm, a depressive phase may intervene, marked by sluggishness, retardation, loss of appetite, insomnia, and somatic distress. Symptoms vary in intensity from being so mild and under control that the illness is overlooked to being floridly psychotic. It is important to distinguish major depressive disorder from bipolar disorder. To establish the unipolar diagnosis, there must be at least three episodes of depression without a manic episode. Atypical symptoms may confuse the diagnosis, such as when mania masks itself as a personality problem in spurts of creative overactivity and productiveness and depression is concealed by dry humor and a smiling countenance. The search for biological markers goes on, but the Dexamethasone Suppression Test (DST), the TRH

Stimulation Test, catecholamine metabolite levels, urinary phenylacetic acid levels, and sleep EEG studies are still inconclusive.

Depressive Reactions

Depression is one of the most common syndromes encountered in psychotherapeutic practice. Approximately 20 to 26 percent of women and 8 to 12 percent of men will be affected by at least one episode of depression in their lifetimes. Symptoms of this illness vary, but most often it is manifested by listlessness, fatiguability, loss of interest in practically all activities, diminution of the sexual drive, disturbances in appetite and sleep, feelings of worthlessness, self-reproach, and, in severe cases, psychomotor agitation or retardation and suicidal ideas or impulses. Bipolar depressions are characterized by periodic manic phases with swings toward hyperactivity. In most severe depressions, psychotic ideation is not uncommon. Once a depression occurs, there is a 40 to 50 percent likelihood of a second attack, and in the majority of these cases, subsequent attacks are possible. The person may then be plagued by recurrent depressions throughout his or her life. Some depressions seem to persist over a period of years with varying degrees of intensity; others apparently disappear; still others disappear only to recur at some time later.

Depression is a common reaction to separation and bereavement. It may become especially intense after the loss of an important person, such as a spouse, parent, child, or love object, inspiring grief and mourning. In most people the depression, after a period, is resolved. Its continuance or appearance and persistence when there is no adequate stimulus to account for it has a pathological significance and may require clinical intervention. Sometimes depression accompanies a severe physical illness, particularly if its chronic quality makes the person feel hopeless or proper functioning is impaired. Thus cancer, crippling arthritis, Parkinson's disease, cardiac failure, and other enduring medical and neurological ailments may sustain a prolonged depression. Aging, with its effect upon one's health, appearance, memory, and work capacities, is an especially provocative depressive stimulus. Substance abuse and detoxification (alcohol, amphetamines,

barbiturates, narcotics, etc.) are frequently followed by a spell of depression that drives the person to more drinking or drug indulgence. The intake of certain medicinal agents such as antihypertensives (Reserpine, Diuril, Hygroton, etc.) and beta blockers (Inderal, Corgard, etc.) may also produce depression.

Depression sometimes merges with anxiety, making it difficult to distinguish the two. Confusing also is "masked depression" that is camouflaged by such somatic symptoms as headache, backache, facial and limb pains, dysuria, dyspareunia, dysmenorrhea, and sundry other complaints. A puzzling relationship exists between certain psychiatric syndromes and depression. Some observers consider conditions such as anorexia nervosa, bulimia, panic attacks, and obsessive-compulsive neurosis to be manifestations of neurotransmitter abnormalities akin to those of depressive illness, and, most important, they are relieved by antidepressants. Depression in childhood often takes the form of somatic illnesses such as headaches and abdominal pain mingled with a dysphoric mood. Aggressive and hyperactive children may also actually be suffering from depression. Depression among the elderly is common and is accompanied by relatively frequent somatic concerns, memory and cognitive deficits, and occasional paranoid delusions.

The diagnosis of depression is not difficult to make with a good clinical interview. Some physical ailments, however, mask themselves as depression. Gianninni et al. (1978) list 91 such ailments, and Hall (1980) lists almost as many. Consequently, a physical examination and laboratory tests should be done on all depressed patients. Similarly, substance abuse may produce depressive symptomatology and if suspected will justify urine and blood drug abuse screens. Some clinicians recommend the Dexamethasone Suppression Test if there is a problem in differential diagnosis. The DST can identify at least 50 percent of severe depressions (major depressive disorder) but is less accurate in detecting mild to moderate depressions. Certain medical problems, commonly prescribed medications, and some psychiatric disorders can distort DST results, and a negative DST does not rule out severe depression. At this stage, therefore, the test should not be employed as a routine diagnostic procedure although it still has some utility in research.

In reactive or neurotic depression (dysthymic disorder) some ostensible blow to security or self-esteem seems to set off the depressive pattern. The stress stimulus may be loss of a love object, of status, or of worldly goods. The meaning to the individual of the traumatic incident is the key to whether or not depression will result. The depressed patient organizes his or her thinking around the precipitating incident. If a love object has died or abandoned the patient, he or she is preoccupied with the image of the departed one. If status is impaired, the patient considers that he or she is "a nothing." Loss of worldly goods sparks off a poverty complex. The question is still not completely answered as to why some people respond with depression to a crisis in their lives, whereas others marshal their adaptive resources and overcome the vacuum created by the incident. Dynamically, reactive depression is related to (1) feelings of loss of a love object (expressed as feelings of isolation and emptiness), (2) a feedback of hostility blocked from external expression (expressed in self-deprecatory comments) in a masochistic maneuver, and (3) a converted form of anxiety (here anxiety and depression may alternate, depression apparently serving as a means of dealing with anxiety).

Major depressive disorder and bipolar disorder spring from biological disturbances presumably hereditary in nature and can develop periodically without identifiable exogenous or internal conflictual provocations. Social and psychological disruptions consequent to such biological depressions in turn can aggravate the symptoms. Depression in such conditions is often ushered in by feelings of loss of self-confidence, the absence of initiative, and fatiguability. The depressive mood itself may not be apparent; it is often covered by an overlay of hollow humor in what has been called the "smiling depressions." As the depression deepens, loss of appetite, insomnia, diminution of the sexual drive, and a general anhedonia (lack of gratification in the pursuit of pleasure strivings) follow. There are difficulties in attention and concentration and variations in mood, the intense depression during the morning lifting as the evening approaches. Interference with work and interpersonal relationships follow. Extreme suffering and regression to early dependency with masochistic behavior then develops in the course of which suicidal thoughts, impulses, and acts may erupt.

Principal goals in therapy consist of the following:

1. Removal of symptoms and a relief of suffering.

2. Revival of the level of adaptive functioning that the patient possessed prior to the outbreak of the illness.

3. Promotion, if possible, of an understanding of the most obvious patterns that sabotage functioning and interfere with a more complete enjoyment of life.

4. In motivated patients, recognition of conflictual patterns and exploration of their meaning, origins, and consequences.

5. Provision of some way of dealing with such patterns and their effects in line with a more productive integration.

Unfortunately, depressions are singularly resistive to treatment in that the mood change imposes a barrier to three of the most important elements in therapy: faith, hope, and trust. Lost is the expectancy of getting well that so often powers the machinery of cure. Gone is the feeling that someone cares, so essential in establishing a therapeutic relationship. Yet beneath the isolation and hopelessness, the depressed individual seeks a restoration of his or her ties with humanity. The person resists relationships, and then credits the feelings of isolation to the fact that he or she is unloved.

Among the therapeutic measures that are most effective are the following:

1. *Establish as rapidly as possible a relationship with the patient.* This is precarious as has been mentioned before. Yet winning the patient over in spite of inertia, gloom, sluggishness, despair, hostility, and self-recriminations is urgent. Depressed patients are insatiable in their demands for help and love. No matter how painstaking are the therapist's attempts to supply their demands, they will respond with rage and aggression, often accusing the therapist of incompetence or ill will. The patients should, nevertheless, be approached with the attitude that the therapist understands and sympathizes with their suffering. Such measures as active guidance and externalization of interests may be attempted. The basis of treatment is a warm relationship between the patient and the therapist. The relationship that the patient establishes with the therapist

will, however, be extremely vulnerable. Much leniency and tolerance are needed, and an attempt must be made to show that the therapist realizes the depth of the patient's fears and misgivings. This, however, is more easily said than done, since the depressed patient has a distrustful nature.

Distrust springs from the fusion of hate with love. Hostile feelings generate guilt that may be so disabling that the person will want to discontinue treatment. The slightest frustration during therapy, such as the unavoidable changing or canceling of an appointment, may be equivalent to rejection and will mobilize a tremendous amount of anxiety. Under the surface there is always fear of abandonment, and there is a tendency to misinterpret casual actions. The patient seeks reassurance but may resent its being called psychotherapy.

The aim in treatment is to develop and reinforce all positive elements in the relationship. This will involve much work, since the attitudes of the patient are so ambivalent that he or she will feel rejected no matter what the therapist does. It is best to let the positive relationship take root in any way it can without attempting to analyze its sources.

One of the means of maintaining the relationship on a positive level is by communicating empathy and by avoiding arguments. It is essential to convey to the patient nonverbally the idea that he or she is liked and that the therapist is a friend in spite of anything that happens. An attitude of belittling, harshness, ridicule, or irritation must be avoided. The therapist must maintain an optimistic outlook and express the sentiment that although the patient may not believe it now, he or she *will* get over the depression in a while.

Hypnosis may be of help for some of the milder depressions as a means of establishing a relationship primarily as an avenue toward inducing relaxation and toward giving persuasive suggestions to stabilize the person. A number of depressed patients appear to thrive under hypnotic therapy, probably because it appeals to their dependency needs.

2. *Use drug therapy when necessary.* Benzodiazepines such as Valium and Xanax may be of help in patients with mild depressions, especially those associated with anxiety, in elevating the mood and supplying energy. Simple mild depression occasionally is helped by methylphenidate (Ritalin) but should be taken for no more than 3 weeks. More severe

inhibited depressions may be approached with imipramine (Tofranil) (100-200 mg daily), while agitated depressions appear to respond better to amitriptyline (Elavil) (100-200 mg daily) combined, if anxiety is especially strong, with Librium (30-40 mg). In very severe anxiety 20-25 mg 3 or 4 times daily may be given. The effects of the latter drugs may not be felt for several weeks. The MAO inhibitors (Nardil, Parnate) are also of some value, especially for atypical or neurotic depressions. Bupropion (Wellbutrin) is an antidepressant with a minimal effect on sexual functioning. Some experimental drugs for depression are being tested, which have low side effect profiles. These include idazoxan and S-adenosylmethionine.

If side effects are intolerable, some of the newer depressive agents may be tried, such as trazodone (Desyrel) and maprotiline (Ludiomil). Mellaril has been employed for depressions of the schizoaffective type. If a schizoid element is present, a phenothiazine drug (Trilafon, Stelazine) may be combined with Tofranil and Elavil. In bipolar depressions, lithium has been given, but in almost one-third of cases it is ineffective or produces bad side effects or sparks of manic attacks. Alternative therapies have been tried, including anticonvulsants such as carbamazepine (Tegretol), valproic acid, (Depakene), tryptophan, thyroid medications, calcium channel blocking agents, and propanolol. Carbamazepine has been increasingly employed because, unlike combined tricyclic-lithium and neuroleptic-lithium treatments, it does not encourage more rapid cycling. Haldol and Navane are often used for psychotic depressions. Depression during medical illness often responds well to triglycerides. (See also Chapter 56, Somatic Therapy for a detailed description of antidepressant medications.)

If drugs are used, patients should be told about the side effects to encourage the continuation of the medications in spite of them. Side effects are the chief reason why antidepressants are discontinued. The need for sleep may be reduced without harmful effect, and the patient may, if not forewarned, take excessive hypnotics. Constipation and weight gain may occur and require remedial measures. Mouth dryness may be counteracted partly by chewing gum or glycerin-based cough drops. Postural hypotension of a severe nature may be handled by advising the patient not to arise suddenly, to avoid standing unmoving in one place, and for women to wear elastic stockings and a girdle. Neuralgias or jactitation of the muscles may require 50 mg vitamin B_6 and 100 micrograms of vitamin B_{12} twice daily. Coffee intake should also be reduced. The troublesome

insomnia in depression is best handled by chloral hydrate (Noctec, 1½ gm) or the benzodiazepine hypnotics (see Insomnia). The patient may be given a mimeographed form about the side effects of drugs (see Appendix T). In older people, antidepressants such as Elavil may be effective, but the dose after the age of 60 must be cut down to 25-100 mg daily. Tetracyclic antidepressants are useful in this group because of the minor anticholinergic and cardiovascular effects. Maprotiline, for example, may be started with 25 mg to 50 mg daily, increasing by 25 mg every third day until 75 to 100 mg is reached, which can then be given in a single-evening dose. Some drugs have been introduced to reduce intolerable anticholinergic effects, e.g. bethanechol, and cyclic tremor, e.g. propranolol.

3. *Administer electroconvulsive treatments immediately in severe depressions, or if there is any danger of suicide.* Electroconvulsive treatments are superior to any of the present-day drugs. (See section on Electroconvulsive Therapy in Chapter 58.) The effect is rapid, 8 ECTs generally eliminating the depression; however, more treatments may be required. In very severe agitated depression, 2 ECTs daily for 2 or 3 days may be followed by 1 ECT daily, and then by treatments twice or three times weekly. Following ECT, energizing drug therapy may be instituted (Tofranil, Elavil) and, if agitation continues, Thorazine or Trilafon can be prescribed. Unilateral ECT may be employed if even temporary memory loss cannot be countenanced. The superiority of ECT over drug therapy for psychotic depression is without question.

4. *Hospitalize patients with severe depression.* Mild depression may be treated at home, preferably under the supervision of a psychiatrically trained attendant or nurse, or, better still, and especially if family problems exist, the patient should be admitted to a rest home. Isolation from parents and friends, bed rest, and constant care by a motherly attendant may prove very beneficial. Because of anorexia, efforts should be made to bolster the diet with high caloric and high vitamin intake in the form of small but frequent feedings. In severe cases of malnutrition, a few units of insulin before meals may be helpful. If the depression is more than mild, hospitalization is advisable. Suicidal attempts in depression are made in almost one-third of the cases, and deaths resulting from these attempts occur with great frequency. The patient's complete loss of interest in himself or herself makes mandatory the establishment of definite daily routines, such as a hospital can best supply. Electroconvulsive therapy, the treatment of choice, can best be instituted in a hospital setting, and, if

the patient requires tube feeding, nursing care is available.

5. *Institute psychotherapy as soon as feasible.* Psychotherapy is usually ineffective during extremely depressed phases. The only thing that can be done is to keep up the patient's morale. Patients should not be forced to engage in activities that they resist because this may merely convince them of their helplessness and inability to do anything constructive. If there is little suicidal risk, patients should be encouraged to continue their work, if they feel at all capable of managing it, since inactivity merely directs their thinking to their misery. In many cases, contact should be regulated with the patient's family and environment. This is necessary since the family of depressed patients often chides them for "not snapping out of it" and constantly reminds them that they must make up their mind to get well. The family members may be told that recovery is more than a matter of will power, and they must be urged to avoid a nagging and critical attitude.

6. Sleep deprivation therapy is still in an experimental state with varied reports attesting to its efficacy (King 1980), uncertainty of benefit (Pflug 1976), and possible worsening of the depression (Vogel et al, 1973). Different procedures have been employed, including sleep deprivation for only one night totally, one night weekly, several nights weekly, and partial sleep deprivation in which the patient is awakened repeatedly during sleep.

Exactly how to conduct psychotherapy is difficult to say. Much depends on the training and skill of the therapist and his or her ability to establish a therapeutic alliance (Arieti, 1978). In general, during the acute depressed stage a supportive, reassuring manner is best, shying away from probing for unconscious material, which may increase anxiety and heighten the possibility of suicide. The patient is given an opportunity to verbalize his or her fears and feelings. Guidance, support, reassurance, and persuasion are used. The patient is told that no matter how bad things seem and how depressed he or she feels, patients with depression recover. There are, however, steps that can be taken to speed recovery: It is essential that the patient get involved in his or her usual activities to the extent that available energy will allow, but not beyond this. Because initiative may be lacking, the patient may require a daily routine for retiring, arising, meals, working, and social and recreational contacts. One difficulty encountered is dealing with the tendency for denial regarding the severity of the problem and the need for treatment. Regardless of

the therapy employed, the countertransferences of the therapist are apt to be brought into play and will have to be handled appropriately. The tendency of the patient to employ the therapist as a replacement for an object of loss has to be handled with tact and understanding, avoiding rejecting the patient without supporting too enthusiastically a dependency relationship and without draining oneself too much with givingness and empathy.

Dealing with the depressed patient calls for a good deal of optimism, support graded to the patient's requirements, and need to control the tendency to be overprotective and overly reassuring. The patient must be made to feel that the therapist understands him or her and will do everything possible to help. The self-limited nature of depression should be repeatedly pointed out and the patient reminded that eventually he or she will feel much better, as others before have. Depressive ideas should never be ridiculed or accepted at face value. The therapist should point out that the situation is not as hopeless as it seems. If the patient harbors suicidal thoughts, a frank aeration of these feelings should be encouraged. It may be essential to extract a promise from the patient that he or she will not try suicide. If suicide is more than a passing fancy immediate ECT is necessary. A physical basis (biochemical, for example) for the depression may be presented and the patient told that there are medications that can help. "When an emotion of depression develops everything seems gloomy, but this will pass." Much of the benefit from psychotherapy is due to the relationship with the therapist. Appreciation of the therapist as a person who cares is important in securing cooperation. Family therapy may be indicated to manage guilt feelings in the members and to educate them regarding factors that can create a more harmonious relationship with the patient. Marital therapy can also be important, as may group therapy and behavioral therapy. Termination of therapy will have to be managed carefully because of the depressed person's sensitivity to loss. Adequate time must be given prior to terminating psychotherapy to allow for the working through of grief and rage reactions, which if neglected may spark off another round of depression. If a transfer to another therapist has to be made, the therapist must be careful not to give the patient the impression he or she is being rejected and pushed off into the hands of substitutes, which may be interpreted as another object loss and precipitate a

deeper depression.

In depressions that have followed in the wake of actual or fantasied loss of a love object we may expect a rapid, positive transference as a means of object replacement. The substitution, however, is often rooted in magical expectations with desires for a giving, loving, nurturing, and omnipotent object reincarnation. The immediate reaction may be a temporary lifting of one's spirits, an overidealization of the therapist, and a stimulation of hope and anticipation that all will be well.

Inevitably, as the relationship with the therapist develops, the patient becomes aware of some failings in the therapist, a realization that the therapist is not the all-giving, all-powerful figure he or she imagined. What will emerge then is hostility and a feeling that the therapist has failed in anticipated obligations. The patient may try to vanquish his or her hopelessness by repressing doubts about the therapist, and passively submitting to the therapist with a sadomasochistic dependency. The hostility is usually suppressed by guilt feelings or in response to disapproving or attacking maneuvers on the part of the therapist. Depression may then return in full force or even become greater than before. Yet the patient will cling desperately to the therapist out of fear of undergoing another object loss.

The countertransference of the therapist will determine the fate of these transferential shifts, the proper handling of which will enable the patient to work through the termination phase of therapy. This involves resolution of the separation and grief reactions associated with loss of the love object that had initiated the depression. Some impact may also be scored on the original separation traumas sustained during the developmental years that sensitized the patient to later object loss.

Klerman has described a brief interpersonal psychotherapy (IPT) (12-16 weeks) for ambulatory, nonbipolar, nonpsychotic depressed patients aimed at symptom relief and enhanced interpersonal adjustment, rather than at personality change. The treatment is organized around the premise "that clarifying and renegotiating the (interpersonal) context associated with the onset of symptoms is important to the person's recovery and

possibly to the prevention of further episodes" (Klerman et al, 1984b). A procedural manual (Klerman et al, 1984a) designating the rationale and techniques has been prepared and the method tested against some other treatments for depression. IPT rests on the assumption that depression issues out of stress induced by life events, especially social adjustment and interpersonal relations. Predisposing to the depressive reaction are personality factors, especially those involving self-esteem and the handling of guilt and anger. Therapy consists of exploring immediate interpersonal difficulties and then clarifying and modifying them. Alteration of maladaptive perceptions is attempted without delving into unconscious conflict or childhood antecedents or developing and exploring transference. Four interpersonal precipitants are particularly dealt with, namely, grief, role disputes, role transitions, and interpersonal deficits. Controlled studies have shown that IPT significantly lessens symptoms and after 6 to 8 months, social impairments. The final appraisal of IPT awaits further replication studies.

Cognitive therapy for depression can also be helpful and in some cases is superior to drug therapy. In cognitive therapy an attempt is made to rectify conceptual distortions in order to correct the ways that reality is being experienced. Interviewing techniques analyze defects in a patient's views of the world (cognitive assumptions or "schema"), methods of stimuli screening and differentiation, and the erroneous ideas that mediate destructive response patterns. Homework assignments reinforce the patient's ability to deal constructively and confidently with adaptive tasks. The treatment is short term, consisting of approximately 20 sessions on a twice-a-week basis. Cognitive therapy for depression is organized around a number of assumptions (Rush & Beck, 1978; Rush et al, 1977). As a consequence of early events, the patient retains a "schema" that makes him or her vulnerable to depression. Among such events is the death of a parent or other important person. What results is a "predepressive cognitive organization." Operative here is a global negative attitude on the part of the patient. Thus the patient misconstrues situations to a point where "he has tailored facts to fit preconceived negative conclusions" (Rush, 1978).

Depressed patients regard themselves as unworthy and assume this is because they

lack essential attributes to merit worthiness. They assume their difficulties will continue indefinitely in the future, that failure is their destiny. These characteristics constitute the "cognitive triad" in depression. In treatment these patients are enjoined to keep a record of aspects of their negative thinking whenever this occurs and to connect these episodes with any associated environmental events that trigger them off. The simple quantifying of any symptoms—in this instance negative thinking— tends to reduce them. Whenever the patient during a session brings up a negative thought, the therapist asks the patient to reality-test it and then to do this away from therapy. Through this means patients are helped to see how they make unjustified assumptions ("arbitrary inferences"), how they magnify the significance of selected events ("magnification,") and how they use insignificant situations to justify their point of view ("overgeneralization"). Other "cognitive errors" are identified, such as how offensive details are used out of context while ignoring more important constructive facts ("selective abstraction"), how circumstances and thoughts that do not fit in with negative "schemas" are bypassed ("minimization"); how unrelated events are unjustifiably appropriated to substantiate their ideas ("personalization"). The patient is encouraged to review his or her record of thoughts, to identify past events that support his or her faulty schemas. Point by point, the therapist offers alternative interpretations of these past events. By so doing, the therapist hopes that sufficient doubt will develop in the patient so that he or she will engage in experimental behaviors, recognizing the fallaciousness of his or her hypotheses, and arrive at different, less destructive explanations for events. A marital partner or family may also be involved in cognitive therapy to reinforce correction of distorted negative meanings.

Step by step the patient is encouraged to undertake tasks that he or she hitherto had considered difficult ("graded task assignment") and to keep a record of his or her activities ("activity scheduling") and the degree of satisfaction and sense of mastery achieved ("recording a mood graph"). Discussions in therapy focus on the patient's reactions to his or her tasks and tendencies at minimization of pleasure and success. Homework assignments are crucial. These range from behaviorally oriented tasks in severe depression to more abstract tasks in less severe cases oriented around correcting existing

schemas. Should negative transference occur, it is handled in the manner of a biased cognition.

The material elicited during the periods of active depression, both as to mental content and as to the character of the relationship with the therapist, may yield important clues to the inner conflicts of the patient. Although notes may be made for later reference, all confrontive interpretations during the active period should be suspended. Only during a remission can interpretive work of any depth be helpful. In most cases interpersonal and cognitive therapies are useful, but depth therapy is avoided in patients with major depressive disorder. Some patients with dysthymic disorder spontaneously express a desire to know more about their illness. Here, a dynamic insight approach may be used. Many patients, however, show an unwillingness to go into their difficulties and resist insight therapy. Having recovered, they are convinced they are well, and they desire no further contact with the therapist. Without the "wish" to get well, little can be accomplished in the way of reconstructive psychotherapy.

Following recovery, the patient should be guided regarding the possibility of further depressions. If the patient has been on medications, half to two-thirds of the effective dose should be continued for at least 4 months. An excellent discussion on therapies helpful for severely depressed suicidal patients may be found in the paper by Lesse (1975). Insofar as prophylaxis is concerned lithium presents promise. Controlled studies have shown that lithium can substantially reduce the long-term morbidity of both unipolar and bipolar disorders. Unipolar patients with endogenous and psychotic features, a family history of depression, and minor disturbance in personality respond well. Prophylactic treatment should be started after 3 episodes in unipolar depression and after the second episode in bipolar depression. Lower lithium plasma levels (0.45-0.6 mEq/l) are maintained best to reduce side effects.

Manic Reactions

The immediate objective in manic reactions is to quiet the patient. This is best achieved with neuroleptics, such as chlorpromazine (Thorazine), which must be

administered in ample dose (up to 1600 mg daily or more). In wild excitements, intramuscular injections (25-50 mg repeated in an hour if necessary) are indicated, followed by oral administration. (See also Chapter 58 on Emergencies.) Dangerous overactivity may call for electroconvulsive therapy (ECT). This may be given twice daily for 3 or 4 days, followed by a treatment every other day. Following this, Thorazine or other neuroleptics may be substituted. Lithium carbonate (see Chapter 56 on Pharmacotherapy) has been employed with considerable success for recurrent manic states. The most effective treatment for mania is reported by Black et al., (1987) to be ECT. Almost 70 percent of patients who did not respond to lithium had marked improvement with ECT.

Psychotherapy is usually ineffective in most manic conditions. The patient's attention is too easily diverted; acting-out is too unrestrained; emotions are too explosive. Because of this, hypomanic and manic patients are extremely difficult to manage in the office. They will seek to involve the therapist in all of their fantastic plans. They will make demands which, when unfulfilled, will release great hostility or aggression. They will try to overwhelm and dominate those around them, and they may become uncontrollable when their wishes are not gratified.

One of the chief reasons for hospitalizing overexcited manic patients is to prevent them from involving themselves and other people in projects that issue out of their overconfidence. Because they are inclined to be erotic, they must be protected from sexual indiscretions and from a hasty marriage that they may contract on the crest of an ecstatic wave. Another reason for early hospitalization is that some manic cases will go into a state of delirium when they are not treated intensively at the start. These delirious attacks may be fatal if they give rise to exhaustion, dehydration, and hypochloremia. Sedation, tranquilization, and electroconvulsive therapy are most easily administered in a hospital setup.

SCHIZOPHRENIC DISORDERS

(Types and DSM-III-R Codes: Catatonic 295.2X, Disorganized 295.1X, Paranoid 295.3X,

Undifferentiated 295.9X, Residual 295.6X)

Schizophrenia, in spite of the massive amount of accumulated data, remains psychiatry's greatest challenge (Bleuler E, 1950; Bleuler M, 1984; Arieti, 1959, 1974; Redlich & Freedman, 1966; Cancro, 1985). The question of whether it is a special disease entity or a unique way of experiencing is still being debated. Although it affects less than 1 percent of the population, its devastating influence on the patients and its cost to society are astronomical. Efforts to understand it along neurophysiological, biochemical, genetic, psychosocial, epidemiological, psychoanalytic, existential, anthropological, cultural, and communicative lines have been heroic. But many aspects of the illness are still unclear. Neither biochemical nor analytic-psychological investigations have brought us closer to its real essence.

While we do not have a complete picture regarding the etiology and pathology of schizophrenia, it is reasonable to assume from all the available evidence that a genetic factor exists. For one thing, the fact that the concordance ratio for schizophrenia is three times greater in monozygotic than in dizygotic twins suggests a hereditary component. But the finding that in 50 to 75 percent of monozygotic twins one member *does not* become schizophrenic when the other twin develops the disease indicates that a genetic deficit is not enough to produce schizophrenia. Nongenetic constitutional factors must also be considered, for example, flaws through damage to the brain during intrauterine life or as a result of birth trauma. In short, while schizophrenia appears to be a genetically determined disease, its phenotypical expression is, at least in part, influenced by life experience.

Among the life experiences that have a destructive impact is the use of the child by the parents as a foil for their own neuroses. When parents are themselves emotionally unstable and mentally confused, they are unable to provide sensible and temperate learnings. The child thus receives training in irrationality, as Lidz (1973) has remarked. Communication patterns are distorted and the child is exposed to contradictory messages. There is defective gender identity and a crushing of the child's efforts at autonomy. The parents offer poor role models for the child. The consequence of the personality deficits

that eventuate out of these conditionings is a deficiency in ways of interpreting reality and of handling and resolving stressful life events.

Of all speculations advanced to account for the outbreak of schizophrenia, the stress hypothesis seems to many to be the most feasible. Postulated here is the idea that stress activates in the schizophrenic individual anomalous biochemical and neurophysiological mechanisms as a result of faulty enzyme action. It is avowed that the end product of this action is hyperactivity of catecholamines, especially dopamine, as well as the release of pathological psychotogenic metabolites, resulting in a disorganization of brain function. Some authorities have also conjectured the existence of increased numbers of dopamine brain receptors to account for dopamine hyperactivity. In some cases, computed tomography shows ventricular enlargement in the brain, which has been correlated with such negative symptoms as emotional flattening, social withdrawal, and lack of energy.

When we search for stress sources that may have precipitated a schizophrenic breakdown we often find it to be environmental events that have a special traumatic meaning for the individual. Perhaps the most powerful sources of stress are disturbed family interactions, and there is ample evidence of difficulties in families of schizophrenic patients. A provocative question is why all members of a family in which there is a schizophrenic member are not affected with schizophrenia. The answer is that there is no such thing as the same environment for all family members, even for identical twins. Some are more protected than others; some are chosen for projective identification by a mother or father; some are scapegoated, or subjected to contradictory demands, or exposed to discriminatively defective communication signals. The consequence is an interference in the character organization, making for conflicts that in themselves become sources of tension. The stresses that impose themselves on the individual therefore are environmental difficulties from without and disturbances from within (biochemical and cognitive). Such stresses may become critical at certain periods in the developmental cycle (as during adolescence) and when pressures and demands both from without and within exceed the individual's coping capacities.

Many schizophrenic patients were exposed to *selective illogic* in early development, which made for irrational thinking around specific areas. The consequence is that the patient can think seriously about certain subjects and disjointedly about other subjects. He or she can deal better with selected stresses and be completely unable to manage other stresses to which he or she is singularly sensitive.

Among the deficits that emerge from a difficult childhood are an overwhelming sense of helplessness, a defective self-image, and overpowering hostilities. These impulses are handled by defenses organized around different levels of reasonableness. Helplessness may be managed by either a dependent clinging to some magical protective figure or movement, or by denial manifested in compulsive independence. Ambivalence toward objects will make for varied responses to people and be so disturbing to the individual that he or she will become apathetic and detached from people to avoid being rejected, hurt, or completely engulfed in a relationship. A defective self-image gives rise to a host of coping devices, ranging from inferiority feelings on one end to grandiosity on the other. The hostility may be turned outward in sadistic attitudes and aggression, or turned inward in the form of masochistic self-punishment. In part, reactions are the product of a massive biochemical upset set off by stressful stimuli with which the individual cannot cope. Impulses are fed through neurophysiological channels disorganized by these biochemical alterations. This produces changes in the transmission messages in the subcortex, ultimately influencing thought processes. Because of the existing pockets of irrationality, the manifestations of these impulses and the defenses that control them may in cases of extreme distortion become highly and even psychotically symbolized and distorted. Thus dependency may be expressed by feelings of being influenced and manipulated by powerful or protective or malevolent agencies or machines. A devalued self-image may take the form of being accused by voices of emitting a foul odor or of having changed into an animal. Or it may be neutralized by the defense of a grandiose delusion. Hostility may be acted out directly in terms of paranoidal delusions and of violence toward persecutory enemies. Periods of rationality may alternate with those of irrationality, and the nature of the symbols may vary. When emotional stability is restored, pathological manifestations may temporarily vanish, only to reappear under the

further impact of stress.

Most people who are able physiologically to deal with stress are threatened with periodic irrationalities but are able to process these cognitively and to control them without distorting reality. Yet psychotic-like impulses may appear in fantasy or in dreams. Other persons maintain their stability by circumscribing and isolating areas of psychotic or psychotic-like thinking or behavior, for example, by paranoidal ideation which serves as an outlet for hostility. This defense permits them to function and to maintain some adaptive capacity. Still other persons decompensate temporarily under the impact of stress and show overt psychotic behavior from which they rapidly recover *(schizophreniform disorder).* If there is a specific genetic vulnerability, however, the cognitive distortion may be extensive and prolonged, resulting in the syndrome of schizophrenia.

The onset of schizophrenia varies. Often it is insidious, becoming apparent only in late adolescence or in early adult life. The individual shows behavioral changes such as isolation and withdrawal and may drop out of school or quit work. Emotionally the schizophrenic may be unstable and depressed and resort to drugs or alcohol for relief. Unhappy at home, the schizophrenic may run away, seeking out groups of other isolated children or young adults with whom he or she may establish an unstable affinity. Affiliations are shallow, ideation more or less fragmented, the self-image devalued, and the boundaries between reality and fantasy blurred. The expression of needs is chaotic, and often fulfilled only in fantasy. Omnipotent, grandiose, and paranoidal ideas prevail. There is constant moving about as the person seeks some refuge in relationships that eventually are distrusted and abandoned. There is repeated experimenting with disorganized ways of regaining control, solving problems, bolstering security, and enhancing self-esteem.

Once a genetic vulnerability exists, the individual always is at high risk. The avoidance, removal, or palliation of environmental situations that have a stress potential for the person, the identification and mediation of faulty behaviors through

psychotherapy, the building of self-esteem through positive achievements and productive work, the presence of accepting role models with whom the patient can identify, the utilization of support systems where necessary, and the administration of neuroleptics when a breakdown threatens may bring the individual back to his or her customary equilibrium.

The big problem for the therapist at this early stage is that the patient has little or no motivation for treatment. He or she distrusts people and resists any kind of close relationship, the vehicle through which psychotherapy is done. If treatment is attempted, it will take all the tact and resourcefulness a therapist can muster to keep a patient coming for sessions in the face of his or her detachment, suspiciousness, fear, and hostility. The therapist should try to avoid giving commands and orders because the patient will resist them. Nor should any mention be made of the need for or direction of change. Clues as to focus are gathered from what the patient is interested in and wants to deal with. No judgments should be expressed about the patient's behavior or dynamics except when the patient asks. Even then, interpretation must be carefully and reassuringly made. Attempts to alter the patient's attitudes, to plan goals, and to offer suggestions on how best to manage one's personal affairs will usually be resisted. Breaking of and lateness in coming for appointments call for great flexibility in time arrangements. The therapist concentrates on ways of solidifying the relationship with the patient and on introducing some reality into the patient's perceptions of what is happening to him or her. In spite of remedial interventions, the schizophrenic process may proceed to an adaptive breakdown that defies all efforts at resolution. An external precipitating factor may or may not be apparent, but a search for it should be instituted.

Removing the Stress Source: Hospitalization

If the patient's psychosis has been precipitated by an *overwhelming* external traumatic situation, simple environmental manipulation may help, if not suffice, to bring the patient back to his or her prepsychotic level of adaptation. Most schizophrenic reactions, however, are associated with such great weakness of the ego that the person is

unable to withstand even average pressures. There is variation in the degree of stress that can be tolerated. In some, ordinary responsibilities of living and relating to people cannot be mediated. Environmental manipulation may not suffice to restore the patient because he or she senses menace everywhere, even in the most obviously congenial atmosphere. There is faulty information processing.

Fears rooted in past inimical conditionings and damaging conflicts seem to generate anxiety continuously and prevent the ego from emerging from its regressed level. The patient erects a wall of detachment and isolation as a protection from further hurt; it is this wall that interferes so drastically with any attempted therapy.

If the patient feels threatened in his or her present environment in spite of efforts at regulation, if his or her responses constitute a potential source of danger to the patient and others, and if the patient cannot be treated satisfactorily in the existing milieu, temporary hospitalization may be inevitable. The employment of psychotropic drugs and consultation with the patient's family in an effort to get them to be less critical, hostile, demanding, and demonstratively emotional toward the patient may enable the patient to adapt outside of an institutional setting. There will still be acute emergencies, however, for which no other alternative is available than hospitalization, either on the psychiatric ward of a general hospital or in a mental institution.

On the other hand, there are certain disadvantages to hospitalization. The most insidious feature of "institutionalization" is that the patient's tendencies to regress will be reinforced enormously by any lack of stimulation in the hospital. As one of a large group of patients, the individual may lose his or her identity. The patient becomes dilapidated in appearance and oblivious to customary habit routines. There may be little in the environment to encourage latent desires for growth and development. This unfortunate feature is due, to a large extent, to the overcrowding of institutions and to the lack of enlightenment and education of the personnel. The motives governing an employee's choice in working in an institution may not be those helpful to restoring the patient to active participation in society.

That hospitalization can prove to be a stimulating rather than a retarding influence is illustrated in institutions with a progressive administration and well-trained personnel. Selected occupational therapy and crafts, carefully chosen to meet the patient's interests and aptitudes, can help prevent the abandonment of reality. Exercises, games, entertainment, dancing, music, social affairs, and group discussions can also be of inestimable benefit. When it is practiced in an empathic setting, group therapy of a short-term nonpsychoanalytic nature (Parloff, 1986) may be helpful. The benefits of such therapy help convince the patient that he or she is not considered hopeless, in this way building up a feeling of confidence in the therapist and in oneself. It is probable that the old-time Aschner treatment for schizophrenia, with its emphasis on detoxification, stimulation, exercise, baths, sweats, venesection, catharsis, emesis, and hormone therapy, was mostly psychological in effect. At any rate, hospitalization should be regarded as a temporary measure, and the patient should be moved back into the community as soon as possible.

Milieu Therapy

Regulation of the environment so that it is therapeutically constructive, meaning that it provides stress relief and gratifying experiences, is important in treating schizophrenia. Occupational, recreational, and social therapy may be gainfully instituted in a hospital or outpatient setting. The atmosphere of a day-and-night hospital, halfway house, or community rehabilitation or recreational center also lends itself to environmental control and social skills training. A total therapeutic community program (e.g., with a suitable group) may prove rewarding. Settlement in the community and encouragement to engage in productive work is much better for the patient than assignment to the barren hinterlands of a mental hospital ward.

As part of a milieu therapy program, family therapy and individual psychotherapy with other members of the family may put a halt to many destructive stimuli within the household. Schizophrenia, more and more, is being regarded as a manifestation of family pathology. Relationship distortions are not only with the mother, but also with the father

and other significant persons in the family constellation (Wynne et al, 1958; Bowen, 1960; Lidz & Fleck, 1960). The importance of the "double bind" as a basis for schizophrenia has been underscored by Bateson, Jackson, Haley, and Weakland (1956). These authors, describing the family interactions in schizophrenia, contend that the "victim" who succumbs to schizophrenia is exposed to (1) a repetition of prescriptive themes or experiences, (2) conflicting injunctions in relation to these "themes" with threats of punishment for disobedience, and (3) further restricting "commands" that prevent the "victim" from escaping the field of communication.

The "victim" arrives at a perception of his or her life as based on a number of key double-bind interactions with family members. For example, a mother's reaction of hostility to her boy may be concealed by overprotecting him. The child may be aware of this deception, but to retain her love, he cannot communicate this knowledge to her. "The child is punished for discriminating accurately what she is expressing, and he is punished for discriminating inaccurately—he is caught in a doublebind." Incongruence between what is said and what is intended is the essence of the faulty communicative process: " . . . the more a person tries to avoid being governed or governing others, the more helpless he becomes and so governs others by forcing them to take care of him" (Haley, 1959a & b, 1961). Family relationships alternate between overcloseness and overdistance; the members become intrapsychically "fused" so that differentiation of one from the other is often impossible. A psychosis may constitute a mirror image of the patient's unconscious. These factors have focused attention on family therapy as a preferred approach in schizophrenia (Midelfort, 1957; Boszormenyi-Nagy & Framo, 1965). Family psychotherapy increases the chances of breaking the schizophrenic's communication "code" (Jackson J, 1962).

Psychotherapy

Psychotherapy with schizophrenics is an art that graces few therapists. In the face of the patient's stubborn resistance, suspiciousness, withdrawal tendencies, and inability to communicate appropriately, most therapists are apt to throw their hands up in surrender.

Yet there are a few experiences as gratifying to a therapist as providing an empathic bridge to reality for a withdrawn patient. It is difficult to define the qualities a therapist must possess for such a successful eventuality. I once asked Frieda Fromm-Reichmann what she considered the most desirable characteristic for work with schizophrenics. She replied, "Humility, persistence, sensitivity, compassion, and *[she added drolly]* a good deal of masochism." It is only human to respond with frustration at repeated therapeutic efforts that slide off the patient with little or no apparent effect. But I am convinced that when such efforts are sustained, with warmth and sincerity, they ultimately will be rewarded.

In my training as a psychiatrist I spent 13 years of my early career working in a state hospital, principally with schizophrenics. Those were the days before psychotropic drugs, and the only tools available to the therapist (other than wet packs and hydrotherapy) were his or her skills in establishing a meaningful relationship with patients. No matter how severely withdrawn the patients were from external stimuli (and sometimes our catatonic citizens retained their frozen, statue-like behavior for years), it seemed obvious to me that they craved and needed consistent and kindly communication, even though this seemed to register no impact on them. When some of the patients "spontaneously" emerged from their deathlike repose, it astonished me to hear them recount in minutest detail some of the things they had observed going on around them, with virtual playbacks of my one-way conversations with them. They particularly recalled the little kindnesses bestowed upon them by the nursing staff and myself, which I am now convinced had a more penetrating effect on them than the most mighty of miracle drugs.

Even wild paranoidal individuals seemed to respond to quiet sympathy and lack of retaliation for their abuses. I remember one of the most disturbed patients I had ever encountered, a middle-aged, distraught and disheveled, hallucinating woman, who accosted me the first day I was put in charge of the disturbed ward on which she had been sequestered for more than 10 years. Blood-curdling shrieks and cries for the police came from her at the first sight of me as 1 walked through the ward protected by a bodyguard of nurses and attendants. She identified me positively as her tormentor—the man who had

for years been making indecent proposals to her and who had been sending electrical impulses up her rectum and genitals. It was all my bodyguard could do to keep her from assaulting me.

Despite the daily indignities that she heaped on me, I took pains each day briefly to talk quietly to her, expressing my concern at her upset and assuring her that if there were anything I could do to help her, I would be happy to do it. Her response was stereotyped— anger, vilification, and occasionally expectoration. On one occasion as I left her, she managed to find a flower pot, which she hurled at me, barely missing my head. Slowly, after many months, her response to my consistent reassurances became more attenuated, although she daily repeated her resentment that I had the temerity to persist in talking to her when I was the last person on earth she wanted to see.

And then something dramatic happened. On one occasion I was in a hurry to get ward rounds over with to attend a special meeting, and I breezed through the ward without talking to her. Her reaction was electric. She became more highly disturbed than before, upbraiding the nurses for their neglect in directing me away from her, and accusing me of having no respect for her and her feelings. The next morning, for the first time, I was able to talk to her without fear of bodily harm. We spoke quietly about matter-of-fact subjects, and although she was still psychotic and hallucinating, she spoke calmly and with good sense about many matters, apparently enjoying her exchanges with me. Shortly thereafter, the patient became ill with lobar pneumonia and was transferred to the acute medical unit. Sick as she was, she refused to allow anyone except myself to treat her. With persuasion, I convinced her that she could trust the regular staff members of the unit. Upon her recovery from pneumonia, she returned to her old building and was transferred to a quiet, open ward.

My final victory occurred when the patient requested that I cut her toenails! Since her admission she had not trusted anyone to get near her feet. Her nails had become thickened like horns, and I had to borrow special shears from the tool shop to do a half-decent job. To my delight and surprise, the patient recovered from her psychosis and was

able to leave the hospital. I am not certain what other forces were responsible for the patient's improvement, but I am convinced that the relationship I developed with her was a prime vehicle in bringing her back to a reasonable contact with the world.

The ability to enter into the patient's life and to share his or her anguish and dis-pair, to refrain from making demands that would ordinarily seem justified, to persist in showing friendship and respect in the face of outrageous and irresponsible behavior may ultimately win out. To carry out this formidable task, a therapist needs to possess a good deal of stamina and an undaunted optimism that the healthy elements in a sick human being will eventually bubble through. Obviously, the average custodial unit and the average therapist are not equipped to render ideal psychotherapeutic care for these vulnerable human beings. Because some therapists can engage effectively with schizophrenics and others cannot, the literature on psychotherapy in schizophrenia is ambivalent. For example, May's 1968 research indicates that psychotherapy had little to offer schizophrenics in comparison with medication. The Massachusetts Mental Health Center study by Grinspoon, Ewalt, and Shader (1972) also cast doubts on the value of psychotherapy. The studies by Rogers et al. (1967) and case reports of Vaillant, Semrad, and Ewalt (1964), Kayton (1975), and McGlashan (1983) are more optimistic. May's research was flawed, however, by the use of only inexperienced therapists and supervisors who were dubious about the use of psychotherapy with schizophrenics. The other studies could also be criticized for faulty design and controls.

There are many pitfalls in working psychotherapeutically with schizophrenics, not the least of which is provoking and nurturing a hostile dependency that cannot be resolved. Transference is frequently a problem, and if it is not dealt with in the early stages, it may evolve into a disturbing transference neurosis or transference psychosis. No less troublesome are the therapist's irritation and anger at the patient, which is understandable considering the vexations inherent in dealing with the patient's obstinacy, querulousness, uncooperativeness, contentiousness, belligerence, and detachment. Such emotions on the part of the therapist must be controlled. Countertransference mismanaged can interfere with the therapist's objectivity and ability to provide an

empathic relationship.

While there may be some advantage to working exclusively with psychotherapy in the few instances when the psychotherapist is especially dedicated and skilled in working with schizophrenics (Laing, 1960, 1967; Arieti, 1974), the vast majority of therapists find antipsychotic drugs most helpful, if not indispensable if a thinking disorder exists. Drugs are capable of keeping many chronic schizophrenics operating so that they can reasonably maintain their responsibilities, of preventing them from regressing to a state of work disability, and of restoring their capacity to communicate. The disadvantages that drugs impose by masking defenses are more than offset in many cases by their ability to make hospitalization unnecessary and to foster better cooperation with the therapist. Nevertheless, one must keep in mind the possibility, of untoward side effects and sequelae such as tardive dyskinesia.

The immediate objective of psychotherapy in schizophrenia is to enhance the adaptive reserves of the patients so that they will be able to come to a rapid equilibrium, to discern their chief sources of stress, and either to help resolve or remove themselves from them as expeditiously as possible. While the schizophrenic's vulnerability will not be eradicated, the patient may be strengthened so that he or she does not shatter so readily upon exposure to stressful stimuli. In extremely uncooperative and withdrawn patients, behavior therapy, employing operant conditioning, has been used with some success (see Chapter 51). When the patient becomes accessible, formal psychotherapy may begin. Sometimes supportive and reeducative group therapy is utilized adjunctively with individual therapy; at times, it constitutes the sole psychotherapeutic modality.

The key to the treatment of schizophrenia lies in the ability to establish some sort of contact with the patient. Most schizophrenics desperately fear relationships with people and erect various obstacles to any interpersonal threat. The withdrawal from reality and the archaic type of thinking and symbolism enhance the individual's isolation, since there is no common means of communication. Yet, beneath the surface, the patient yearns for a friendly and loving relationship. The patient wards it off, however, because he or she has

been injured by past interpersonal contacts. He or she does not wish to encounter further rebuffs. The patient's apathy, detachment, and expressed hostility and aggression are means of protection from the desire for a closer union with people. Establishing rapport with the patient is in line with two objectives: first, to reintegrate the patient in more intimate relationships with people to where he or she can obtain at least partial gratification of personal needs without fear of abandonment or injury and, second, to bring the patient back to the realistic world by proving that reality can be a source of pleasure rather than pain.

The technique of developing rapport varies with the patient. A great deal of activity is essential. In very sick patients whose productions are seemingly irrelevant and incoherent, a careful analysis of the productions will disclose a language that is very meaningful to the patient. The ability to show the patient that his or her words and gestures are understood may be the first constructive step. Sullivan (1931) has stressed the need to communicate understanding of the patient's language and gestures as a means of solidifying the interpersonal relationship. To do this, it may be necessary to talk to the patient on his or her own regressed level. J. M. Rosen (1947, 1962) has interpreted the utterances of the patient in terms of their symbolic meaning and has been able to develop a relationship with some of his patients through this method. Entering into the psychotic world of the patient, Rosen and his followers attempt to make contact by intensive daylong sessions, overwhelming the patient with direct interpretations of his or her unconscious. How valid these interpretations are may be challenged, but the fact that the patient is showered with attention and is shocked with statements coached in harshly frank and sometimes sexually explicit terms may in a relatively short time bring the patient out of his or her regressed state. This approach has been practiced in foster homes, where the patient is provided with a therapeutic environment throughout the day and night. It is, consequently, an expensive form of therapy and one that can be indulged by a limited clientele. Moreover, follow-up studies are not encouraging.

Employing symbolic objects, Sechehaye (1951) evolved a nonverbal method of communicating with a regressed schizophrenic girl. This was necessary, Sechehaye

believed, because the primary trauma occurred before the stage of verbal language. For example, only by realizing that apples symbolized mother's milk was it possible to offer the patient love through drinking "the good milk from Mummy's apples." In ways similar to this, the therapist may gather clues to essential needs and conflicts from the bizarre symbolic thought content, translating it the same way as if it were a dream. Cryptic as these utterances may be, they contain important messages that may well be heeded by the sensitive therapist, who will answer them in ways that indicate to the patient that his or her plaints are recognized and acknowledged.

Using an existential approach as well as family therapy, Laing (1960) and Laing and Esterson (1971) have explored the despair of patients, siding with them against their families and the environment and, in this way, establishing intimate contact. The relationship is utilized as a vehicle for recasting patients' concepts of themselves. The approaches of Harry Stack Sullivan (Mullahy, 1967, 1968), Frieda Fromm-Reichmann (Ballard, 1959), Otto Will (1967, 1970), and Harold Searles (1960, 1966) also make worthwhile reading.

In patients, therapy may consist of nothing more than sitting with them, without prodding them to express themselves. The very fact that the therapist refrains from probing their trends, avoids discussing the causes of their breakdown, and accepts them as they are may help these patients to regard the therapist as a less threatening force than other people. In many cases therapy may consist of working with the patient at occupational projects and playing games, such as cards, checkers or chess. Sometimes a more positive approach is made to the patient by giving him or her food, such as milk, candy, and cake. For a long time it may seem that these gratuities are the only reason that the patient desires to see the therapist. In querying the patient after recovery, however, one becomes convinced that the patient actually had a desire for closeness and was testing the therapist constantly.

Any relationship that the patient is able to establish with the therapist is at first bound to be extremely unstable. The schizophrenic individual feels very vulnerable and

helpless. His or her level of frustration tolerance is inordinately low. Schizophrenics are distrustful, suspicious, and inclined to misinterpret the motives of the therapist in accordance with their inner fears and prejudices. They feel incapable of coping with life and resent the intentions of the therapist to return them to reality, which holds unbounded terrors. Schizophrenics fear injury and frustration from people, and it may be months, sometimes years, before they are willing to accept the therapist as a friend. Even then they will sense rejection and neglect in the most casual attitude. Anxiety with a temporary return to regression will interrupt therapy repeatedly, and it must be handled by a consistently reassuring and friendly manner. Violent reactions may punctuate treatment from time to time, especially when the patients sense that liking the therapist will force them to leave the relative security of their reality retreat.

Fromm-Reichmann (1939) has commented on the unpredictable nature of the schizophrenic's relationship to the therapist. A sympathetic, understanding, and skillful handling by the therapist of the relationship is far more important than an intellectual comprehension of the operative dynamics. She ascribes difficulties in therapy to the fact that the therapist is unable to understand the primitive logic and magical reasoning that governs schizophrenic thinking.

Unless we analyze our own reactions repeatedly, our sense of frustration may arouse strong aggression that will interfere with treatment. It is manifestly impossible to treat any psychotic person if one does not genuinely like him or her. If we are able to regard the actions of the patient as essentially childlike, we shall best be able to understand the patient's outbursts. Cold logic fails miserably in explaining the reactions of the schizophrenic. Despite his or her age, the patient seeks an infantile relationship to the therapist and desires unlimited warmth, understanding, protection, and help. He or she seeks a mothering affiliation rather than a give-and-take encounter between two equals. At the same time, the patient distrusts the therapist and resents his or her own helplessness in seeking nurturing.

The therapist should try to be as sympathetic and reassuring as possible,

approaching the patient casually and informally and conveying an interest in him or her and in matters of immediate concern. Sometimes it is desirable to encourage the patient by touching a shoulder or arm as a gesture of friendship. I have found that I have been able to establish a relationship in a remarkably short time by offering to show the patient how to relax his or her tensions, utilizing a simple hypnotic relaxing technique (*q.v.*). Even frightened patients can be helped, but, obviously, they must be willing to cooperate. The therapist may say, "It's been rather tough on you, and you can't avoid being upset by all that has happened. If you'd like, I can show you how to relax yourself, which should make you feel a lot better." Patients who respond positively are asked to make themselves comfortable in their chair and to shut their eyes while relaxing suggestions are made.

It is important not to cross-examine the patient or subject the patient to questioning. An attitude of acceptance without reserve is best while conveying sincere interest in his or her needs and problems. Sicker patients will usually flood the therapist with their irrational ideas and delusions. One way of handling this situation is to focus as much as possible on matter-of-fact reality items. This is not as difficult as it sounds, although the therapist must avoid giving the impression of being bored with or disbelieving the patient's irrational concerns.

Probing for conflicts is taboo, as is the lying-down couch position. Only when the patient brings up topics for discussion is it desirable to discuss them, but this should be done in as a matter-of-fact way as possible. This does not mean that depth interpretations are always to be avoided; they may be made once the therapist-patient relationship is solidified and the patient brings up a conflictual topic and shows some awareness of its nature. It may be reassuring to the patient to have a dynamic explanation for some distressing problems. This may relieve the patient of the mystery of what is happening to him or her.

Therapy in schizophrenia must, in summary, be oriented around the immature ego of the patient. The patient's emotional reactions to people, like those of an infant, are unstable and ambivalent. Schizophrenics are easily frustrated and feel rejection without

ostensible cause. They are unreasonable and demanding. Their concept of reality is unreliable; they often confuse inner mental processes with outside reality. They may assume that the person on whom they depend is omniscient and will supply their every demand, expressed or unexpressed. They will react with hostility if they are not granted what they believe to be their due. Alone, their egos are so weak that they are unable to tolerate complete responsibility. They need help and support, and yet fear and resist assistance.

Federn (1943) has advised enlisting the aid of a relative or friend, preferably a motherly person who can look after the patient. He stressed that schizophrenics should not be allowed to depend on their own resources. They should at all times be surrounded by an atmosphere of love and warmth. Their stability and strength grow as a result of positive identifications with loved ones. If they are at all able to develop to self-sufficiency, their independence will grow best in the soil of this positive identification. The hope is to bring them to a point where they can function satisfactorily without the aid of a parental figure. In many cases the latter stage of self-sufficiency is never attained, and all one can do is adapt the individual to reasonable social functioning while attached to some kindly person.

The need to surround schizophrenic patients with a favorable atmosphere necessitates work with their families or with people with whom they live. This is essential to relieve the burden induced by demands and responsibilities that the patient imposes on the members. Often the inertia and apathy of the patient stir up resentment on those present, and when the patient is aware of their hostility, he or she may retreat further from reality. Considerable work with the patient's relatives may be required before they are sufficiently aware of the dynamics of the patient's reactions and before they are willing to aid the therapist in the treatment plan.

The chief emphasis in treatment in chronic schizophrenia must be on the creation of a human relationship with the patient that has pleasure values for him or her. Only by this means will the patient relinquish the safety and gratification of regression and, utilizing

the relationship with the therapist as a bridge, return to reality. The handling of treatment, however, requires considerable tact. No matter how detached the patient is, he or she is extremely sensitive to everything that the therapist says or does. An avoidance of situations that evoke anxiety in the patient is essential. This is often a very difficult task because the most casual remark may stir up powerful emotions.

The patient may choose to remain silent throughout the treatment hour and will appreciate it if the therapist refrains from challenging refusal to talk. It is expedient with such a mute patient to point out occasionally that perhaps there is abstinence from talking because of a belief that the therapist is interfering or because there is fear of what he or she might say. The patient may feel more at ease with such remarks and may finally break through the silence.

In most cases schizophrenic patients at first will feel alone, helpless, and misunderstood. They resent the intrusion of the therapist into their private lives and believe that the therapist, like everyone else, is unable to understand them. The initial task is to show them that their impulses and wishes are respected and that they are not required to comply with demands that are unreasonable. Usually in all of their previous interviews they have been bombarded with questions about their breakdown, and, even when they have responded to these questions in a more or less frank manner, they have sensed disapproval. The fact that the therapist accepts them as they are may eventually build up their self-respect and strengthen the desire to return to reality.

Constantly, during treatment, the patient may react with detachment or withdrawal or may subject the therapist to a testing period during which he or she is recalcitrant and hostile. The purpose may be to find out whether the therapist is the kind of person who can be trusted or whether the therapist, like all other people in his or her experience, makes unfair stipulations or react to expressed hostility with counterhostility. The patient may believe that what the therapist demands is that a person be "good." This "goodness" means to the patient that it is urgent to comply with standards that all other people impose. At first he or she will act as if the therapist actually expects unyielding submission

to these standards, threatening the patient with rejection or aggression if he or she resists. The testing period may be a trying one for the therapist, since it may continue for many months during which the patient constantly rejects the therapist's friendship. When the patient realizes that the therapist does not expect compliance with certain things, that the therapist sides with the patient against unreasonable demands made by the family, the patient may begin to regard the therapist in a new light.

The beginning of a feeling of closeness can precipitate panic; the patient may try to run away from therapy, or he or she will exhibit aggression toward the therapist. The ability to see the patient through this stage may finally succeed in breaking down the patient's reserve and in establishing for the first time an identification with a person based upon love. There exists within schizophrenics a psychic tug of war between the spontaneous forces of mental health that drive them to seek gratifying relationships with people and the security of their regressed state that harbors them from the imagined dangers of a hostile world. The therapist's attitudes will determine which of these impulses will triumph.

The method of handling the treatment hour is of signal importance. It is best not to cross-examine these patients because they may interpret this as censure. They must be convinced that the therapist does not want to invade and remove them from their private world, but rather seeks to participate in it with them. This does not mean assuming a cloying sweetness during sessions, because the patient will be able to see through this. It must be expected that the patient's attitudes will be ambivalent. He or she may profess little interest in the interview, yet resent its termination at the designated time. There may be attempts to defy or to provoke the therapist or refuse to cooperate. If the therapist becomes ill and cannot keep an appointment, the patient may react with rage and refuse to continue treatments. If the therapist is unavoidably late for an appointment, peevishness can occur. The patient may resent the therapist's taking any vacation or assigning another person as an assistant. Where customary routines have to be interrupted, it is best to prepare the patient far in advance and, if necessary, to enlist the help of family members with whom the patient has an attachment. If the patient becomes

hostile toward the therapist, every attempt must be made to explore why there is suspicion the therapist has failed. Should the patient persist with hostility and insist on seeing another psychotherapist, these wishes should be respected, for it is futile to do any work with a patient while being governed by feelings of resentment.

Once a positive relationship has been established, it is necessary to cherish it carefully. Nothing must jeopardize the relationship. For example, the patient must never be led to feel that cherished delusions are ridiculous. Any fanciful feelings and attitudes must be respected at all times. It is unnecessary to reinforce these attitudes by agreeing with them; but they should be accepted as something that the patient believes in sincerely. It may be impressed on the patient, however, that there might possibly be another explanation for a certain experience than the one that he or she supports. All probing for dynamic material must assiduously be avoided at this point. This is one of the most frequent errors in the handling of psychotic patients. It is also an error to interrogate the patient regarding previous mental upsets.

Because the aim in the psychotic patient at first, at least, is to increase repression, since the ego is already too weak and permits the filtering through of disturbing unconscious material, such techniques as free association are to be discouraged. Rather, the patient should be enjoined to talk about everyday reality happenings. In general, the past had best be avoided, and the patient may be aided in any expressed desire to regard it as a "bad dream" or something that should be forgotten. Under no circumstances should a positive relationship with the therapist be analyzed. If the patient exhibits inhibitions or phobias, these too should be respected, since they probably have protective values. All resistances the patient uses to repress psychotic material must be reinforced, although the symbolisms employed may sometimes be interpreted to the patient. Unlike the treatment of neurosis, analysis of resistances should be avoided to prevent the release of the unconscious content that will upset the patient more. When the patient brings up delusional material or symptoms and spontaneously talks about the connection with traumatizing circumstances in his or her past, an effort may then be made to explain in uncomplicated terms how these manifestations originated. The rule never to dissolve

resistance does not apply to resistances to getting well or to integrating more closely with the therapist and with reality. These impediments should be analyzed and removed if possible. Guilt feelings may be met by reassurance and hostilities dealt with in a manner that does not put responsibility or blame on the patient.

One of the ways in which a positive relationship with the therapist may be used is to try to show the patient that his or her thoughts and ideas often appear to be realistic but that it is necessary always to differentiate between what seems to be real and what actually is real. In the patient's case, too these may have been confused, even though there is no question of doubt in his or her mind that the two states are identical. An excellent sign of restoration of ego strength is the ability of schizophrenic patients to recognize the irrational nature of their ideas while they were in an upset condition.

While some patients achieve a fairly good grasp of reality and tend to return to their prepsychotic habitude, and even to tolerate relationships with other people along the lines of the close attachment they establish with the therapist, it may be necessary to continue the treatment process to prevent a relapse. The problems of some patients are kept alive because they harbor bloated ambitions of what they should accomplish in life. Their grandiose expectations inevitably lead to constant frustration. Under such circumstances it is essential to help the patient modify exorbitant goals through the careful use of the therapeutic relationship. It may be possible, for instance, to convince the patient that it is better to devote his or her life to the attainment of happiness in the immediate present than to strive for things in the unknown future. Character disturbances may exist that make relationships with people fraught with anxiety. An active manipulation of the patient's environment through consultation with interested family may enable the patient to function more comfortably. Attempts should also be made to motivate the patient gradually toward making contacts with other people.

In spite of such corrective measures, hostility, tension, and anxiety may constantly be created by inner cognitive, affective, and autonomic derangements. The intensity of untoward emotions may again tend to shatter the patient's ego. The danger of another

schizophrenic collapse may, therefore, be imminent. *It is best here, as mentioned before, not to attempt probing for conflicts until the patient evinces an interest in understanding his or her own problems.* Schizophrenic persons are remarkably intuitive and can grasp the dynamics of their disorder better than most neurotics. This is probably because they live closer to their unconscious and because ego barriers to deep impulses and fears are not so strong. It is for this reason that one must proceed very carefully in analyzing the patient's deepest impulses (Bychowski, 1952; Eisenstein VW, 1952; Fromm-Reichmann, 1952; Bruch, 1964). Haley (1961) has outlined some excellent suggestions for the practical handling of schizophrenics. Other suggestions, namely the use of projective techniques, may be found in the section on the treatment of the borderline patient (p. 1183).

Although the therapist assumes a directive role, it is the patient who is expected to uncover the meaning of ongoing communications (Bruch, 1964). This fact has been stressed by many therapists working with schizophrenics, particularly Sullivan (1962), Fromm-Reichmann (1954), and Lidz and Lidz (1952). In this way the therapist avoids bombarding the patient with useless interpretations or confronting the patient with a road map of his or her unconscious that will lead the patient nowhere. Inevitably, the relationship between therapist and patient will begin to stir up feelings and impulses that the patient will have to clarify with the help of the therapist. For example, if the patient identifies the therapist with his or her mother, interpreting this may mean little. Exploring in what way the therapist *acts* like a mother may, on the other hand, become meaningful.

The realization of unconscious guilt, hostility, and erotism has a dual effect on the psychic apparatus. On the one hand, it floods the ego with destructive emotion; on the other, by forcing a more realistic cognition, it attempts to liberate the psyche from incessant conflict. In this way the dynamic probing is like a two-edged sword; the ego has to be traumatized by the liberated emotions before it is able to mobilize defenses less destructive to the person than regression. In neurosis and character disorders this may prove helpful. In schizophrenia however defenses are so fragile and ego so weak that it collapses under the impact of emotion before it can adapt itself in a more adequate manner. This is always a danger in psychotic and prepsychotic conditions. All

interpretations must, therefore, be very cautiously applied. Reconstructive techniques should be abandoned if any excitement or great hostility develops, for only when the patient is positively attached to the therapist will it be possible to bear the suffering brought out by a realization of the deeper stirrings within.

Summary of general psychotherapeutic rules in schizophrenia:

a. *Establishing a relationship.*

1. The initial task is to establish a relationship and not to collect information. Asking the patient if he or she hears voices or believes someone is against him or her is a poor tactic. Nor should the patient be grilled about previous attacks or hospitalizations. The therapist should act attentive and reassuring. Sitting behind a desk is not as good as facing the patient directly. Walking with the patient, having coffee together, and touching the patient occasionally are not contraindicated.

2. Do not argue, cajole, or try to reason with a delusional or hallucinating patient, no matter how absurd the ideas or fantasies may seem. Not only will the effort be useless, but it may also convince the patient that you are aligned with the forces of evil against him or her. Listen respectfully to what the patient has to say. If he or she complains about something and if you must make a comment, simply say reassuringly, "This must be upsetting you."

3. If the patient is perturbed or agitated, one may say: "I certainly understand how upset you must feel, If such a thing happened to other people they'd be upset too."

4. If the patient prefers to remain silent, accept this, and do not try to bully or shame the patient into talking.

5. If an upset patient asks you for help in allaying tension or anxiety, you may reassure the patient that you will do everything you can. If the patient is not taking medications, ask if he or she would like to have some medicine to quiet the restlessness. You also may suggest teaching the patient how to relax his or her tensions. If he or she responds positively, utilize relaxing exercises or relaxing hypnosis. This may rapidly expedite the relationship.

6. Give the patient regular sessions, and be sure you keep the appointment times. If you will be late for a session, notify the patient in advance if possible and tell him or her you will make up the lost time. Anticipate the patient's breaking appointments and being tardy. If this happens do not chide the patient—merely say you missed him or her.

7. Bizarre behavior or attitudes may strike the therapist as humorous. To succumb to ridicule or laughter may shatter the chances of a relationship.

b. *The treatment process*. I have found the following 20 suggestions useful in working with schizophrenics:

1. Any activity that can bolster the patient's self-esteem should be supported. This includes the patient's grooming and clothing habits and positive achievements of any kind. These should be talked about and encouraged; the patient should be praised for even slight accomplishments in work, hobbies, and creative activities.

2. The best way to handle delusional or hallucinatory material is to listen respectfully and never ridicule or make light of them. One may even act as if uninterested in the hope of discouraging the frequency of these pathological responses. On the other hand, reasonable talk should command alert attention and active responses in an effort to reinforce rationality. If the patient is disturbed by what he or she brings up, the therapist may agree that if matters were as the patient reported, anybody would be disturbed. Then the therapist may gently offer an alternative explanation as a possibility, not pressing the point if the patient does not agree.

3. No matter how truculent, neglectful, disrespectful, or hostile the patient acts toward the therapist (even if the patient throws a tantrum), punitive, scolding, or rejecting responses should never be indulged. The patient may be merely testing the therapist. Nor should the therapist encourage any regressive behavior or talk to or treat the patient as if he or she were a child. In other words, irrespective of how "crazy" the patient acts, he or she should be treated with dignity and respect as an adult. After their recovery, many patients talk about how they appreciated the therapist's manner.

4. For a long time direct interpretation may have to be delayed and projective techniques used instead. The therapist may by illustration make comments such as: (to a patient in despair at being rejected) *"Most* people feel hurt if people neglect them"; (to a patient with fantasies of death and killing) "It often happens that when a person feels angry he may imagine that the person he is angry at will hurt him, or will die"; (to a woman who felt her looks repelled men) "I knew a woman once who felt she was so ugly, no man would want her and she would get furious if a man wanted to date her because she believed he was teasing her." These comments illustrate how one does not directly confront the patient with his or her actions, but uses other individuals as examples. The patient may or may not then pick up the implications. If the patient applies what is being said, the interpretations can be made more directly.

5. With paranoidal patients who have fixed delusions, disagreeing with these delusions will put the therapist in the class of all other persons who have tried to argue the patient out of what he or she believes to be true. Thus, a therapeutic relationship may never get started. Yet, to support the patient's delusion completely may not be wise. Here the therapist may give credence to the patient's right to believe what he or she knows to be true and express an interest in all the facts that have led to the patient's conclusions. One should not directly support the patient's conclusions but merely state: "I can understand how facts like these lead you to feel the way you do." For example, a patient felt he was being pursued by the Mafia, who wanted to steal his business away from him. As evidence, he cited seeing an automobile with New Jersey license plates in the area of his apartment. He was sure he was being watched and followed by New Jersey gangsters who were out to kill him. His complaints to the police and district attorney were greeted with amused disdain. Instead of challenging the patient, I asked him to be sure to keep a diary of all of his daily observations that pointed to his persecutions. At every visit he would bring many sheets of written matter containing detailed rambling "observations," which I would greet as interesting and important and which I promised I would later read in studied detail after our visit. I would then put the material aside and we would talk about his other interests and daily activities, avoiding the psychotic area as much as possible. The volume of the reports gradually dwindled to a single sheet and then stopped altogether, the patient apologizing for his neglect in bringing in this material. With

the cessation of his reports he began to concern himself with immediate problems in his daily life and work and soon lost interest in the Mafia delusion.

6. The management of transference reactions will call for fortitude on the part of the therapist. The range of how the patient regards the therapist is great: God, mother, father, sibling, the devil, seducer, lover, persecutor, friend. Dependency reactions must be expected and these release other impulses and defenses such as sexuality, hostility, masochism, devalued self-esteem, and detachment. Different phases of these reactions express themselves at varying times and the patient will try to involve the therapist in his or her schemes. The therapist must resist acting out with the patient and becoming countertransferentially rejecting, seductive, overprotective, or punitive. Yielding to the patient's importunate transferential demands will breed more irrationality. Yet, an honest careful explanation of why it is impossible to fulfill the patient's demands must be given so that the patient does not feel rejected as a person.

7. Expressed hostility will be especially difficult to handle, since it can be like a never-ending spring issuing out of depths that have no bottom. So long as it remains on a verbal level, the therapist may be able to tolerate it, realizing that some of the rage is in the way of a test, some a means of warding off a threatened close relationship with the therapist, some a belated effort to resolve a needed breaking away from the maternal figure, some a rebellious desire to assert and be oneself. We may suspect that the patient retains a ray of hope that the therapist will handle the patient's anger and not respond in an expected retaliating way that would justify a continued withdrawal. If the therapist can stand this test, feelings of unthreatened love and closeness may bubble through. On the other hand, should rage take the form of expressed violence that does not cease when met by a calm and self-assured manner on the part of the therapist, and by statements that the patient should try not to lose control, it will require firm but kindly and considerate action or physical restraint to protect the patient, the therapist, and others. The patient should later be given an explanation for the preventive action. The therapist here must act in a composed but determined way without giving the impression of retaliating for the patient's behavior. One way of diluting transference reactions is by involving the patient in some

group activity—a hobby, social group, or therapeutic group.

8. If there is no desire to work intensively with the patient (which will happen in a majority of psychotic patients), visits are gradually lessened in 12. frequency once improvement is stabilized but never discontinued completely. Rather, the patient is given the option of seeing the therapist once in two weeks, then once a month, and then at longer intervals.

9. False promises should never be made to a patient because they will inevitably be broken and with this the therapeutic relationship may terminate. Nor should deception be utilized as a way of escaping a difficult situation because here too the patient somehow will divine the deceit. Sometimes it is necessary to withhold the true facts temporarily from the patient since the patient may not be prepared to deal with them but may be able to handle them later when his or her ego gets stronger. Whatever explanations or interpretations are given the patient, these should be coached in frank but reassuringly optimistic terms.

10. Whether to engage in deeper insight therapy is a decision one must reach after working with the patient for a long period, seeing how he or she handles interpretations and observing the buildup of ego strengths. Schizophrenics live close to their unconscious and are often first in arriving at insights themselves. Whether such insights can help the patient is another matter. When stress becomes too 17. strong, the patient will collapse, insight or no insight.

11. The greatest use of therapy is to increase the patient's stress tolerance, and this means doing a careful assay of current and future stressors, preparing and helping the patient to cope with them. Behavior therapy can be of great value when properly employed (Agras, 1967).

12. Avoid language the patient cannot understand. If possible, use the dialect of the patient.

13. Point out in a non-accusatory and non-judgmental way patterns the patient exploits that can prove harmful and that tend to make others withdraw. The message should be given in as reassuring a manner as possible, reflecting the therapist's confidence in the patient's ability

to change.

14. Avoid interpreting the dynamics of the patient's symptoms. Without a firm working relationship with the patient and evidences of his or her trust, this will be counterproductive. Do not belittle or ridicule the patient's delusions, no matter how foolish they may seem.

15. Do not take notes while with the patient. This will enhance suspiciousness, especially if there is some paranoidal tendency. Notes can be made after the patient leaves.

16. Credit the patient's disturbed behavior, if he or she shows it, to the fact that he or she is being frightened and upset and not to the fact that the patient is a difficult violent person. The patient may be responding to the environment as dangerous and will need reassurance and support, not condemnation.

17. Before prescribing medications, explain why drugs are useful in quieting a person down, helping one sleep, and so on.

18. As soon as the patient's symptoms subside, reduce medications to as low a level as will control symptoms. When the relationship becomes firm, the medications may even be discontinued. If symptoms reappear, drug dosage may be increased.

19. Start family therapy as soon as the patient quiets down, building a relationship with the family and counseling them as to steps each member can take to improve communication. Establish a contact with the most stable family member, who will act as a liaison. Instruct this member when to increase medications. Invite this member to telephone you if problems occur.

20. There is no reason why patients cannot be taught to medicate themselves when they feel their equilibrium threatened. Having the proper medications on hand and utilizing such medications to quiet and stabilize oneself can often nip a psychotic break in the bud.

21. Flexibility in approach is the keynote of good therapy with schizophrenics.

General rules such as I have cited here are useful but they will have to be adapted to

each patient and modified according to individual reactions. Similarly, the use of aftercare services will depend on what special needs each patient has and the availability of services in the community in which the patient lives.

Somatic Therapy

The introduction of neuroleptics has introduced a new and more hopeful outlook in the therapy of many schizophrenics. Phenothiazines (e.g., Thorazine, Mellaril, Prolixin), butyrophenones (e.g., Haldol), thioxanthenes (e.g., Navane), and dihydroindolones (e.g., Moban) in proper dosage may, when indicated, rapidly resolve psychotic states and render the individual more accessible to social demands. (The choice and dosage of neuroleptics have been outlined extensively in the section on Pharmacotherapy in Chapter 56).

Useful as they have proven to be, neuroleptics unfortunately have their drawbacks since, apart from the side effects and serious sequelae (e.g., tardive dyskinesia) with prolonged employment, they tend to discourage the application of psychologically based therapies. Too frequently, young people suffering an initial psychotic break are saturated with massive amounts of drugs, which, while restoring homeostasis, prevent them from integrating the significance of the psychotic experience, which may, with the help of an empathic therapist, have a beneficial impact on their future development. This in no way minimizes the value of the neuroleptics, but it does necessitate some restraint in their use. With rare exceptions in the initial stages of therapy, patients with acute schizophrenia manifesting thought disorders will need neuroleptics. Once the patient's symptoms are brought under control and environmental stress factors regulated, the patient should be slowly taken off drugs but rehabilitative and psychosocial therapies continued. Should the patient decompensate again, medications may be resumed, although a considerable number of patients can be managed solely with counseling, milieu therapy, group therapy, family therapy, and other psychosocial treatments. Only if stress factors in the environment cannot be controlled satisfactorily or the stress from internal sources is unmanageable will the patient require prophylactic drug therapy. If neuroleptics are

resorted to after the acute phase is over, interruptions of drug intake with drug holidays are in order. While the utilization of insulin coma therapy has practically disappeared, some authorities still believe it has a utility in younger patients who have been ill for less than 6 months. Electroconvulsive therapy is also considered to be helpful under certain conditions, such as when a severe depression develops during a schizophrenic episode.

Aftercare

The aftercare of hospitalized schizophrenic patients constitutes a serious problem because of the large numbers of such persons in the community as a consequence of deinstitutionalization and the high rate of relapse. Good facilities for aftercare rehabilitative services are lacking in most communities. Those that are available provide the patient with an important means of retarding relapse because of the many modalities offered and the opportunities for patients to establish relationships with a case manager and rehabilitation counselor. If organized services are not available, some patients are able to take advantage of self-help groups such as Recovery, Inc., and Schizophrenics Anonymous. Different therapies are required at different stages of a schizophrenic illness. The proper choice of interventions can best be assured in an organized outpatient setting. Long-term social, behavioral, and problem-solving groups are of special importance, Additionally, social skills training, psychoeducation, supervision of maintenance drugs, resocialization techniques, work adjustment counseling, family therapy, and a variety of other activities geared to the special needs of patients can help many attain stability and lead more rewarding lives. We have seen this happen repeatedly in the Social Rehabilitation Clinic of the Postgraduate Center for Mental Health. What is outstandingly absent are residential facilities where patients without families and those whose homes are too riddled with stressors can be securely housed. But what is even more confounding is that those patients who most need rehabilitation services do not seek them for many personal reasons, including fear of new strange surroundings and of being sent back to a mental institution.

Chronically ill patients, especially when they are hospitalized for a long period and

then deinstitutionalized, lose their independent living and practical problem-solving skills, so essential for adaptation. Rehabilitative procedures designed to equip the individual to live independently and cooperatively in the community are important and pitifully lacking in programs of deinstitutionalization.

Examples of how chronic mentally disabled patients may be trained in community living skills have been described in the literature (Hersen & Bellack, 1976; Trower et al, 1978; Wallace et al, 1980). More recently, Wallace et al. (1985) have detailed a program organized into 10 modules designed to teach conversational skills, vocational rehabilitation, medication management, self-care and grooming, personal recordkeeping, how to find and maintain housing, leisure/recreational skills, food preparation, use of public transportation, and money management. How to obtain the necessary resources to implement the skills taught in each module is also included in the training, as well as how to adapt oneself to unexpected or unsatisfactory outcomes for the performance of the different community survival skills and problem solving under various contingencies. Such a program calls for staff who are empathic, resourceful, and capable of tolerating small increments of progress with difficult clients who are confronted with unique personal, environmental, motivational, and other deficits. The use of role playing, modeling, rehearsal, feedback, reinforcement, and homework assignments must regularly be employed as part of the training in social and independent living skills.

Some therapists believe that work rehabilitation is "more powerful than drugs, psychotherapy, social therapy or any other kind of intervention" (Greenblatt, 1983). The vital role of sheltered workshop programs in the rehabilitation of the mentally ill has been amply demonstrated (Black & Kase, 1986). Though a sheltered workshop is a valuable modality, we must realize that some patients will probably never be able to return to a normal competitive work role. Short-term hospitalization should be available should this be necessary. The psychiatric unit in a general hospital is adequate for this purpose. Psychotherapy on some level, ranging from supportive to behavioral, will be most effective if the above priorities are adequately fulfilled.

The use of maintenance medications as a routine procedure in aftercare has undergone challenge in recent years (Marder & May, 1986). Neuroleptics, once regarded as the greatest advance in the treatment of schizophrenia, have now become more conservatively evaluated in aftercare programs. They have not altered the long-term outlook of the disease; some patients do refuse to take the medications; some fail to respond to them; and there are side effects, some of which may be permanently disabling (e.g., tardive dyskinesia). All in all, neuroleptics are more carefully and selectively employed; acute active symptomatology such as excitement, for example, (hallucinations and delusions) responds best to drugs. On the other hand, their influence on symptoms such as withdrawal, apathy, and anhedonia is minimal. Prescribed prudently, drugs are an important asset, especially in patients with a poor prognosis whose ability to adapt to a stressful environment is enhanced through a regulated drug maintenance program. Contrarily, for patients with a good prognosis, neuroleptics may be detrimental. One of the problems produced by long-term maintenance neuroleptic therapy in aftercare is that the sensitivity of the dopamine receptors is so increased that any withdrawal of the drug causes a rebound of symptoms. On the whole, good psychosocial treatment is still the preferred approach in the average case of chronic schizophrenia. Psychosocial treatments operate under a handicap if the environment is irreparably stressful, and in this case one may be forced to employ supplementary drug maintenance to avoid a critical psychotic break.

A compromise solution for the maintenance drug dilemma considers that patients who have recovered from an attack of schizophrenia be withdrawn from medications and then watched carefully for symptoms of relapse, which may be detected at least for a week before the break occurs. These consist of tension, loss of appetite, problems in concentrating and sleeping, withdrawal tendencies, and depression. If these symptoms appear, appropriate pharmacotherapy is immediately instituted along with psychosocial treatment and family therapy, the intensity of such interventions being titrated to the seriousness of the patient's condition. In many cases the relapse may be aborted by these measures (Herz et al, 1982; *JAMA,* 1984).

In some patients continuing external or internal stress will put the individual on the brink of a relapse. In these cases, maintenance drug therapy will be needed. Some patients spontaneously take medications or increase the dose when their tensions increase or when they feel reality slipping away. But most patients will go off drugs if they are not closely supervised. Cooperation of the family is necessary to ensure that the patient takes the medications. Periodic visits to an outpatient clinic may help the patient maintain the proper drug balances and arrange for drug holidays.

One of the great problems in aftercare is that the schizophrenic is so often used as a foil to hold his or her parents or the rest of the family together. Even when a patient has been removed from a home where there is highly expressed emotion or continuing criticism, the family will not let go. As long as a vehicle for projection exists in the form of a sick child or young adult, hostility and other disturbed feelings are focused on the assigned target and disguised by overconcern. The patient's illness becomes a valuable investment, and signs of recovery threaten the tenuous family balance. A sabotage of treatment may then be expected. Under such circumstances it is vital to get the parents or the entire family into couples, family, or individual treatment to safeguard the patient's treatment. The combination of family treatment and medication has been shown to lower the relapse rate greatly (Hogarty et al, 1986).

Rehospitalization

Rehospitalization for severe psychotic disorganization may be mandatory not only to provide the patient with an atmosphere of protection and to dispense therapeutic measures, but to get the patient away from the family and other environmental stressors that may have initiated the relapse and tend to sustain it.

More and more patients are being admitted for treatment of acute attacks to selected wards of a general hospital rather than to mental institutions. To an extent this is due to the regulations governing compensation by insurance companies and other third-party payment resources. It is due also to the growing deemphasis on institutionalization in mental hospitals. One disadvantage is that payments for hospitalization may be restricted

to a limited number of days. This encourages massive tranquilization to bring the patient speedily out of the psychotic state, resulting in discharge before the patient has had an opportunity to establish a relationship with a therapist who may carry on treatment in the posthospital period. What is sorely needed are units strong on psychosocial treatment in which the patient can live for 5 or 6 weeks. This provides the patient with sufficient time to work through his or her experience, in part at least, and to consolidate a continuing therapeutic plan.

To prevent another relapse as much as possible, the home to which the patient returns must be relatively free from stress. If members of the patient's family continue to be hostile, unconcerned, or disturbed, the chances of a further relapse are great. Under such conditions, the patient, if possible, should be housed elsewhere. If this is not feasible, provision should be made to get the patient out of the house, to a day hospital or rehabilitation unit, for instance, for a good part of the day. Maintenance drug therapy is more essential for these patients than for those whose families are loving and understanding. In either instance, psychosocial treatment is important.

Continued hospitalization over a long-term period may be required for certain patients and is preferable to depositing those lacking in social skills in a furnished room where they will languish in psychotic isolation, refusing to participate in social rehabilitation programs on an outpatient basis and, if they are on maintenance drugs, eventually giving them up.

Prognosis for Schizophrenia

Among patients discharged to families with high degrees of emotion, we can expect a rate of relapse of about 68 percent within the first year of discharge. Maintenance drug therapy will cut this high relapse rate to about 41 percent. A controlled study by Hogarty et al. (1986) has shown that adding psychoeducation and other family-oriented treatments for families, as well as social skills training for patients, lowers this figure to 20 percent. In households where the high degree of emotion has been reduced, the relapse rate has been brought down to negligible percentages. Beyond the first year, the relapse

rate rises even among treated patients and families, probably because many schizophrenic patients have psychobiological deficits in dealing with what would be ordinary life experiences for those not affected by the disorder. Internal stress factors include faulty information processing and inherent affective and autonomic dysregulations that over a period of time can override maintenance drug and psychosocial therapies, although the latter interventions may, as indicated above, reduce the relapse rate.

The outlook for chronic schizophrenics is not nearly as gloomy as it was once believed to be. In Third World countries, where schizophrenics are more socially accepted in the community and family and where they do not suffer rejection, discrimination, and degradation for manifesting their symptoms, the illness runs a relatively benign course. In Western industrial countries, however, patients do not have opportunities for appropriate work, social acceptance, or means of improving their status or integrating into community life. These deficiencies tend to interfere with emergence from the psychotic illness and to promote retreat from relationships so characteristic of this group of patients (Warner, 1985). But even in the United States, long-term studies have shown that many patients released from institutions somehow, after years have gone by, adjust to the outside world and even do productive work, marry, and have children. A 30-year longitudinal study by a group of researchers from Yale University and the University of Vermont have shown that "one-half to two-thirds of 82 subjects released from a State mental hospital and rehabilitation program in the mid-1950's now live in the community, care for themselves, act as productive citizens involved with their families and friends, and show few or no signs of schizophrenia" *(Psychiatric News,* 1985). Other long-term studies of 1400 schizophrenics observed over two decades have revealed that more than half are significantly improved or recovered. This argues for a change in our traditional pessimistic attitude about chronic schizophrenia toward a more favorable outlook.

Psychosurgery

Psychosurgery has been prescribed with variable results for seriously ill schizophrenic patients who have failed to show improvement after 2 or 3 years on

psychotropic drugs and psychotherapy. This form of treatment is said to yield the best results where the prepsychotic personality was fairly well integrated, there is no emotional deterioration, and the patient's current symptoms include tension, restlessness, motor activity, combativeness, and destructiveness. Catatonic and paranoid reactions respond best; hebephrenic reactions poorly. After schizophrenia has existed for 10 years or more, psychosurgery is rarely of value.

MISCELLANEOUS PSYCHOTIC REACTIONS

A number of other categories of psychotic disorder are included in DSM-III-R Codes: *schizophreniform disorder (295.40), brief reactive psychosis (298.90), atypical psychosis (298.90), schizoaffective disorder (295.70),* and *induced psychotic disorder (297.30).* There are also a number of organic mental disorders in the form of dementias arising in the senium and presenium, as well as a host of psychoactive substance-induced organic mental disorders, and those associated with physical disorders or conditions.

In *schizophreniform disorder* the duration of the illness is less than 6 months; there is a rapid onset and a high degree of confusion and emotional turmoil, but there is also a good likelihood of recovery to pre-morbid functioning. A *brief reactive psychosis* must be differentiated from schizophrenia. Here the psychosis follows a strong stressful environmental stimulus and there is recovery within 2 weeks. If no such psychological stress has occurred and there is still a psychosis (disturbed behavior, hallucinations, delusions, associational disorganization, etc.) that disappears in less than 2 weeks, the diagnosis of *atypical psychosis* is often given. The diagnosis of *schizoaffective disorder* is more difficult to make since it is a wastebasket for combinations of affective and schizophrenic symptomatology in the form of mood-incongruent psychotic features that do not fit into any of the other categories.

Induced psychotic disorder occurs when a dominant psychotic person, the primary patient, influences others in the family to display the same delusional beliefs. One form of this disorder is *folie a deux* involving two persons. The intensity of the psychotic symptoms in these conditions may necessitate hospitalization during which antipsychotic

drugs are administered. In schizoaffective disorder antidepressants and lithium may additionally be needed and, if medications are ineffective, occasionally ECT.

Symptoms of psychosis may occur with various organic brain diseases of neurological origin or as a toxic effect of drugs (alcohol, hallucinogens, etc.). Among the most common of these neurologically based disorders is primary degenerative dementia, especially Alzheimer's and Pick's diseases, which are characterized by progressive deterioration of intellectual, social, and occupational functioning. Multi-infarct dementia presents similar symptoms, combined with focal neurological disease and cerebrovascular residues. Impulsiveness, poor judgment, memory loss, and personality problems create difficulties for the patient and those around the patient. A variety of other organic brain syndromes may be seen in which the symptoms are delirium and dementia, clouding of consciousness, disturbances in psychomotor activity, memory impairment, aphasia, and other disturbances of the higher cortical functions. Persistent delusions and hallucinations, appearing in a normal state of consciousness, may also develop as a consequence of organic illness and are diagnosed according to the symptoms (organic delusional syndrome, organic hallucinosis, organic personality syndrome). Management of these conditions depends on the symptoms. Restlessness and uncontrollable hostility may be helped by Thorazine or Mellaril (10-50 mg or more in divided doses). Sometimes a beta-adrenergic blocker like Inderal (60 mg daily) or an antidepressant like Desyrel (200-400 mg daily) may be found useful. Delirious overactivity, confusion, agitation, and paranoidal excitement call for antipsychotics (Haldol, 5 mg, or Navane, 4 mg, intramuscularly) repeated as needed. Cogentin (1-2 mg) intramuscularly to offset extrapyramidal complications is sometimes coordinately given as a precautionary measure. Intravenous benzodiazepines (Valium, 10 mg; or Librium, 50 mg; or Ativan, 2 mg) repeated every 2 hours until symptoms are under control are often preferred as an alternative. When the delirium has abated, oral medications may be employed. A search for causes of both delirium and dementia is imperative, and, when found, specific and nonspecific therapies should be instituted. Supportive and directive psychotherapy may be required, bolstered by antianxiety, antipsychotic, and antidepressive medications as needed. Needless to say, family counseling will usually be adjunctively required.

Supervision of the Psychotherapeutic Process

Supervision of the work of the beginning therapist is an essential requirement in the learning process (Greben, 1985). Without supervision it will be difficult or impossible for the therapist to translate theoretic knowledge into effective practice, to work through blocks in understanding, and to develop skills to a point where the therapist can help patients achieve the most extensive goals. Supervision, then, in psychotherapy is essentially a teaching procedure in which an experienced psychotherapist helps a less experienced individual acquire a body of knowledge aimed at a more dexterous handling of the therapeutic situation.

LEARNING PRINCIPLES IN SUPERVISION

Adequate learning necessitates, first, an appropriate presentation of data in terms meaningful to students, second, the incorporation of this data by the students, and third, the ability of the latter to organize experiences cognitively and to generalize from them to related aspects of their work.

The first requirement presupposes an ability on the part of the teacher to develop an empathic understanding with the students and to discern what aspects of the available material are pertinent to their immediate needs and to the teaching task. The second essential assumes the existence of motivation, an adequate intellectual capacity to integrate the information, and the relative absence of anxiety. The third requisite entails the presence of a synthesizing function of the ego that enables students to examine themselves critically, to give up old modes of conceptualizing, and to apply themselves to new creative tasks. Helpful is alertness and ability of the teacher to keep the relationships on a level where transference resistances' do not interfere with this process. Helpful also is detection of the students' specific learning problems and the evolvement of techniques designed especially to deal with these problems.

Unfortunately, there are many interferences with the expeditious learning of psychotherapy, not the least of which is the ambiguity of the concepts that constitute the marrow and lifeblood of the psychotherapeutic process. It is difficult to authenticate techniques that are universally applicable. A method that works in one case may not be effective in another; it may produce good results for one therapist and a string of failures for another with a different kind of personality; it may be highly productive at a certain phase of treatment and backfire in the same patient at another phase. What appears to be necessary is more research into the actual procedures of teaching psychotherapy. Christine McGuire (1964) has pointed out that much of the ongoing clinical teaching is conducted in a manner that runs counter to basic principles about learning long known to educators and psychologists. A professional coach who sends his or her players out to complete a number of practice games with instructions on what to do and who asks them to provide at intervals a verbal description of how they had played and what they intend to do next would probably last no more than one season. Yet this is the way much of the teaching in psychotherapy is done. What is lacking is a systematic critique of actual performances as observed by peers or supervisors. This is not to say that an account, highly screened as it may be, of what a therapist says he or she has done with a patient may not lend itself to a dynamic learning relationship. The account, however, is most valuable when it is compared to what the supervisor has actually observed in a live session between the student and patient through a one-way mirror or in viewing a videotape of the session.

A sensitive question relates to the validity of using data in teaching psychotherapy drawn from the teaching of related disciplines. Can the information, for example, derived from such areas as social work supervision, the psychology of learning, communication theory, and programmed instruction be applied to psychotherapy? On the surface the reply would be "yes." Yet there are special problems in the teaching of psychotherapy that force a qualification to this answer.

An individual who masters a complex skill proceeds through a number of learning phases, namely (1) the acquisition and retention of certain factual information, (2) the

development of ways of using this information in a practical way, and (3) the evolvement of a capacity of altering this information when new situations arise that call for different approaches. In psychotherapy modern methods of acquiring information embrace exposure to didactic materials through fact-finding learning (lectures, reading, and observation of therapy performed by expert therapists through a one-way mirror, videotapes, and sound movies) and problem-solving learning (programmed instruction and role playing with immediate feedback). Practical applications of what has been learned are inherent in observing the consequences of treatment techniques by actually *doing* psychotherapy under supervision, by listening to audiotapes and watching videotapes of one's own performances, by observing others performing in psychotherapy through a one-way mirror, or viewing videotapes of their actions, and by clinical conferences and case seminars. The creative employment of psychotherapy with the development of methods designed for the special problems of each patient are consequences of continued supervision and prolonged experience. Through such a program of scholarship, searching inquiry, observation, and experiment, a body of organized knowledge is eventually developed in the matrix of sophisticated theory.

Research into teaching method indicates that the effectiveness of teaching is increased "when the teacher accepts a teacher's responsibility for directing learning, providing every opportunity and inducement for the student to accept a larger responsibility for his own education, and holding out always his and their goal the maximum achievement of which they are both capable" (Hatch and Bennet, 1960). Fundamental is a spirit of inquiry that provides the motivational fuel for the powering of proper learning (Matarazzo, 1971). This is the most sustained when the content of teaching is related to the needs and educational level of the students.

Once teaching goals have been explicated in operational terms and the most effective methods have been designed to help the students achieve these goals, the effectiveness of learning experiences must be tested through the students' demonstrating how much they have mastered. Reliable methods of recording and measuring performance are needed here. This should be more than a matter of clinical impressions, for, as McGuire (1964) has

pointed out, these "are no more acceptable in a scientific study of the educational efficacy of a training program than they are in a scientific appraisal of the therapeutic efficacy of a new drug." The crucial obstruction is, of course, the current relatively undeveloped methods of evaluation. In psychotherapy, where the clinical data may be interpreted in endless ways and where criteria of competence are so vague, evaluation techniques are still more pedantic than precise. Yet it must be agreed that, however tenuous they may seem, measures of competence must be constructed to require students to demonstrate that they can perform in a desired way. Both the continuous case conference and supervision offer means of approaching the thorny problem of evaluation. Important leads may perhaps be taken from the study of the evaluation of the teaching of psychiatry at the undergraduate level in the film test series developed at the University of Rochester, the University of Nebraska, and the University of Pittsburgh. At the postgraduate level a number of interview films have been developed—for instance, those at Temple University Medical School, which may be used to test clinical judgment and problem-solving skills and which can be adapted to the evaluation of different training programs.

PSYCHOANALYTIC CONTRIBUTIONS

Some outstanding work on supervision has been done in the field of social work (Towle, 1954). But the area that has commanded greatest interest for many psychotherapists has been psychoanalytic supervision (Balint, 1948; Benedek 1954, 1972; Blitzstein & Fleming 1953; Brunner, 1957; Dewald, 1969; Ekstein, 1953; Gitelson, 1948; Kubie 1958(a); Sloane, 1957). The early publications of Ekstein and Waller-stein (1958), Fleming (1963), and Fleming and Benedek (1964) are still considered valuable. The latter authors, using electrically recorded sessions of students with patients and their supervisors, developed a project to investigate "the processes of interaction between communicating systems in the teaching-learning relationship" that involved the triadic dimensions of supervisor, student-analyst, and patient. Assessment of students brought into play a complicated network of motivations in the supervisor, for instance, the preconceived expectations of students, the supervisor's own investment in teaching, and the defensive reactions to students' resistances. "Our experience demonstrated again and

again the necessity for a supervisor to listen to and evaluate himself in interaction with his student; and it is our opinion that the more aware a supervisor is of the various aspects of his educational role, the more effective he will be as an object for identificatory learning and as a developer of students in general."

These and later data from studies of supervision of the psychoanalytic process (Chessick, 1985; Buckley et al. 1982; Gauthier, 1984; Glass, 1986) require a reconciliation with treatment situations of greater activity and more limited goals, as in the less intensive dynamic, reeducative, and supportive therapies (Sandell, 1985; Winokur, 1982).

It is almost inevitable that psychotherapists will be influenced by unconscious processes in their patients. Patients who have incorporated parental messages and repudiated their presence may through projective identification accuse the therapist of the very impulses that they deny within themselves. More insidiously the projections may not be direct, but the therapist will become aware of them through countertransference, perhaps reflected in dreams or fantasies (Langs, 1979). Failure to understand what is happening may provoke defensiveness and hostility. Moreover, the therapist may with some patients develop transference, which can lead to antitherapeutic acting out manifested by smothering overprotectiveness, aggressiveness, or sexual misbehavior. One of the supervisor's prime duties is to be alert to such transferential and projective identification interferences and, when they occur, help the supervisees recognize them. This is a tricky task because the supervisor will in so doing be playing the role that should be assumed by the supervisor's therapist, if there is one. What may result is that the supervisees will begin developing more irrational transferences toward the supervisor and, if the supervisor does not watch it, the supervisory teaching process may become converted into a prolonged therapeutic venture with the focus away from the learning of psychotherapy and the welfare of the supervisees' patients.

FUNCTIONS OF SUPERVISION

All participants in the supervisory process bring to it a separate agenda. The supervisees are interested in learning how to do good psychotherapy, and perhaps in

achieving certification or earning a degree. The supervisor seeks to demonstrate competence as a senior clinician while teaching the students a skill and contributing to their growth. The institution that sponsors the treatment desires that standards imposed by licensing and regulatory bodies be meticulously followed. The paying agencies insist that records and documentation be carefully maintained and available for auditing. The central members of the conglomerate, the patients, seek the most effective help to reduce their problems and want to be assured that their therapy is going well. Such aims may be contradictory, and the supervisor will deftly have to weave through the tangle of these self-oriented objectives and bureaucratic rules. There may be difficulty in deciding where loyalties should be placed. Good supervisors are able to fuse the disparate elements into a serviceable amalgam. Skills *can* be taught while considering the welfare of the patient, the needs of the student, and the rules of the institution. Coordinately the supervisor will have to deal with personal frustrations and countertransference, with the students' transferences and resistances to learning, with the intransigence and arbitrariness of the school or agency, and, by remote control, with the anxieties of the patient.

The traditional type of supervision, unfortunately, has become so contaminated with overseeing, directorial, and inspective functions that it has frequently been diverted from its teaching objective. This has particularly been the case in agency work, where the supervisor, as part of the administrative body, is responsible for the quality of service rendered to clients. Many difficulties arise here because the supervisor serves in a dual role—as an overseer and a teacher.

As overseer, the supervisor may be so concerned with maintaining the standards of the agency that he or she may not be able to exercise the kind of tolerance and patience required in a teacher. For instance, under press of responsibility, the supervisor is likely to "jump in" and interfere with the treatment plan set up by the supervisees, the execution of which, while perhaps less expert than a plan devised by the supervisor, would prove of greatest learning value to the supervisees. Because the students' status is dependent on evaluations by the supervisor, the process of supervision in agencies is apt to become extremely trying. A parallel situation develops when the supervisees are in training at a

psychotherapeutic or psychoanalytic school and their careers are dependent on the evaluation by the supervisor. Similarly, if the supervisees are staff members of a clinic, the supervisor as part of the administration may subordinate the teaching role to overconcern with the total case load. This shift in emphasis cannot help but influence adversely the quality of training received; this is inevitable whenever the training is oriented around circumscribed goals set up in relation to specific kinds of service for which the clinic is responsible. Much less complicated is the supervision of psychotherapists in private practice, who choose a supervisor principally to expand technical skills, not being dependent on the supervisor for an evaluation that may destroy their careers or eliminate their means of livelihood.

In schools or clinics, the supervisor will usually operate as a teacher, an evaluator, an administrator, and a policymaker.

Teaching

The first responsibility of the supervisor is observation of the total functioning of therapists to help in the supervisees' educational growth. Toward this end, it may be essential to bring the supervisees to an awareness of how they have failed to live up to therapeutic potentialities, either because of insufficient knowledge or because of neurotic character problems that inject themselves into the psychotherapeutic relationship. It is incumbent on the supervisor, among other things, to help the supervisees (1) to gain knowledge that is lacking, (2) to achieve an awareness of their own character problems that may interfere with the establishment and maintenance of a therapeutic relationship, and (3) to overcome resistances to learning.

Evaluating

A second responsibility of the supervisor is an evaluation of the capacities and progress of the supervisees for the purposes of determining professional development and current skills as a therapist. Evaluation involves a number of areas, including theoretic understanding, therapeutic aptitudes, and the kinds of relationships that are

established with patients and the supervisor.

Administration and Policy Making

The third responsibility of the supervisor lies in the helping of administration and policy making of the school or clinic under whose aegis the program is being conducted. The supervisor recommends modifications of the therapeutic and teaching programs that may influence adversely the training and the work of the therapists as well as the patients' responses to treatment.

To summarize, supervision in psychotherapy is fundamentally a teaching process in which a more experienced participant, the supervisor, observes the work of less experienced participants, the supervisees, with the aim of helping the supervisees acquire certain essential therapeutic skills through better understanding of the interventions involved in mental illness and through resolution of personality factors that block performance of effective psychotherapy. Supervision embraces a sharing of experiences; not only those gathered in the relations between therapist and patient, but also those occurring in the relationship between the supervisor and supervisees.

Qualifications of a good supervisor are the following:

1. Ability to function expertly as a psychotherapist.

2. Ability to function effectively as a teacher.

3. Ability to accept the supervisees unconditionally, without contempt, hostility, possessiveness, and other unwarranted attitudes and feelings.

Supervisory problems may roughly be divided into five categories of problems: orientation, recording, technical performance, learning and termination of supervision.

PROBLEMS IN ORIENTATION

Differences in Theoretic Orientation

Important and often irreconcilable differences occur in the theoretic background and orientation of the supervisor and the supervisees, a product usually of varying kinds of preclinical training. Illustrative of such differences are the following:

1. The relative weight to be placed on constitutional as compared with experiential factors in the genesis of neurosis.

2. The importance of biologic as contrasted with sociologic factors.

3. The respective emphasis on past childhood experiences and on current environmental hardships.

4. The degree of stress placed on unconscious conflict as the focus of neurotic and behavioral difficulties.

5. The extent of acceptance of the Oedipus complex, castration fears, and penis envy as universal phenomena.

6. The primacy of sexual over other drives and behavioral disorders.

7. The significance of character structure in creating and sustaining emotional disturbance.

8. The relative emphasis of conditioning theory in accounting for anxiety.

9. The value of short-term as compared to long-term approaches and of psychoanalytic versus behavioral and cognitive therapy.

The most effective supervisor is one who respects the right of therapists to their own ideas and opinions, yet who realizes that some of these may interfere with good psychotherapy.

Differences in Communication

Since communication is the basis of the supervisory relationship, it is important that verbalizations and concepts be understood by both supervisor and supervisees. Assuming that there are no important language differences, problems in communication are frequently related to differences in terminology.

A poignant objection to psychology by scientists in other fields is that it is partial to neologisms. Tendencies to use unconventional and complex terms have been one of the strongest barriers in a rapprochement with other sciences. Both supervisor and supervisees may be victimized by dedication to an esoteric terminology. Translation of complex terms into concepts with which supervisor and supervisees are conversant is vital to a mutual understanding and to the establishment of a common frame of reference.

Difference in Method

Another problem in supervision relates to differences in method—that practiced by the supervisor and that accepted or practiced by the supervisees. Such differences may involve various matters, such as the most desirable number of treatment sessions per week, whether or not to employ routine history taking and psychological workups, the use of free association, the emphasis on dream material and the manner of its employment, the use of the couch, the degree of activity in the interview, the extent to which a transference neurosis is permitted to develop, and the adjuncts to be used during therapy. Resolution of serious differences in method is to be expected in the course of good supervision.

Considerable flexibility will be required in methodologic approaches, particularly when the therapists are expected to handle, in the practice for which they are being trained, a wide assortment of clinical problems. Supportive of the principle of technical eclecticism is the fact that no single approach is applicable to all types of emotional difficulties. Some problems seem to respond better to certain kinds of therapeutic intervention than to others.

Differences in Goals

Problems may arise between supervisee and supervisor on the basis of varying concepts of what makes for success in psychotherapy. Is success in therapy the achievement of complete resolution of all blocks in personality maturation with effective functioning in all areas of living? Or is success to be graded in terms of optimal

development within the practical limitations imposed on individuals by their existing motivations, ego strength, and environmental pressures from which they cannot reasonably escape?

Reasonableness dictates that though a responsibility exists in bringing patients to the most extensive personality reconstruction possible, there are circumstances that block this. A modest treatment objective may be the only possible alternative. Supervisees trained in the tradition that therapeutic change falling short of complete reconstruction is spurious, however, may look askance at the supervisor who considers goals in terms of optimal functioning within realistic limitations. Or conversely, the supervisor may be unwilling to accept goal modification and may downgrade changes that fall short of absolute psychosocial maturity and then blame the supervisees for not being able to do the impossible.

PROBLEMS IN RECORDING AND REPORTING

Careful listening to the supervisees' accounts, to the manner of reporting, to evasions and points of emphasis, to slips of speech, and to casual off-the-record references to feelings about patients help the supervisor to evaluate the therapeutic work of the supervisees.

In making this appraisal, the supervisor must take into account that the role being played by the supervisees with the supervisor, and the attitudes harbored, are not a reliable index of what the supervisees actually do with patients. With patients, supervisees are operating in an entirely different setting than with the supervisor, with whom they are in a more subordinate status, more vulnerable, and more capable of being challenged or criticized. They may respond to the supervisor with fear, detachment, resentment, and other character patterns related to feelings about authority. Therefore, it may not be possible for supervisees to communicate to the supervisor their true capacities to be spontaneous, empathic, and responsive such as may occur with patients in the relatively secure atmosphere of one's office.

For instance, a therapist presented material to her supervisor in a cocky, superior manner, reflecting a somewhat contemptuous attitude toward the patient about whom she talked. It soon became obvious to the supervisor, however, in listening to tape recordings of actual treatment sessions, that hostile feelings were not manifest in the therapist's responses nor in her manner with the patient. Hostility, marshalled by transference feelings toward the supervisor, was seeping into the supervisory session and was influencing the nature of the reporting.

Neurotic feelings toward the supervisor may thus distort therapists' presentation of material. Pertinent data may be deleted, irrelevant items may be introduced, and secondary elaboration may destroy the value of the presentation. Fear of exposing deficiencies, of appearing ridiculous, and of incurring the displeasure and contempt of the supervisor are among the more common causes of poor reporting.

Anxiety to please the supervisor, to hold back differences of opinion, and to suppress transferential displays so as not to antagonize the supervisor may interfere with factual reporting. The supervisees may fear revealing what is happening in treatment so as not to appear incompetent.

Some of the difficulties in reporting may be obviated by insisting on process recording in which there is a verbatim account of both patients' and therapists' verbalizations. Process recording has the advantage of presenting a reasonably cogent picture of what is going on, since the tendency toward distortion or deletion will be minimized. There are certain objections to this method, however, in that the supervisees may be unable to record simultaneously while doing good therapy or because patients protest not being able to make good contact with someone immersed in writing. Furthermore, no matter how careful an attempt to record, the students will be unable to include everything that is said. There will then be a tendency to curtail the material, consciously or unconsciously eliminating elements that cause them to feel that they are revealing themselves unfavorably. In intensive supervision, in which one case is being presented over a long period of time, the supervisor may, nevertheless, have to insist on

process recording until convinced of the therapist's ability to report correctly in a more abbreviated way. (See [Appendix K](#) for a case outline.)

Perhaps the most effective type of recording is done with a video machine. These machines are now sufficiently improved and modest in price to become an almost indispensable item of equipment for supervision. This use is described and illustrated by Maguire et al. (1984) and Morgan (1984). Videotaping is valuable not only to the supervisor but also for playback to patients, who observe and listen to themselves communicating (Geocaris, 1960); Gutheil et al. 1981). Video recording is also helpful for playback to the supervisees, who may learn as much by self-observation as from the supervisor (Moore et al, 1965; Beiser, 1966). Moreover, the supervisor may profit from self-observance in supervisory operation. Audio recordings on tape are cheaper but less effective. For purposes of record keeping and for later transcription, however, audiotapes are sufficient. Few patients object to the use of machine recorders, and once the fears about revealing themselves have been overcome, the supervisees can function freely.

The value of video recording cannot be overestimated. It gives a most factual picture of what has actually gone on in the session, not only in content, but also in revealing bodily movements, intonations, and subvocal utterances that cannot be communicated in written types of recording. The method enables the supervisor to observe aspects of the interviewing process that are handled well or poorly. It helps to understand how the different kinds of content are dealt with, whether the supervisees exaggerate, minimize, or negate the importance of certain types of material. It permits observation of how the therapist responds to unreasonable demands of patients, to hostilities and other transference manifestations that are developing in the relationship. It enables the supervisor to study how techniques are being implemented. The difference between the written or verbal account and what actually went on, which is revealed in observing and listening to a playback, is often so astonishing as to leave little question about the value of this kind of recording (Gutheil et al., 1981; Maguire, 1984; Morgan, 1984).

For instance, one supervisee's verbal account made no mention of hostile feelings in

the patient, to which the therapist was responding by shifting the topic of discussion and by complacent, reassuring utterances whenever the patient introduced a slightly antagonistic remark. The supervisee was totally unaware of his diversionary responses, but in the playback he could not escape what had happened. Another supervisee reported a progressively deepening depression in a borderline patient. The process recording related that the patient talked incessantly about how she had been neglected, particularly by a mother preoccupied with outside activities, and a detached father. The supervisee, in her recorded responses, appeared to be saying the right things. A session of the supervisee working with the patient, which was recorded on videotape, however, demonstrated that the therapist had placed her chair so that she was not facing the patient; she was in effect detaching herself from her and repeating the patient's childish trauma. Correction of this position, with the closer interaction that the face-to-face placement encouraged, rapidly brought the patient out of the depression and accelerated progress.

The advantage of watching students performing with patients behind a one-way mirror and of recording the session on videotape so that it may be played back for the students is incalculable, since immediate feedback is possible. Parenthetically, a session in which the supervisor treats a patient, observed by students through a one-way mirror or by watching a video recording, is helpful in pointing out techniques that are difficult to describe verbally. Understandably, it will be impossible to use recordings at every supervisory session due to lack of time. Several recorded sessions presented during each six months of supervision will usually suffice to measure the therapist's progress, and in themselves will justify the use of the video machine. A unique device described by Boylston and Tuma (1972) is "bug in the ear," a receiver placed in the therapist's ear through which a supervisor gives instructions via a transmitter from behind a one-way mirror.

From the standpoint of research, recordings, videotapes, or sound film recordings of interviews permit the researcher to approach the problems of both process and outcome evaluation with greater objectivity (Davidman, 1964; Kubie, 1950b; Strupp, 1960).

Although the students' written notes and observations about therapeutic work are valuable (Beckett, 1969; Bush, 1969; Moulton, 1969), they are rendered more significant by studying the inclusions, omissions, and exaggerations in video recordings of the same sessions. As Schlessinger (1966) points out, different kinds of data are dealt with in both types of recording, each of which has a different potential for teaching but which is by no means mutually exclusive.

Recently, computer programs have been made available that have been found useful by some therapists, for example, Harless's Computer-assisted Simulation of the Clinical Encounter (Harless, 1971, 1972), which deals with diagnostic problem solving. Elaborations of this computer-assisted instruction involving typical psychotherapeutic situations will probably have a significant impact on some students since, as Hubbard and Templeton (1973) have pointed out, they can expose students to a wide variety of clinical problems, provide modes of practice and diagnostic skills in a simulated therapy setting, and permit early feedback by a consensus of experts in the field. The authors predict, because of such technological instruction, that a different role for teachers is possible. Heifer and Hess (1970) and Lomax (1972) have published interesting material on related new trends in teaching.

PROBLEMS IN TECHNICAL PERFORMANCE

The supervisees will experience trouble in various areas in the process of psychotherapy. These difficulties are the consequence either of lack of understanding, experience and skill, or of negative countertransference. They will have to be handled by the supervisor in relation to their origin and function. Most common are the following problems:

1. Difficulties in the conduct of the initial interview.

2. Inability to deal with poor motivation.

3. Inability to clarify for the patients misconceptions about psychotherapy.

4. Inability to extend warmth and support to the patients or to establish a good

initial contact with them.

5. Inability to define for the patients goals in therapy.

6. Inability to structure the therapeutic situation adequately for the patients.

7. Inability to recognize and to handle manifestations of transference in the therapeutic relationship—specifically, dependence, sexual feelings, detachment, hostility, and aggression.

8. Lack of knowledge about how to explore and to bring to awareness conflicts that mobilize anxiety in the patients (in insight therapy).

9. Lack of sensitivity and perceptiveness to what is going on in therapy.

10. Lack of technical skill in the implementation of free association, dream interpretation, and analysis of the transference (in insight therapy).

11. Inability to deal with resistances in the patients toward verbal exploration of their problems.

12. Tendencies to avoid problems of the patients that inspire anxiety in the therapist.

13. Tendency to probe too deeply and too rapidly at the start.

14. Impatience with resistances toward the acquisition of insight (in insight therapy).

15. Faulty techniques of presenting interpretations.

16. Frustration and discouragement at the patients' refusal to use insight in the direction of change.

17. Tendency to push the patients too hard or too rapidly toward normal objectives.

18. Fear of being too directive, with resultant excessive passivity.

19. Lack of understanding of how to create incentives for change.

20. Lack of understanding in dealing with forces that block action.

21. Lack of understanding about how to help the patients master anxieties surrounding normal life goals.

22. Inability to scale down therapeutic goals when modification of objectives is mandatory.

23. Lack of understanding about how to implement the translation of insight and understanding into action.

24. Inability to deal with resistance toward abandoning primary and secondary neurotic aims.

25. Inability to deal with resistance toward normality.

26. Inability to deal with resistance in the patients toward activity through their own resources.

27. Tendencies to overprotect or to domineer the patient.

28. Inability to assume a nondirective therapeutic role.

29. Lack of understanding about how to deal with the refusal on the part of the patients to yield their dependency.

30. Lack of understanding of how to handle the patients' fear of assertiveness.

31. Lack of understanding about how to analyze dependency elements in the therapist-patient relationship.

32. Lack of understanding about how to terminate therapy.

Good supervisors exercise tolerance for the specific style of activity of the supervisees. They realize that irrespective of intensive training and exposure to specific schools of psychological thought, basic personality patterns of the supervisees will infiltrate the treatment situation. These cannot help but influence the techniques that have been learned. Some modification of learned techniques will always occur, particularly those that are not compatible with the therapists' style or personality structure. The supervisees will probably never be able to duplicate the exact style of the supervisor, nor vice versa, since they are individuals and relate to patients in their own unique ways. Yet

certain basic principles in psychotherapy must not be violated, no matter what kinds of relationships are established and what types of techniques are employed. By defining the broad bounds of psychotherapy, and by elucidating on the fundamental principles to which every therapist must adhere, the supervisor may help the supervisees perfect skills yet maintain spontaneity, which is a most cherished characteristic in the psychotherapist.

PROBLEMS IN LEARNING

A number of propositions are involved in the learning of psychotherapy that may be expressed as follows:

1. All learning necessitates a substitution of new patterns for old. This requires a working through of blocks that constantly impede the acquisition of new patterns. Sometimes the struggle is minimal; sometimes it is intense.

2. The manner in which learning proceeds is unique for individuals both in relationship to the rate of learning and the methods by which material is absorbed and integrated. Some people learn by leaps and bounds, others by cautious, precarious crawling. Many variants expedite or interfere with learning in different people. What is taught to individuals has to be accepted by them in their own terms.

3. Learning involves both an understanding of theory as well as its integration and translation into effective action. The instruction leading toward an understanding of theory is vested in the instructors and teachers with whom the supervisees have had preliminary training. The instruction for execution of theory into practice is vested in the clinical supervisors.

4. Little learning is possible without a motivation to learn. This motivation must be sufficiently intense to overcome the difficulties that are inherent in all learning. It is assumed that the supervisees have sufficient motivation— in terms of desire to be psychotherapists—to expose themselves to the ordeals of the learning process.

5. Anxiety is present in all learning. Its sources are related to fear of change and the desire to cling to familiar patterns as well as to resistance in altering basic accepted attitudes and behavior tendencies.

6. Some resistances to learning are present in all people in response to anxiety.

The kind and the degree of resistance will vary with each individual. Most common are lack of attention, lack of retention, amnesia, and simulated stupidity. In addition, resistance may take the form of dependency, submissiveness, self-depreciation, ingratiation, arrogance, grandiosity, resentment, aggression, and detachment. These are products of specific neurotic character problems but there also may be a universality of expression of such trends in certain cultures, reflecting accepted attitudes toward education and toward the authorities that are responsible for education.

7. Resistances to learning must be overcome before learning can proceed. The attitudes of the supervisor are crucial here. The supervisor's tolerance, flexibility, and capacity to extend warmth, support, and acceptance toward the supervisees, irrespective of the errors that the latter make, promotes the most effective medium for the handling of resistance.

8. Learning is thus facilitated by a warm working relationship between supervisor and supervisees. It is impeded by hostility that develops in this relationship. A primary focus, then, in the supervisory process is the existing relationship between students and teacher, with thorough ventilation of negative feelings before these exert a corrosive influence on the learning process. The supervisees must be encouraged to express disagreements, criticisms, or feelings in relation to the supervisor. The supervisees must also be able to accept criticism, and this will be possible where there is a good rapport with the supervisor.

9. As a general rule, learning blocks are resolved during the first few months of supervision. An inability to master such blocks after several months indicates a severe problem that necessitates incisive investigation.

10. In learning, the supervisees have a backlog of past experiences on which to build. They cannot be expected to progress any faster than would be warranted by the degree of this experience, no matter how hard the supervisor may push; severe demands will be a hindrance.

11. As a rule, in the early stages of learning, the supervisees will feel resentful, unsure, and certain of failure. They will want to be told how to function— indeed, will demand that the supervisor demonstrate exactly what to do. The supervisor must accept the presence of dependency and yet treat the supervisees as equals. The setting of supervision is best permissive, the supervisees being given the feeling that they are free to act, experiment,

and make mistakes. Mistakes are to be expected since even expert therapists make them.

12. Learning how to become a therapist is a tedious process enhanced by the active participation in the learner's growth. It is facilitated by selected case studies that serve a specific purpose in filling in gaps in experience, as well as by assigned readings and recommended courses. At all times, critical thinking is to be encouraged.

13. Learning is more an educational than a therapeutic process, and the focus in good supervision is on supervisees' work rather than their personal problems. It is essential that supervisees be treated as adults and not as problem children.

14. Learning is expedited by successes, and it is impaired by failures. Provision should be made for some successes that will reinforce learning. If supervisees encounter repeated failures, damage will be done to their learning capacity. The supervisor should therefore be encouraging and commendatory of any successes that are scored.

PROBLEMS IN TERMINATION OF SUPERVISION

The relationship that supervisees establish with the supervisor will, in general, proceed through various phases, including the establishing of rapport, the understanding of problems that occur in relationship to the supervisor, the translation of this understanding into corrective action, and, finally, the ending phase in which supervisees develop the capacity to carry on, on their own, with working through of the dependence on the supervisor.

If the supervisor has an authoritarian personality structure, it may be difficult to operate on equal terms with the supervisees. The supervisor will want to continue to make decisions, to utter judgments, and to offer interpretations, consciously or unconsciously resenting the supervisees' right to self-determination. Under these circumstances the ending of supervision may impose great hardships on both supervisor and students.

On the other hand, the greater the dependency needs in the supervisees, the more

difficult it will be to countenance termination. An inability to resolve dependence on the supervisor indicates severe characterologic problems for which the supervisees may require further therapeutic help.

During the terminal phases of supervision the supervisor, in anticipation of the trauma of separation, may assume a nondirective role, insisting that the supervisees be more active and figure things out entirely alone. One may expect that the supervisees will respond to such nondirectiveness with anxiety and hostility and that there will be an attempt to force the supervisor to abandon this passive role. If the supervisor is persistent, however, justifying the passivity displayed on the basis of a respect for the supervisees' growth process, the latter will eventually be convinced of the rationale of the supervisor's behavior.

TECHNICAL DETAILS OF SUPERVISION

Preclinical Training of the Therapist

Before supervision begins, the supervisor will desire information about the preclinical training of the prospective supervisees. Questions that may arise include these: Is the theoretic background of the supervisees adequate for functioning in psychotherapeutic practice? Have the required courses been taken and the essential reading done? Has this theoretic material been integrated satisfactorily? Do the supervisees have the personality qualities that will make for a good therapist? How profound an understanding do the supervisees have of their own emotional and interpersonal processes? Will the supervisees be able to resolve or to control the expression of hostility, detachment, sexual interest, overprotection, rejection, and other strivings on the part of the patient that will be inimical to the psychotherapeutic relationship? Can it be reasonably assumed that the supervisees are sufficiently adjusted to life now, so that they will not use the therapeutic situation and the experiences of the patient to live through vicariously certain frustrated ambitions. dependencies, and hostilities? Do the supervisees have a capacity to empathize with people, to feel warmth

toward them and to communicate it? Is there the capacity to be resolute and firm on occasion, capable of insisting on certain essential actions during the therapeutic process? How much experience have the supervisees had in psychotherapy? What kinds of cases have been treated and with what results? Has there been previous supervision, and if so, with whom and for how long? Do the supervisees believe such supervision has been beneficial?

There is general agreement that the prospective psychotherapist requires an extensive amount of preclinical training. A review of training that is being given in most of the recognized schools reveals a close similarity in prescribed courses and requirements. These include the following:

1. Courses in basic neuropsychiatry, normal psychosocial development, psychopathology, psychodynamics, techniques of interviewing, techniques of psychotherapy, dream interpretation, child psychiatry, group psychotherapy, and behavior modification.

2. Clinical conferences and continuous case seminars that have been attended regularly.

3. Readings in psychiatric literature of sufficient scope to provide the students with a good background in history, theory, and practice.

4. Ideally, enough personal psychotherapy or psychoanalysis to provide the students, first, with an opportunity to achieve self-understanding through self-observation, studying their own emotional conflicts, the genesis and projection of such conflicts into present functioning; and, second, to liberate themselves sufficiently from personal problems and character disturbances that interfere with the establishment and maintenance of a therapeutic interpersonal relationship.

Should the supervisees be lacking in any of these basic requirements, the supervisor must help find ways of making up these deficiencies. (See Appendix L, for a form that supplies the supervisor with essential information.)

The Beginning Stages of Supervision

The first contact of the supervisor with the supervisees is in the nature of an exploratory talk. At this time there may be a discussion of the supervisees' preclinical training, and arrangements may be made as to the hours, frequency of visits, and the method of recording and presentation. The supervisees may be given preliminary orientation as to what will be involved in supervision and how supervisory sessions may best be used. Arrangements may be made for the handling with the supervisor of any emergency situations that may occur during the course of supervision.

In the early months of supervision, a period of disillusionment is to be anticipated. Supervisees will be brought face to face with practical problems in implementing therapy that may be at variance with what has been learned from books. Student therapists often are upset by the fact that the specific kinds of problems that provoke their patients may be precisely those that are disturbing to themselves. They may be exposed to certain situations that develop in treatment that have a violent impact on them and tax their own capacities for adjustment. It is incumbent upon the supervisor to extend to the supervisees during this period a good deal of warmth and understanding. The primary focus in early supervision is the relationship between supervisor and supervisees, since little progress will be possible until good rapport exists.

Later Phases of Supervision

In supervision the supervisor seeks to ascertain whether or not the supervisees are living up to their potential. If not, the sources of this lack must be diagnosed. For instance, the problem may relate to deficiencies in the kind of preclinical training received, or in the assimilation of educational materials presented in training. It may be due to an absence of perceptiveness or to insensitivity about what is going on in the therapeutic situation. It may be the product of personality problems that prevent the supervisees from establishing a meaningful contact with patients.

The areas in which supervisees need help will soon become apparent. In the main, technical problems break down into difficulties in diagnosis, conduct of the initial interview, use of interviewing techniques, understanding of the operative dynamics,

detection and handling of transference, awareness and mastery of countertransference, dealing with resistance, use of interpretations, and termination of therapy.

The task of the supervisor here is not to tell supervisees what to do but rather to teach them how to think through solutions for themselves. Toward this end, it will be essential to ask questions and to structure problems so that the supervisees can come to their own conclusions. Learning problems are to be diagnosed and handled along lines indicated previously. Modes of improving sensitivity are described by Fielding and Mogul (1970).

In the course of supervision, supervisees are bound to show transference manifestations. The supervisor will also have emotional attitudes toward the supervisees. Both positive and negative feelings will have to be subjected to close scrutiny to permit development of empathic yet objective attitudes. Furthermore, the supervisor will have to maintain a certain amount of tension in the supervisory sessions to expedite activity.

The beginning supervisor, particularly, may respond to supervision with untoward feelings. There may be a tendency to be pompous and overbearing and to overwhelm supervisees with material. The supervisor is apt to feel irritable when supervisees do not learn rapidly or defy suggestions and criticisms, even though these are offered in a constructive way. The supervisor may be provoked when there is persistence in errors that are so obvious that they scarcely need identification. Such attitudes on the part of the supervisor will, of course, interfere with learning. An honest self-questioning by the supervisor will often reveal tendencies that stifle the development of supervisees. It must be emphasized again that some countertransference is always present and that it need not be destructive to the teaching objective, provided that the supervisor is capable of understanding his or her feelings and of modifying and correcting them before they get out of control.

Disagreements between the supervisor and supervisees are inevitable, even desirable. All learning inspires resistance. Supervisees will voice protests in changing habitual patterns. They are bound to be critical. Actually, they cannot change unless they

are given an opportunity to voice and to work through their criticisms. The supervisor may be offended by such challenging reactions, but will best be able to respect the supervisees' right to their own opinions, realizing the unavoidable learning struggle that is involved.

Essential for learning is an open mind to new ideas. Some students have already settled their opinions about psychological theory and process and seal themselves off from fresh points of view. What they seek from the supervisor is a confirmation of their frozen ideologies. Similarly, there are supervisors so rigidly wedded to their credos that they insist on their students becoming a mirror image of themselves. Vital for learning in the supervisory process, then, are participants who are willing to collaborate, share experiences, and, if necessary, change. Students must be able to countenance exposure of deficiencies in psychotherapeutic performance. The supervisor must be able constructively to bring students to an awareness of these deficiencies and to provide students with an appropriate means of rectifying them.

Illustrative of some of the problems are the following comments of a supervisor:

> I have a supervisee who is a chatterbox and who is highly defensive about any comment I make—even a casual comment on the dynamics is interpreted as a criticism of her. Her defense is to interrupt, challenge me, justify herself, etc., without permitting me to finish what I have to say. Often, by the end of the session, I find that I have been able to tell her very little. I have been debating with myself whether to take up the problem with her directly, which might merely provoke additional defensiveness, to pull back and tell her virtually nothing until she complains about it to me, or to go on as I have but being very supportive until she feels less threatened.

These are the remarks of a student:

> The trouble with my supervisor is that he is constantly trying to force his point of view on me. I would think that he would know I can't do things exactly how he does them. I would like to have him help me work better with my good points and to help me eliminate my bad points. When I show him what I believe is a gain in my patient, he usually criticizes it as merely defensive, a new resistance.

In both of these illustrations effective learning is being blocked by problems that are influencing the relationship between student and supervisor. The supervisory encounter is far more complex than that of a simple teaching contingency. It embraces unconscious

processes that may require mutual exploration. In any of the social sciences where professionals function as investigative or therapeutic tools, there are bound to be differences in theoretical assumptions and methodological approaches. These differences may interfere with the manner in which individuals communicate themselves to other professionals. Even within the same school, problems in communication may be vast. They are particularly annoying in the psychotherapeutic learning and teaching situation.

The supervisor is constantly involved in a process of self-analysis while relating to supervisees and examining personal reactions, both transferential and reality determined. There is recognition that students will be carrying out therapy with their own personalities and not with the personality of the supervisor. Students may not be able to perform exactly the way the supervisor performs, nor will students be able to deduce from interactions with patients all of the nuances that are apparent to the supervisor. A tremendous amount of tolerance and acceptance will be required from the supervisor that may tax the latter's patience and bring countertransference into play. Although the supervisor serves as a model for the student, it must be a flexible model and not one that demands a clone. These conditions should readily be acceptable to anyone who possesses the sophistication that is a prerequisite for becoming a supervisor, understanding from experience that there is no single accurate way of providing therapy. There are many ways. What can be taught is a broad framework of psychotherapy with a buttressing up of those elements of the students' functioning that permit good therapeutic process, while expurgating interfering elements.

'Intensive' versus 'Technical' Supervision

In practice, two general types of psychotherapeutic supervision may be defined. The first type, "intensive" supervision, consists of the "continuous-case" type of reporting with a single patient, preferably from the initial interview to termination, using video recordings if possible. This enables the supervisor to help supervisees in all phases of treatment by observing operations with one patient over a long-term period. "Intensive" supervision is the most effective kind of teaching for beginning therapists.

The second type of supervision, arbitrarily called "technical" supervision, may be further divided into two subtypes. The first, or "case-load" supervision, which is usually prescribed especially for beginning therapists in a clinic, covers the general progress and specific difficulties being encountered in the entire case load of the supervisees. This might be considered a kind of administrative supervision. The second subtype, which we may, for want of a better name, call "special-problem" supervision, is handled in a manner similar to a clinical conference. Any pressing problem in diagnosis, psychodynamics, or technical management may be presented, and the discussion is centered around the specific difficulty encountered by the supervisees.

The latter kind of supervision is more highly advanced than other types and presupposes more experience on the part of the supervisees. It may also be effectively practiced in a group of no more than three or four therapists, who participate in the discussion with the supervisor. Each therapist may be given the privilege of presenting material on successive sessions. In practice, this proves to be a highly provocative teaching device, provided all the supervisees are on approximately the same level.

The Evaluation of the Supervisee

Evaluation is a means of helping supervisees develop skills through a continuous assay of strengths and weaknesses. As such, it becomes part of the teaching method, pointing to areas in which more development is needed and helping in a positive way to promote such development. Criteria of evaluation may be along the following lines:

1. Method of presentation, and recording ability.

2. Theoretic understanding.

3. Diagnostic ability.

4. Integration of theory into practice.

5. General therapeutic aptitudes, sensitivity, empathy, and capacity for critical thinking.

6. Kinds of relationships that the supervisees establish with patients and the skill in handling these relationships.

7. Type of relationship that the supervisees have with the supervisor and the use made of the sessions.

8. Types of relationships that the supervisees establish with colleagues and personnel of the clinic, if any, with which they are affiliated.

9. Supervisees' good points and special skills.

10. Supervisees' deficiencies.

11. General learning ability and the progress that has been made in learning.

12. Positive recommendations for increasing learning, including recommended readings, prescribed courses, and preferred kinds of cases to be assigned.

Yardsticks of expected progress have never been set. Arbitrarily, a rough gauge such as the following may be useful to indicate minimal levels of achievement:

End of first six months of supervision: Ability to make diagnoses, ability to keep patients in therapy.

End of first year: Ability to understand what promotes, aggravates, and helps emotional illness; capacity to establish good rapport with patients.

End of one and one-half years: Recognition of personal problems in therapeutic functioning.

End of second year: Ability to overcome most personal problems in therapeutic functioning.

End of two and one-half years: Ability to function without serious mistakes. *End of three years:* Ability to do good psychotherapy.

Evaluation imposes burdens on both supervisor and supervisees. The supervisor may not want to criticize out of fear of hurting or offending the supervisees. The latter, in turn, may feel humiliated at having weak points exposed. The manner in which evaluation is presented, and the purpose for which it is used, will largely determine the reactions of

the supervisees. If understanding is clear that there will be periodic evaluations, say every six months, to point out the areas in which the greatest or least development has been made, the experience can prove to be an aid to learning.

The evaluation conference may be set up in advance, and supervisees and supervisor may prepare their observations for mutual discussion and consideration. At the conference a common understanding must be reached. If a written evaluation must be sent to the head of a clinic or school, agreement on as many points as possible is best achieved in advance of sending the report.

The point at which the supervisor certifies the student therapists as competent to do psychotherapy will vary with the kind of therapy for which the students are being prepared. Table 61-1 shows an outline for evaluation for certification that has been used at the Postgraduate Center for Mental Health.

Administrative Responsibilities

If the supervisor and supervisees are associated with the same clinic, the supervisor will have further responsibilities. For instance, the supervisor may participate in an analysis of administrative or intake policies, making recommendations toward alteration of old, or the devising of new, policies. The object here is the elimination of influences that are destructive to the patients' therapy or to the therapists' functioning. If supervision is part of a school training program, the supervisor will also probably be engaged in an analysis of administrative and pedagogic procedures in the program. This will include methods of choice of students, modification of curricula, introduction of new courses, and proposed changes in instructors or instructional methods. Routine meetings among the supervisors, or between supervisors and the supervisory head, will cover discussion of such problems in detail, with the introduction of whatever current difficulties the supervisor is having with supervision and routine evaluations of the progress shown by the different supervisees.

SUPERVISION AS AN INTERPERSONAL RELATIONSHIP

The supervisory relationship is one to which supervisees react with mingled attitudes of admiration, jealousy, fear, and hostility. Admiration and jealousy are usually inspired by the supervisor's superior knowledge, training, and status. Fear of the supervisor is often the product of the therapists' helplessness in the face of an authority, who, they feel, may judge them unfairly and destroy their careers and livelihood in the event they fail to live up to expectations. Hostility issues from many sources. On the one hand, it is the product of dependency on the supervisor, which is especially inevitable at the beginning of supervision. Dependency yearnings that are mobilized are usually accompanied by expectations that these yearnings will be frustrated. Feelings of being victimized by these dependency needs, and the threats imposed by these needs on independence and assertiveness, inspire further resentment. The very acceptance of supervision implies to some supervisees a kind of subordination that imposes burdens on adjustment, particularly when independence has become the keynote in the students' life struggles. The supervisees, in addition, resent demands that they believe the supervisor makes on them. The restrictions imposed on the students, the criticisms directed at their functioning, deliver blows to their narcissism and contribute to further fears of loss of self.

Supervision will thus produce feelings in the supervisees that are related to neurotic attitudes toward authority. Difficulties may come out openly in the form of verbalizations or behavioral acting-out. They may also be concealed behind a barrage of defenses that reflect supervisees' habitual covert patterns in their dealings with authority.

The supervisor, in turn, will respond in supervision with untoward feelings toward the supervisees, many of which are the product of neurotic attitudes toward subordinates. In a flush of omnipotence, a patronizing attitude may be displayed toward the supervisees, with presentation of ideas as if they were irrevocable pronouncements. Contempt may be expressed for the relatively inferior knowledge, skill, or status of the supervisees. Hostility may appear when supervisees challenge the supervisor's opinions or theories. The growth or advance of the supervisees may be resented from a desire to keep them on a subordinate level, in an effort to preserve superiority. Accordingly, successes of the supervisees may be threatened with chariness of praise, so important in learning. Such

attitudes are rarely expressed directly. They may be cloaked in solicitous, ingratiating behavior with overkindliness and overattentiveness. Or they may show up as disinterest, offering the supervisees little help or reassurance. Searles (1955) and Benedek (1972) have written on the use of the supervisor's feelings and "intuition" as a way of gaining understanding into the problems of supervisees.

The supervisory process will thus arouse varied feelings and attitudes in both supervisor and supervisees that are inimical to learning. Sufficient resolution of such deterrents must occur before progress is possible. As a general rule, assuming that the participants are mature people capable of facing their feelings and communicating with one another, differences should be satisfactorily resolved. Problems may persist in some cases, however.

The supervisor may be tentative, indecisive, irritable with the students, overprotective, and patronizing, all of which put a damper on the students' need to express criticism and verbalize doubts. Lack of interest in the students and their growth acts as a damper to learning.

In supervisees, character problems show up in the form of many resistances, some of which persist with an amazing tenacity. Among these are attitudes of conformity and a seeming absorption of every gesture and utterance of the supervisor. This spurious kind of admiration is accompanied by a constant repetition of mistakes, as if all knowledge is shed immediately after leaving the supervisor's office. There may be a continuing fear of losing one's independence by yielding to the supervisor's dictates and demands. Resisting learning then becomes for the supervisees a means of retaining identity.

Another kind of resistance is the need to dominate and to take control by out-supervising the supervisor. In such cases, the supervisees overwhelm the supervisor with material, edit reports—even falsifying material—to impress the supervisor. Belittling and derisive attitudes and feelings may exist toward the supervisor that are only indirectly expressed and that serve to protect the supervisees from fancied exploitation and injury.

On the other hand, those supervisees with many personal problems may become so terrified about what is happening in the relationship with the supervisor as to seek reassurance, affection, and support in sundry ways. One way is to become helpless and hopeless, assume a defenseless attitude, and seek from the supervisor various panaceas for difficulties. In making such demands, the student-therapist may express lack of confidence in resolving developing problems in an attempt to force the supervisor to shoulder all obligation for decisions. Self-devaluation may follow in the wake of this attitude, much of which is an effort to avoid criticism and to forestall responsibility.

Resistance to learning may also be expressed in the form of hostility. The patterns that hostility takes are legion, depending upon the individuals' habitual modes of dealing with this emotion. When supervisees find it hard to express rage, their response may be depression and discouragement. One individual may seek to terminate supervision on the basis that he is completely incapable of learning. Another may mask her hostility with dependence, with feigned amiability, and with strong gestures to force the relationship with the supervisor into social channels. In instances where the student-therapist is capable of expressing her hostility openly, she may become defiant, challenging, and overcritical. She may develop feelings of being exploited, misunderstood, and humiliated, and she may attempt to find evidence for these feelings by misinterpreting what goes on between herself and the supervisor. She may become suspicious about the supervisor's abilities, training, and personal adjustment. She may enter into active competition with the supervisor, bringing in materials, quotations, and references from authoritative works to challenge the supervisor or to nullify suggestions the latter has made. In some instances, the supervisee may actually become uncooperative, negativistic, and even defiant. In other instances, hostility is masked by apathy and detachment. Here one will get the impression that the supervisee, while presenting material and listening to the comments of the supervisor, is mentally "off in the clouds."

Supervisees may also try to ward off the supervisor by discursive talk about superficial topics or by self-interpretations that are expressed with great vehemence. This attempt to disarm the supervisor by spurts of productivity has little corrective value for

the supervisees, since it is motivated by an effort to belittle the supervisor rather than to learn.

Other resistances take the form of an inability to think clearly and an incapacity to express one's ideas. There may be an insistence by the supervisees that there is great development that is not supported by facts, and though self-confidence and assertiveness may be expressed, these will be found to be without substance. Another defense is an attempt to seduce the supervisor with gifts, lavish praise, and compliments. The overvaluation of the abilities of the supervisor may be boundless, and an unwary supervisor is apt to respond to these devices with omnipotent feelings.

Assuming that the supervisor is capable of controlling or of resolving countertransference, can help be rendered the supervisees to overcome such varied resistances to the supervisory relationship?

One must remember that supervision is a student-teacher, rather than a patient-therapist, relationship. Emotional problems stirred up in supervisees during work with patients cannot entirely be handled by the supervisor in the setting of supervision. Although the outcome of supervision may be therapeutic for supervisees, the goal is toward more adequate functioning in psychotherapy rather than the helping of personal neurotic difficulties. Naturally, the supervisor does point out neurotic problems that express themselves in resistance to learning and in countertransference in the hope of dispelling blocks in functioning. Since some of the problems that supervisees experience with the supervisor may be similar to those being experienced with their patients, working them out with the supervisor is bound to have some salubrious effect on overall therapeutic functioning. It is assumed that most supervisees have had sufficient personal psychotherapy, or are sufficiently integrated emotionally, to be able to resolve blocks through their own resources in the supervisory setting. The supervisor will have to handle those aspects of feeling and attitude that impede the acquisition of therapeutic skills. This experience, as has been mentioned, may prove itself to be therapeutic for supervisees, but, if this occurs, it is a byproduct of the chief objective—the learning of psychotherapy.

Should the supervisor's effort to help supervisees resolve difficulties fail, referral for personal psychotherapy may be advisable, which the supervisor may also benefit from receiving if personal problems in the existing relationship with particular supervisees cannot be worked through. In the event mutual trust and respect do not develop between supervisor and certain supervisees and no progress in learning has occurred after these avenues have been tried, transfer to another supervisor may be necessary.

These difficulties are not uncommon in a school or clinic. They are attenuated, though not entirely obliterated, when a therapist in private practice chooses and pays for a supervisor who does not need to render reports to the school or clinic.

Among the recommended readings on supervision are Alonson (1935), Arlow (1963), Blumenfield (1982), Caligor (1983), Collins (1962), DeBell (1963), Ekstein and Wallerstein (1958), Fleming (1961, 1963, 1967), Fleming and Benedek (1966), Grinberg (1970), Grotjahn (1955), Hess (1980), Kris (1956), Langer et al. (1964), Langs (1979), Schuster (1972), Solnit (1970), Steinhelber (1984), Szasz (1958), Towle (1954), and Windholz (1970).

Sundry questions plague the individual doing psychotherapy. Answers to these questions are not easily provided, since there are many ways of accomplishing the same task in psychotherapy, some of which are suitable for one therapist and wholly inappropriate for another. In this chapter a number of common questions, posed by therapists participating in case seminars conducted by the writer, and not answered completely in the text of this book, are considered. The answers given to these questions are, of course, not absolute and will require modification in terms of the individual's unique experience and specific style of working.

Q. If a patient attacks you verbally at the initial interview, how would you handle the situation?

A. An aggressive outburst in the first interview is clearly an indication of great insecurity or fear in the patient. Patients will generally rationalize the hostility on one basis or another. A way of handling the situation is to accept the patients' hostility and to inform the patients that under the circumstances, you do not blame them for being angry. As a matter of fact, it would be difficult for them to feel any other way. If possible, an effort should be made to bring the meaning of the aggressive outburst to the patients' awareness. If this can be done, it may alleviate their tension and initiate more positive feelings toward the therapist.

Q. How do you handle patients who come to see you while they are being treated by another therapist?

A. This situation occasionally happens and will have to be managed diplomatically. There are a number of reasons why patients find it necessary to consult a second therapist. They may be in a state of resistance, and their visit constitutes an attempt at escape from, or a gesture of hostility toward, their therapists. Or the patients may sense that they are unable to relate to their therapists, or that their therapists are unable to relate to them, and they are reaching out for a new, better therapeutic relationship. In either instance, one must respectfully listen to the patients and focus particularly on the specific meaning of their consultation with you. Under no circumstances should one participate in criticism of the other therapists, no matter what outlandish activities are ascribed to them by the patient. On the contrary, one should be alerted to transference manifestations and attempt to clarify any misconceptions or irrational attitudes about the patients' therapists that present themselves. The ultimate result of the interview may be emotionally cathartic for patients, and they may return to their therapists with insight into their resistance. Should there be reason for your considering treating the patients, and if they had not informed their therapists about the prospective consultation with you, it will be important to emphasize the need to discuss the situation with their therapists. The patients may be told that for

ethical reasons it will be impossible to start treatments with them unless both they and their therapists agree that a transfer is indicated. In the event the patients have, when they consult you, discontinued treatment with their therapists, the visit may, of course, be conducted as an initial interview.

Q. Is it permissible to treat one's friends or relatives?

A. It is extremely difficult to be therapeutically objective with friends and relatives. Nor will they be able to establish the proper kind of relationship with you. For these reasons, if they need treatment they are best referred to another therapist.

Q. How far can the therapist go in making interpretations at the beginning of therapy?

A. An experienced therapist may discern important dynamics in the first interview or shortly thereafter. To interpret these to patients may be harmful. A strategic moment must be waited for—which may come many months later—before revealing to patients what the therapist already knows. New therapists, in their enthusiasm, frequently violate this rule, as do experienced therapists with strong narcissistic leanings who attempt to demonstrate to patients how much they know about them.

Q. What causes violent feelings that are stirred up in patients after the first interview?

A. These may be caused by transference or by something the therapist has done in error.

Q. Are mistakes that a therapist makes in psychotherapy irretrievably destructive?

A. Even the most experienced psychotherapist makes mistakes in the conduct of therapy. There are many reasons for this, including the fact that the therapeutic relationship is so complex that the therapist cannot see all of its facets. Such mistakes are not too important if the working relationship with patients is a good one.

Q. Are the various psychotherapeutic approaches ever used together?

A. Practically all forms of psychotherapy purposefully or inadvertently employ a combination of approaches. Even in formal psychoanalysis one may, at times, be unable to avoid suggestion and reassurance. Persuasive and other supportive influences may by design enter into insight therapy from time to time, and disturbing environmental factors may deliberately have to be handled in order to promote maximal progress. Wittingly or unwittingly, then, no approach is used in isolation. Rather, it is blended with other approaches, made necessary on occasion by the exigencies of the therapeutic situation.

Q. Does one ever start off using one approach and then, in the course of treatment, switch over to another approach?

A. This is very frequently the case. One may start off with an approach aimed at a supportive or palliative goal. In the course of treatment it may become apparent that no real improvement will be possible unless one deals with underlying causative factors. One will consequently have to motivate the patient toward accepting therapy aimed at more extensive goals. On the other hand, one may begin reconstructive treatment and, in the course of administering this, discover that circumstances make less extensive goals desirable. A supportive

approach may therefore become advisable.

Q. Should patients be required to pay for their own treatment?

A. Some patients will get more out of therapy if they feel in some way responsible for its payment. This does not mean that they will not benefit from treatment financed for them if they cannot afford it. With the increasing incidence of third-party payments (insurance, Medicare, Medicaid), a considerable body of experience shows that good psychotherapy is possible even though patients do not pay for it themselves. In child and adolescent therapy, parents or guardians assume responsibility for fees, and this fact does not denigrate the therapeutic effort. When therapy is given free, and no payment is made for it by any party, some patients are handicapped in expressing any feelings toward the therapist that they believe will cause offense. A perceptive therapist can detect this reluctance and deal with it to promote freedom of expression.

Q. How is the matter of fees best handled?

A. The matter of setting a fee satisfactory to both therapist and patient, and of agreeing on the manner in which payments are to be made, is part of the reality that therapy imposes on patients. Many therapists gauge their fees according to patients' ability to pay. In setting a fee, it is important that the therapist consider the patient's capacity to carry the financial responsibility over the estimated treatment period. Unless this is done, both therapist and patients will find themselves in a difficult situation later on. Though grading the patients' fees according to the patients' ability to pay over the estimated time period of treatment, the therapist must be assured that the fee is adequate. Should the therapist accept a fee too low to meet personal obligations, the therapist will feel insecure. Resentment or anxiety may occur that will impose a destructive influence on the therapeutic relationship. Once a fee is set, it is difficult and unfair to raise it unless patients' financial situation has improved. Often a neurotic problem interferes with the work capacity and productivity of patients. At the start of therapy, patients' earning ability will therefore be minimal. Once therapy gets under way, patients may be able to earn a great deal more money. Under such circumstances, discussing with them the raising of a fee is justifiable, and an adjustment of fees upward usually will be acceptable. On the other hand, financial reverses may occur during the course of therapy. In such instances a reduction of fee may be required.

Q. What do you do when patients neglect payment of fees?

A. Lack of punctuality in the payment of fees may be a manifestation of temporary financial shortage, a problem related to money or to giving, or an indication of resentment toward, and desire to frustrate the therapist. Should patients disregard the payment of bills for a considerable period, the matter may merit inquiry and therapeutic handling. If the therapist has neurotic problems in relation to money, he or she may evidence marked anxiety when payments are not being made on time. The therapist may consequently tend to overemphasize the importance of punctuality in payments and may introduce the matter of finances completely out of context with the material that concerns the patients. On the other hand, the therapist may be negligent on the matter of payments and may fail to bring to the patients' awareness possible avoidance of a responsibility that is part of reality. Unless justified by financial reverses, the accumulation of a debt creates hardships for patients that may be harmful to their relationships with the therapist.

Q. If you discover that patients' finances are greater than those reported at the beginning of therapy, would you boost the fee?

A. Financial arrangements with patients may have been made on the basis of a reported low income. If patients have purposefully concealed their finances from the therapist, this deception will, in all probability, later create guilt and tension. The therapist may assure patients that there must have been reasons for falsification of income. Understandably, careful handling is necessary to avoid mobilizing further guilt. In the event the set fees require adjustment because of patients' larger income, this matter must be discussed thoroughly with the patients, no change of fees being made except on mutual agreement. If the patients' fees are arbitrarily raised without their complete cooperation, grave difficulties may be anticipated in the therapeutic relationship.

Q. Should the therapist ever visit patients in their home?

A. Only in the event of a crisis or serious incapacitating illness or accident when it is impossible for the patients to come to the therapist's office and when it is urgent to administer psychotherapy.

Q. What do you do when patients talk too much and don't allow the therapist to speak?

A. If patients are focused on an important area and doing good therapeutic work, one does not interrupt. If they are talking about irrelevant things or their rambling seems to be resistance, one interrupts and focuses on pertinent topics. If this does not help, one may question the reason for rambling, or perhaps attempt its interpretation.

Q. Is there not a similarity between friendship and a working relationship?

A. Only peripherally. The therapeutic relationship is a professional one. Implicit in it is the absolute promise of confidentiality, the recognition that the time span is a limited one, and that termination of the relationship will eventually come about.

Q. What do you do if patients have been in negative transference for a long time and this continues no matter what the therapist does?

A. First the therapist might undertake self-examination to see if he or she is provoking these feelings. If the therapist is sure there is nothing in the therapeutic situation that is stirring up the patient, analysis of possible projections by the patients into the present relationship of negative attitudes toward important past personages may be undertaken. If this does not help, the therapist may go back to the first phase of therapy and actively try again to establish a working relationship with the patients.

Q. What is the relative merit of focusing on past, as compared with present life difficulties in reconstructive therapy?

A. In reconstructive psychotherapy, some controversy exists as to the relative importance of material that deals with the past and material relating to the present. Extremists of both points of view argue the merits of their particular emphasis. On the one hand, there are those who regard the present problems of individuals as a peripheral product of personality disturbances arising out of insecurities in childhood. These insecurities have undermined

self-esteem and blanketed sexual and aggressive drives with a mantle of anxiety. Environmental difficulties and current situational distortions stir up hardships for individuals by agitating past problems. Dealing with provocative current situations may restore the individuals' equilibrium. This stability is, however, precarious due to the continued operation of immature strivings. Although harmony may be reconstituted, the recurrence of environmental stress will promote a new breakdown in adaptation. It is fruitless, therefore, always to concentrate on the present since the roots of the difficulty, imbedded in the past history, will remain firmly entrenched. On the other hand, there are therapists who are opposed to an emphasis on the past. It is claimed that individuals repeat in present-day patterns their important childhood disturbances. A concern with the present must of necessity involve a consideration of the past. To discuss the past in detail results in a mere raking over of dead historical ashes; though interesting material may be exposed, it may bear little relationship to current happenings. A dichotomy may then be set up between the past and the present, without unifying the two. As irreconcilable as these two viewpoints appear, they are not so disparate as the proposed arguments would seem to indicate. In psychotherapeutic practice one constantly uses current life experiences as vehicles for discussion, for it is in the present that individuals live and feel. Yet, a consideration of the past is mandatory in understanding what is happening in the present. Current life experiences may be regarded as reflecting the past through the use of present-day symbols. It is therefore necessary to blend the past and the present and to focus on whichever element is of immediate importance.

Q. Is it ever permissible to assign "homework" to patients?

A. This can be very rewarding, particularly if patients are not too productive and do not work industriously at therapy. Asking them to keep a kind of diary, writing out their reactions, observations, and dreams between sessions, may get them to approach treatment more seriously. Each interview may be organized around discerning and exploring basic patterns that are revealed in the patients' notes or observations. Patients should leave every session with a general problem to focus on until next session. They may then work on this problem, observing themselves and their reactions, noting which environmental or interpersonal situations tend to aggravate or moderate it. This "homework" may catalyze the patients' thinking and get them to assume more responsibility for treatment.

Q. If patients want information about a subject like sex, do you give it to them?

A. First find out why they ask for information and then give it to them or assign appropriate reading.

Q. Should all patients have a physical examination prior to psychotherapy?

A. All patients about to enter psychotherapy should have a good physical examination and, if the practitioner deems necessary, a thorough neurological examination performed by a competent neurologist. The findings will be negative in the vast majority of patients, but the occasional case of early cancer, brain tumor, or other operable maladies that are detected will justify the precaution of routine physicals.

Q. How would you handle patients who appear to have read just about everything on the subject of psychiatry and keep citing the opinions of different authorities that may or may not agree with your point of view?

A. Some patients may have read more on psychiatry than you, but this does not mean that they have integrated what they have read. As a matter of fact, they will probably tend to use the knowledge they have gained in resistance, by intellectualizing what goes on, or by criticizing the technique or formulations of the therapist. At some point in therapy it may be necessary to mention to such patients that, while their reading has given them a good deal of information, this information may be a hindrance to therapy rather than a help. No two problems of an emotional nature are alike, and facts patients have read applying to other people surely do not exactly apply to themselves. They can be fair to themselves only by observing their feelings and attitudes, without speculating what these must be like on the basis of readings. Sometimes it may be necessary to be very blunt and to tell patients that it is important for them to forget what they have read since this seems to interfere with their spontaneity.

Q. What do you do when patients ask a question the therapist is unable to answer?

A. The therapist may say that the question cannot be answered at this time but will be later when the answer becomes more clear.

Q. Is it ever justifiable to lie to patients?

A. Lies eventually reveal themselves and shatter the patients' trust and confidence in the therapist. Truthfulness is, consequently, the keynote in therapy. In an effort to be truthful, however, one should not reveal things to patients that may be harmful to them. It may be essential, therefore, if their security and health are menaced, to avoid answering certain questions directly. If, for instance, patients show symptoms of an impending psychosis, and are dangerously tottering between sanity and mental illness, and if they are frightened by the upsurge of archaic unconscious material to a point where they believe themselves to be insane, it may be harmful to tell them that they are approaching a psychosis. Rather, they may, if they question the therapist, be told that their preoccupation with becoming insane is more important then the symptoms they manifest. These are evidence of great insecurity. Whenever the patients asks a direct question, an honest answer to which may be upsetting in view of existing ego weaknesses, the patients may be asked why they ask this question, and their concern may be handled without upsetting them with a straight reply. It is important to remember that truthfulness must not be confused with necessary caution in divulging information and interpreting prematurely. If patients are insistent on a complete answer to their questions, it may be helpful to point out that therapy involves a mutual inquiry into a problem and an avoidance of premature judgments. One must patiently wait until enough evidence is available before being certain of one's observations. The answer to questions will soon become evident, both to the patients and to the therapist. If for any reason the patients cannot perceive the truth, the therapist will point out why it is difficult for them to understand what is happening. The patients will eventually develop confidence in the fact that the truth will not be withheld but that ideas must be checked and double-checked for their validity before they can be communicated.

Q. Sometimes it is necessary to break an appointment with patients. How can this best be done?

A. Appointments should, if possible, never be broken without adequate notice being given to the patients. Unless this is done, the relationship may be injured and a great deal of work may be necessary to undo the damage. If circumstances make it necessary to break an appointment, the therapist or the therapist's secretary should telephone the patients,

explain that an emergency has developed that necessitates a a revision of the therapist's schedule, and that, consequently, it will be necessary to make a new appointment or to skip the present appointment. In instances where the therapist is ill, or expects to be away from the practice for an indefinite period, patients may be informed that the therapist will get in touch with them shortly to set up a new appointment. If a reasonable explanation is given, there will probably be no interference with the working relationship.

Q. How would you handle patients' resentment because you do not keep appointments on time?

A. The patients' resentment may be justified. Because of ambivalent feelings, patients usually have difficulties trusting any human being completely. The therapist must, therefore, give patients as little basis for distrust as possible, always explaining the reasons for unavoidable irregularities in appointment times so patients will not assume that the therapist is irresponsible. Giving patients an allotted amount of time is part of a reality to which both patients and therapist must adjust. When appointments are forgotten by the therapist, or patients have to sit around and wait for the therapist because the therapist has not finished with a preceding patient, resentments will develop that may interfere with therapy. Of course, there will be occasions when the therapist cannot help being late for a session. Emergencies with a preceding patient may develop, and the therapist may have to run over in time into the next session. Under such circumstances an explanation must be given patients to the effect that an emergency occurred that could not be avoided and that necessitated a delay in starting the session. To impress on patients the fact that they are not being exploited, they may be told also that time taken from their sessions will be made up. In the event a mistake has been made in patients' appointments, and the patients appears for their session at a time allotted to another patient, they must be taken aside and given an explanation to the effect that an unfortunate error in scheduling has occurred that resulted in the patients' being given the wrong appointment time. Another appointment should then be given the patients, during which any resentment resulting from the errors may be handled.

Q. If you are unable to understand what is going on dynamically in a case you are treating, what do you do?

A. Occasions will arise when the therapist may be unable to discern exactly what is going on in treatment. Should this continue for long, it may be indicative of such blocks as unyielding resistance in the patients or of countertransference. In either instance, where the therapist is disturbed by what is happening or where progress is blocked, one or more supervisory sessions with an experienced psychotherapeutic supervisor may be helpful in resolving the difficulty.

Q. When do you increase the frequency of sessions?

A. During the course of therapy it may be necessary to increase the number of sessions weekly for the following reasons: (1) an upsurge of intense anxiety, depression, or hostility that the patients cannot themselves control; (2) violent intensification of symptoms; (3) severe resistance that interferes with progress; (4) negative transference; (5) unrestrained acting-out that requires checking; (6) threats of shattering of the ego unless constant support is given; and (7) when the therapist wishes to stimulate transference to the point of creating a transference neurosis.

Q. When would you decrease the number of sessions weekly?

A. A decrease in the number of weekly sessions is indicated (1) when patients are becoming too dependent on the therapist, (2) when alarming transference reactions are developing which one wishes to subdue, (3) when patients have a tendency to substitute transference reactions for real life experiences, and (4) when patients have progressed sufficiently in therapy so that they can carry on with a diminished number of visits.

Q. How important is adhering to the exact time of a session?

A. From the standpoint of scheduling, adhering to a set time may be necessary. The usual time is between 45 to 60 minutes. But shorter spans, as low as 15 minutes, can be effective in some patients, and certain situations can arise that require extending the scheduled time.

Q. Is advice-giving taboo in reconstructive therapy?

A. Generally. One must keep working on the patients' resistances to the solving of their own problems. The ultimate aim is self-assertiveness rather than reliance on the therapist. On rare occasions, however, advice-giving may be unavoidable.

Q. Should the therapist ever insist on patients' engaging in a specific course of action?

A. Only when it is absolutely necessary that patients execute it and its rationale is fully explained to and accepted by patients.

Q. Should the therapist ever try to forbid patients from making crucial decisions during therapy?

A. Although important changes in life status, like divorce or marriage, may best be delayed until patients have achieved stability and greater personality maturity, it is obviously difficult for the therapist to "forbid" patients to make any decisions. Patients may be reminded that it is important not to take any drastic steps in altering their life situations without discussing these thoroughly with the therapist. If the therapist believes the decisions to be neurotic, the decisions may be questioned, presenting interpretations if necessary. In the event patients decide, nevertheless, to go through with a move that is obviously impetuous, it means that they are still at the mercy of neurotic forces they cannot control, that their insight is not yet sufficiently developed, or that they have to defy or challenge the therapist. The therapist may have no other alternative than to let patients make a mistake, provided the patients realize that they have acted on their own impulses. It is important not to reject patients or to communicate resentment toward them for having made a move against advice. Only when patients are about to take a really destructive or dangerous step is the therapist justified in actively opposing it.

Q. What do you do if patients bring in written material for you to discuss?

A. Occasional written material may be important, but if large quantities are brought in, this practice should be discouraged.

Q. What would you do if patients refuse to talk spontaneously session after session but offer to write out their ideas?

A. If this is the only way patients will communicate, it should be accepted. An attempt must be made, however, to handle the patients' resistance to talk at the same time that they are encouraged to bring in written comments.

Q. What do you do if patients say they fear they will kill someone?

A. One should not reassure the patients or minimize what they say. Rather, they may be told that there are reasons why they feel so upset that they believe that they will kill someone. They may then be encouraged to explore their impulses and fears. If the patients are psychotic or destructively dangerous, hospitalization may be required. If acting-out is likely, the intended victim should be notified.

Q. Should the therapist permit patients to express hostility or aggression openly in the therapeutic situation?

A. Any overt behavioral expressions of hostility or aggression are forbidden, although verbalization of these emotions or impulses is permissible, even indispensable.

Q. Do you ever reassure patients during insight therapy?

A. Reassurance should be kept at a minimum. Gross misconceptions, however, will require reassuring correction, or patients may be in an emotional crisis which needs mitigation. Reassurance should never be given patients when they are in a negativistic state, since this may produce an effect opposite to what is intended.

Q. Are fleeting suicidal thoughts arising in patients during treatment important?

A. Suicidal thoughts are not uncommon during therapy. They often serve a defensive purpose, acting as a kind of safety valve. Vague ideas of suicide may be entertained as a way of ultimate escape from suffering in the event life should become too intolerable. In most instances such ideas are fleeting and are never put into practice no matter how bad conditions become. They are handled therapeutically in the same way that any fantasy or idea might be managed. It is important not to convey undue alarm when patients talk about suicide as an escape fantasy. To do so will frighten patients or cause them to use suicidal threats against the therapist as a form of resistance. Rather, the therapist may listen respectfully to patients and then state simply that there may be other ways out of their situation than suicide. Suicide is an irrevocable act. More suitable ways of coping with the situation will present themselves as they explore their difficulty. If, however, the patients have, in the past, made attempts at suicide, fleeting suicidal thoughts must be taken very seriously. A careful watch is indicated since the attempt may be repeated. Any evidence of hopelessness or resentment that cannot be expressed as such must be explored and resolved if it is possible to do so. Should resolution be impossible and should the danger of suicide continue to lurk, hospitalization may be required. Suicidal thoughts in patients who are deeply depressed must be considered as dangerous, and the patients must be handled accordingly.

Q. What do you do when patients you are treating telephone and insist on seeing you that very day?

A. If possible, this request should be respected, provided the situation is an emergency. Should the therapist be unable to arrange for an appointment, or for a partial appointment, a promise

may be made to telephone the patients at a specified time that day to discuss the situation with them. As early an appointment as possible may be arranged.

Q. What would you say to those patients who ask whether they may telephone or write to you whenever they desire?

A. Lack of time will obviously make it difficult for the therapist to answer telephone calls or to read all the material that patients wish to communicate in writing. The therapist may handle a request on the part of patients to telephone by saying simply that it is much better to take up matters during a session, since the limited time available during telephone conversations may create more problems than are solved. In response to excessive written communications, the therapist may remark that verbalization is to be preferred to writing. Patients may be informed that when emergencies occur, they may feel free to telephone the therapist. If a crisis has developed, patients may be given specific times at which they may call or may be told that the therapist will telephone them at a certain hour. It is usually best to keep such telephone calls at a minimum and to increase the sessions of the patients should a more intensive contact be required.

Q. How would you handle patients who are insistent that you inform them of your whereabouts at all times so that they can get in touch with you?

A. One would deal with this the way any other symptom in a neurosis would be handled. Patients may be told that it is important to find out why they need to know the therapist's whereabouts. It may be that they feel so helpless and insecure that they must be convinced that the therapist will not desert them or deny them help in the event of a catastrophe. Patients may be assured that the therapist will, in the instance of a real emergency, always be happy to talk with them but that it is important to understand what is behind the patients' insecurity in order that they be able to overcome their feelings of helplessness.

Q. In the event patients in psychoanalysis who have been using the couch position manifest anxiety and ask to sit up, would you encourage this?

A. Anxiety may be the product of penetration of unconscious material into preconsciousness, or it may indicate a feeling of isolation from or a fear of the therapist. Encouraging patients to continue their verbal associations on the couch may enable them to gain awareness of important feelings or conflicts. If anxiety becomes too great, however, their request to assume the sitting-up, face-to-face position should be granted. This will generally permit a restoration of stability, especially if supportive measures are coordinately employed.

Q. Should patients be encouraged to use the couch in psychotherapy?

A. In most cases this is not indicated or advisable. The possible exception is in formal psychoanalysis in which free association is employed.

Q. What do you do when patients have reached a stalemate in therapy? They are completely unproductive, and any attempts of the therapist to mobilize activity and to resolve resistance fail.

A. Group therapy with alternate individual sessions often stimulates activity, as may several sessions of hypnosis or narcotherapy. Continued resistance may justify a vacation from

therapy, or, as a last resort, transfer to another therapist.

Q. When is psychotherapy likely to become interminable?

A. Patients whose personalities have been so damaged in early childhood that their personalities have never allowed for a satisfactory gratification of needs or for an adequate defense against stress may feel they require a continuing dependent relationship to function. Transference here is organized around maneuvering the therapist into a parental role. There is strong resistance to a more mature relationship. If the therapist enters into the patient's design, due to needs to play parent, therapy is apt to become interminable.

Q. What does dreaming indicate when it becomes so excessive that it takes up the entire session?

A. If patients deluge the therapist with dreams, the therapist should suspect that the dreams are being used as resistance, perhaps to divert the therapist from other important material.

Q. Which dreams that patients present should one consider of great importance?

A. Repetitive dreams and those with an anxiety content may be of great importance.

Q. What do you do when patients constantly bring up important material several minutes before the end of a session, leaving no time to discuss it?

A. This is usually a manifestation of anxiety. It may be handled by mentioning to patients the fact that the material they have brought up sounds important and should be discussed at the next session. If patients do not spontaneously bring it up, the therapist may do so, handling whatever resistances arise.

Q. How would you handle parents who bring a child to you for therapy, and you are impressed by the fact that the parent needs treatment more than does the child?

A. It may be important to determine how much motivation the parents have for therapy and their level of understanding. Should the parents be unaware of how they participate in the child's neurosis, it may be necessary to inform them that the treatment of their child will require seeing the parents also, both to determine what is going on at home and to help the parents understand how to handle developing problems. In this way the parents themselves may be brought into a treatment situation.

Q. Are interviews of any value with the patients' families or with other people important to adult patients?

A. The therapist may frequently get information from people close to patients that the patients themselves has been unable to convey. Often a conference reveals distortions in the patients' attitudes and behavior that are not based on reality. One or more interviews with important family members may thus be useful. Furthermore, if patients are unable to correct disturbed environmental situations by themselves, the cooperation of a related person as an accessory may be helpful. If patients are reacting destructively to a relative who then responds in a counterdestructive manner, if demands on patients by relatives are stirring up problems in the patients, if relatives are opposing patients' therapy—and it is obvious, help, financial and other, is needed—an interview with the relative, aimed at the

clarification of these issues, may yield many dividends. These relatives may require reassurance to neutralize their guilt about the patients. Sometimes relatives can be prepared for contingencies that may arise in therapy, such as rebelliousness and hostility directed at them by the patients. An explanation that such occurrences are inevitable in treatment, and that they are part of the process of getting well, may forestall retaliatory gestures. The patients' needs for independence and assertiveness may be explained for the benefit of relatives who unwittingly overprotect the patients. Statements to the effect that the patients will get worse before they get better and that it will require time before results are apparent often prevent discouragement and feelings of hopelessness among concerned relatives. Because a therapeutically induced change in the patients' attitudes brought about by therapy may impose new and unaccustomed burdens on people with whom the patients live or associate, preparing these people for the change may avoid a crisis. An interpretation of the patients' actions in dynamic terms will often relieve relatives' guilt and lessen their resentment. For instance, if an adolescent is beginning to act cantankerous and resistive, an explanation to the parent that this behavior is to be expected at the patient's time of life, as a gesture toward cutting the umbilical cord of dependency, that all adolescents are often difficult to live with, and that parents are bound to feel resentful at the behavior of their offspring, may foster greater tolerance. Or a wife distraught at her husband's inattentiveness may be helped to realize that her spouse is responding not specifically to her as a person, but rather to her as a symbol of some actual past or fantasied personage against whom the patient had to build a wall of detachment. This insight may help avoid the creation of the very situations that would drive her husband deeper into isolation.

Q. How would you approach patients should you decide a conference with a relative is necessary?

A. The patients may be told that in psychotherapy the therapist may want to have an occasional conference with a relative or other person close to the patients. The purpose is to get to know the relatives and their attitudes. Following this, the therapist may say, "I wonder how you would feel if 1 thought it necessary to talk with _____ *[mentioning name of person]*?'' The patients may acquiesce; they may question the need for such a conference; or they may refuse indignantly to permit it. If patients are insistent that no contact be made, their desire should be respected. Important material concerning the relative will undoubtedly be forthcoming and may constitute the material of later interviews.

Q. If an interview with family members or other significant people is decided on, are there any rules one should follow?

A. Experience has shown that a number of precautions are necessary when it is decided to contact the family. First, the patients' consent should always be obtained, the only exception being where they are dangerously psychotic or suicidal. Second, confidential material revealed by patients must never be divulged, since the breach of confidence will usually be flaunted at the patients even if the relatives promise to keep the revelations to themselves. Third, in talking to the relatives or friends, the therapist will often have a temptation to blame, to scold, or to enjoin them to change their ways or attitudes toward the patient. Distraught, confused, frustrated, and filled with guilt and indignation, the relatives will expect the therapist to accuse them of delinquencies toward the patients. Permitting them to talk freely, sympathizing with their feelings, and encouraging them to express their ideas about the situation will tend to alleviate their tension. It is important to try to establish a rapid working relationship with them, if this is at all possible. Once they realize that the therapist is sympathetic toward them, they will be more amenable toward accepting interpretations, and more cooperative in the treatment plan. Indeed they may, if they have been hostile to

the patients' therapy or to the therapist, become helpful accessories. Fourth, should they telephone the therapist, they must be told that it is best that the patients be informed about the call, although the specific details need not be revealed. Fifth, if the patients are insistent on knowing what went on in the conference or conversation with the therapist, they may be told that the conversation was general and dealt with many personal and other problems, as well as their relationships with the patients. Sixth, it may be necessary to see these relatives or friends more than once, perhaps even periodically. Seventh, the therapist should not participate with the patients in "tearing down" family members, nor should the members be defended when the patients launch an attack. A sympathetic, impartial attitude is best.

Q. Under what conditions would you advise relatives of patients to get psychotherapy?

A. If the patients are in close contact with neurotic relatives and they are being traumatized by the relatives, psychotherapy may be advised, provided the therapist has a sufficiently good relationship with the relatives to make this recommendation. Therapy may also be advised when a change in the patients' condition makes a new adjustment by the relatives necessary. For instance, a frigid wife, living with an impotent husband, may, as a result of psychotherapy, on the basis of experiencing sexual feelings, make sexual demands on her husband that the latter will be unable to fulfill. For the husband to make an adjustment, he may require psychotherapy.

Q. Is it permissible to treat several members of the same family?

A. The situation often becomes complicated, but it can be done. Whether or not simultaneous treatment is possible will depend on the therapist's ability to handle the inevitable complications. Reconstructive individual therapy with several members of the same family is not easily managed. Treating all or a number of family members together in a group (family therapy) may result in better family adjustment. Marital problems are often advantageously handled in joint marital therapy.

Q. How should one act when one meets patients on the street or at a social affair?

A. A professional therapeutic relationship requires reducing social contacts to a minimum. Occasions will, however, arise when the therapist will run into patients on the street, in public places, or at private social affairs. This may prove embarrassing to both therapist and patients. One cannot handle such situations by running away from them. Once the therapist is recognized by patients, the former may greet them cordially and then proceed with activities as usual. Understandably, at private gatherings, one's spontaneity will have to be curtailed to some extent. The patients' reactions to seeing the therapist in a different role may have to be handled with them during the ensuing sessions.

Q. Should you expect all your patients to like you?

A. Except for very sick patients, a satisfactory resolution of prejudices, suspicions, and resentments will occur relatively early in therapy, leading to a good working relationship. Periodically, however, the patients' feeling about the therapist will be punctuated by hostility, issuing either out of transference or out of an inadvertent error in the therapist's handling of the patients. Analysis and resolution of hostilities as they develop should bring the relationship back to a working level.

Q. If patients continue to dislike you no matter what you do, should you discontinue therapy?

A. A continued dislike is usually indicative of either errors in therapeutic management or of transference that the patients cannot resolve. As long as the dislike persists, little progress can be expected in treatment. Should the patients' feelings persist, the therapist may have to suggest the possibility of transfer to a different therapist. This must be done in such a way that the patients realize that the transfer is being recommended out of consideration for their welfare and not because the therapist rejects them. As a general rule, very few patients will need to be transferred because of persistent negative feelings. If a therapist encounters this problem frequently, the chances are that he or she is doing something in the therapeutic situation that is inspiring the dislike of patients. The therapist should, therefore, seek supervision with an experienced psychotherapist who may be able to help in understanding what is happening.

Q. How should you act to displays of crying or rage on the part of patients?

A. One generally permits these to go on without reassurance until the meaning of the reaction is explored and determined. If the reaction is dangerous to patients or to others, it should be controlled by supportive measures.

Q. Should the therapist engage in a confessional, confiding about his or her life to the patient in an effort to show the patient that the therapist also has some personal frailties?

A. This can be very destructive to the relationship, especially at the beginning of therapy. Patients may use any revelations made as a confession of the therapist's weakness and ineptness and may then decide to discontinue treatment. Patients will usually discover enough frailties in the therapist spontaneously without being alerted to them.

Q. Should you ever admit to patients that you may be wrong about certain things?

A. It is important to admit an error when this is obvious to patients and they question the therapist about it.

Q. If patients ask you if you are ill or tired, would you admit it?

A. If it is true, it may be important to confirm the patients' observation, adding that you do not believe this will interfere with your ability to work with them.

Q. What happens in insight therapy if the therapist's personality is authoritarian?

A. If the authoritarianism of the therapist interferes with the patients' ability to express hostility, and with their assertiveness, it will probably limit therapeutic goals.

Q. Is it possible that a therapist may develop a deep hate for certain patients?

A. If a circumstance like this develops in therapy, there is something seriously wrong with the therapist or the technique used. It is not possible for the therapist to like all patients to the same degree, nor is it possible to avoid disliking some patients temporarily in certain phases of treatment. When this happens, the therapist must resolve the untoward feeling before it interferes with therapeutic progress. If this is not possible, the therapist should

transfer the patients to another therapist and perhaps seek personal psychotherapy.

Q. Does a therapist ever fall in love with patients?

A. If such a situation develops, it is a manifestation of countertransference that will seriously interfere with the therapist's essential objectivity. Failure to analyze such a feeling and to resolve it will make it necessary to transfer these patients to another therapist.

Q. Does a therapist ever develop sexual feelings for patients?

A. It is possible that certain patients may arouse sexual feelings in the therapist. If this happens, such feelings must be subjected to self-analysis and resolved.

Q. Should not the conduct and attitudes of the psychotherapist be as passive and noncommittal as possible?

A. The idea that the therapist should remain detached and completely passive stems from the notion that this attitude will best demonstrate to patients how they automatically project onto the therapist attitudes and feelings that are rooted in past relationships. Not having done anything to incite their attitudes, the therapist is in a better position to interpret transference. The passive, detached attitude also is believed to avoid dependency and to throw the patients on their own resources. Experience shows, however, that the projections of patients, which are sparked by past distortions in interpersonal relationships, will emerge whether the therapist is passive or active. Patients with hostility problems will thus develop hostility toward the therapist who acts detached as well as toward one who acts accepting. If patients have dependency problems, they will get dependent on the most passive therapist. Rather than cripple the spontaneity of the therapist in the dubious quest of interpreting transference phenomena, or of mobilizing assertiveness, it is best for the therapist to act natural and not to assume artificial passivity if the therapist is not normally a passive person. Such an assumption may signify rejection to patients and, in mobilizing hostility, may interfere with the working relationship.

Q. Are not warmth and emotional support necessary for some patients?

A. Yes, especially when the patients' adaptive resources are at a minimum. Unfortunately, some therapists have been reared in the tradition of passivity and nondirectiveness to a point where they provide for patients a sterile, refrigerated atmosphere that, in seriously sick patients, is anathema to a working relationship.

Q. Is the assumption of a studied role by the therapist of any help in insight therapy?

A. It has been recommended by some authorities that the therapist play a deliberate role in insight psychotherapy that is at variance with the therapist's usual neutral, though empathic, position. Such role playing, however, may inspire intense transference that the therapist may be unable to control. As a general rule, the therapist should not transgress the defined role of a professional person who seeks to enable patients to help through self-understanding. An exception to this rule is an extremely experienced and skilled therapist who is thoroughly acquainted with the existing dynamics operative in a patient and who, by dramatizing a part and becoming actively involved in the patients' lives, strives to expedite change. Such activity is not without risks, but it may, in some cases, produce brilliant

results. On the whole, deceptive role playing is not to be recommended. Most patients quickly perceive the artificiality in the assumed part played by the therapist.

Q. What about role playing to provide patients with corrective emotional experiences?

A. One of the reasons that role playing with that aim is frowned on is that it is sometimes employed with incomplete evidence about what requires correction. Premature assumptions about factors responsible for patients' pathology, and about the dynamics of existing interactions with others, may be nothing more than guesswork. To act merely on such impressions is not only unscientific but also may be counterproductive. What could be most propitious is to observe patients in their actual life settings to study their interactions with people and examine their dreams, fantasies, and verbal associations. Since it is not possible to be with patients 24 hours a day and to observe them in their habitual environments, therapists have to rely only on fragmentary observations within the therapeutic situation. Some therapists believe that the therapist is playing a designed role with the patient in any case and that a specifically designed role offers the greatest opportunity for taking advantage of the limited time available. My own feeling about the active providing of patients with corrective emotional experiences is that good therapy in the medium of nonjudgmental and empathic attitudes, as well as reasonably accurate interpretations of transference, will do this without the therapists' disguising their true selves by playacting in a deceptive manner. This is not to depreciate artificial role playing when it is needed to practice more desirable responses or to probe repudiated attitudes and fantasies. But here the patients are aware that no deception is being employed and that the therapist is not putting on a false front by engaging in theatrical maneuvers.

Q. If the therapist acts consistently permissive and accepting, will this not in itself eventually reduce the patients' irrational responses to authority?

A. The behavior of the therapist, no matter how well controlled will, to some degree, always be subject to distortion in terms of the patients' conceptual framework, which, in turn, is based on their previous experiences with authority. This is not to say that gross deviations of behavior on the part of the therapist will not bring about appropriate reality-determined responses. A brusque, disinterested, detached, or hostile manner will produce untoward reactions in most patients. It must not be concluded, however, that absolutely correct activity and behavior will always bring about good responses, since patients may interpret the therapist's actions as a hypocritically conceived lure.

Q. Should deprivations ever by imposed on patients?

A. Occasionally, it is necessary to enjoin patients to deprive themselves of certain sources of gratification to help the exploratory process. Thus, patients with destructive sexual acting-out tendencies may be urged to control their sexual impulses so that tensions may accumulate that will facilitate an analysis of their problem. If patients are shown the reason for their need to give up certain pleasure promptings, they will be less inclined to resent the therapist.

Q. How would you handle overanxious and completely unreasonable patients who act more like children than adults?

A. It is essential to remember that though patients may be chronologically adults, emotionally they

may not have progressed beyond a childhood level. One may expect, therefore, childish tantrums, ambivalent feelings, unrestrained enthusiasms, and other reactions. If one can respect patients despite their unreasonableness, one will best be able to help them.

Q. What do you do when your relationship with patients starts getting bad?

A. All other tasks cease, and one must concentrate on bringing the relationships back to a satisfactory level. It is useless to explore patterns, to interpret and to engage in any other interviewing tasks so long as good rapport is absent. Essentially one must go back to the first phase of therapy and focus on reestablishing a working relationship.

Q. Why is the handling of transference important in reconstructive therapy?

A. Since much of the suffering of patients is produced by destructive transference involvements with people, part of the therapeutic task in reconstructive therapy is to put a halt to such reactions and to replace them with those that have a foothold in reality. If, for instance, patients respond automatically to authority with violent hate, as a result of an unresolved hatred toward a parent or sibling, their reactions may have a disorganizing effect on their total adjustment. Patients usually do not appreciate that this response to all authority is undifferentiated. They may not even be aware of their hate, which, considered to be dangerous in expression, becomes internalized with psychosomatic or depressive consequences. Liberation from such reactions is essential before patients can get well. This can best be insured in therapy by bringing them to an awareness of their projections. Several means are available to the therapist in executing this goal. First, on the basis of functioning in the role of an objective and impartial observer, one may help patients realize how many of their reactions outside of therapy have no reality base. Second, by watching for instances of transference toward the therapist, one may demonstrate to patients, often quite dramatically, the nature of those projections that constitute basic patterns.

Q. What is the difference between "transference," "transference neurosis," "parataxic distortions," and "positive relationship?"

A. Stereotyped early patterns, projected into the relationship with the therapist, were called by Freud "transference reactions." When these became so intense that patients acted out important past situations, this was known as a "transference neurosis." No satisfactory name was given to repetitive early patterns occurring with people outside of the therapeutic situation until Sullivan invented the term "parataxic distortions," which included all stereotyped patterns that developed inside or outside of therapy. A "positive relationship" usually refers to a good working relationship with minimal transference contamination.

Q. Isn't the accepted idea of transference as a manifestation of purely infantile or childish attitudes or feelings a restricted one?

A. Probably. A broader concept of transference would consider it to be a blend of projections onto the therapist of attitudes and feelings that date back to infancy and childhood, as well as more current attitudes that have had a formative influence on, and have been incorporated into, the character structure.

Q. Do all patients have to go through a transference neurosis in order to achieve very deep, structural

personality changes?

A. There is much controversy on this point, but experience shows that some patients can achieve extensive personality growth without needing to live through a transference neurosis.

Q. What activities on the part of the therapist encourage neurotic transference responses?

A. Dependency may be stimulated in patients by such therapist activities as overprotecting patients, making decisions for them, and exhibiting directiveness in the relationship. Sexual feelings in patients may be provoked by seductive behavior displayed toward the patients, by socializing with the patients, and by physical contact of any kind. Fearful attitudes and hostile impulses may be mobilized if the therapist acts excessively passive, detached, authoritarian, overprotective, hostile, pompous, or belligerent. It must, however, be remembered that transference may arise without any provocation whatsoever on the part of the therapist. This is the case when needs are intense and can be voiced and expressed due to the permissiveness of the therapeutic relationship.

Q. What is the best way of handling transference?

A. There is no best way; methods depend on the kind of therapy done and the therapeutic goals. Transference may not be explored or handled in supportive therapy. In reeducative therapy it may be immediately interpreted in an effort at resolution whenever it becomes apparent as resistance. In some types of reconstructive therapy it may be allowed to develop until it becomes so disturbing that the patients themselves achieve awareness of its irrational nature. In Freudian analysis it may be encouraged to the point of evolution of a transference neurosis.

Q. Are so-called "transference cures" ever permanently effective?

A. Structural personality changes rarely occur. A "transference cure," however, may permit patients to relate better to their life situations. This facilitates the development of more adaptive patterns that can become permanent.

Q. How does countertransference lead to an improper assessment of neurotic traits in patients?

A. Countertransference may cause the therapist to make incorrect interpretations of the patterns exhibited by patients. Thus, the therapist may, if welcoming hostile outbursts, regard these as manifestations of assertiveness rather than as destructive responses. If the therapist relishes a submissive, passive attitude on the part of patients, he or she may credit this to cooperation and to the abatement of neurotic aggression rather than to a neurotic need for compliance.

Q. Should you ever emphasize positive aspects of the patients' adjustment?

A. Therapists too often tend to regard patients as a repository of pathologic strivings, emphasizing these to a neglect of constructive traits, mention of which is very important in reinforcing constructive behavior.

Q. Is acting-out always a bad sign?

A. No. It may be a transitional phase in therapy indicative of a shift in the psychic equilibrium. Thus repressed, fearful individuals, realizing that they have been intimidated by an archaic fear of physical hurt for assertiveness, may become overly aggressive and act-out their defiance of authority as a way of combating their terror. Proving themselves to be capable of this expression without experiencing the dreaded punishment may enable them to temper their outbursts. In the same way, sexually inhibited people may become temporarily promiscuous, almost as if liberation from fear is tantamount with indulgence in sexual excesses. Incorporated also in the acting-out process are unresolved impulses and conflicts, in relation to early authorities, that have been mobilized by the transference. When the therapist becomes aware of acting-out, it is important that it be discouraged in favor of verbalization. As verbalizations replace impetuous acts and as understanding progresses, a more rational solution is found for neurotic drives and impulses.

Q. How do the value prejudices of therapists interfere with treatment?

A. Whether intentional or not, therapists will accent in the interview attitudes and feelings that are in line with their value systems, and will minimize those that are opposed to it. If, for instance, therapists have a problem in their relationships with authority, manifesting submission and ingratiation, they may overvalue these traits. They may then tend to discourage assertiveness or aggressiveness when patients seek to take a stand with authority. Therapist may credit this philosophy to "good common sense" and justify it in terms of the benefits that accrue. This may seriously inhibit patients from working through neurotic feelings toward authority. On the other hand, if therapists themselves react to authority with aggression and hostility, they may inspire defiance or promote aggressive attitudes toward authority figures, which may seriously endanger the patients' security.

Q. What do you do with patients who break or cancel appointments consistently?

A. This can be a disturbing problem since consistency in attendance is vital to good therapy. Should confrontation and discussion fail to resolve this problem, the therapist may suggest discontinuance of therapy. If, as in a clinic, the therapist is obliged to see patients irrespective of the latter's motivation, the therapist may insist on the patients' calling for an appointment when they want to be seen. In this way the burden of stopping therapy is put on the patients, and if there is any motivation at all, the patients may "shape up."

Q. Shouldn't therapists be trained in all therapeutic approaches?

A. The most effective therapists are those who can implement whatever therapies are indicated, whether these are of a supportive, reeducative, or reconstructive nature. If therapists have a broad understanding of various therapeutic procedures, know how to execute them, and are sufficiently flexible in personality so as not to be tied to a single treatment process, they will score the greatest therapeutic successes. This, however, is an idealistic situation. Most therapists learn only one kind of technique, which enables them to handle only a certain number of problems—those which are amenable to their technique. They may also be limited by their character structure so as to be unable to use certain techniques. For instance, a therapist may be an essentially passive person and, on this account, be unable to employ the directiveness and authoritativeness of approach essential for symptom removal, reassurance, guidance, persuasion, environmental manipulation, and other supportive therapies. On the other hand, the therapist may be so extremely authoritarian and dogmatic that patients may not be allowed to make mistakes, work out their own problems, or

establish their own sense of values, so essential in reconstructive therapy.

Q. Is there any consistency in therapeutic focus among therapists appraising the same patients?

A. A therapist's judgment concerning existing core problems involves speculations that are not always consistent with what another therapist may hypothesize. Given the same data, different therapists will vary in choosing what is significant. In a small experiment I conducted, three experienced therapists trained in the same analytic school witnessed the first two sessions conducted by a fourth colleague through a one-way mirror. Each therapist, including myself, had a somewhat different idea of what meaningful topic was best on which to focus. But such differences, in my opinion, are not significant. Even if one strikes the patient's core difficulties tangentially, one may still register a significant impact and spur patients on toward a better adaptation. After all, reasonably intelligent patients are capable of making connections and even of correcting the misperceptions of a therapist when a good working relationship exists and the therapist does not respond too drastically with wounded narcissism when challenged or corrected.

Q. Is not insight a basic factor in all therapies?

A. Insight on some level is helpful in all therapies. Even in supportive therapy, an understanding of the existing environmental encumbrances may eventually lead to a correction of remediable difficulties or to an adjustment to irremediable conditions. In reeducative therapy knowledge of the troublesome consequences of existing behavioral patterns may ultimately sponsor a substitution with more wholesome interpersonal relationships. In reconstructive therapy insight into unconscious conflicts, and their projected manifestations into everyday life, encourages patients toward actions motivated more by the demands of reality than by the archaic needs and fears of their childhood. Obviously, insight alone is not equivalent to cure.

Q. What is the difference between the level of insight effectuated in reeducative therapy and the kind in reconstructive therapy?

A. In reeducative therapy an inquiry is conducted into conscious and preconscious drives, impulses, feelings, and conflicts with the object of suppressing or changing those that disorganize behavior and of encouraging others that expedite adjustment. In reconstructive therapy the exploratory process deals with the more unconscious drives and conflicts. Due to the intensity of repression, one must implement the inquiry through examination of, and the inculcation of insight into, derivatives from the unconscious as revealed in verbal associations, dreams, fantasies, slips of speech, and transference. The object in reconstructive therapy is to liberate individuals as completely as possible from anachronistic values, attitudes, strivings, and defenses and to remove blocks to personality growth.

Q. What is the best kind of therapy to use when the sole object is symptom relief or mere control of certain obnoxious personality traits?

A. The objective in the treatment effort may be limited to the restoration of habitual controls to individuals, to the mediation of any continuing environmental stress, and to the modification of strivings and goals that are inimical to the patients' well-being or that are beyond their existing potentialities. Through the use of supportive and conditioning

techniques, and by fostering an awareness of some of their character distortions and strivings, these objectives may be accomplished in a satisfactory way. There are, however, some conditions when character structure is so disturbed, and when elaborated crippling mechanisms of defense are so tenacious, that even the objective of mere symptom relief presupposes an extensive exploration of aspects of personality that have been repressed. This will necessitate reconstructive approaches.

Q. Is it possible to do reconstructive therapy on the basis of once-a-week sessions?

A. The effectiveness of therapy is dependent upon factors more important than the number of times each week patients are seen. Reconstructive therapy is possible in some patients on the basis of sessions once weekly; it is not possible in others. Great skill is required to bring about reconstructive changes when there are long intervals between visits. When a transference neurosis is to be created, four to five sessions weekly will be needed.

Q. What is the difference between an apparent and a permanent recovery as related to reconstructive therapy?

A. An apparent recovery is mere restoration to the premorbid level with the strengthening of the defensive techniques that have served, prior to illness, to maintain the ego free from anxiety. A permanent cure involves a real alteration of the ego to a point where those compromising defensive attitudes and mechanisms are no longer necessary to keep it free from anxiety. Under these circumstances, individuals are capable of gratifying their basic needs and strivings without undue conflict. Recovery in psychotherapy is permanent only insofar as it produces a real change in the character structure of individuals and a reorientation of their relationships with others and themselves. Due to the operation of resistances that blanket offending impulses, and because of repressions that keep from awareness the most important problems of the individual, reconstructive psychotherapy offers the greatest chance of overcoming a severe emotional difficulty.

Q. What would you consider an acceptable minimal goal in reeducative therapy?

A. The least we can do for patients is to bring them to as great an awareness of their problems as is reasonably possible, to enable them to lead as useful, happy, and constructive lives as they can with their personality and environmental handicaps, to help them overcome remediable life difficulties and adapt to irremediable ones, and adjust their ambitions to their existing capacities.

Q. What is the difference between a "normal" and "neurotic" person?

A. "Normality" is a social designation that embraces characteristics not entirely consonant with a definition of mental health. Average "normal" people in a culture possess many neurotic drives that are sanctioned and perhaps encouraged by society. Although these drives nurture some anxieties, "normal" individuals are still capable of functioning and of making a satisfactory social adjustment. If people are no longer able to adjust themselves and begin to manifest excessive anxiety and maladaptive mechanisms of defense, they may be classified as "neurotic." In therapy the objective may be to restore the individual's social adjustment and their "normal" neurotic tendencies. A more extensive objective, however, would be a correction of all neurotic traits, even those condoned as "normal," which is more idealistic than realistic.

Q. If ideal goals of complete reconstruction are impossible, what would be reasonably good goals in reconstructive therapy?

A. It is manifestly impossible for any one individual to reach the acme of emotional maturity in every psychic and interpersonal area. One may decide that a satisfactory result has been achieved when patients lose their symptoms, abandon their disturbing neurotic patterns, deal with their difficulties spontaneously without needing help from the therapist, manifest productivity and self-confidence, show absence of fear following expression of assertiveness, and exhibit an improvement in their interpersonal relationships with increased friendliness and respect and lessened suspiciousness, detachment, aggression, and dependency.

Q. In interviewing patients, should a therapist disclose intimate personal facts as a way of positively influencing the therapeutic relationship?

A. Studies of the effects of self-disclosure on the part of the therapist are inconclusive insofar as their influence on the relationship is concerned. The results cannot be predicted in advance. Depending on their personalities, patients may respond to a therapist's revelations positively ("My therapist is marvelously human," "He does not present himself as a flawless god," "She trust me by revealing these intimacies") or negatively ("This person has such weaknesses that I'm not sure she can help me," "If he can't help himself, how can he help me?"). Some research studies do indicate that therapist self-disclosure facilitates patient self-dis-closure and greater therapist trustworthiness (Bierman, 1969; Sermat and Smyth, 1973). My personal view is to use self-disclosure very sparingly and only when it does not point to severe neurotic problems in the therapist. It may, for example, be employed to show how a therapist handled a problem or situation akin to that confronting patients, thus enhancing modeling.

Q. How do therapists' personalities influence their techniques?

A. Therapists eventually evolve their own therapeutic method, which is a composite of the methods they have learned, the experiences they have had, and their specific personality traits. For instance, analytically trained therapists, inclined by personality to be authoritarian, may be unable to maintain the traditional silence and passivity demanded by classical psychoanalysis. To do so robs them of spontaneity; it provokes tension and prevents them from exhibiting the kind of relaxed objectivity that is most helpful in treatment. They may find it necessary to abandon passivity and to permit themselves to participate more actively in the treatment process. Their patients will perhaps respond to this change in a gratifying way and react more positively than when the therapists were behaving in a stultified manner. This success may encourage the therapists to be themselves, and they will probably find that their results continue to justify their alteration of technique. For them, then, the shift is justified since it liberates them from acting in an artificial, inhibited way. Yet other therapists may not be able to do the same thing; for instance, those who by personality are more retiring, quiet, and unobtrusive. For them the passive technique will probably work well; to attempt to force activity would be as artificial as to expect active therapists to assume a feigned passivity.

Q. How do you explain the misunderstanding that exists among the different schools of psychiatry and psychology?

A. In so virgin a territory as the uncharted psyche, a diversity of theories, interpretations, and methods may be expected. A great deal of animosity has, however, unfortunately come to the surface among groups with divergent points of view. Splinter societies have erupted, justifying their break with the parent body on the basis of discrimination and lack of academic freedom in the older organization. Sparked at first by the impulse to create groups possessed of scientific liberalism, a number of the splinter organizations have, upon achieving independence, then practiced the same intolerant bigotry that initiated their secession, developing their own dogmas and rejecting original thinking among the members. Such entrenched and reactionary attitudes are to be condemned in any scientific group.

Q. Should a good therapist be able to cure or help all patients?

A. No matter how highly trained the therapist may be, some patients will be able to be helped more than others. There will be certain patients therapists will not be able to treat—patients whom other therapists may successfully manage. On the other hand, therapists will probably be able to cure some patients with whom other therapists have failed. Therapists will make some mistakes during the course of therapy with all of their patients, but these mistakes need not interfere with ultimate beneficial results. Finally, therapists will be rewarded by a large number of successes, but they will also have their quota of failures.

Q. Does it follow that psychoanalytically trained therapists will do better therapy than those who have not been analytically trained?

A. It is fallacious to assume that non-analytically trained therapists are incapable of doing many kinds of psychotherapy as well as those who have been analytically trained. If therapists plan to do reconstructive psychotherapy, however, using dream interpretation, transference, and resistance, they will be helped by sound training in reconstructive therapy, including a personal analysis.

Q. Must the therapist be completely free from neurosis?

A. It is doubtful that any person in our culture is entirely free from neurosis, no matter how much personal psychotherapy has been undergone. To do psychotherapy, however, therapists must be sufficiently free from neurosis so that their own personal problems do not divert the relationship from therapeutic goals.

Q. Will personal psychotherapy or psychoanalysis guarantee good functioning on the part of an adequately trained therapist?

A. In most instances it will. Serious personality difficulties may in some cases not be resolved to a point where individuals will be able to function as therapists, however, although they might work satisfactorily in some other field. In other words, where their egos have been so damaged through a combination of constitutional predisposition and traumatic life experiences, individuals may not, even with extensive psychotherapeutic help, be able to achieve that kind of personality flexibility, objectivity, sensitivity, and empathy that are prerequisite for functioning as an effective psychotherapist.

Q. Why should not psychotherapy or psychoanalysis be able to resolve the neurotic problems of psychotherapists, since they actually are not as sick as most patients and should benefit

greatly from psychotherapeutic help?

A. The motivation to carry out psychotherapy, which is what inspires many therapists to seek personal therapy, may not be sufficient to enable therapists to endure and to work through the anxieties underlying their character distortions. For instance, the individuals may, prior to their determination to become therapists, have been functioning in a more or less detached manner, removing themselves from disturbing interpersonal situations periodically when these had become too difficult to handle. Under ordinary circumstances, and in average relationships, they would be able to function quite effectively with this kind of a defensive attitude. This detachment, however, may seriously affect their capacity to operate in a therapeutic interpersonal relationship, in which they will constantly be brought into contact with critically disturbed people who will seek to extract from them constructive responses they may be unable to give. A tremendous amount of personal psychotherapeutic work may be required before therapists will be able to give up their detachment as an interpersonal defense. If they do not have sufficient anxiety to incite them, however, to seek new modes of adjustment, they may not have the incentive to tolerate the great amount of work and suffering that will be involved in effecting a reconstructive change in their own personalities. Consequently, in their personal therapy, they will keep warding off the deepest character change and may go through their treatment without significant modification of their detachment. The fact that many therapists have exposed themselves to extensive personal therapy or psychoanalysis and have emerged from it without any basic character changes is no indictment of psychotherapy. Rather, it is an indication of how difficult it is to treat certain kinds of emotional disturbance without adequate motivation. In other words, the desire to become a psychotherapist is not in itself sufficient motivation to promote deep character change.

Q. What can therapists do whose personality problems interfere with their executing good psychotherapy even after they has gotten extensive personal therapy and supervision?

A. If a qualified supervisor finds that the supervisees' problems are interfering with their therapeutic effectiveness, the supervisees may be advised to seek further personal psychotherapy. Should no change occur, it may be necessary for the therapists completely to give up psychotherapy as a career. They should not regard this as a personal defeat or as a sign of devaluated status, since they will probably be able to function very effectively in another role. For example, psychiatrists may decide to do diagnostic, institutional, or other kinds of work that do not bring them into an intimate therapeutic relationship with patients. Caseworkers can confine activities to an agency organized around areas other than therapeutic services. Psychologists can restrict functions to diagnostic testing, research, vocational guidance, and counseling.

Q. Don't you believe that every therapist should learn the principles of preventive mental health in addition to knowing how to do psychotherapy?

A. Mental health needs are only partially served by an exclusive program of psychotherapy. This is because the impact of emotional problems on the lives of people so often reflect themselves in disturbances in work, family, marital, interpersonal, and social relations without causing collapse in adaptation characteristic of neuroses. The providing of help for these preclinical problems requires an ability to consult with, and to supervise, community workers and professionals such as social workers, teachers, nurses, physicians, psychologists, correctional workers, and ministers, who are unable to handle such problems alone. It is advisable that every therapist be acquainted with the principles of preventive mental health

and know how to communicate well with community agencies and the ancillary professions.

Q. What do you do if you make an outlandish error like forgetting patients' ages or marital status?

A. Being human, therapists will, from time to time, unintentionally commit some blunders. They may forget patients' ages, details about their families, or items in the history that patients have already recounted. Distracted, the therapist may even forget the patients' first names. Sometimes a more flagrant blunder may occur, such as calling patients by the wrong name, or asking them if they have dreamed recently, when they already have in the first part of the interview recounted a dream. Should such slip-ups happen, there is no need to conceal them or to be too apologetic. Therapists may merely say: "Of course, you told me this" (or "1 know this") or "It just temporarily slipped my mind." Patients will not make too much of such errors if a good relationship exists. At any rate, it may, if it seems indicated, be important to explore the patients' feelings immediately upon commission of a mistake.

Q. Should psychiatrists do physical examinations if necessary?

A. Psychiatrists will probably not be as skilled in diagnosis as the internists to whom they can refer patients needing medical treatment. A physical examination in any therapy other than psychoanalysis, however, theoretically need not interfere with the therapeutic process, if the patients' reactions to it are examined and explored. It may bring many interesting and important feelings to the surface.

Q. Should two therapists, each working on separate members of the same family, confer?

A. A conference may be helpful to clarify the patient's interactions with the other member and to check on data significant to both. Usually, however, this is not routine. If it is done, each therapist should be mindful of personal competitiveness with and need to impress the other therapist and of defensiveness regarding the patient's progress.

Q. What is multiple therapy, and does it have a use?

A. Multiple therapy is the treatment of a single patient or a group by two or more therapists. It is preferred by some therapists in the management of difficult patients, such as psychotics and psychopaths. Differences in opinion and transference reactions between the therapists will require careful handling, sometimes within and sometimes outside of the therapeutic session. There may be advantages in employing multiple therapy in cases that do not respond to conventional treatment.

Q. Does not behavior therapy circumvent transference and other resistances?

A. Behavior therapy possesses ingredients that are common to all psychotherapies. Inaugurated almost immediately is a relationship, patients responding to the therapist as an idealized authority who holds the key to their well-being. The trinity of faith, hope, and trust, while not openly expressed, are aspects that cannot be avoided. The placebo element is as much a component of behavior therapy as it is of any other kind of treatment. Factors of motivation and dyadic group dynamics undoubtedly come into play and act as accelerants or deterrents to progress. If readiness for change is lacking, one might expect a negative result in behavior therapy. Subtly, transference will be set into motion, no matter how assiduously

the behavior therapist attempts to avoid it, and resistances of various kinds will rear their obstructive heads at almost every phase of the therapeutic operation. Some behavior therapists refuse to acknowledge the presence of these intercurrent elements, though this obviously will not negate their influence.

Q. If psychological tests indicate that particular patients are very sick, shouldn't you approach them carefully in therapy, and isn't this a sign that your goals have to be superficial ones?

A. One may be forewarned about the strength of the individuals' egos from psychological tests, but this should not prejudice the treatment process. One of the disadvantages of testing is that it puts a label on patients the therapist may be reluctant to remove, even though the therapist's clinical judgment disagrees with the test findings. The therapeutic relationship is a better index of how deep one may go in therapy and the extensiveness of goals to be approached than any psychological test or battery of tests.

Q. Isn't it difficult at present to develop a real science of mind because of the many divergent ideas about psychodynamics?

A. The subject of psychodynamics opens up many founts of controversy because authorities with different orientations have different ways of looking at psychopathological phenomena. Irrespective of orientation, one can always find data that seems to substantiate one's particular point of view. The same interview material may thus be variously interpreted by several observers. Some regard it as confirming their theory that neurosis is essentially a clash between instinctual strivings and the environment. Others as enthusiastically demonstrate cultural forces as the primary provocative agent. Still others may find in the material evidence that neurosis is fostered by disturbances in the integrative functioning of the ego. Such divergent ideas are not too serious; they are to be regarded as the inevitable forerunners of a real science of mind. In the study of the uncharted psyche, theories in abundance were bound to emerge, supporting many rifts and controversies. Fortunately, the beginnings of amalgamation are occurring, an honest effort to blend the findings of the various schools into a body of knowledge shorn of prejudice and bias.

Q. Is it possible for a therapist to be supervised by several different supervisors who espouse different theoretical viewpoints?

A. Unavoidable, particularly in an eclectic atmosphere, is the fact that student therapists will be supervised by several supervisors whose approaches reflect wide theoretical differences. It is to be expected that these divergencies will mobilize insecurity in students who are seeking a definite structure in theory and process. The function of the good supervisor is to help students see that different views merely expose contrasting aspects of the same phenomenon. These multiform facets may seemingly conflict with each other, though they are actually constituents of a unified whole. One must handle the students' disappointments that everything does not harmonize and fit together into a master plan. Should their anxiety prove too great, students may need special, even psychotherapeutic, help. Appreciating that other points of view exist is one of the most important contributions of the supervisor. Only a supervisor who is sufficiently secure not to regard differences in approach as interferences and can view them as a challenge toward further scientific inquiry will be able to render the kind of help that students need and have a right to expect.

Q. Can dependent patients progress in therapy beyond the goal of achieving freedom from symptoms?

A. It is sometimes contended that if patients seek guidance and an authoritarian relationship in therapy their mental set will prohibit their entering into the participatory mode of activity essential for deeper therapy. Their desire for paternalism, it is said, will block essential collaboration. This is not always correct. The majority of patients, even those who have read tomes on psychoanalysis, seek a relationship with a strong, idealized parental figure who can lift them out of their distress. The stronger the anxiety, the greater the expectation. The task of the therapist is to promote a shift in motivation toward expanding the patients' inner resources and working cooperatively with the therapist. A fundamental task in all therapy is to promote the conviction in patients that they have the inner resources to resolve feelings of helplessness. Good technique in psychotherapy takes this factor into account. Understandably, there are some characterologically dependent souls and borderline patients so inwardly damaged that they will need a dependency prop in order to function. No amount of therapeutic work will deviate them from this aim. But even here the therapist owes it to the patients to make an effort to promote greater self-sufficiency. Patients may diagnostically be written off as candidates for reconstructive psychotherapy in view of the depth of their disturbance, their habitual infantile relationships with people, wretched past conditionings with emotionally ill parents, uncontrollable acting-out propensities, paranoic ideas, and so forth. On this basis, a supportive relationship is provided the patients, only to find that they press for deeper self-understanding. Yielding to this pressure, the therapist may institute reconstructive treatments, helping some to rise out of their dependent morass and to use their understanding toward great self-actualization.

Q. Are there any diagnostic signs that will indicate how patients will actually respond to psychotherapy?

A. Very few diagnostic or other rules can be laid down to anticipate patients' responses to therapy. The only true test is the way patients take hold of the opportunity offered them in psychotherapy to approach their lives from a different perspective. Trial interpretations may be instituted to determine how patients will respond in the relationship. Will they deny, resist, fight against, or accept the interpretation, and will they act on it?

Q. What is the effect on patients of passivity in the therapist?

A. Passivity on the part of the therapist may produce frustration and anxiety, which, if not too intense, may mobilize patients to think things through for themselves and to act on their own responsibility. Should excessive hostility and anxiety be engendered, however, or should patients interpret the therapist's passivity as rejection or incompetence, it may have a paralyzing effect on their progress. This is particularly the case when patients, in their upbringing, have been victimized by a neglectful or uninterested parent who put too much responsibility on their immature shoulders. The therapeutic situation then will merely tend to recapitulate the early traumatizing experience and reinforce the sense of rage and helplessness.

Q. Should a trial period be instituted in psychotherapy to see how patients will react?

A. Freud [1913] originally recommended that a trial period of a week or two be instituted to see if patients are suitable for psychoanalysis. A trial period is more or less inherent in all psychotherapeutic endeavors. Patients and therapists mutually survey one another to see whether they feel comfortable and confident about working together. Patients test

therapists. Does the therapist like them? Does the therapist have confidence in them? Does the therapist trust them? The therapist subjects patients to an empirical scrutiny. Can he or she interact with the patients? Are the patients properly motivated, and if not, how can incentives be developed? Are patients operating under misconceptions about treatment? How far will they be able to go in therapy—toward symptom relief? Toward reconstructive personality change? The therapist may, during this trial phase, make a few interpretations to test the patients' receptivity, flexibility, and capacities for change. At the same time that ground rules are established; a working hypothesis is laid down, and the beginnings of treatment are instituted. Reformulations of this early hypothesis will have to be made periodically in accord with the patients' reactions, resistances, and rate of movement.

Q. Shouldn't therapists always remain neutral?

A. Therapists as human beings have feelings, values, prejudices, and needs. They will reveal these to patients sooner or later, if not verbally then nonverbally, both directly in their interpretations and indirectly in their silences, pauses, content of questions, and emphasis. While ideally therapists should avoid prejudicial pronouncements, they should not deceive themselves into thinking that they can always maintain a neutral stand. Nor is this desirable. It may be quite suitable to apply value pressure where it is needed and sometimes, as in patients' acting-out proclivities, it is the only tactic that makes sense. Though maintaining the philosophy that patients have an inalienable right to their points of view, decisions, and behavioral twistings and turnings, therapists do not need to accept the validity of some ideas and actions. There is no such thing as true "neutrality" in therapists. Otherwise they would not care whether patients remained sick or got well. Therapists have opinions and prejudices. They will display these in one way or another, if not one day then the next.

Q. Are there differences among psychoanalysts regarding the use of activity as opposed to passivity in psychoanalysis?

A. Polemics have been organized around the matter of activity versus passivity. On the one hand there are purists like Glover who defend the sanctity of the passive classical procedure. There are nonpurists, like Franz Alexander, who insist that the rejection of activity can only lead to therapeutic stagnation. Activity is generally eschewed in the classical technique on the basis that it tends to produce a refractory and insoluble as opposed to an ameliorative transference neurosis (Mitchell, 1927). Since the time of Ferenczi (1950b, 1950c) who instituted "active" approaches, many analysts have introduced manipulations that to Glover (1964) exceed the limits of pure analytic practice on the basis that "deliberately adopting special attitudes and time restrictions for special cases changes the character of therapy in these cases, converting it into a form of rapport therapy." Although such methodological innovations may produce excellent results and even be the best therapy for cases inaccessible to the customary technique, they should not be confused with "psychoanalysis" in which one analyzes and does not manipulate the transference. Supporting rigidity in approach, Glover avows that "flexibility in both psychoanalytic theory and practice has in the past been a frequent preamble to abandonment of basic principles." Passivity and the adoption of a "blank screen" are advocated as the best of deliberately nurtured attitudes to reduce complications. On the other hand, there are analysts who disagree with Glover, recommending modifications in method from the manipulation of the transference to the open exhibition of interest in and modulated demonstrations of affection toward the patient (Bouvet, 1958; Eissler, 1958; Nacht, 1957, 1958). Commenting on the fact that few cases of simple transference neurosis are seen in practice, Lorand (1963) points out that

psychoanalytic technique today "is quite different from that of earlier periods of analysis." Unless active interference is used in certain cases, for example in character disorders and infantile patterns of behavior, the analysis may stagnate or break down. Obviously, it is impossible at all times to adhere to the basic rules of psychoanalysis. Directiveness and active interference are sometimes essential, especially during stages of resistance "where the standard technical methods are of little help." Such variations in technique within the framework of classical psychoanalysis may be used to further therapeutic progress. The "dosing" of interpretations may also be necessary to activate the unconscious, to eliminate defenses as well as to prevent their too ready emergence. In a past contribution, Glover (1955) himself considered *complete* neutrality a myth and wondered whether adhering to the rule of not making important decisions was really desirable. When deviations from classical technique are in order, however, they must, he insisted, be dictated by the needs of the situation and not by countertransference. In practice, modification of analytic rules is frequently necessary. But whether we should label such deviations as "psychoanalysis" is another matter. There would seem to be some justification in restricting the term "psychoanalysis" to the classical technique and to entitle procedures incorporating modifications and active interventions as "modified psychonanalysis" or "psychoanalytically oriented psychotherapy."

Q. What is the theory behind cognitive therapy, and does it have utility?

A. The theory underlying cognitive therapy is that people are dragooned into maladaptive actions by distortions in thought that they can both understand and control; within themselves they possess capacities for awareness of such understanding and solution of their difficulties. Therapeutic techniques organized around this hypothesis are directed toward correcting deformities in thinking and developing alternative and more realistic modes of looking at life experiences. It is said that this is a much more direct approach to problems than other approaches since it draws on patients' previous learning encounters. Interventions are aimed at rectifying misconceptions and conceptual flaws that are at the basis of individuals' difficulties. This technique involves explorations of the stream of consciousness with the object of modifying the ideational content associated with the symptoms. Among the basic assumptions here are that the quality of therapists' thinking will inevitably influence the prevailing mood and that the *meaning* of a stimulus to patients is more important than the nature of the stimulus itself.

There is a good deal of overlap of cognitive therapy with behavior therapy. Albert Ellis (1962, 1971) in his rational-emotive therapy pioneered cognitive approaches in a behavioral setting. Meichenbaum (1977) attempts to blend cognitive-semantic modification with behavioral modification. Aaron T. Beck (1976) has written extensively on cognitive therapy and has claimed advantages for it in treating depression over all other therapeutic methods, including drug therapy. A new magazine, *Cognitive Therapy and Research* (Plenum), is devoted to explicating the role of cognitive processes in human adaptation and adjustment. Whether cognitive therapy is useful for therapists depends on their skill and conviction and the special learning capacities of individual patients.

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Recording in Psychotherapy

Satisfactory recording is conducive to good psychotherapy. It acts as discipline for the beginning therapist. It is helpful even to experienced therapists, facilitating the following of the progress of a case and helping in the rendering of a report. It is indispensable for purposes of research (Wolberg, LR, 1964b).

Except in those clinics where an ample budget provides dictating facilities and secretarial services, records of patients receiving psychotherapy are apt to be pitifully sparse. To some extent this is due to the absence of an organized routine recording system. Additionally, note taking during the treatment session is distracting to therapists and annoying to some patients. Of utmost value, therefore, would be a recording system that is both simple to follow and not too disturbing to patients.

Most patients expect that some kind of record will be kept. They usually accept note taking during the initial interview and do not object to occasional notes being written during later sessions. If objections are voiced, these may be dealt with by an explanation to the effect that the keeping of a record is helpful in following patient's progress. Should the patient continue to object to notes being taken during sessions because this is much too distracting, or should the practice distract the therapist, a note may be entered into the record following each session. If fear is expressed that confidential material may be read by another person, the patient may be informed that under no circumstances will the record be released, nor any information divulged, even to the patient's family physician, unless the patient gives written permission for this. Excellent outlines and suggestions for recording may be found in the books by Menninger (1952b) and Beller (1962).

CASE RECORD

The case record should minimally contain the following data: (1) statistical data

sheet, (2) initial interview, (3) daily progress notes, (4) monthly progress notes, (5) termination note, (6) summary, and (7) follow-up note.

Statistical Data

Basic statistical data include the following:

1. Patient's name

2. Address, home and business telephone

3. Age

4. Sex

5. Marital status, how long married, previous marriages, ages and sex of children

6. Age and occupation of mate

7. Education

8. Occupation, salary, sources of income if unemployed

9. Military record

10. Referral source

These data may be entered on a separate sheet or on a form (see Appendix A), or the first sheet of the initial form interview (see Appendix C). A more complete statistical form, which is useful in clinics, is illustrated in Appendix B.

Sometimes the patient may be asked to fill out certain questionnaires to help get statistical data without taking up too much of the therapist's time. Short forms are included under Appendix D, which is a Personal Data Sheet, and Appendix E, which is a Family Data Sheet. In using these forms, the Personal Data Sheet is given to the patient to fill out immediately prior to the initial interview. The Family Data Sheet is filled out after the therapist has accepted the patient for treatment.

Initial Interview

The data to be included in the recording of the initial interview are the following:

1. Chief complaint

2. History and development of complaint

3. Other symptoms and clinical findings

4. Patient's attitudes toward family members

5. Previous emotional upsets

6. Previous treatment

7. Estimate of existing insight and motivation

8. Tentative diagnosis

9. Tentative dynamics

10. Disposition of the case

A convenient initial interview form is included under Appendix C, the first sheet of which is for statistical data.

Daily Progress Notes

At the end of each session, the date and a brief note, which may consist of no more than one sentence, should be entered on a progress note sheet. This should contain the dominant theme of the session. Other entries may include the following:

1. Present state of symptoms or complaints (absent, improved, the same, worse)

2. How the patient feels (anxious, placid, depressed, happy)

3. Important life situations and developments since last visit and how they were handled

4. Content of the session

5. Significant transference and resistance reactions

6. Dreams

Since the wording of the patient's dreams is important, it is best to write dreams down during the session while they are related by the patient.

Appendix F is a convenient form for progress notes.

Monthly Progress Notes

A summarizing monthly progress note is of value in pulling together the events of the month. This may be a succinct recapitulation of what has been going on in treatment. In clinics where supervision of the total caseload is essential, a monthly progress summary (such as illustrated under Appendix G), which is routinely reviewed by the supervisor, may make for a more efficient kind of reporting.

Termination Note

A termination note is important and contains the following:

1. Date of initial interview.

2. Date of termination interview.

3. Reason for termination.

4. Condition at discharge (recovered, markedly improved, moderately improved, slightly improved, unimproved, worse)

5. Areas of improvement (symptoms, adjustment to environment, physical functions, relations with people)

6. Patient's attitude toward therapist at discharge

7. Recommendations to patient

8. Diagnosis

A termination form will be found under Appendix H.

Summary

The summary should contain the following information though curtailed.

1. Chief complaint (in patient's own words)

2. History and development of complaint (date of onset, circumstances under which complaint developed, progression from the onset to the time of the initial interview)

3. Other complaints and symptoms (physical, emotional, psychic, and behavior symptoms other than those of the complaint factor)

4. Medical, surgical, and, in women, gynecologic history

5. Environmental disturbances at onset of therapy (economic, work, housing, neighborhood, and family difficulties)

6. Relationship difficulties at onset of therapy (disturbances in relationships with people, attitudes toward the world, toward authority, and toward the self)

7. Hereditary, constitutional, and early developmental influences (significant physical and psychiatric disorders in patient's family, socioeconomic status of family, important early traumatic experiences and relationships, neurotic traits in childhood and adolescence)

8. Family data (mother, father, siblings, spouse, children—ages, state of health, personality adjustment, and patient's attitude toward each)

9. Previous attacks of emotional illness (as a child and later). When did patient feel completely free from emotional illness?

10. Initial interview (brief description of condition of patient at initial interview, including clinical findings)

11. Level of insight and motivation at onset of therapy (how long ago did the

patient feel that treatment was needed? for what? awareness of emotional nature of problem, willingness to accept psychotherapy)

12. Previous treatments (when did the patient first seek treatment? what treatment was obtained? any hospitalization?)

13. Clinical examination (significant findings in physical, neurologic, psychiatric, and psychologic, examinations)

14. Differential diagnosis (at time of initial interview)

15. Estimate of prognosis (at time of initial interview)

16. Psychodynamics and psychopathology

17. Course of treatment:

   (a) Type of therapy employed, frequency, total number of sessions, response to therapist

   (b) Significant events during therapy, dynamics that were revealed, verbatim report of important dreams, nature of transference and resistance

   (c) Progress in therapy, insight acquired, translation of insight into action, change in symptoms, attitudes, relationships with people

18. Condition upon discharge (areas of improvement, remaining problems)

19. Recommendations to patient

20. Statistical classification

A summary form with spaces for the

above items will be found under Appendix I.

Follow-up Note

A note on follow-up visits, or the inclusion of follow-up letters from patients, helps the therapist to evaluate the effectiveness of treatment. A follow-up letter may be mailed

out 1,2, and 5 years after therapy. A form letter such as the following may be used:

> Dear_:
>
> In the past year I have wondered how things were progressing with you. Would you drop me a note telling me how you feel, and indicating any new developments. You may perhaps want to comment on your experience in treatment and how this was of help to you.
>
> Sincerely yours,

Case Folder

A manila folder is advisable to hold the case record of the patient. The name of the patient is written on the flap, and, if the patient is being treated in a clinic, the case number is also entered. Some therapists prefer a folder that has several pockets that may be used for correspondence in relationship to the patient, as well as for detailed notes. Under Appendix J, there is a folder the writer has found useful in private practice as well as in clinic practice. Printed on the front of an ordinary folder are spaces for entry of the date of each visit, payments made, and certain items that are pertinent to the treatment of the patient. It is a simple matter of only a few seconds to check on the total number of visits, the number of broken or cancelled appointments, the payments that have been made, and the dates of completion of the statistical data sheet, initial interview, monthly progress notes, consultations (psychiatric, medical, psychological, and casework) if these were obtained, tests administered by the therapist, or others, termination note, summary and follow-up notes. There is space also for entry of supervisory sessions if these were obtained in relation to the patient. Printed on the back of the folder are lines for entry of dates for more visits if the space on the front of the folder is not sufficient.

Miscellaneous Enclosures

Included in the case record, in addition to the above data, are other notations and forms used by the therapist, such as psychological test results, notes on medical and other consultations, detailed notes made by the therapist, written comments and notes by the patient (see Appendix S), and correspondence in relation to the patient.

The flexibility of computers in selection, orderly storage, and rapid recovery of data —beyond the capacities of human performance—puts them in the forefront as instruments for research in the mental health field, not only for the calculating of results in experiments designed around specific hypotheses but also in delineating trends and significant information and in generating new hypotheses (Cappon, 1966). Computer programs capable of carrying out principle components factor analysis with varimax rotation may measure clinical change with greater objectivity and probable reliability than other methods (Cole, 1964). By proper programming it may be possible to ask computers to make decisions between alternate futures, thus expediting the predictability of human behavior.

Electrical Recording in Psychotherapy

The employment of videotape recorders (see also Videotape Recording) has also introduced a new dimension into psychotherapeutic recording, with vast potential for teaching and the expediting of treatment (Alger and Hogan, 1969; Berger MM, 1970; Czajkoski, 1968; Danet, 1969; Melnik and Tims, 1974; Stoller, 1967, 1969; Torkelson and Romano, 1967). Therapists, viewing themselves interacting with their patients, may learn as much as they do in a good supervisory session (Geocaris, 1960; Beiser, 1966; Moore, FJ, et al., 1965). The initial shock value of seeing oneself performing inadequately, however, usually induces one to change for a limited time only. Therapists will soon adapt themselves to their television image unless there is a reworking of the material by a supervisor to reinforce learning. Observance by the supervisor of therapists in actual operation with patients is feasible by videotape, the contrast between what the therapists' reports of what they believe has been going on and the recorded events lending itself to emotional learning in the students. Supervisors also may be able to sharpen their own techniques in supervision by videotaping some of their supervisory sessions. Finally, beginning therapists may learn the process of interviewing and the management of various stages in treatment by watching videotapes (or sound movies) of expert therapists working with patients.

Although useful, written records and sound tape recordings alone are limited in bringing about an awareness on the part of patients of incongruous or paradoxical communication patterns. Sound films (Scheflen, 1963) and videotapes are more useful. Alger and Hogan (1966), employing videotape recordings in conjoint marital therapy, have pointed out that many levels of communication, as well as discrepancies between levels, become readily apparent to patients watching themselves immediately after interacting during a session. Differences between the televised actions and remembered responses are beneficially registered on patients. In individual therapy the videotaped interview may help patients see themselves as others see them. This is an excellent way of demonstrating to patients how they communicate. Use of the playback technique has proven valuable for many syndromes, including speech problems and alcoholism. A view of themselves in a drunken state may help motivate some alcoholics to stop drinking. Videotaping may be of value in group and family therapy.

Obviously, it is impossible to record all of the treatment sessions of patients even if therapists possess the proper equipment. Apart from the expense of recording materials and the problem of storage of the recordings, transcription of serial recorded sessions is costly. Occasional recordings that are saved until they have served their purpose will, however, be found valuable. From a practical viewpoint, audio cassette tape recordings may serve the purpose of preserving the verbal interactions of patients and therapists. Although not nearly as valuable as videotapes, they are less expensive and are easily transcribed.

If therapists are not resistive to recording sessions, generally there will be relatively little difficulty in gaining patients' permission and cooperation. The apparatus is placed unobtrusively (it must not be concealed) in the room. When patients enter the room (usually when recordings are to be made, it is best to introduce this possibility to the patient at the initial interview), they may be approached in a way somewhat similar to this:

> *Th.* Hello, I'm Dr___

> *Pt.* Hello.

Th. Won't you sit down in this chair so we can talk things over?

Pt. Yes, thank you.

Th. (pointing to the tape recorder) Don't mind this machine. Sometimes I record an important session during therapy. It saves me the need to write everything down, so I can pay attention better to what is said.

Pt. I see.

Th. (smiling) Does this scare you?

Pt. Oh, no, if it's useful, I've never been recorded.

Th. Of course, what is recorded is completely confidential between us, but if you object for any reason, we don't really have to record.

Pt. No, I don't mind.

Th. If, for any reason, it interferes in any way or bothers you, tell me and I'll turn it off.

Pt. All right, I really don't mind.

Th. All right then, would you like to tell me about your problem so we can decide the best thing to do for you?

The recorder may be turned on at this point, or, if it has been on, no further attention should be paid to it. During later sessions it may be started prior to the patients' entering the room, so that the first comments may be recorded. If the recording is to be used for teaching purposes or transcribed for publication, a signed release is usually necessary. If, for any reason, patients object to the machine, it should immediately be turned off and not used again unless the patients' permission has been obtained.

Recording is being revolutionized by advances in computer technology. Machines can never replace the heuristic propensities of humans. But machines can supplement decision making and contemplative facilities by sorting, storing, categorizing, and retrieving vast amount of information with astonishing rapidity, efficiency, and accuracy. As new developments in switching, information theory, and automatic coding techniques become incorporated into computers, the machines' capabilities will undoubtedly be expanded to include preparation of software programs for instructions fed into the machines. For 30 years, computers have been indispensable instruments in medicine, aiding in diagnosis by categorizing and analyzing symptoms and physical findings (Brodman and van Woerhom, 1966).

New means of cataloging, storing, and dealing with complex variables have made it possible to employ the modern computer in psychiatric hospital systems Glueck and Stroebel, 1975b; (Laska et al., 1967) and even statewide systems (Sletten et al., 1970). In clinical practice, attempts have been made to computerize data regarding the history of patients, their mental status, and symptom clusters in an attempt to aid in diagnosis, prognosis, progress evaluation, and treatment outcome (Colby et al., 1969; Spitzer and Endicott, 1969). The making of computer diagnosis has been especially challenging and has attracted an increasing number of experimenters (Glueck and Stroebel, 1969; Maxwell, 1971). Glueck and Stroebel (1975b) have estimated that classification-assignment techniques are now available to permit accuracy in diagnostic labeling comparable to that of expert clinicians with an accuracy nearing 100 percent, but they point out that there is a lack of ability "of any classification system to achieve more than 70 to 75 percent interrater reliability in the prediction of psychopathological criteria."

Some attempts have also been made to refine computerized analysis of the electroencephalographic and neurologic findings, and innovative tactics have been

evolved for various other types of data recording. The development of automated files help expedite the tabulation and retrieval of diagnostic, treatment, progress, and disposition information. Simple and effective methods for computer programming immeasurably help administrators, auditors, researchers, and ultimately clinicians by simplifying the massive amount of memoranda included in the traditional case record, enabling the scanning of essential elements of a case without needing to spend endless hours looking for pertinent facts.

The programming of computers to process the data of psychotherapy requires that therapists reduce the complex interpersonal transactions that take place to mathematical symbols that can be coded. Because the full encoding of human pursuits is not now, and probably never will be, complete, only limited parameters can be assigned to the circuitry of electronic computers. A number of interesting experiments have been reported. For instance, Colby (1963) has described the simulation of a neurotic process by a computer, and Bellman (1957, 1961) has, through dynamic programming, attempted to contribute insights into the interviewing process. A computer-assisted simulation of the clinical encounter is described by Harless and his associates (1971, 1972) and Hubbard and Templeton (1973).

More mundane operations that are being performed by computers include work with psychiatric records and other data related to the patient's history, symptomatology, and responses to therapy that may speedily and systematically be "memorized," synthesized, and retrieved. Feeding into the machine the recorded history, the psychological test results, and the symptoms of the patient, computers will quickly process these facts against the statistics of relative possibilities of diagnosis, prognosis, and treatment approaches (Rome et al., 1962; Swenson et al., 1963).

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challenging and has attracted an increasing number of experimenters. Classification-assignment techniques are now available to permit an accuracy in diagnostic labeling estimated as comparable to that of expert clinicians.

For the most part, computers in psychiatry have been used mainly in clinics, hospitals, and group practices for purposes of office automation. In this capacity they have improved productivity greatly, providing access to satellite offices and to vast data banks. For word processing, data processing, electronic mail, record keeping, billing, accounts payable, accounts receivable, preparation of insurance forms, and other office functions they are proving indispensable. This is invaluable when extensive reporting is necessary to qualify for third-party payments and in response to demands for better accountability and quality of care. A number of computer service bureaus now exist to provide fiscal-administrative help to mental health facilities in line with these demands. Software packages are available that help streamline office management, accounting, scheduling, billing, insurance form preparation, and online inquiry.

With the evolvement of efficient, low-cost microcomputers, clinicians are increasingly using computers for data organization and management of their practices. The possibilities are enormous and, for certain functions—as when vast amounts of data must be recorded, processed, stored, retrieved and printed—there is no equal to the efficiency of a computer. Whether computerization can be cost-effective for the therapist in solo practice is another matter. Simple office tasks such as billing and the balancing of checkbooks can be done more rapidly by hand. Although patient records take a good deal more time to process in a computer, they can be meticulously kept and easily and accurately updated. The preparation of reports and manuscripts can efficiently be accomplished through word processing. Programs such as Word Perfect and Microsoft Word, once mastered, can be a godsend for a therapist writing a paper. If a literature search on a certain topic is necessary, a communications program using a modem enables rapid access of data bases that will produce in minutes a printout equivalent to days of painstaking exploration in a library. The National Library of Medicine has a computerized literature retrieval service, MEDLARS (Medical Literature Analysis and Retrieval System),

consisting of 20 data bases that are accessible from terminals at more than 2000 U.S. institutions. Among the most commonly used component is MEDLINE, which has about four million references to journal articles and books. An area that is now being developed is artificial intelligence, with the goal of answering questions beyond the MEDLAR system that are often diagnosis related and "perform at the level of a human expert in the area that they're programmed for" (JAMA 252: 2337, 1984). Other commercial databank services for literature searches include SCIMATE, Knowledge Index, BRS Catalogue, and Psychoinfo Database, the latter developed by the American Psychological Association and which has more than four million references and abstracts. In research, the computer is irreplaceable for statistical analysis, data management, graphics plotting, creation of tables, and indexing references.

Apart from word processing and research, the clinician may find sundry other uses for the computer. Among the software programs now in use are ones for automated history taking, clinical records management, patient interviewing, mood assessment, treatment planning, medication monitoring, outcome monitoring, projective testing, and patient-therapist simulation. Therapists may through rating scales be helped in estimating the mental status of patients, evaluating prognosis, predicting outcome, making a diagnosis, assigning special treatments, and tracking progress in therapy (Glueck and Stroebal, 1980).

The question arises as to whether computers can improve quality control of patient care. In medical practice this has been shown to be feasible (Poliak. 1985). In psychiatry this also is possible in some areas. Thus, where psychotropic medications are prescribed, anticipated cross-reactions with miscellaneous drugs the patients habitually take for existing physical ailments— as well as tabulation of dosage, complications, and side effects —can be expeditiously accessed. Sophisticated software programs oriented around the DSM-3 classification system may be helpful in diagnosis and thus in the selection of appropriate treatment. As a diagnostic helpmate, computers are acceptable to patients and do at least as good a job as clinicians and at lower cost (Sawyer, 1966; Scharfstein, et al., 1980). A number of programs are also available for diagnostic psychological testing.

Automated testing with the Minnesota Multiphasic Personality Inventory (MMPI), Beck Depression Scale, and Strong Campbell Interest Inventory permits rapid administration and scoring with as good patient compliance as with traditionally administered tests. Moreover, the level of accuracy is relatively high in culturally diverse clinical settings (Ensel, 1980; Labeck et al. 1983; Green, 1982; Colligan and Offord, 1985). The application of a computerized information system to the psychotherapeutic care of individual patients and families is obviously more complicated. Psychiatric problems involve much more complex data than do medical conditions. For example, in nephrology the data base consists of limited physical signs, symptoms, laboratory findings and relevant therapeutic information. In any psychiatric problem, however, there is a host of interrelated biochemical, neurophysiological, intrapsychic, interpersonal, social, and philosophic systems, each of which is tremendously complex and influences treatment progress.

Computers have been programmed to give clinicians reliable information about such variables as symptom change, work and social adjustment, sexual functioning, and risk of suicide (Greist et at., 1973).

Computer interviewing is efficient, reliable, accurate, and highly acceptable to most patients. Up to 85 percent of markedly disturbed patients may be interviewed by computers at the time of admission to a hospital (Erdman et al., 1981). A number of programs lend themselves to consultation, performing as effectively as clinicians in making clinical decisions. For example, Greist et al. (1973) have evaluated an online computer program that makes predictions about suicide risks that are more accurate than those of clinicians. A number of computer software programs have been designed to meet the needs of handicapped people. Thus successes have been secured in cerebral palsy, learning disabilities, and hyperactive and autistic children to improve attention and performance. Computers are increasingly being used in psychoeducation to dispense information about topics such as birth control and sex, and it is often easier and less embarrassing for patients to learn via computer rather than a human lecturer. If therapists are looking for silent, nonarguing cotherapists, they may find it in computer programs such as BARRY which engages patients in dialogue; this can be of help in

monitoring the depth of depression and adherence to the medication schedule. Computers can be programmed to help interview patients regarding substance abuse (alcohol, tobacco, drugs) in a relatively relaxed atmosphere.

By interacting with the computer, clinicians can obtain or substantiate DSM-III diagnoses with a high degree of reliability. Facilitating this is the software program "Psychiatric Diagnostic Assistance." Helpful also in making clinical decisions are such programs as MYCIN, CADUCEUS, AND PUFF. A rapid screening for most mental disorders is now possible (Carr et al., 1981; Fischer, 1974). Attitudes, beliefs, and intimate important bits of information may be revealed by patients to the computer in many cases more readily than to a human interviewer (Greist and Klein, 1981) which is an important aid in treatment planning. Suggested treatment programs already exist in relation to agoraphobia, obsessive-compulsive neurosis, and depression, and more are being developed. Computerized information regarding new psychotropic drugs, changes in administration of existing medications, and side effects and their management can be a valuable aid in pharmacotherapy. The best known data bases for drug information (interactions, contraindications, warnings) are Medline, International Pharmaceutical Abstracts, and the University of Wisconsin Lithium Information Center. Other uses for computers are the updating of available pamphlets, books, and other materials for bibliotherapy and psychoeducation; information regarding social, recreational, and therapeutic resources in the community; and location of self-help groups. Computer-elicited case histories have been shown to be more than 90 percent accurate and reveal data of importance in the management of patients, some of which were not divulged to human interviewers (Carr et al., 1983; Greist et al., 1973, 1977; Lang et at., 1970).

Experiments with computers to enhance psychotherapeutic operations have resulted in the development of a number of interactive programs. Computer mediated psychotherapy systems are to an extent organized around the symbolization of the computer as another human being with which one can interact. People often do this with animals who as pets substitutely serve an important but limited interpersonal function. The computer can become much more anthropomorphized than an animal when it is

programmed to communicate in language the person can understand. The earliest example of a computer therapist is provided by ELIZA, a program devised by Weizenbaum (1966, 1976) a Massachusetts Institute of Technology computer scientist, which simulated a Rogerian non-directive therapist (Colby, et al. 1966). If we observe subjects "talking" to ELIZA we can see how easily transferential phenomena can be elicited, and we may speculate about the usefulness of computers as therapeutic instruments for cognitive and value change above and beyond their proven educational value (DeMuth, 1982).

Attempts have been made to do this (Colby, 1980; Rokeach, 1975; Cole et al., 1976; Friedman, 1980; Spero, 1978; Hedlund, 1979; Selmi et al., 1982; Trappi, 1981; Wagman, 1980; Wegman and Kerber, 1980; and Zarr, 1984). The consensus of opinion by these authors is that despite the threat of dehumanization, there will be important future uses for the computer as an adjunct in organized psychotherapy programs. Caution nevertheless dictates not to compare the brainpower and skill of a computer to that of well-trained and empathic therapists. Granted that some computer behavioral, cognitive, and relaxation programs may be conveniently and economically administered, computers have not yet reached the stage where they have made psychotherapists obsolete.

Computer fantasy games, fashioned after the popular computerized games for youngsters, Dungeons and Dragons, and Adventure (Adams, 1980; Clarke and Schoech, 1984) have been developed for child and adolescent patients which allow them to control the actions of characters on the display monitor with whom the patients identify (Allen, 1984). Children may even construct the main characters in the game—identifying them with the angels and monsters in their own inner world— give them names, and design their dodges and achievements. A tremendous amount of material becomes available to the therapist through such modern play therapy and this can provide an opportunity to question, encourage, and support the children in working through fantasies, needs, and defenses. The responses of the children may be saved on disk for later replay, to procure associations, to invite more reality oriented revisions, and to improve decision making.

The program ELIZA and the interactive fantasy games devised for children with

emotional problems open up the vast possibilities of the computer as a way of influencing behavior that can serve as an adjunct to psychotherapy. As has been mentioned before, the computer can never replace the professional who provides the warmth and empathy of a skilled human relationship (Spero, 1978) but in some ways it can do selective tasks better—for example, educational reinforcement. Required is appropriate software prepared by creative innovators. Some leads in this direction have been provided by a number of experimenters. Reitman (1985) has described a self-help program for impotence oriented around cognitive restructuring that has produced excellent results. Thirty-eight other programs of psychoeducation, sex education for children, sex therapy for varied sexual problems, and therapy for couples' problems are being developed. Lang et al. (1970) have developed a program for desensitization of phobias that has produced results equal to that of a clinician. Schneider (1984) has devised a four-week "Quit-by-Mail" antismoking program with clients treated at home who mail to the author's clinic diary sheets of smoking control progress and responses to smoking questionnaires. These data are entered into a computer, and a personalized reply, prepared by the computer, is mailed back to clients. Initial successes have been encouraging.

Because verbal psychoeducation is an important aspect of a well-organized psychotherapy schema, it has been more and more incorporated into some therapeutic designs. It is, however, costly and inefficient when it is employed by therapists themselves especially in short-term psychotherapy where time is limited. Bibliotherapy has been of some use in providing supplementary readings, but often these cover a subject too diffusely and do not zero in on the specific problems of patients. It is posited that improved computer methods will revolutionize education with replacement of present-day teaching technologies by computer systems that permit active personalized conversational dialogue between student and instrument, thereby eliminating the highly inefficient lecture techniques that reduce the student to an immobilized, passive, and resistant receiving station. An actual attempt in this direction, the teaching of interviewing by employing a suitably programmed computer to simulate an initial psychiatric interview, has met with some success (Bellman et al., 1963, 1966). Here trainees assume the role of therapists, and the computer, properly programmed, replies as patients would

respond. The computer may be programmed to represent a range of problems and patients. Jaffe (1964) has described specific techniques for interview analysis through the aid of computers with special methods of coding interpersonal phenomena; such computers have potential research applications. Wedding (1984) has developed a technique of mailing letters to patients after the third or fourth session that reiterate and elaborate many of the points brought out in therapy—occasionally even anticipating points to be made in the future. A personalized letter typed on the computer is merged with psychoeducational data and specific instructions relevant to the problems of the patient avoiding irrelevant and counterproductive information. The planning of vocational and educational counseling can be vastly enhanced through the use of a computer in an automated "Educational and Vocational Guidance System" (Murray, 1984). A modem provides a telecommunications link between the computer and a data base, such as the "Guidance Information System" of TSC, a Houghton Mifflin Company. The advantages of computer-assisted instruction for patients over written materials and verbal educational methods have repeatedly been demonstrated.

The interactional aspects of computer instruction permit learners to proceed at their own pace, minimizing the transference reactions common in interviewing that may interfere with learning, getting immediate feedback to data provided by the computer, allowing for greater flexibility in learning, and providing great stores of relevant information. A tremendous amount of literature has accumulated detailing the advantages and drawbacks of computer-assisted information systems (Flynn and Kuczeruk (1984), Misselt (1980), Schoech (1982).

Microcomputers are being used in remedial training for correction of memory, perception, concept formation, and problem-solving deficits resulting from brain impairment (Kurlychek and Gland, 1984). Rehabilitation professionals are also employing computers to assist their work with handicapped learning-disabled children and adults. Patients who have suffered a stroke may be asked to acquire and use an inexpensive computer in their homes for cognitive rehabilitation (Brady, 1984). Programs are available to enhance attention, initiation/inhibition skills, cognitive discrimination, and

differential responses.

These examples of computer use in psychotherapy merely provide an inkling of what the future has in store for this remarkable instrument. Zarr (1984) has pointed out the need for enthusiasm and belief in computers' effectiveness as a requirement in computer-mediated psychotherapy. He also believes that the best uses are in brief and focused therapy, especially of a cognitive behavioral type. Excellent accounts of future trends in uses of computers in mental health may be found in the books by M. D. Schwartz (1984) and Crawford et al. (1980).

The optimistic reports are to some degree offset by some emerging problems. For example, attempts made to develop checklists of symptoms and levels of function to enhance psychiatric record keeping have been thwarted by both technical difficulties and resistance by clinicians who find it difficult to accept computers. The old hardware problems that involved a batchmode use of mainframe systems with difficult-to-manage punched cards have more or less been eliminated by the use of interactive mainframe and microcomputer systems. A number of problems have not yet been resolved, however, such as the programming of computers to simulate clinicians' summaries of input data, or to make inferences about diagnosis, prognosis, and treatment. What appears essential is refinement of the data that are most suitable for psychiatric summary statements.

Prevailing complaints are that the need to adhere to a preset and rigid reporting system that requires the skills of a human clinician cannot be subtly managed by a computer. Moreover, because the variables of human behavior are so complex and diverse, the computer reports to date have failed to differentiate patients who present even dissimilar clinical pictures. Sometimes a failure occurs in entering key pieces of information, and this results in wrong diagnoses. Gradually, greater sophistication is entering computer usage, but there still remain the difficulties of clinical compliance and acceptance.

Among the reasons computers do not enjoy greater popularity among clinicians than they do are the difficulties inherent in mastering them. Not only must users learn a new

language, acquire typing skills, and technical know-how but also plow through complicated reading. Many instructional manuals are not monuments of conceptual clarity or good writing. It takes a great deal of time and patience to master operations that are more complex than simple word processing. Learning to develop new computer programs is difficult, but if interest is there are and time of no essence, the effort can be rewarding. Examples of such use is provided in an article by Klepac (1984). The complexity of the data elicited in psychotherapy makes it difficult to organize data for purposes of computerization, although some preliminary attempts have been made toward providing greater regularity in this direction. Mergenthaler (1985), for example, describes an attempt to integrate information technology following guidelines of fundamental research in psychoanalysis.

Therapists first entering the world of computers may be bewildered by the vast variety of hardware equipment and software programs available. It is best in purchasing a computer to deal with a reliable agency locally to which a machine may be returned for repair or adjustment if necessary. The most popular computers are IBM instruments, or IBM-compatible clones that are less expensive; in the latter case, purchasers must be sure that repair facilities will not be too difficult to find. Apple (including Macintosh) computers are excellent, but buyers should ascertain beforehand that any software purchased is suitable for these machines. If possible, a computer with at least 640 K of RAM (memory) and a hard disk should be purchased, but 256 K of RAM and two drives for floppy disks may be adequate for most purposes. A monochrome monitor is eminently suitable, but some therapists prefer a color monitor, even though this is more expensive, because color makes some interactive programs more interesting. A good dot-matrix printer will be needed for speed and, if desired, near-letter-quality printing. A stand to support the printer and covers for the fanfold paper rounds out the basic equipment. Accessory purchases can include a modem (with at least 1200-band speed) for accessing outside data bases and equipment for use with compact disks.

Elaborations of computer programs are proceeding at an enormous pace, covering the entire field of practitioners', interests. Thus software programs, such as psQ "Practice

Partner" (psyQ systems, 1730 Rhode Island Ave., N. W., Washington, D.C. 20086) and "Insight Billing Software" (Applied Innovations, Inc., South Kingstown Office Park, Wakefield, RI02879) are sold with the object of managing the paperwork requirements of mental health practitioners in relation to preparation of billings, daily schedules, accounts receivable, insurance forms, and special reports.

Some programs exist that prepare a DSM-III diagnosis as required by third-party payers. In the "P.D.M. 2000 computerized Diagnostic Interview Schedule" (p.r.n. systems, 222 N. Midvale Blvd., Suite 1, Madison, WI 53705) patients are interviewed on a computer, the data are processed, and a "clear, concise, and documented written report of suggested DSM-III diagnoses" is offered. A "computerized textbook" is available in "Decision Base," which diagnoses all DSM-III disorders, takes histories, and programs other functions (P.W. Long, M.D., II 1206-750 West Broadway, Vancouver, B.C., V5Z Canada). One program, MORTON, administers the Beck Depression Inventory for diagnostic purposes. Tests such as the MMPI are executed with a written narrative describing the personality dynamics and interpreting the scale scores. (Behaviordyne, Inc., 994 San Antonio Road, P.O. Box 10994, Palo Alto, CA 94303-0997; Applied Innovations, Inc., South Kingstown Office Park, Wakefield RI 02879). A computerized stress-inventory program generates a stress profile for diagnostic purposes and suggests changes (Preventive Measures, Inc., 1115 West Campus Road, Lawrence, KS 66044). A "Chronic Pain Battery" screens for psychopathology (Pain Resource Center, Inc., P.O. Box 2836, Durham, NC 27705). "Q Fast" converts questionnaires and surveys into interactive computer programs useful for practioners and researchers who administer tests, and "Psychostat" is a complete statistical package (Stat Soft, 2833 East 10th St. Suite 4, Tulsa, OK 74104).

The "Gordon Diagnostic System" administers game-like tasks for diagnostic and treatment recommendations for attention-deficit disorders and hyperactivity (Gordon Systems, P.O. Box 746, DeWitt, NY 13214). Software programs are being developed for automating test-report writing, statistical analysis of data, projective drawing tests, diagnostic screening batteries for children and adults, and many other purposes. A number of other microcomputer software programs are designed for initial evaluations,

session summaries, treatment planning, termination and discharge, summaries, child and adolescent diagnostic screening, intelligence test interpretation, and Rorschach data summary and report (Psychologistics, Inc. P.O. Box 3896, Dept. A, Indialantic, FL 32903).

For therapists interested in research, a statistical analysis package is available (Walonick Associates, 6500 Nicolet Ave. S., Minneapolis, MN 55423). "PsycINFO" has prepared a compact disk (which will require special equipment) providing summaries of the world's literature in psychology from more than 1400 journals. For quick, convenient searches there is "PsycLIT" (The American Psychological Association, 1400 North Uhle Street, Arlington, VA 22201). The use of microcomputers to provide direct access to databases has increased markedly in the past few years. It is not unusual for clinicians to keep terminals in their offices and also in their homes. New user-friendly computer literature search systems are available from various sources. BRS/Saunders Colleague is a medical literature and information-retrieval service accessible 22 hours daily containing both bibliographic and full-text references. Some of the data bases are MEDLINE, Medical and Psychological Previews, Psyclnfo, Excerpta Medica, the full text of the *American Journal of Psychiatry* and also of the *Comprehensive Textbook of Psychiatry,* 4th edition. Colleague, another data base, can be menu driven or accessed by direct commands (BRS/Saunders, 555 East Lancaster Avenue, St. Davids, PA 19087.) KNOWLEDGE INDEX is DIALOG'S after-hours, simplified search service, available weekends and evenings. It is intended for the weekend user and the at-home user. Its data bases include Mental Health Abstracts, MEDLINE, and Psyclnfo (available through local DIALOG offices or DIALOG Information Services, Inc., 3460 Hillview Avenue, Palo Alto CA 94304). Health-sciences librarians can provide further information.

Some periodicals that may be of interest to therapists are (1) *Computers in Psychiatry/Psychology* (26 Trumbull Street, New Haven, CT 06511; quarterly, $40 a year), (2) *Computer Use in Social Science,* (CUSS Network, Graduate School of Social Work, University of Texas, Box 19129, Arlington, TX 76019; quarterly, $10 a year). Recommended books are (1) J. D. Lieff, *How to Buy a Personal Computer Without Anxiety.* Cambridge, Mass., Ballinger Publishing Co., 1980; (2) J. D. Lieff, Computer Applications in

Psychiatry. Washington, DC, American Psychiatric Press, Inc., 1987; (3) M. D. Schwartz: *Using Computers in Clinical Practice,* New York, Haworth Press, 1984. To use telecommunications for accessing data bases, a subscription to systems such as "Source" or "Telenet" is recommended. Mental health software catalogues may be obtained from (1) American Association for Medical Systems (AAMSI, 1101 Connecticut Avenue N.W., Suite 700, Washington, DC 20036); (2) Psychological Software Specialists, 1776 Fowler, Suite P, Richland, WA 99352; (3) Computers in Psychiatry/Psychology 26 Trumbull Street, New Haven, Connecticut, 06511; and (4) National Health Information Clearinghouse, Dept. GGG, P.O. Box 1133, Washington, DC 20013. Recommended reports and articles are (1) M. D. Schwartz: "Resources for Computer Users." *Hospital & Community Psychiatry* 35:537-539, 1984; (2) J. L. Hedlund et al.: *Computers in Mental Health: A Review and Annotated Bibliography.* NIMH Clearinghouse, Room 1 SC-17, 5600 Fishers Lane, Rockville, MD 20857; (3) J. H. Johnson: Computer Technology and Methodology in Clinical Psychology. Psychiatry and Behavior Medicine, Vol. 13, No. 4, Aug. 1982; (4) *Applying Computers in Social Service and Mental Health Agencies: A Guide to Selecting, Equipment, Procedures, and Strategies.* Administration in Social Work, N.Y., Haworth Press, 1981.

There are critical stages in the development of personality in which crucial incidents and experiences have a destructive impact that are not registered during another period. The stages of weaning, habit training, bodily exploratory activities, entry into school, puberty and adolescence, marriage, pregnancy, child rearing, and retirement and old age pose special problems that influence psychotherapeutic interventions when these are needed.

CHILD AND ADOLESCENT THERAPY

Psychopathology in children must at all times be viewed against the backdrop of developmental norms. Moreover, it must be considered in relation to existing family and social distortions that deprive children of needs essential to their growth or subject them to rejection, violence, or overstimulation with which they cannot cope. Among common noxious influences are parental absence, rejection, seduction, overprotection, or cruelty. Contemporary disruptions in family life, such as a detached and disinterested father, subjection to television bombardments of violence and sexuality, poverty, lack of intimate family ties, and racial conflicts at school, exaggerate the normal problems inherent in growing up. Fears of separation, resistance to socialization, defiance of discipline, sibling rivalry, and Oedipal crises may also interfere with the resolution of developmental disturbances. Emotional difficulties in childhood usually express themselves in symptoms of excessive irritability, hyperkinesis, fearfulness, daydreaming, obsessions, compulsions, bed-wetting, or excessive masturbation. Sleep, speech, eating, and learning disturbances are common, as are psychophysiological manifestations such as tics, spasms, vomiting, diarrhea, headaches, asthma, ulcers, and colitis.

During the first three years of life, excessive and continuous crying unrelieved by

attention from the mother signals a state of unresolved tension (Cramer, 1959). Inordinate rocking, thumb sucking, head rolling, sleeplessness, food refusal, vomiting, retention, soiling, temper tantrums, ritualistic behavior, defiance, stammering, and unusual aggression often indicate disturbances in the child's environment, particularly in the relationship with the mother. In a small number of instances, these are manifestations of organic physical or neurological ailments.

During the fourth and fifth years extravagant fears, nightmares, excessive masturbation, and enuresis reflect sexual identity difficulties. Overactivity, tantrums, negativism, and destructiveness constitute another type of patterning for conflicts developed during this period. Such difficulties are often nurtured by sexual and hostile acting-out in parents and by their seductive use of the child to satisfy their own neurotic needs.

Neurosis during the sixth to ninth years of life frequently manifests itself in failing adjustment at school, the outcroppings taking the form of school phobias, truancy, aggression toward fellow pupils and teachers, and learning disabilities. Outright neurotic symptoms may appear in other types of phobias, tics (blinking, grimacing, jerking of the head and extremities), stammering, compulsions, and conversion phenomena. Excessive withdrawal and daydreaming or aggressiveness and antisocial activities (e.g., stealing, exhibitionism, fetishism, peeping) interfere with social adjustment. Frank, unbound anxiety may erupt. Eventuating psychophysiological disturbances may derange various organ functionings.

In the preadolescent (latency) stage, between nine and twelve, there may be enhanced aggressiveness, fighting with siblings and friends, and occasional depressive states stimulated by disappointments and failures.

During adolescence, potential problems incorporate the full spectrum of psychopathology from behavior disorders to psychoneuroses to psychoses. The emotional disorders that are most common in adolescence, however, are adjustment difficulties, personality disturbances, scholastic failure, school phobia, enuresis, psychosomatic

complaints, delinquency, anorexia, bulimia, and identity disorders.

In the tumultuous growth period of adolescence, with the extensive alterations in the physical, biochemical, and emotional makeup characteristic of this epoch, therapists must, in judging the degree of disturbance, take into consideration the normal anxieties and concerns that plague individuals.

Adolescents have a need for both uniqueness and difference, a desire to conform and a fear of being different from others of their age and sex. Strong and strange impulses dominate the body as the sexual glands mature and the adolescent comes under the influence of erotic thoughts and feelings. New demands are made by family and community; no longer is the youth considered a child. Swings into independence and aggressiveness are followed by refuge in childish dependency and passivity. The need for recognition vies with the impulse to defy. Drives for success and prestige are paramount, while conflict rages over issues of religion and death. A fluctuating sense of values and confusion in identity add to the adolescent's turmoil.

Constructive solutions will be needed. The adolescent must first dissipate dependency ties sufficiently to enter into a more assertive and independent attitude toward the world. This is especially necessary in a society where the burden of one's own support and ultimately that of one's family will fall on the individual's shoulders. Second, the adolescent must learn to control sexual feelings so that there will be a proper balance between restraint and expression. Evolvement of adequate sexual role identification is mandatory. Third, one must change from the subordinate manner of a child to the dominant habitude of a grownup, to feel equal with other adults. Fourth, one must develop a cooperative attitude toward authority, without feeling victimized or excessively hostile. Fifth, one must learn to be assertive and creative and to assume leadership on occasion, without ulterior motives of control or power. A proper educational and career choice must be made.

In primitive cultures the adolescent struggle is less intense than in civilized societies because there is much more continuity in the behavior patterns of child and adult.

Primitive economies are less complex and consequently afford an easier and earlier emancipation from parental support. Child marriage and premarital intercourse are more or less condoned. This sanction affords the growing child an outlet for energies. Civilized societies impose barriers against which the adolescent will struggle. While relatively mature biologically, the adolescent cannot become economically self-sufficient until well along in adult life. A large proportion of today's young people are forced by the requirements of their chosen careers to enter into a long and expensive period of study that must be financed by their parents.

Hostility and resentment are frequently the outcome of the conflict between the impulse to break dependency ties and the need for material help and support. Although adolescents feel an urge to lash out at their parents, most realize that such action will result in retaliatory measures that threaten personal security. In addition, the hostile urge clashes with some of the adolescent's ideals. Thus a youth is at the mercy of many ambivalent and conflicting values and goals. Sometimes the child is driven by contradictory impulses reflecting both the secret sexual and delinquent wishes of one or more parents that they have projectively and covertly conveyed to their offspring, as well as guilt feelings of the parents that have prevented the parents from personally expressing these impulses. The child here acts as a messenger for the parents, who stealthily relish the exploits of their offspring and then heap blame on the child.

Under the best of circumstances the adolescent period is a chaotic one and is characterized by a recrudescence of problems that had their origin in childhood and were never adequately resolved. Often parents have not been aware of these problems, and they are dismayed and frightened by the eruption of severe behavioral disturbances in a previously exemplary child. The early adolescent (12 to 15 years) is plagued by regressive thrusts that conflict with the new growth demands of this stage. The child ambivalently veers between submission and rebellion, sociability and isolation, friendships and enmities, overactivity and retreat, depression and overexcitement. Delinquency and acting-out are common. The struggle in this period is a process of resolution of sexual identity, object ambivalence, and needs for separation and individuation. In middle

adolescence (14 to 17 years) there is some resolution of sexual conflicts with greater ability to relate. Narcissistic defenses alternate with more mature coping mechanisms. Homosexual episodes, depersonalization, anxiety, and runaway tendencies may occur. In late adolescence (17 to 21 years) separation-individuation accelerates, object choice solidifies, identifications strengthen. Identity crises, depression, and adjustment difficulties continue, however, often encouraged by available peer groups involved in sexual and deviant exploits.

In summary, *adjustment reactions* to growing up are a normal byproduct of socialization. They occur in all children. The reactions become exaggerated in those who are subjected to extraordinary stress, or whose developmental needs are not being met by parents, or who are being grossly mismanaged, improperly disciplined, or subjected to cruel and abusive treatment. The constitutional makeup of the child will influence the severity of reactions and the ability to cope with the stress being experienced. The responses of the parents to the child's reactions will also influence the outcome. If they are kindly and caring adults, capable of maintaining control of the situation and their own emotions, the child may be helped through the critical adjustment years. If they are not so equipped, minor maladjustment reactions may explode into severe behavior disorders that can persist and influence adversely later stages of the child's development. The ultimate outcome may be a pathological neurotic or psychotic reaction for which treatment will be needed.

General Principles of Child and Adolescent Therapy

Choice of techniques in child therapy is complicated by a wide variety of available interventions. These are usually determined more by predilections of the clinician than by precise diagnostic assessments. This, in the words of Harrison (1979), has produced a state of "undisciplined chaos" in the field. Experience is the mother of compromise and the great leveler of differences in therapeutic operation. For example, whereas in past years there was a tendency to segregate behavioral from psychodynamic approaches, a fusion of these methodologies has more and more dominated the practices of many child therapists.

Family therapy, with its transactional system orientation, has become an indispensable mode and is often executed coordinately with behavioral-psychodynamic-medicinal approaches and environmental therapy. It seems obvious that therapists cannot neglect any links in the behavioral chain among children any more than they can neglect them in adults, and this will necessitate the use of interventions designed to influence different zones of pathology. With the present knowledge, therapists can match a number of syndromes with appropriate interventions provided a proper diagnosis can be made.

The basic rule in treating disorders in childhood is providing an adequate climate in which developmental needs are met, opportunities for impulse gratification supplied, and proper discipline and restraints imposed. Alterations of the milieu are usually required and the cooperation of the parents and family may be essential even to the point of exposing them to individual or family therapy. Unless this is done, work with the child alone may prove to be fruitless, the parents and other family members sabotaging the child's efforts at adjustment. Indeed a sick child may be the vehicle for holding a family together.

Therapeutic interventions will accord with the accepted theoretical model. Thus, if deviant behavior is regarded as originating through reinforcement of unhealthy patterns by the family, treatment tactics will be organized around modifying the consequences of such patterns through behavior therapy (Ross, A, 1972). Should a psychoanalytic family interaction model be adopted, a search for pathogenic conflicts and their resolution through insight and working-through in the patient-family-therapist relationships will be embarked on. If constitutional organic neurological factors are considered most significant, developmental and language lags that interfere with the normal timetable in the evolution of essential functions will be looked for. Prescription of medications and the institution of adequate training routines will follow.

The existence in childhood of relatively undeveloped personality functions, strivings for independence and.mastery that inevitably conflict with dependency yearnings, heightened motor activity and fantasy life, lowered frustration tolerance, greater needs for

discipline, and extraordinary plasticity of the developing ego will require innovations in therapy technique. Environmental manipulation, crisis intervention *(q.v.),* family therapy *(q.v.),* drawings *(q.v.* art therapy), the use of play materials *(q.v.* play therapy), and the employment of greater activity and supportiveness with efforts at symptom control are more or less standard aspects of child treatment. The key to management is a proper diagnosis with assessment of the potential of the child as well as the role the mother and family will play in organizing a therapeutic milieu.

The majority of child therapy clinics use therapeutic methods that stress the interpersonal therapeutic relationship, focus on the presenting problems, and encourage therapist activities of a friendly, active, and supporting nature to provide a corrective experience for the child. Psychotherapy is considered a new and unique growth experience that is family centered with the focus of concern on the child (F. H. Allen, 1962, 1963).

In mental health clinics for children that emphasize careful evaluation, diagnosis, and treatment planning, both the child and parent are given attention. Thus at the beginning of therapy, parents require help in expressing their feelings about the plans being made for therapy. Prior to bringing their children into a treatment situation, parents are aided in ventilating their hopes, doubts, and fears. Discussions consider the part they can play in preparing their offspring for treatment. In these early interviews the role distortions of the parents with each other and their children usually become apparent. It is essential to involve both parents, when possible, in the planning to avoid distorting the family drama further. The beginning phase of treatment with children is diagnostic for the therapist. The therapist witnesses how the children react to a unique experience of acceptance and empathy, their degree of accessibility, the content and manner of their communications, and the ways that they express or conceal feeling. At the start, children will probably perceive the therapist as they do other adults—hostile, dogmatic, overprotective, or omnipotent. Expectations, fears, and desires for magical cure are sooner or later projected onto the therapist. Recognizing this the therapist encourages the child to express and then to test out misconceptions in the hope of inspiring a more

realistic life orientation. Dealing with the child's need to transform the therapist into a good or bad parent, steady maintenance of one's identity helps to provide for the child a truly differentiating experience. But even in the first interview a therapeutic process may begin. Winnicott (1969), using the child's drawings, has demonstrated that therapists can score a significant imprint on the child and increase their understanding in just one interview.

Emerging from this diagnostic phase is a therapeutic plan determined by the children's physical condition, the evaluative studies of the psychologist, the ability of the children to form a relationship with the therapists, and the cooperation of the parents. A definite schedule is set up, usually once weekly, the children and parents having separate and sometimes concurrent appointments. In a team plan different team members may see the parents and the children.

Changing paradigms of therapy have placed an accent on *child behavior therapy*. Its briefness, ease of administration, and effectiveness in behavior and habit disorders have enabled therapists to help some children, particularly those who because of deficiencies in motivation, cooperation, intelligence, and verbal skills have not been able to use traditional interview and play techniques. The focus is on altering the environmental circumstances that initiate and support deviant patterns. No effort is made to probe for conflicts or to promote insight. There is little emphasis on the importance of the child-therapist relationship except to establish sufficient rapport to enhance the acceptance of social reinforcement. The traditional diagnostic categories are not considered of great importance.

Initially, a behavioral assessment is made of the problem, consisting of an exact description of its nature, its history, its frequency, the circumstances under which symptoms occur, the reactions of the parents or teachers, and the consequences to the children. Many pertinent techniques on behavior therapy are delineated in Chapter 51. The selective method used with particular children will depend on the specific behavior to be altered. Bijou and Redd (1975) have outlined some useful methods. Monitoring

procedures are set up to provide data about progress, and parents are trained in proper responses, and at home to act as accessory behavior therapists.

Thus, in children who have tendencies that are upsetting to others (such as pushing, fighting, hitting), a program may be organized that grants rewards (candy, a token or points exchangeable for something the children like to receive or do, praise) for each instance of desirable social behavior. Coordinately, an aversive contingency may be employed whenever the obnoxious behavior occurs, for example, removal of the children from the room for a period and placement in a room without toys. Or the children may be penalized for conduct by taking away some tokens or points.

If children are psychologically withdrawn or show shy or phobic behavior, they are rewarded with praise and attention when they manifest sociable and non-phobic behavior. They are ignored when they do not. Reinforcements are gradually spaced and delayed, and requirements for reinforcement gradually are made more stringent to shape behavior. Modeling appropriate behavior may be utilized both for the children and the parents, the latter observing how the therapist responds through a one-way mirror if one is available. Systematic desensitization may also be employed. Thus, a school phobia is treated by gradual introduction to the school environment for slowly increasing periods, each success being rewarded.

The acquisition of new and desirable behavior repertoires will call for contingent positive reinforcement for initial improvements then for increasing intensities of the new behavior. Inappropriate normal responses (e.g., of speech, conduct) may gradually be extinguished and displaced to suitable situations by adequate reinforcements.

These operant techniques are also applicable to hospitalized adolescent patients. Their effectiveness is illustrated by the experience in the Adolescent Service of the Boston State Hospital (Lehrer et al., 1971). A token economy is tailored to individual needs or problems. Patients are given points that can be redeemed for money, school attendance, and participation in various activities. Points buy food (hot dogs, pizza, hamburgers, soda, or ice cream). Then patients are permitted to play a jukebox, games (pinball, table tennis,

board games) as well as purchase various items in a special teenage lounge that has a soda fountain and grill. Points are also exchangeable for parties, dances, camping expeditions, and so on. Points are taken away for infraction of the rules. Serious violations, such as assaultiveness and abuse of property, lead to restriction of all activities until the patients have worked out with a psychologist strategies for controlling their behavior and proper point payment for any damages that they have done to property.

Some therapists use the findings of dynamic psychology to conceptualize the development and problems of children. The therapeutic focus of *child psychoanalysis* follows this model and brings to the children's awareness the anxieties, unconscious wishes, and defenses that produce their difficulties. Since children do not respond to therapy as adults do, classical technique must be modified taking into account the children's tendencies to project problems onto the environment and the lack of motivation for therapy. The parents and other important members of the family also have to be brought into the therapeutic situation through parent guidance, family therapy, or individual therapy in accordance with what is required in each individual case. Because children express themselves most readily in play, play therapy is seen as an important tool for probing conflicts and for interaction with therapists. The analysis of children's problems was originally explicated by Sigmund Freud in his "Analysis of a Phobia in a Five-Year-Old Boy." The two main orientations that emerged were those of Anna Freud (1928, 1945, 1946) and Melanie Klein (1932, 1961). According to Anna Freud, children as young as three years of age may be analyzed. Free association and the couch position, however, cannot be employed. Instead the children's activities in movement, play, and random talk are used for interpretation, as are stories, dreams, and the children's reactions to the therapist. Caution in making interpretations is essential since the egos of children are not as firmly developed as those of adults. Generally children do not develop a transference neurosis, instead reflecting more of the immediate situation than the past. The cooperation of the parents should be enlisted as an adjunct to their children's treatment but no attempt is made to offer direct advice. In Melanie Klein's technique, children as young as two may be treated. Unlike Anna Freud's method, the deepest interpretations to fantasies revealed by children in play are given, starting with the first

interview. These are concerned with Oedipal wishes, awareness of parental intercourse, the desire to destroy the mother's body, and the desire to incorporate the father's penis. Since the reality situation is not considered significant, the cooperation of the parents is not sought; indeed, it is considered an unnecessary inconvenience. In recent years the formulations of self-psychology (Kern-berg, 1980; Kohut, 1977; Mahler, 1968) have been applied to work with the more seriously disturbed children and adolescents (Marohn et al., 1980). Interesting descriptions of the psychoanalytic process in children may be found in the writings of Aichorn (1936), Bios (1962, 1970), Born-stein (1949), Erikson (1963), Fraiberg (1965), Gyomroi (1963), Isaacs (1930), and Winnicott (1958). There is some disagreement among analysts regarding how thoroughly the unconscious should be probed.

Instead of an expressive-exploratory approach it may be decided to employ a supportive-educative-suppressive type of therapy to bolster repression of offensive conflicts and active promotion of more constructive behaviors. Here combinations of therapies are commonly used such as environmental manipulation, promotion of emotional release, family therapy, educational techniques, behavior therapy, and play therapy as means of maintaining communication and releasing fantasies that may be explored. Examples of play therapy are Winnicott's (1977) squiggle game and Gardner's (1971) storytelling methods detailed in a number of books published by Creative Therapeutics of Craskill, N.J. In play therapy, psychotherapists may employ psychodynamic concepts and in essence integrate psychoanalytic with behavioral, educational, family, and environmental-manipulative approaches, an integration which is probably for the majority of cases the most rational mode of operation.

Children and adolescents are less motivated for therapy than adults and a good part of the time may have to be spent by therapists developing a relationship with the recalcitrant youngsters. Children are more likely than adults to project their difficulties onto the environment, acting out their needs and conflicts while avoiding inner exploration and self-observation and inhibiting the constructive use by the therapist of transference as a therapeutic tool. On the other hand, the children's natural use of play as

a form of communication enables trained therapists to harness some of the bubbling energies that seem so chaotic. Working with the material elicited during play therapy calls for a great deal of skill, particularly in knowing how and when to interpret defenses, conflicts, and the underlying impulses (Harrison et al., 1984; Fraiberg, 1965). In adolescents the capacity for self-observation is somewhat more developed than in children. This is balanced by the ambivalence and confusion of identity that are hallmarks of this developmental period. Because adolescents tend to project their conflicts and to act out explosively at times, therapists may have to abandon their preferred roles as participant observers and intervene when the acting-out assumes dangerous proportions.

Technical modifications are necessary in adolescents that take into account the identity struggles going on within them (Es-man, 1983). Because adolescents are so resistive to receiving help of any kind, an empathic, active, non-challenging approach is more effective than a confrontational one, which inexperienced therapists are tempted to employ, especially when the adolescents test them by acting-out. Periodically, therapists may have to substitute game playing for interviewing. Patients may find it difficult during puberty or early adolescence to discuss sexual concerns, and to lessen anxiety, therapists of the same sex may be preferable. Between 15 to 17, adolescents are somewhat less in a tumult and become more amenable to an exploratory approach, but here the relationship with therapists must be sufficiently firm to support this effort and to handle the adolescents' inevitable countertransference reactions. Therapists who have had difficulties in their own adolescence are likely to adopt an anti-therapeutic stance in working with patients exhibiting defiance, or resistance. Short-term psychotherapy may be especially suited to adolescents (Proskauer, 1971; Rosenthal and Levine, 1971) focused on certain problems that patients choose to handle. Because children's and adolescents' pathology occurs before the maturational cycle is complete, because dependency on parents and family is still high and economically necessary, involvement of the parents and/or family is, as has been mentioned before, essential for good therapy. Family therapy is especially of value when dysfunctional transactional family processes exist, when scapegoating of patients is suspected, when the patients' difficulties are related to a pathological family structure, and when urgent intervention is required as a consequence

of a family crisis (Berlin, 1970; Williams, 1973). Adolescents with borderline problems may require a special approach using some of the insights from object relations theory (Masterson, 1972).

Attempts to use more formal psychoanalytic therapy in late adolescence are more successful than in earlier years. A search is made for fixations and problems in the infantile period and in early childhood that reappear in direct or disguised forms as well as the defenses against regression, castration anxieties, and superego guilt. From these therapists may better understand how hitherto adjusted children become converted into disorganized, willful, or violent adolescents. Youthful patients are, however, usually resisting participants in probing noxious early experiences and reactions, not seeing the connection with what is happening in the present.

Gladstone (1964) describes three major groupings of adolescents for whom different treatment approaches are applicable. The first group consists of acting-out character problems and offenders who will require extreme therapist activity to promote a relationship, a firm setting of limits, and a constant emphasis on human values and their communication in the relationship. In another study, Gladstone points out how this may be done. The second group includes neurotic disorders and dependency problems. Here observant and interested objectivity is offered patients, emotional catharsis is encouraged, there is a probing of underlying conflicts toward insight, and there is a minimum of interference from therapists in working out the conflicts. Illustrations of such tactics are provided by Josselyn (1952, 1957). The third group is composed of withdrawn schizoid reactions. With such patients are best employed supportive techniques, experience sharing, continuous correction of distorted perceptions with efforts at reality testing, and educational correction and filling in of learning deficits. Silber (1962) gives examples of these procedures.

Group therapy (q.v.) with children has been described by Slavson (1949, 1952) and has become an accepted way of dealing with problems in childhood, both as a principal therapy and as an adjunct to individual therapy. Of note, too, are Moreno's methods of

using psychodramatic play with groups of children (Moreno, 1965).

The size of children's groups must be kept below that of adult groups (Geller, 1962). For instance, in the age group six years and under, three children constitute the total. Both boys and girls can be included. Single-sex groups are those (1) from 6 to 8 years, which optimally consist of 3 to 5 members; (2) from 8 to 12 years, which may have 4 to 6 members; and (3) from 12 to 14 years, which also have 4 to 6 members. Mixed-sex groups at the oldest age level are sometimes possible. Play therapy is the communicative device up to 12 years, the focus being on feelings and conflicts. It is obvious that the ability to communicate is a prerequisite here. Beyond 12, discussions rather than play constitute the best therapeutic medium. Techniques include confrontation, analysis of behavior in the group, and dream and transference interpretation. Both activity (during which acting-out may be observed) and discussions are encouraged at various intervals. Interventions of the therapist should be such so as not to hamper spontaneity. Discussion is stimulated by the therapist, and silences are always interrupted. Ideally, individual therapy is carried on jointly with group therapy, particularly at the beginning.

Group therapy may be helpful for adolescents even though resistance is prominent. Identity crises and confusion respond better to group treatment than to any other approach (Rachman, AW, 1972a & b). The therapist must function in roles other than that of psychotherapist—for example, as guide counselor and teacher (Slavson, 1965). A behavioral group approach is often helpful, for example, with disturbed adolescents in a hospital, such as was previously described, as well as in a residential setting (Carlin and Armstrong, 1968). The introduction of several young adults of ages 21 to 24 helps foster healthier transference reactions and provides identification models. The therapist amid the impulsive behavior in the group (which is spontaneous among adolescents) cautiously introduces interpretations.

Some therapists find a cotherapist (preferably of the opposite sex) useful (Evans, 1965; Godenne, 1965). Countertransference phenomena that often occur in cotherapy include excessive attraction to young patients of the opposite sex, fear of "liking too much"

certain patients of the same sex (due to homosexual fears), projection of feelings and frustrated impulses in relation to the therapists' own mates onto the cotherapists or patients of the opposite sex, competition with the patients of the opposite sex for the cotherapists, competition with the cotherapists for the group's admiration and support, and transfer of emotions originally felt for children of the therapists onto members of the group.

The *drug therapy* of children with behavior disorders, schizophrenia, and chronic brain syndromes has included the use of a number of substances (Fish, 1963, 1965, 1966). The most important drug influence has been registered on psychomotor excitement, a control of which reduces other symptoms, such as perceptual and thought disorders. As a result of being calmed down, the children may become amenable to group activities, educational offerings, and psychotherapy (Fish, 1960a & b).

Generally no drug is given until it is proven that environmental manipulation and psychotherapy have had no effect on the prevailing symptoms. Diphenhydramine (Benadryl 12.5-25 mg 3 or 4 times daily; average dose 100-200 mg daily, maximum dose 300 mg) is valuable in behavior disorders with hyperactivity in children over 20 pounds of weight and in anxiety reactions in children under 10 years of age. Since it produces drowsiness, it may be employed as a bedtime sedative. Other drugs that can be used are chlordiazepoxide (Librium) for children over 6 years of age, 5 mg 2 to 4 times daily, increased if necessary to as much as 10 mg 2 to 3 times daily; and diazepam (Valium), 1 to 2.5 mg 3 or 4 times daily, increased gradually as needed and tolerated for anxiety. Promethazine (Phenergan) for severely disturbed children (Bender and Nichtern, 1956) acts as a sedative when 25 mg is given at bedtime or 6.25 mg to 12.5 mg is given three times daily. Phenothiazines may be tried for primary behavior disorders, as well as schizophrenia and organic brain disease where milder therapies are ineffective. Chlorpromazine (Thorazine, 1 mg per pound of body weight daily, or 50-100 mg daily) is used in excited states; should an emergency necessitate intramuscular injection, 0.25 mg per pound of body weight every 6 to 8 hours as needed are given. Trifluoperazine (Stelazine, 0.15 mg per pound of body weight daily, or 1-15 mg daily) is used sometimes in

apathetic, withdrawn children. Taractan (in children over 6 years of age) in dosage of 10 to 100 mg daily, Navane (in adolescents) in dosage of one to 40 mg daily, Haldol (in adolescents) 0.5 to 6 mg daily, and Moban (in adolescents) in dosage of 10-50 mg daily may be tried, in that order, where phenothiazines are ineffective. Haldol may be effective also in tic disorders and Tourette's disease. The employment of Ritalin and Dexedrine will be described later in drug therapy for attention-deficit disorders. Barbiturates should not be given to children. Should hypnotics become necessary, Benadryl or chloral hydrate may be used. The latter is prescribed as Noctec syrup (each teaspoon equals 500 mg) in a single dose depending on body weight up to a total of 750 mg. In depressive disorders in adolescents where psychosocial treatments have failed, imipramine (25-75 mg daily) may be tried, recognizing that cardiovascular symptoms may occur. MAO inhibitors are not recommended. Antidepressants have also been found useful in separation-anxiety disorder, attention-deficit disorder with hyperactivity, enuresis, and obsessive-compulsive disorder (Rancurello, 1986). The use and dosage of imipramine (Tofranil) in enuresis is described in the section on habit disorders. The use of stimulant drugs in attention-deficit disorders is detailed later in this chapter.

The Management of Aggression

The management of aggression constitutes an important aspect of working with children. Methods of handling aggression range from extreme permissiveness—even to the undesirable extent of allowing physical attacks on the therapist—to rigid disciplinary measures and physical restraint.

Aggression is representative of many diverse conditions. It may be a reaction to frustration of a fundamental need or impulse. It may be a means of coping with overwhelming inner fears stirred up by terror of a menacing world. In the detached child it may signify an averting of close relationships with people; in the child with power strivings, a way of gaining control; and in the masochistic youngster, a technique of provoking others to a point where they retaliate in kind. In some children it is the only form of relationship to another human being that they know, and it constitutes a frenzied

appeal for companionship or help. Aggression may be a camouflage for a deep feeling of inner helplessness, and as such it is motivated by the conviction that the only way to escape hurt is to overwhelm others. It may be a manifestation in compulsively dependent children of disappointment in the adults to whom they cling, on the basis that the children's whims are not being satisfactorily gratified or because more favors are being shown to others than to themselves. Before adequate therapy can be instituted, it is essential to know the symbolic significance of aggression to the children and the situations under which it is most likely to appear.

A number of children who exhibit behavior problems in the form of direct or subversive aggression never seem to have developed an inner system of moral restraint or the ability to tolerate an average amount of frustration. Neglected children—those reared without proper guidance or discipline or those brought up by parents who themselves fear aggression and are consequently unable to take a stand with the child—frequently develop a defective repressive mechanism that is incapable of inhibiting rage or of directing it into socially approved channels. Such children usually have no fear of, or respect for, authority. They are narcissistically oriented and use aggression as a coercive tool to force others to yield to their will. There is little contrition or guilt associated with their destructive acts, and the children usually take the attitude that people or objects on which they vent their rage are worthy of its consequences. Retaliatory measures have little deterrent influence and actually may incite the children to further bouts of aggression.

In treating children showing this form of aggression, a permissive environment is worse than useless. This is because a sympathetic tolerance of the children's rage plays into the children's contemptuous attitudes toward authority. Actually, the children themselves see no necessity for change, and a permissive atmosphere merely perpetuates aggressive strivings.

The ideal objective in these children is to build up a superego capable of exercising control of their inner impulses. Much as growing infants develop a conscience from

external restraints and prohibitions, so the children with diminutive superegos need discipline to nourish this impoverished portion of their personality. A kindly but firm expression of disapproval, and even irritation in response to destructive behavior, are much more rational approaches than its sanction or tolerance. The children must be taught that there are limits to their conduct beyond which they cannot go, that they have responsibilities for their daily acts that they must face, that definite things are expected of them, and that they have to live up to these expectations. When, in the therapeutic setting, limits to the children's conduct are first established, the children are apt to react violently; but as firm discipline continues, they will themselves discover that they are much more comfortable knowing that there are boundaries beyond which they cannot go. This is not to say that they yield themselves readily to such circumscription of their freedom. The usual reaction is to engage in a prolonged struggle with the therapists to break down the limits imposed on behavior.

The therapeutic situation differs from any previous atmosphere because the children soon begin to feel in it a warmth and expectation such as they have never before experienced. Indeed, while in the realistic world their impulses have brought them a measure of gratification they have also isolated them from people. They gradually begin to understand that therapists are adults who are not threatened by their aggression and do not yield to it or withdraw love even in the face of the most provoking tantrum.

As the children continue therapy, affection for the therapist gradually increases. Eventually, the children seem to go through a stage in development similar to that of the normal evolution of the conscience, namely, they feel it essential to win the therapists' approval and love. Whereas punishment and threats of abandonment have had little influence on the children's aggression, the fear of losing the approval of the only adults who have become significant to them has an extremely potent effect on the ability to inhibit rage. Needless to say, the process during which the children reintegrate themselves with authority, in which they identify themselves with loving adults and seek to win the latter's love and approval, is a long and tedious one. But the conscience, even in normal children, never develops precipitously; rather it extends over a period of years. One must

not get too discouraged if the youthful patients have temporary setbacks in relationships with authority, including therapists.

There is another type of aggression in the form of a power striving that resembles the aggression in children with an undeveloped superego, but it has an entirely different dynamic significance and calls for a radically different kind of approach. The superego, instead of being diminutive, is hypertrophied and takes on a terrifying and punitive aspect. The image of authority is that of a fearful and destructive force that can overpower and mutilate the children if they yield to its control. The way that the children cope with their helplessness is by overwhelming others with their power drive and aggression.

The object in therapy here is not so much to reinforce and solidify the superego, but rather to undermine it and replace it with one that does not threaten the children for the exercise of their impulses or functions. It is consequently necessary to tolerate aggression as much as is possible within reasonable limits of safety and decorum. Unlike the case of the first type of aggression, a permissive environment is essential. The permissive atmosphere at first often incites power-driven children to exaggerated acts of aggression. These seem to be defensive techniques by such children to avoid yielding their vigilance against authority.

Power-driven children often have difficulty in expressing softness, love, or tenderness. These emotions conflict with their self-ideals, and this is especially the case in children reared in environments where toughness and strength are the only admirable qualities in life. During therapy in a permissive situation, such children gradually begin to let down their guard. One sees them working cautiously with creative materials, and there often emerges from deep within the children a great deal of esthetic feeling that has been buried previously under a crust of hardness. The amount of anxiety that accompanies the expression of tender emotions is amazing. As the attitude toward authority gradually undergoes a change, the children usually find it more permissible to enjoy softer impulses. In a hospital ward, for example, many children who have been egocentric and destructive may be seen, after a while, making active attempts to help the crippled and defenseless

children in dressing, in their habit training, and in other routines. During the period when I was in charge of a boys' ward in a large mental hospital that housed violent and intractable boys who had not been able to get along in any other setting, I noticed this phenomenon repeatedly.

Another form of aggression frequently encountered is that in dependent children, who cling to the therapist or to other children in a submissive and ingratiating way. The aggression is stimulated by a feeling in the children that they have not received a sufficient amount of attention or love. The demands of dependent children are often so inordinate that it is impossible to live up to their expectations. There is involved an element of magical wish fulfillment, and rage occurs when wishes are not automatically granted. There is another important reason for aggression in the dependent child, and this emerges from their conviction that independence is being crushed by the people upon whom they lean. As long as dependency remains the keynote of living, assertiveness, activity, and creative self-fulfillment are constantly subdued. Great hostility may be underneath the outer core of submissiveness and ingratiation, and the children may regard the adults who care for them as overpowering beings who prevent them from attaining to self-sufficiency. This is one reason why aggression is precipitated without any apparent cause in those children who receive unlimited privileges and favors. It is essential for personnel who deal with children to understand this, because the eagerness of adults to overprotect dependent children may actually rob the children of the necessity of participating actively in their own growth.

Dependent children may burn up their energy cajoling or forcing others to carry them, because they feel too helpless to accomplish things through their own efforts. Therefore, a program must be instituted in which the children learn to accept responsibility for daily routines of living. Self-growth is attained primarily through achievement. It is understandable that the children will exhibit episodes of aggression when they sense that others insist that they stand on their own feet. It is important not to yield to the children's aggression when it is obvious that the children are trying to force the therapist to care for them.

Finally, it is necessary to consider the aggression exhibited by shy and detached children. Such children are usually referred to a clinic or to a hospital because of neurotic symptomatology, psychosomatic complaints, or severe psychoses. Aggression, here, is at first not expressed, and the outward behavior of the children is usually of a compliant and innocuous nature. Detached children are threatened constantly by life and by people. They maintain their safety either by submitting to others or by building a defensive chasm that separates them from the world. In individual play therapy they will sit quietly awaiting instructions with little show of spontaneity. In a group of other children they will isolate themselves and play alone. They possess an enlarged and punishing superego as well as a great undermining of self-esteem. Beneath the shell of compliance are great quantities of hostility that they fear expressing openly. The object in treatment is to get them to mingle intimately with other children, to engage in competitive activities freely, and to express their aggression without counteraggression on the part of surrounding adults. This necessitates an extremely permissive environment.

Detached children are driven by a spontaneous force to assert themselves with other children and with adults, but their efforts in a normal environment are usually frustrated. In the permissive environment of the clinic or hospital these children gradually experiment with self-expressiveness. In play therapy they may reach a point where they break through their reserve and begin working with pliable materials that they can manipulate or destroy. Later on, they may begin to penetrate from the periphery of the group to its center, participating in activities that bring them into contact with others.

As the children realize that they will not be hurt in closer relationships with others, they may engage gradually in mild competitive activities. Later, they may actually take a stand in life, defending their own rights and demands. At this point a tremendous amount of aggression is released, and they may become very destructive or assaultive. The aggression frequently is in the nature of a test to provoke adults around them into acts of retaliation in order to prove to themselves that their previous concepts of the world as menacing were justified. Furthermore, as the permissive environment begins eating away at their repressive images of authority, they may begin experiencing feelings of love

toward the therapist. They may become so overwhelmed with terror out of fear of getting close to anyone they may direct their aggression at the therapist with little external provocation. Therefore, some tolerance of the children's aggression is therapeutically indicated.

Aggressive acting-out children have been helped by behavioral reinforcement programs. Rewarding desired behaviors with complete ignoring of unacceptable behavior has resulted in significant improvement. Working with parents and teachers to educate them regarding the meaning of the disturbed behavior is indispensable as a way of helping the children retain their gains. If behavior therapy does not help the problem, a program of psychotherapy (which may be a long-term one) with the children and parents will be required.

The Hyperkinetic Child (Attention-Deficit Hyperactivity Disorder (DSM-III-R Code 314.01)

Whenever therapists encounter an aggressively hyperkinetic child, it is important to rule out organic syndromes that may manifest themselves purely as a behavior disorder (Wender, P, 1971). Symptoms of aggression, frustration intolerance, hyperactivity, and disturbed behavior occurring prior to 6 years and even 10 years of age may be a consequence of damage to the brain brought about by such etiological factors as a high forceps delivery, severe infantile infectious illness (e.g., whooping cough, measles), and frequent spells of high fever without apparent cause (Levy, S, 1966). Before making a diagnosis, however, it will be necessary to rule out ordinary physiologic hyperactivity, reactive and neurotic behavior disorders, childhood schizophrenia, and mental retardation. Childhood depression also may mask itself in hyperactive and psychosomatic reactions (headache, abdominal pain). A rule of thumb has been applied to the effect that if children do not have enough control over themselves to sit still while watching their favorite television programs, an organic brain problem should be suspected. In true hyperactivity of organic origin there is a limited attention and concentration span, emotional lability along with impulsiveness, an inability to delay gratification, and poor frustration tolerance. Minor neurological signs and an abnormal electroencephalogram

may be present. Often a learning disability is the reason children are referred for treatment. Because of sadistic, uncontrollable behavior, the children may be ostracized by other children and may be excluded from school. This undermines self-esteem and sponsors paranoidal ideas and more violent behavior.

Therapy is difficult and prolonged and is best administered by child therapists, preferably those who have had experience with hyperactive children. Work with both children and parents is essential. The latter must be counseled and educated regarding the nature of the problem and the need to refrain from applying the labels of "good" and "bad" to the children. It is often difficult for parents to accept the diagnosis of organicity and to control their desperate fears and guilt feelings. The cooperation of a neurologist may be helpful. Tutoring for special learning difficulties may be essential, as may exercise programs to improve motor skills. A comprehensive treatment approach is thus best. Feighner and Feighner (1974) describe one such program consisting of a complete evaluation of the child, pharmacotherapy, behavior modification, curriculum counseling, training for parents and teachers, parent-child interaction videotaping, and feedback sessions while coordinating the treatment of the children with the family.

Drug therapy is usually symptomatically effective, the object being to stimulate the braking mechanisms of the brain to inhibit the motor overactivity. The drug that is most popular is methylphenidate (Ritalin), which is used in children over six years of age. Before breakfast and before lunch, 5 mg is given, gradually increasing by increments of 5 to 10 mg weekly up to a total of 60 mg if necessary. Usually 20 to 40 mg will be effective. If there is no improvement in one month, the drug should be discontinued. Other drugs that may be employed are the amphetamines. Dextroamphetamine (Dexedrine) may be given to children over three years of age as tablets or elixir. In children of 3 to 5 years, 2.5 mg is given daily, increased at weekly intervals by 2.5 mg until an optimal response occurs. In children over six years of age, 5 mg is given once or twice daily, raised weekly in increments of 5 mg until the best response is obtained, which is usually below 40 mg. Pemoline (Cylert) is an alternative drug and is given in dosages of 37.5-112.5 mg. All of these medications may be reduced or discontinued over weekends or during school

vacations. After the patients reach puberty, the drugs may not be needed at all. Hyperactive children in a classroom setting may be helped by the stimulant drugs Dexedrine and Ritalin to control their behavior by improving attention and completion of classroom assignments. Behavior therapy is also effective in reducing fighting and quarrelsomeness, improving frustration tolerance, and controlling temper outbursts. Much of the behavior therapy can be done at home, the parents being trained in operant-reinforcement techniques. Target behaviors to be controlled are listed, their frequency and provocative stimuli charted, and contingent positive reinforcements of appropriate conduct and negative reinforcements of misbehaviors consistently applied (Safer and Allen, 1976). Self-instructional, self-control training may also be possible in some children (Meichenbaum and Goodman, 1971).

Coordinately, other adjunctive modalities previously mentioned should be employed. Parent groups meeting in six weekly sessions have proven beneficial. Reading materials should be assigned to parents, such as the article by M. A. Stewart (1970). Teacher groups also have their use. Play therapy, contact with teachers, videotape sessions with the parents to play back interactions, remedial tutoring, and special exercises are other useful techniques.

In the medium of their relationship with their therapists, the children are encouraged to explore their feelings and attitudes. The poor impulse control and the motor incoordination of the children during treatment may stir up countertransference reactions in the therapist, at home in the parents, and at school in the teachers. A passive neutral attitude will create insecurity in the children. On the other hand, counteraggression will add fuel to the fire. A firm, kindly attitude is best. Should the children become violent, they should physically be removed from the disturbing situation so as not to perpetuate their behavior. Slowly, with proper management, mastery of behavior may be established, and there will be an ability to cope with increasingly challenging situations.

Hyperactive reactions may occur in situations other than in minimal brain

dysfunction and present the same symptoms as the latter—for example, in children with unsocialized aggressive behavior, anxiety disorder, sociopathic personality disorder, and psychosis. In such cases stimulant drugs may not be effective or may actually exaggerate the symptoms. Appropriate diagnosis is essential in treatment planning. Individual, family, group, and behavioral approaches are productively employed in these conditions, but stimulant medications are definitely contraindicated.

Residual-attention-deficit disorder in adults, characterized by emotional lability, restlessness, and impulsive outbursts that are not due to schizotypal or borderline personality disorders also respond to methylphenidate (Ritalin) and pemoline (Cylert) (Wender et al., 1985).

Juvenile Delinquency (Childhood or Adolescent Antisocial Behavior, DSM-III-R Code Y 71.0)

A famous writer presented the problem of juvenile delinquency in these words: "Our youth now love luxury. They have bad manners, contempt for authority, disrespect for older people. Children nowadays are tyrants. They no longer rise when their elders enter the room. They contradict their parents, chatter before company, gobble their food, and tyrannize their teachers." These are the words of Socrates, written in the fifth century B.C. In the thousands of years that have passed since Socrates, we are not only still grappling with how to control youth's defiance of convention, but also with serious infractions of law that are represented by offenses of violence, stealing, fire setting, vandalism, dangerous drug use, rape, and other crimes.

Delinquency among children who belong to asocial gangs is common in economically depressed areas. Here a cultural-transmission theory has been posited by such authorities as Tannenbaum (1938) and Topping (1943). Other authorities insist that the quality of family life is what is of greater etiological significance. Susceptible children are those from families in which there is no cohesiveness, no clear-cut authoritative model with which to identify, and little or no constructive supervision and discipline (Glueck and Glueck, 1950). Delinquent groups are powered by forces in opposition to the social world. (Cohen, AK, 1955). Collective solutions are evolved that, though antisocial, gain mutual support

and identification. Work with delinquents, therefore, must take into account both the disruptive family organization and the deprived environment from which they come. Therapeutic directions are milieu oriented. These focus on a broad community approach, enlisting the aid of religious leaders, social agencies, and police groups. Economic help, counseling, and casework for the delinquents' families and rehabilitative group work with the delinquents themselves are given within the strictures of the available personnel and budgetary restraints of the involved community. Individual psychotherapy generally fails unless comprehensive environmental approaches are employed. A peer group can be the treatment of choice. Nevertheless, the need for individual therapy with a therapist who can act as a role model should not be minimized. Therapists directing adolescent groups require training and experience in working with adolescents.

Delinquency does not confine itself to children from deprived and lower socioeconomic families. It affects upper- and middle-class groups as well. A. M. Johnson and S. A. Szurek (1952) have shown that the inability of parents to set limits due to poorly integrated impulses and "superego lacunae" (Johnson, AM, 1949), and the goading of children to act out unconscious perverse and hostile parental strivings that were unresolved in the parents' own relationships with parental figures, produced delinquent behavior. "It is possible, in every case adequately studied, to trace the specific conscience defect in the child to a mirror image of similar type and emotional charge in the parent" (Johnson AM, 1959). A specific superego defect may thus be created in the children that reflects the parental flaw. Szurek (1942) insists that many cases of psychopathic personality are products of unconsciously determined promptings from both mothers and fathers that encourage amoral and antisocial behavior. The child "victims" chosen are the recipients of subtle insinuations and suggestions that may often, even though the parents are not aware of their presence or implications, be detected by a good clinician during an interview. Indeed, psychotherapy with delinquents may have to be focused on the parents rather than the children since they will tend to undermine the children's treatment should the children stop responding to their messages.

Modifications of technique are obviously very much in order in working with a

family neurosis, and this was years ago pointed out by Aichhorn (1936). Aichhorn's methods, employed during the residential treatment of delinquent adolescents, inspired the founding of special residential units organized around providing emotionally corrective experiences (Brady S, 1963; Redl, 1959). Bettelheim (1950), E. Glover (1956), Noshpitz (1957), Szurek (1949), and Szurek, Johnson, and Falstein (1942), among others, have introduced methods that have proven of value in dealing with the problems of delinquent children and their families.

The treatment of delinquency is eminently unsuccessful, however, no matter what strategies are utilized. This is in large part due to the effect on the people handling the children. The children's expectation of rejection and punishment promote rampancy and rowdyism, to which the human targets of this turbulence respond with retreat, outrage, and often brutality. The self-fulfilling prophecy of the children that they will be hurt creates a feeling of hopelessness and distrust. They move from one situation to another with the same result. Ultimately, the children may be placed in a *residential treatment unit* organized around the philosophy of a structured therapeutic community (Alt, 1960; Balbernie, 1966, Noshpitz, 1975). Various orientations exist among different centers. Thus, a center may operate as a school, casework agency, or hospital with appropriate personnel such as teachers, caseworkers, nurses, and physicians. Psychotherapy of a group and behavioral nature is usually available in such units depending on the philosophies and skills of the therapists.

Residential centers have increased in numbers, but unfortunately not in quality. An exception is the unit in England known as Finchen Manor described by Langdell (1967), which was organized for selected multiproblem families. An effective unit requires a special design. *(Roche Report,* 1966). Most present-day units are not well organized or operated effectively for ideal management of delinquent children. Moreover, residency is too short term, less than the minimum of two years usually required for any change to register. In addition, there is a lack of coordinated services (provision for educational and vocational opportunities, outlets for aggression, need for privacy, and an absence of well-trained staff and other personnel who are both caring and capable of maintaining

adequate control. Too often the aggression of the children leads to rememdies of isolation, punishment, and drug treatment, which, while temporarily effective, do not alter the existing difficulty. A pertinent problem in some settings is the insistence in retaining the medical model in the institution, which is an inappropriate one for children (Linton, 1973). Here the responsible psychiatrists, clinical psychologists, and psychiatric caseworkers are not in as intimate contact with the children as would be childcare workers, teachers, and other people who can be intimately related to the children's daily life and behavior. A reeducational model that involves total milieu planning is more appropriate than a medical model. It has been recommended that a different type of professional is needed for residential units, one who has received comprehensive training designed for the tasks that he or she will pursue. In France, Denmark, and the Netherlands, for example, a new discipline is evolving concerned with mediating child problems ("education orthopedagogue").

A great deal of the failure in treatment is also due to the paucity of aftercare services once the children leave the residential unit. Little continuity usually exists between the residential center and the environment to which the children are returned, which continues to impose on them the original traumas and deprivations. *Intensive home therapy* by medical and non-medical personnel has been employed with some success (Dornberg et al., 1968). Therapist activities will vary from guidance and support to formal marital or family therapy depending on the needs of the family. The home therapists usually work under the supervision of the child therapists who are in charge of the program. Among the conditions for which home therapy is especially indicated are the presence of a psychotic parent at home, refusal of children or parents to accept office treatment, the dealing with double and multiple binds, adverse reactions of a mother to a baby or her pregnancy, and projective mechanisms in parents that activate the children's disturbed behavior.

A *day care center* constitutes a useful modality for some children, particularly those who manifest such problems as severe withdrawal, lack of object relationships, impulse control, and blocked language use (Westman, 1979). Reinforcements are provided for

constructive conduct (North, 1967). Day-care treatment often avoids prolonged hospitalization, providing the children with a therapeutic environment for many hours a week while remaining a part of their families. A disadvantage is the low therapist-to-child ratio, which is ideally one to one. One way of meeting this dilemma is to train ancillary workers, some of whom can be recruited as part of a corps of volunteers.

Learning and Reading Developmental Disorders

A host of academic skill disorders exist under the umbrella of specific developmental disorders that have distinctive DSM-III-R Codes. These include *developmental arithmetic disorders (315.10), developmental expressive writing disorders (315.80), developmental reading disorder (315.00), developmental expressive language disorder (315.31), developmental receptive language disorder (315.31), and developmental articulation disorder (315.39).*

Learning and reading disabilities are the commonest single immediate causes for the referral of children to guidance clinics (Rabinovitch, 1959, Silver, 1975). In prescribing appropriate treatment, psychological tests are in order to ascertain the general intelligence and to assess the potential, achievement level, developmental readiness, and degree of emotional disturbance; neurological examinations are recommended to rule out brain injury and aphasic disorders. Generally there is a close relationship between learning disabilities and emotional disturbance, but the presence of emotional illness itself does not presuppose that there will be failure in school work. A psychological inability to learn or to read is often a symptom that serves a specific purpose, such as to punish the parents, to defy authority, to refuse to grow up, to avoid competition, or to punish oneself. Anxiety that emerges from the children's school failures adds to their inability to attend and to concentrate on work. Even when the problem is organically determined, as when there is damage to the associational patterns controlling visual-motor functioning, such anxiety may act as a prime disorganizing factor. The treatment of learning and reading difficulties will depend upon their cause. Problems rooted in organic brain disorders will require retraining, using visual, auditory, and kinesthetic approaches (Kephart, 1955;

Strauss, AA and Lehtinen, 1947; Strauss, AA and Vernon, 1957). Disabilities provoked by emotional factors will call for psychotherapy, aided, if necessary, by special tutoring and remedial reading.

School Phobias(Separation-Anxiety Disorder, DSM-III-R Code 309.21)

A school phobia is really a family problem and usually involves an immature, indulgent, or highly controlling mother who has been unwilling to separate herself from the child. A prephobic conditioning occurs prior to the school years. Children who have been reared with the idea that the world is an unsafe place, and that a mother is necessary to protect them and make things safe, are particularly vulnerable when thrust into the strange environment of a school. Often the mothers are unaware of their own dependent needs and of their ambivalence toward their own mothers, which they are projecting onto the children.

Once realistic causes for fear have been ruled out, such as stressful situations within the school itself, juvenile terrorists who threaten or attack the child, a disturbed teacher, identifiable handicaps such as reading disabilities and other cognitive dysfunctions, or childhood depression, treatment may be started. The first step is to insist that the parents be firm with the children to the effect that school must be attended. Sometimes the children will have developed a host of somatic complaints (headaches, "stomach trouble," intestinal cramps) to reinforce the stay-at-home position. After a physical examination has revealed no organic problem, the parents will have to handle their fear that they will damage their children by insisting on school attendance. They must be persuaded of the fact that the longer the children stay away from class the more difficult it will be for the children to return. The school personnel may have to be brought into treatment planning to bolster the parents' resolve that the children must go to school even if the children complain and act ill in class.

Some family therapy with the parents is usually necessary to apprise them of their own involvement in the situation (in terms of their personal history and problems) and to give them support in the handling of the children's recalcitrance. The parents have to

bring the children to school at first, and therapists should be available on the telephone to render assistance to these flagging parents who are wilting under the children's intransigence. Occasionally, behavioral desensitization is helpful as an adjunct (Eysenck, 1960a).

If the children's fear is associated with children who terrorize or threaten, this will have to be handled with the school authorities. Should the problem be the children's classroom teachers who are disturbed, the children may do better in another class. Coordinately, psychotherapy may be needed for the children, as well as the parents, and sometimes they may all be seen together. If the children have a serious emotional problem, such as depression, intensive therapy may be required and perhaps some antidepressant medications. The parents may have to continue in long-term therapy after the children's symptoms have come under control to work through their own dependency problems.

Psychotic Children

Apart from *autistic* disorder (DSM-III-R Code 299.00) no generally recognized subtypes are classified in the existent group of "pervasive developmental disorders". In the past they have been loosely lumped in the categories of Atypical Development, Symbiotic Psychosis, Childhood Schizophrenia, and Childhood Psychosis.

The treatment of psychotic children is organized around a design that takes into consideration "the severity of the psychological impairment, the creation of a therapeutic relationship, the formulation of realistic expectations, and the maintenance of therapeutic agility" (Shafii, 1979). Psychoanalytic approaches are of greater use in exploring the dynamics than in contributing to practical management. This will necessitate flexible combinations of pharmacology, behavioral techniques, family therapy, and milieu therapy. Drug treatment has many drawbacks but in active psychotic states it may be essential. What has to be kept in mind is that children require relatively higher doses of psychoactive medication in relation to their weight than do adults and adolescents, that low dosage exposes children to risk with little chance of benefit, and that medications may

result in unforeseeable long-term complications. When deemed necessary, neuroleptics such as chlorpromazine (Thorazine) and haloperidol (Haldol) may be employed with overactive children. Haldol is especially valuable in children with tics and Tourette's disease. Operant conditioning techniques may be indispensable in psychotic children, and especially with autistic children, in whom they may establish some measure of social conformity and reality-based behavior.

Residential treatment of children and adolescents is sometimes essential in youngsters who are out of control and who constitute a danger to themselves or others (Wolberg, LR, 1959). Psychotic children particularly will need hospitalization (Gralnick, 1966) as may severe cases of anaclitic depression (Spitz, RA, 1946), certain delinquencies (Aichhorn, 1936), and severe psychosomatic and organic conditions (Rapaport, HG, 1957).

Childhood schizophrenia (Bender, 1947; Despert, 1948), early infantile autism (Kanner, 1959), and the "symbiotic psychosis syndrome" (Mahler, 1952) are characterized by profound disturbances of behavior on every level of functioning—physiological, psychological, and interpersonal. Withdrawal tendencies and problems in communication make treatment extremely difficult. Therapy aims at establishing a better integrity of body image, a sense of entity and identity, a consolidation of object relationships, and a restoration of defective developmental ego functions (Mahler et al., 1959). Therapists provide for the patients auxiliary egos and encourage a living through of those developmental phases that were thwarted in the patients' actual growth experience. An interesting account of such a working-through with a schizophrenic in an intensive relationship is described by Sechehaye (1956). Due to the primary process nature of the children's behavior and communication, it may be difficult to comprehend the meaning of their verbalizations and actions. Here therapists may have to serve an educational function.

Emergencies

Sometimes emergencies arise in children that the psychotherapist may be called on to resolve. Usually they are the climax of a long preceding period of maladjustment to

which the parents may have been oblivious or indifferent. They are differentiated from the normal developmental crises that call for minimal interventions since they may be the means to conflict resolution. Acute disturbances in adolescents may occur as a result of identity crises. Here a quiet youngster may suddenly become aggressive and destructive. Often we find this among adolescents who have been forced to be "good." As they enter into the turmoil of adolescence they break through their passivity by outbursts of aggressiveness. On the other hand, aggressive and violent behavior, as toward people, may be the result of a psychosis, which will call for entirely different management. To put a youngster with an identity crisis into a psychiatric institution as a result of the crisis will only contribute to the identity confusion.

True emergencies will call for accurate assessment of underlying causes. A detailed history of the children's development and interviews with the parents and perhaps teachers and other significant adults is in order. The therapeutic plan will then be discussed with these people. The plan may follow a crisis interventional model.

One of the most common emergencies is *running away* from home (Jenkins RL, 1973). It is estimated that there are 600,000 to 1 million runaway children yearly in the United States. Often the elopement is to communes of peers who encourage drug and promiscuous sexual indulgence. Some runaways are normal children escaping from a situation of intolerable stress or complete rejection. Some seek constructively to effectuate separation-individuation, which is impossible in a home that continues to infantilize them.

The effect of this gesture may be disturbing to the families, but it calls for an examination of their role in blocking the children's personality growth. Since over 90 percent of cult members leave the group within two years, patience, understanding, and resumption of communication with the children are essential.

Some schizophrenic children resort to disorganized runaway tendencies and may be accepted in a group that seeks to protect them, though they in fact offer little. Commonly, running away is a delinquent response, all the more dangerous since the children may be

attracted to delinquent gangs that wreak havoc in the community. Diagnosis is important since *why* the children run away will determine the kind of treatment that must be instituted. In all runaway problems, work with the families as well as the children is mandatory.

Another emergency is a *suicidal attempt,* which most frequently occurs in teenagers between 15 to 19 years of age. These are often impulsive in nature, precipitated by disproportionately minor provocative incidents that, for the youths, are interpreted as of major importance. What is behind the attempt (conflict over sexual impulses, self-punishment for forbidden impulses or thoughts, projected aggression against a parent or sibling, frustrated dependency, persecutory delusions, toxic drug reaction, hopelessness, depression) will require persistent probing. Whether or not hospitalization will be needed must be assessed. At any rate, environmental rearrangements may be required along with therapy for the children and at least counseling for the parents.

The easy accessibility of *drugs* during period of school attendance or during leisure hours has, particularly in adolescents, produced emergencies brought on both by the discovery of the indulgence by parents and by an overdose of the intoxicating substance. Although casual temporary experimentation with such drugs as marijuana may not be too significant, substances such as amphetamines, barbiturates, codeine, and heroin can lead to serious emergencies and addiction. The use of mind-expanding drugs, such as LSD, substances in glue (glue sniffing), and gasoline is also fraught with dangerous consequences. Usually, combinations of drugs have been taken, and their exact identification is difficult when the children are admitted to a detoxification center, since they themselves usually will not know what they have imbibed. Behind the taking of such destructive drugs may be efforts to escape from depression, boredom, stresses of separation-individuation, and impulses of aggression. Often the only signs that these youngsters exhibit are anxiety, excitement, and overactivity. The temptation for clinicians is immediately to use sedatives. Without knowing whether or not drugs have been taken, and their nature, it is dangerous to contribute to the drug toxicity by adding other substances to an already overloaded nervous system. In recent years there has been a

shift from hallucinogenic and tranquilizing drugs to alcohol, and it may be anticipated that cases of acute alcoholic toxicity will be increasing among adolescents. After successful detoxification, a psychotherapeutic program, often prolonged, will be required.

In *car crash cases* where one youngster is killed and another survives with minor injuries, it is often helpful in the emergency room for the doctor or nurse to communicate to the survivor that it is common in such cases to feel guilty and, if this happens, to recognize that it will eventually be gotten over. Allowing the youth to verbalize feelings while listening sympathetically may be important. Sedatives should not be offered since refuge may henceforth be found in drugs. The parents should also be informed regarding the turmoil the child is likely to experience and to anticipate it.

In the event of *death of a parent* the surviving parent should be encouraged to talk about the departed member openly with the children and not to cover the matter up by denying the validity of the pain that the children are bound to suffer. A great area of prevention can be instituted in the emergency room when an adult with a coronary attack is brought dead on arrival. The surviving parent may have no opportunity to see any other professional people than the personnel in the emergency room, who should try to explain how best to guide the children through their grief. A few minutes spent with the parent explaining the need not to cover matters over with a pall of silence may prevent a great deal of misery, particularly among adolescents.

Other emergencies include school phobias, anorexia nervosa, parental beating of the child (the battered child), sexual and other violent assaults, and deaths in the family. These will call for special handling and perhaps extended treatment (Morrison, 1975).

In the U.S., where the divorce rate is almost 50 percent and father absence (due to separation, abandonment, or divorce) is approaching a national epidemic, the breakup of the family may be considered another crisis in child development. Recent studies (Mallerstein and Kelly, 1982) indicate that the effects of divorce are persistent and pervasive for children as well as their parents, with stress, anxiety, and depression lasting as long as five years after the event. Particularly vulnerable are children under six years of

age, when the presence of the father during the Oedipal phase plays a critical role in healthy development. Both mothers and children need special support to weather this crisis. The stress provoked by separation and divorce may need to be dealt with through special counseling, crisis intervention, divorce mediation, and psychotherapy.

PSYCHOTHERAPY IN OLD AGE

As people mature they are confronted with ravages of aging that make a mockery of the advertised joys of the golden years. Eyes, ears, teeth, joints, heart, and other organs gradually deteriorate and physical energies slowly give way. These burdens are increased by the death of loved ones, as well as the detachment of children who insist on leading overly independent lives. Loss of the great ego supports of job and professional position, along with disillusionment with the false promises of retirement, add to the strains of loneliness and devalued self-esteem. The elderly are subject to multiple personal losses due to their longevity (Goodstein, 1985). As medical advances add years to peoples' lives, diseases of aging (arthritis, cardiac ailments, kidney disease, arteriosclerosis, cataracts, cancer) and associated infirmities complicate the existence of the elderly person. But even more devastating are the ravages of fear and insecurity. Little wonder, then, that depression and growing old are so often inseparable.

Women experience such consequences of aging somewhat later than men do. They must, however, endure the disabling illnesses of their aging mates, whose enhanced dependency needs and importunate demands for attention may make them difficult to manage. For the spouse of a depressed, phobic, hypochondriacal, paranoidal, or mentally deteriorating partner, individual or group psychotherapy may be vital to the couple's welfare.

The loss of a mate through death or divorce during the elderly years is especially traumatic, and bereavement reactions not too uncommonly terminate in suicide. Therapeutic help is often focused on crisis intervention followed by continuing psychotherapy of a combined counseling and supportive nature. The ideal philosophy on which bereavement therapy should be based is that although, in the words of Nemiah

(1984), humans do "have a built-in-clock, and are programmed to a destiny to which we all must yield," a happy and fulfilling existence can still be enjoyed in the years remaining.

The assumption that the elderly cannot benefit by psychotherapy, that their dulled cognition and blunted memory are permanently gone, has been proven false (Cath, 1982). Therapy will require an empathic immersion by therapists into the relationship and the ability to deal with countertransference that often involves the therapists' own terror of growing old. There is resistance also on the part of therapists to being viewed as objects of idealized identification.

The employment of environmental support systems is vital as an adjunct to psychiatry. Unfortunately, our culture fails to provide adequate roles for the many old people who retire or who, because of their age, are pushed aside by younger and more energetic citizens. In making efforts at facilitating adjustment, counseling and casework methods may help resolve problems of housing, finances, health, occupation, socialization, and recreation. Proper information and guidance may be all that an older person requires to continue to maintain self-respect and to shore up feelings of self-sufficiency. In many cases more will be needed. Community health centers for the aged are increasingly being demanded that consider the common problems of medical care, housing, transportation, finances, nutrition, job training, recreation, and hospitalization. Preparation for retirement is urgent, and some enlightened industrial groups have taken responsibility for development of educational and social-action programs to ready their executives and employees for termination of their jobs. The economic burden of medical care has for many been lightened by Medicare, but the rising costs of delivery of health-care services are creating many budgetary problems. The economic, legislative, and administrative bodies of government are accordingly constantly being reminded of the growing problems of dealing with the aged.

A shift in living arrangements alone may eliminate a host of difficulties. Any changes must obviously take into account both the person's desire to live in familiar surroundings and the practical needs of one's situation. Dwelling units especially designed for the

elderly have become increasingly popular, and retirement villages containing medical, recreational, and rehabilitative services are available.

Many aged people are needlessly condemned to the wretchedness of nursing homes or the segregation of poorly run retirement communities. In some cases private-home placement may be a more suitable solution, supplemented with the facilities of community centers that have programs for the aged. On the other hand, if individuals are unable to care for themselves, a hospital or old-age nursing or convalescent home may be what is required.

Finding suitable work for an active older person may restore vitality, interest, and self-esteem. It is totally unrealistic to assume that leisure alone can bring contentment to those who have been occupied productively all of their lives. Nor is it sensible for the community to turn people out to pasture who have acquired skills and knowledge that cannot easily be duplicated.

The problems of retirement make preretirement counseling an important preventive measure. New adaptations will be required. Spouses should be prepared for irritation at being with each other full time. Role playing is helpful in preparing the retirees for what is inevitable—time on their hands, a feeling that they are out of the mainstream of life and "has beens." A search for new meanings to existence will be needed.

Education in an aging society is an important aspect of a comprehensive program. Properly implemented, it supplies information to the older person regarding the physical changes in the body and new emotional requirements that take place with ongoing years. It clarifies confusion about sexuality. It furnishes guidelines for continued creativity and vocational usefulness. It encourages enjoyment of positive assets and minimization of liabilities. Programs of adult education to prepare individuals for aging and to help develop new leisure-time interests must include instruction for people working with older people about various phases of geriatrics. The booklet, *Planning for the Later Years,* issued by the U.S. Department of Health, Education and Welfare (Washington, D.C., U.S.

Government Printing Office) contains some excellent suggestions for health maintenance, nutrition, emotional adjustment, housing and living arrangements, retirement income, work, and legal problems. It may be profitably read by the aging person. Other reading materials for the aged or their relatives are given elsewhere in this volume (see the section on old age in the Addenda, [Selected Texts]). For professional persons the writings of Weinberg (1975), Butler and Lewis (1973), Rossman (1971), and Simon and Epstein (1968) and the publications *Medical World News, Geriatrics* (1973) and *Psychiatric Annals,* (vol. 2, no. 10 and 11, 1972) are recommended.

Among the most useful measures are the development of appropriate recreational facilities in churches, schools, community centers, and the various old-age institutions that encourage hobbies, handicrafts, dancing, lectures, and discussions. Social participation increases morale and counteracts withdrawal and deterioration.

The above measures designed to meet the diversified needs of older people may avert or delay the development of untoward senile reactions. The most common of these are confusional syndromes that come on suddenly, particularly when individuals are moved to unfamiliar surroundings or subjected to situations to which they cannot adjust. Old people have a tendency to prowl around at night and during the day to wander away from home. Providing them with activities to occupy their minds tends to keep them more focused on reality.

Perhaps the most difficult problem in providing a solution to the elderly in family settings is the inability of children to accept the inevitable change in role that will be demanded of them as their parents become more helpless and dependent. The psychotherapists consulted by the families will usually have to involve the entire families in the treatment plan, helping children to face the physical and emotional changes in their parents, and educating them about the need for becoming substitute parents for their own parents in response to the latter's developing dependency needs. What the aged person often requires is "a surrogate-protector in much the same way that he approached a parent as a child. . . . It is possible for the therapist to use this delegated authority to foster

and maintain an illusion that the patient has found a protector and one who will satisfy many psychological needs" (Goldfarb Al, 1964).

Mental disorders in elderly people are characterized by a superimposition of psychological reactions (usually depression and paranoidal projections) on an organic substrate. Assessment of the degree of organic involvement is essential in outlining an appropriate program of therapy. This will require clinical observation, laboratory tests, and an electroencephalogram. Once the degree of affective and organic components implicated is estimated, a comprehensive treatment plan includes physical care, rehabilitation, drugs, and psychotherapy. With good supervision the vast majority of unstable older people may be treated outside of a hospital. Geriatric day treatment is both therapeutic and cost effective (Roche Report (March 15, 1982). Transfer to a mental institution causes great anxiety and agitation and may shorten life. If home conditions are unsuitable or upsetting, institutionalization may be inevitable, and, if proper facilities can be found, the last years of life may be made tolerable if not enjoyable.

Depression is the most common symptom in the elderly. Frequently it is misdiagnosed as dementia, memory loss, or other presumed organic conditions, which disappear when the depression clears up. Depression in the elderly is accompanied by frequent somatic concerns, memory or cognitive defects, and occasionally, paranoidal ideas that may expand into delusions. The treatment of depression in old age differs in some respects from that in younger years (Charatan, 1975). Modest treatment goals are pointed toward symptom relief employing a directive, supportive approach with frequent brief sessions rather then infrequent long ones.

If drugs are needed, it must be remembered that elderly people are extraordinarily sensitive to psychotropic medications, which may produce untoward and sometimes dangerous side effects even with lowered dosage. Pressure to prescribe medications is brought to bear by relatives because of disturbing symptoms such as confusion, somatic complaints, insomnia, nocturnal wandering, behavior disturbance, and especially, depression. Adverse side effects are common especially when cardiovascular, kidney, and

other ailments exist, and when various drugs employed to control these ailments interact with the psychotropic substances. Yet psychotropics properly employed can be useful. For example, depression may be the basis of an elderly person's confusion, impaired memory, and personality change. A misdiagnosis of organic brain disease fosters hopelessness and "giving up" by the patient. Here antidepressants may be valuable, with selection of those drugs that produce a minimum of sedation and cardiotoxic and anticholinergic effects, such as trazodone (Desyrel) nortriptyline (Pamelor), desipramine (Norpramin), and monamine oxidase inhibitors (e.g., Nardil). Neuroleptics like thioridazine (Mellaril) or chlorpromazine (Thorazine) should be used with awareness of their anticholinergic side effects. If sedation must be avoided, haloperidol (Haldol) or fluphenazine (Prolixin) may be selected. The anticholinergic effects of antidepressants and antipsychotics (constipation, blurred vision, dry mouth, difficulty urinating) may be very annoying and can be minimized by choosing the least anticholinergic agents available. A good antianxiety drug is alprazolam (Xanax), which has a half-life of eight hours; it may also be used as a hypnotic and mild antidepressant. Oxazepam (Serax) and Lorazepam (Ativan) are preferred to diazepam (Valium). Other good hypnotics for elderly insomniacs are temazepam (Restoril) with a half-life of about nine hours and triazolam (Halcion), whose half-life is very short (3 to 4 hours). Temazepam has been shown to mix Well with other drugs used by the elderly. Since low blood pressure and ataxia, which lead to falls and disabling injuries and fractures, are often caused by psychotropic drugs, patients must be warned to take special precautions in footwear and walking. Absorption of drugs is delayed when taken with food. Medications should, therefore, be given on an empty stomach at least 30 to 60 minutes before retiring. In treating depression in the elderly, it should be kept in mind that depression can be produced or exaggerated by medications taken for cardiovascular disease, such as reserpine (Serpasil), methyldopa (Aldomet), and beta blockers, e.g., propranolol (Inderal). Substitutes for such medications may have to be found. Severe depressions may require electroconvulsive therapy (ECT) after a thorough physical examination, blood count, urinalysis, electrocardiogram, and x-ray of the chest and spine show no contravening abnormalities. A total of 8 to 10 biweekly treatments is best.

Insomnia may require chloral hydrate (Noctec), Dalmane, Restoril, or Halcion. Barbiturates should be given sparingly, if at all, and central analeptics should never be given in confusional states. There are many other substances in use whose virtues are mixed (Hollister, 1975). These include the cerebral dilators Pavabid, Cyclospasmol, Vasodilan, and Riniacol, the ergot alkaloids (Hydergine), and procaine (Gerovital), although the latter can produce a mild antidepressant effect. Small doses of stimulants such as Ritalin sometimes help fatigue and mild depression. Vitamin supplements are often used, but a balanced diet should eliminate the need for heavy vitamin intake.

The conditions requiring psychotherapy in geriatric patients include all of those in younger groups as well as syndromes arising with the deteriorative, metabolic and systemic disturbances of old age. Relationship and interpretative therapies are employed in combination as needed (Goldfarb Al, 1955, 1959; Meerloo, 1955). The question arises as to whether reconstructive changes in the elderly can be achieved through alteration of the basic character structure and development of new potentialities. Or must therapists be content with a holding operation, with symptom relief and better adaptation in areas of living in which the patients are failing, with at best a reorganization of attitudes and value? Elderly people with a basically good ego structure and in whom organic brain damage is minimal may, if sufficiently motivated, be brought to some reconstructive change (Yesarage and Karasu, 1982). Generally, however, significant alterations in character structure are not to be anticipated. Psychotherapy serves to alleviate the anxieties of aging individuals, providing a means for emotional catharsis, reassuring them about their physical condition, helping them deal with depression, grief, and the death of family members and friends, assuaging frustrated sexual feelings, correcting misinformation, managing problems of retirement and difficulties in living alone, mollifying paranoidal projections, and convincing them that their basic needs will be met because somebody cares. Chronically ill patients who live in fear of death appreciate friends and counselors. In psychotic states, psychotherapy may be coordinated with drug therapy even in those with brain damage (Hader, 1964). Short sessions (10 to 15 minutes weekly or bimonthly) may be all that is required. This usually suffices to support dependency needs and to give patients a feeling of being protected.

Group therapy and group discussions are ideally suited to the needs of elderly people, fostering group belongingness, reducing the sense of isolation, and enabling people to deal with feelings of separation and fears of loss and death (Cooper, 1984). The goals in group methods are to support existing personality strengths, inculcate knowledge of human behavior, expand tolerance and flexibility toward individual differences, accept a changing role in life, deal with personal prejudices, facilitate group cooperation, and promote better interpersonal relationships (Burnside, 1970; Goldfarb Al and Wolk, 1966; Klein WH et al., 1966).

One of the problems, however, is getting older people to break through their isolation and join a group. Often individuals will come to an outpatient clinic in search of help for somatic complaints and will resent being referred to a psychiatrist. A well-explained referral, however, will often be accepted, such as that physical problems and suffering always give rise to tensions that make it difficult or impossible for a physical problem to heal and that group therapy often will help resolve tensions and aid the healing process. Most patients experience great relief as a result of group therapy. This may ameliorate somatic complaints as well as mollify problems of living. Through group interactions the virtues of continuing work, sexual, and exercise activities are discussed and encouraged and social isolation is reduced. Many "organ deficits" vanish when personal life interests and social activities are restored (Levenson, 1982).

Psychotherapy was never designed to cure everybody. With present techniques, therapists are able to effectuate symptomatic improvement in almost all patients, behavioral changes in the majority, and complete cure in some. The fact that reconstructive alterations are possible is an encouraging sign, however, since it contradicts the commonly accepted adage that human nature cannot be changed. With continued empirical research the understanding of personality will undoubtedly be advanced, and with more clinical experience therapeutic methods should become enriched. In the meantime, therapists may follow the old Chinese proverb, "It is better to light one candle than to curse the darkness."

Failures in psychotherapy, apart from the employment of improper interventions, are generally the product of mismanagement of the therapeutic relationship. Most commonly, patients are pushed toward reconstructive goals that are beyond their competence and motivation. Also some may seek extensive personality change even though they are incapable of achieving more than symptom relief.

No matter how ambitiously therapists may pursue treatment, they are confronted with limitations in all patients in their potential for growth. Three kinds of patterns may be clinically observed. First, there are promptings so deeply imbedded in the personality matrix that they seem to pursue an autonomous course. No amount of insight or authoritative pressure seems capable of modifying their expression or lessening their force. These tendencies are rooted in conditionings sustained during early childhood, perhaps in the preverbal period before the individuals were able to conceptualize experiences. They may, if sufficiently intense, disorganize adult adjustment. For instance, separation from a mother for extended periods during infancy may sponsor profound feelings of distrust. Apathy, depression, pressing drives for oral gratification, suspicion regarding the motives of people, and a view of the world as menacing may survive in traits

that distort the most bountiful reality in later years. The ego, structured on an infirm basis, sustains disintegrative proclivities. In most people, however, symptomatic residues of early conditionings, though present, are not so pronounced. Minor as the symptoms are, they still defy change and energize maladjustment.

A second group of patternings develops somewhat later, which are remembered, at least in part, and can be verbalized. Serving spurious neurotic functions, they may in execution promote conflict, this group of patternings is subject to some control through willful inhibition once the individuals appreciate the nature and consequences of their inclinations. While these strivings may continue to press for expression, their mastery by patients becomes an important goal. Many of these strivings are rooted in needs and drives that, in promoting anxiety, are repressed. Their recognition, if the individuals are sufficiently motivated, may enable them to bring these forces under control and, in fortunate instances, to eliminate them completely.

For example, a girl whose assertiveness during the second and third years of life was inhibited by parents wedded to the doctrine that children are to be seen and not heard may discover that when she mobilizes sufficient aggression and rage she can get her own way. "Hell-raising" then becomes a pattern essential to the expression of assertiveness. Recognition that her aggression is resented by her colleagues, and insight into the sources of her affiliation of assertiveness with aggression, may enable her to experiment with modes of assertive display dissociated from acting-out. A boy fondled seductively by a parent may become too stimulated sexually and detach from his sexual feelings. Intimate relationships in adult life may precipitate an incestuous association that inhibits sexual expression. Awareness of the roots of his difficulty may enable the individual to experiment sexually with the objective of establishing new habit patterns. A host of pathological conditionings may, as Freud pointed out, invest the sexual and aggressive drives, and the person may develop inhibitions of function or distorted and perverse modes of expression. Burdened by essentially childish needs, he or she may be fixated in activities that survive as outlets for sex or aggression. To gratify these drives, a toll must be paid in currencies of insecurity and damaged self-esteem. This group of neurotic

promptings, with proper therapy—should the individual strongly desire it—may undergo modification. The patient thus either learns to live with handicaps, once they are understood more thoroughly, or is better able to control them. With reconstructive therapy an individual may be able to develop more mature ways of managing sexual and aggressive feeling and behavior.

A third group of patterns present in all people is relatively flexible. This group is not subject to severe repression and does not press for release against all reason. Developing both during early and late childhood and in adult life, the group constitutes the bulk of the individuals' coping maneuvers. These, the most malleable of tendencies, may be influenced most significantly in therapy.

Disappointment in psychotherapy is often registered when, after an ambitious, carefully designed and prolonged program of treatment, patients continue to resist giving up the first set of patterns and must exercise their will power constantly to keep the second group in check. Faulty habit patterns, disorderly study and work activities, conditioned phobias, and many maladaptive attitudes and values are among such tendencies. All human beings are so constituted that no amount of therapy, as practiced today, can alter some personality components, since they have become so firmly entrenched that they function like organic fixtures. Yet, properly designed psychotherapy offers individuals a substantial opportunity to rectify many destructive personality traits and to achieve a measure of happiness that, prior to treatment, was outside their grasp.

UNTOWARD REACTIONS DURING PSYCHOTHERAPY

The bulk of patients in psychotherapy move along well. Obstructions in progress and inimical emotional outbursts are readily handled. There are conditions, however, that pose hazards even for experienced psychotherapists. Personality structures in which emotional instability is ingrained, having existed since early childhood, will in all probability erupt with greater bursts of violence, responding with insurgency and defying control. Impartial as they may try to be, therapists will be drawn into the patients' onslaught and may be unable to maintain an even tenor, either yielding to unreasonable

demands or counterattacking in retaliation. The greatest incidence of untoward reactions in psychotherapy occurs when the relationship between therapists and patients is faulty. Inexperience and improper conduct of treatment, as well as countertransference, account for a large percentage of unfortunate results, although it is unclear how these take place. The work of Bergin (1963, 1971) and Strupp & Hadley (1977) accents the need for further research into deterioration effects and reasons for failures in psychotherapy.

It may not be amiss to mention the virtue of therapists' seeking consultation or supervision for a case that is not going well. This will necessitate courage and honest self-confrontation in facing the fact that they may be acting nontherapeutically with a patient or be employing interventions that do not satisfy the patient's needs. Talking things out with a colleague will often break through the current obstruction and promote satisfactory future movement.

Constituting treatment failure is the emergence during therapy of certain disturbed reactions. These are most apt to erupt when the customary defenses of the individuals are challenged or blocked, as in reeducative and reconstructive therapy; however, they may break loose in certain patients as a consequence of mere contact with the therapists, however supportive therapists may try to be. Thus, borderline patients who are maintaining a delicate balance in holding onto reality are particularly vulnerable to close interpersonal relationships. Even ordinary human encounters stimulate undue tension and conflict. Underlying morbid traits—kept under control by tenuous defenses—may emerge, often with explosive violence. Depressive manifestations may deepen into suicidal attempts; psychopathic aberrations may be acted out in total disregard of consequences; feelings of unreality and depersonalization may spread into an outright psychosis. During any kind of psychotherapy with borderline patients, the course of treatment is customarily stormy, punctuated by fluctuations in the sense of reality. The patients may interpret the relationship as an assault on their integrity, particularly if the therapists are excessively authoritarian or have unresolved hostile or sexual difficulties that filter through in manner and speech. Borderline patients sensitively divine these from the tiniest cues (Schmideberg, 1959). Emotional crises constitute the usual climate in

which therapy is conducted.

Problems are also commonly encountered in the treatment of somatoform disorders, characterized by intensified recrudescence of symptoms. When such eruptions are minor, there is no great danger; however, severe outbreaks of somatic disturbance may occur, such as a thyroid crisis, violent asthmatic attack, or fulminating ulcerative colitis that may lead to death. Suicide is also a possibility. The most disturbing reactions occur in patients who have habitually had a tenuous relationship with other people and a fragile self-image since childhood. "These individuals easily react . . . with a violent frenzied emotional flood, or with destructive violence at times turned in on themselves, or with a more complete withdrawal and inaccessibility. Any of these reactions may be fused with various disturbances of organ function (oral, excretory, circulatory, and also genital) and may reach the point of abandoning adequate contact with reality" (Mittelman, 1948b).

Patients suffering from brain injuries are apt, during psychotherapy, to manifest outbreaks of euphoric, paranoidal, sexually aggressive, or suicidal behavior (Weinstein and Kahn, 1959). Probing procedures employed in manic-depressive psychosis and involutional psychosis may release great anxiety and resentment and activate latent suicidal drives (Arieti, 1959). A treatment relationship in dependent individuals who mask their hopelessness by a thin overlay of indifference may precipitate a deep depression when the patients realize the realistic limitations in the degree of closeness possible with the therapists. Exploratory activities in reactive depressions, are notorious for exciting intense anxiety (Muncie, 1959).

Paranoid reactions respond adversely to almost any kind of human contact. Thus individuals who are burdened with self-doubt and suspicion may in a relationship of even moderate intensity find themselves responding with strong mechanisms of denial and projection. Ego defenses may then shatter, with emergence of oversensitivity, estrangement, preoccupation, distrust, suspicion, fears of physical and sexual attack, litigious tendencies, homosexual impulses, delusional jealousies, and grandiose delusions (Cameron N, 1959). Schizophrenics who interpret psychotherapy as an intrusion on their

privacy often will be provoked into fearful or aggressive reactions. Personality disorders manifest diverse reactions to therapeutic contacts. Urgent dependency needs may be projected onto the therapists, with excessive clinging, release of intense erotic feelings, and liberation of resentment at the inevitable frustration. Detachment with needs for control may be threatened by the patients' belief that yielding to another person implies a trap from which there is no escape. Masochistic promptings may enjoin the individuals to torture themselves with luxurious symptoms. Homosexual strivings kept in check prior to treatment may suddenly appear, promoting panic. Impulsive characters may exhibit acting-out proclivities without warning, engaging in outlandish and dangerous activities (Michaels, 1959).

Antisocial personalities may when challenged respond with excited and even psychotic behavior. Alcoholics and drug addicts are notoriously treacherous, indulging in defiant and occasionally destructive practices. Some patients with conversion reactions display alarming conduct when an attempt is made to alleviate or reduce their symptoms. A psychotic disorder of a depressive or paranoidal type may supervene (Abse, 1959). In obsessive reactions, frightening extremes of anxiety and rage may from time to time be released, along with guilt feelings and expiatory self-punishment, the therapists being accused of promoting the appearance of these symptoms (Rado, 1959).

RISKS OF PSYCHOTHERAPY

Difficulties will also develop as a consequence of the new adaptations forced on individuals as a result of removal of the problem for which they originally sought help. Sometimes a neurotic disorder constitutes the best compromise individuals can make with life and with themselves. Although they may complain bitterly about the disabling effects of their condition, when they are relieved of it, they may expose themselves to new circumstances that will or will not terminate happily. This, of course, is something for which practitioners cannot be held responsible. There is no crystal ball with which to predict the ultimate outcome of any problem. The responsibility of therapists is to help patients overcome an illness and to enable them to make a constructive future adjustment.

The end issues, however, may leave much to be desired, under which circumstances therapy may be scored as a failure. Thus a patient with migraine gets insight into the fact that she is complying, with strong internalized rage, to the authoritative demands of a widowed mother who seeks to infantilize her only child as an outlet for her controlling needs. Therapy helps the patient to liberate herself from her mother. The latter, unable to accept her daughter's freedom, commits suicide. The ensuing guilt, recriminations, and depression in the patient make her regret having started psychotherapy. An obese girl, helped to diet by psychological treatments, finds herself attractive to men. Unable to cope with the sexual demands made on her by her admirers, she responds with panic. A patient with frigidity dramatically overcomes her sexual indifference. Responding passionately to a seductive male, her episode terminates in pregnancy and the birth of an illegitimate child, which complicates her life detrimentally.

It is often impossible to foresee and to forestall future calamities that follow even traditional medical and surgical treatments. Thus the relieving of anginal pain, through prescription by an internist of a vasodilator, may encourage a cardiac patient to overtax the heart through physical efforts beyond one's endurance, initiating a massive coronary attack. Plastic surgery often exposes patients to responsibilities that their devalued self-image is unable to countenance, sometimes initiating many adverse reactions.

Another example would be refusing to treat travel phobias by psychotherapy to protect patients from the possibility of an airplane crash; this would constitute a foolish if not irresponsible shirking of therapists' duty. The best course to follow is to attempt to anticipate possible consequences of therapy and to work with patients until a reasonable stabilization is reached in their life situations.

FAILURES IN RECONSTRUCTIVE THERAPY

There are certain patients in whom long-term reconstructive treatment is not only useless but constitutes a definite hazard. Such patients, in good faith, enter into treatment with well-trained psychoanalysts, and after years of futile probing reach a desperate dead end. In many instances the hope of cure enjoins patients to engage a succession of

therapists, each espousing a well-documented theoretical system that promises success but ultimately results in failure.

If a hard look is taken at what has been happening, it is often found that the therapists have become incorporated by the patients into their neurotic schemes. It becomes obvious that what the patients are seeking from treatment is not cure, but satisfaction of dependency needs, a relief from the suffering that their conflicts foster, but which they refuse to relinquish, and replacement of amputated aspects of themselves that, with present knowledge, are far beyond the power of science to supply. Freud, astute clinician that he was, recognized that not all people were ready for the long-term pull of psychoanalysis when he advised that only individuals able to develop a transference neurosis be treated with his method. Although the diagnostic boundaries are diffuse, empirically it is possible to designate the kinds of conditions in which failures are common with reconstructive therapy.

The most unacceptable of candidates are patients who seem to be unable to get along on their own. These individuals are possessed of such great fragility in their defenses that they tend to fall apart in the face of even reasonable stress. Often they protect themselves from hurt by restricting needs and circumscribing the zones of their interpersonal operations. Yet their helplessness enjoins them to fasten themselves to some host who, they insist, must supply them with love, support, and other intangible bounties. Such unfortunate individuals have been so damaged in their upbringing that no amount of help, affection, discipline, entreaty, supplication, or castigation seems to repair their hurt. They tend to find and fasten themselves to individuals, movements, and institutions from whom and from which they hope to gain sustenance and strength. They act like exsanguinated people in need of perpetual transfusions.

Diagnostically these individuals spread themselves over a wide nosologic spectrum. They include schizophrenics, borderline patients, alcoholics, drug addicts, and antisocial personalities. They may have obsessive-compulsive, depressive, phobic, and somatoform disorders. Essentially they are characterologically immature, never having achieved inner

freedom and independence. It is as if they have become marooned on an island of infantile affect. Outwardly they may present a facade of assurance, but inwardly they are anchored to pitifully dependent moorings.

When such individuals enter psychotherapy, they soon sweep therapists into the orbit of their dependent designs. The grim objective of making therapists idealized parent figures is not diverted in the least by therapists' technical skills, astute observations, lucid interpretations, management of countertransference, encouragement of emotional catharsis, transference revelations, expert unraveling of dream symbolisms, the uncovering of forgotten memories, free association, structured interviews, firm directiveness, punishment, kindness, support and reassurance, suggestion, hypnosis, drugs, or by any other method therapists may exploit or devise. Therapists who are deceived by the earnestness with which patients dedicate themselves to the therapeutic task will credit the patients' lack of progress to the obstinacy of the patients' resistances, which, the therapists imagine, will eventually be resolved. And the patients, coasting along on the premise that time itself brings the cherished gift of unconscious motive or memory, will become increasingly helpless and will then supplicate for greater professions of dedication from the therapists. The liberated hostility serves no purpose other than to make the mutual lives of patients and therapists miserable in a futile tug of war.

With expanded public education and the exciting promises of fulfillment through psychotherapy, more and more individuals—unable to gratify their pathological dependency promptings in their habitual relationships, or through religion, or by affiliation with special movements—have flocked to the office of therapists seeking the elusive pot of gold that never quite materializes. And because hope springs eternal, the therapeutic diggings go on for years in the vain quest of bringing up treasure that somehow, according to legend, must eventually be exposed. Both patients and therapists enter into this undeliberate deception only marginally aware that the quest is a useless one and that what the patients really seek from therapy is supportive aliment for their emptiness.

The great danger in long-term reconstructive psychotherapy is not only its becoming a never-ending placebo to such characterologically dependent individuals who would otherwise find an object of faith outside of therapy, but, more insidiously, its activation of latent dependency needs in those who have managed their lives, prior to treatment, with a modicum of independence and assertiveness. As treatment continues, the defenses, organized around avoiding dependency, break down and are swept away. This contingency is useful, of course, in patients who have a solid enough core to reconstitute themselves. Indeed, unless the shaky superstructure is removed, the defective underpinnings cannot be strengthened to support more adequate defenses. But what happens in individuals who do not have the materials, let alone the tools, to rebuild their lives? That which once served to carry them through daily chores, albeit not as mature as might be ideal, no longer can be used. The patients have thrown away their crutches, and their legs are now too weak to propel them in any direction. The specter of patients being damaged by prolonged therapy is one that unfortunately haunts every psychotherapist.

Can therapists, by proper diagnosis, select patients for reconstructive therapy more appropriately, eliminating those who are subject to the dependency hazard? Are there ways that poor therapeutic risks can be spotted in advance? Psychotherapists find themselves in a quandary because morally and ethically they are committed to helping people develop and grow no matter how sick. A corollary may, therefore, be appended to the questions: When poor therapeutic risks are detected, are there effective treatments?

Before an attempt is made to answer these questions, the qualities of a good therapeutic risk for protracted reconstructive treatment should be designated. For individuals to benefit from reconstructive therapy, the following conditions should prevail.

1. The presence of a personality disorder serious enough to justify the sacrifices inherent in an extended period of treatment.

2. The presence of symptoms or behavioral difficulties that are intensely annoying to the patient.

3. An ability to accept the conditions related to time and finances, and cooperation to undergo techniques that probe the unconscious.

4. The presence of rigid resistances that cannot be resolved by less ambitious approaches.

5. A level of dependency that is not too high.

6. The ability to tolerate anxiety without severe disintegrative reactions.

7. The presence of some flexible defenses, ample enough to support the patients when anxiety is mobilized.

In advance of starting an actual therapeutic program, there are a few prognostic indicators that may be of value. If the patients have been seriously maladjusted since childhood—have failed to achieve goals ordinary for their age levels; have not had a good relationship with at least one person in the past; are not psychologically minded; are prone to severe acting-out; have been in psychotherapy for a number of years, particularly with a series of therapists without achieving benefits; have been institutionalized in a mental hospital; or manifest symptoms of schizophrenia, manic-depressive psychosis, organic brain disease, severe compulsion neurosis, antisocial personality, alcoholism, drug addiction, severe psychosomatic illness, or obstinate sexual perversion—trouble is likely. Projective psychological testing is helpful diagnostically, but it may not reveal much in relation to the outcome.

The best clues will be supplied by the psychotherapeutic experience itself. If patients show favorable responses to interpretations, evidenced by constructive reactions inside and outside of therapy, and particularly an ability to implement insight in the direction of change, therapists may be encouraged. Material from free associations, dreams, and transference reactions will reveal much that is not apparent on the surface. These are usually good indicators of therapeutic movement. If patients respond catastrophically to interpretations, or if they do not respond at all, if they manifest few or no transference reactions or the transferences are too violent, if acting-out persists in spite of interpretation, if their associations and dreams consistently reveal no constructive

developments—these are warnings that danger may shadow continued intensive explorations.

TREATMENT OF POOR THERAPEUTIC RISKS

When signs indicate patients are poor therapeutic risks, the objective will be to bring them to homeostasis as rapidly as possible with short-term supportive and reeducative approaches. It may be useful to confront patients frankly with the realities of their situation. Remarks may be couched in terms such as these:

> *Th.* You have problems that date way back in your life. It will require some time to reverse these completely. There may be some things we may not be able to alter entirely because they go so far back and are so firmly welded into your personality that they may not budge. But you can still live a comfortable and happy life. Now one of the problems in a situation like yours is that you feel helpless to do things by yourself. You will then get very dependent upon me, and it will set you back. For this reason we will keep our treatment short. Please don't feel that I am neglecting you if I encourage you to do things on your own.

These directives obviously will pass over patients' heads. Even though they may appear to agree intellectually, emotionally they will continue to press for a long-term dependent relationship. In some cases they will really need to be dependent on someone or something the rest of their lives since they cannot get along by themselves. If this is a possibility, therapists may still acquaint patients with the dynamics of their problems in the hope of enlisting their reasonable egos as allies. By showing patients the relationship of their dependency to other elements of their personalities, of how and why they get angry, of what they do with their anger, of how they undermine their self-esteem, of why they detach, they are given a reality explanation for manifestations that they have hitherto considered to be mysteriously ordained.

If patients persist in retaining therapists as their dependency agents—and there are many patients who are able to afford this luxury and some therapists who are willing to play such an exhausting role—therapists may graciously accept the post and inform the patients of willingness to treat them and work with them on their daily problems. The therapist may add, however, that the situation will be very much as in diabetes, where insulin must be taken constantly. There are some emotional problems that are like

diabetes and that will require help on a regular basis. Patients need not be ashamed if this is their situation.

There is hardship in working at depth under these circumstances. The patients will merely regurgitate their insights and recite their dynamics like a catechism. The best practice is to settle back with the patients and handle their immediate reactions with logical, persuasive arguments, attempting to inculcate in them a philosophy of living that will help them to accept their limitations and difficulties with grace. At the same time, deep material is interpreted whenever it is propitious to do so. Should the patients rail at the therapist and objurgate him or her for failing to transform them, the therapist must try to control the patients' frustrated feelings. A simple reply is best here: "Maybe it is impossible for you to change." This may have a startling effect on patients for the good, often shaking them out of their therapeutic lethargy.

Recognizing that there are patients who will require aid the rest of their lives and cognizant of the ever-expanding waiting lists, therapists may attempt to provide these sicker patients with a dependency prop that does not require a tie-up of services. For instance 15-, 20-, or 30-minute sessions may be all that is needed. Medications are prescribed intermittently if necessary, and the patients may be encouraged to join groups. Group approaches offer advantages to patients, since they help them to diffuse transference. Within any group, patients generally will select one or two people as their dependency target, but they know they can draw on the group at large when necessary. It is helpful, therefore, to encourage joining various activity groups, such as social and discussion groups. These may eventually replace the therapists as the prime supportive mainstay.

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The Psychotherapist in Community Mental Health

There is a story about a unique way of diagnosing mental illness developed in a small community in Scotland. The "suspected" person is placed in a basement room that has a water tap. The faucet is turned on to flood the floor, the person is handed a mop and asked to dry the floor. If he or she continues to dry the floor without turning off the faucet, the diagnosis of "madness" is confirmed. This droll story is sometimes used to illustrate the situation of mental disturbances in the community. By concentrating efforts on managing the pressing disorders of the mentally and emotionally ill, therapists often lose sight of the fact that they coordinately fail to turn off the faucet in the polluted social system that is pouring out more patients than can be treated.

Such a statement assumes that enough is known about what causes emotional illness and that there are means to remedy the causes to turn off the faucet. Such assumptions are only partially true, but there certainly is sufficient knowledge at the present time, if not to dry the floor, to keep the basement from being flooded. The point is that such knowledge is not being used, nor does our society yet support with adequate economic and other means its implementation.

On the debit side it must be admitted that what was posited 20 years ago as "community mental health" is still a relatively unchartered field that embodies a variety of theoretical systems and methodological approaches. Designs for essential services vary with the characteristics and problems of the community being accommodated, with the needs of the individuals and agencies who constitute the consumers or the client systems, and with the philosophies and training of the personnel staffing the center or clinic that is executing the program. The problem areas for reform potentially are limitless, and, obviously, a rigid selection of zones of involvement will be in order. These range from clinical services for severe emotional problems, to counseling or casework for circumscribed personal and environmental difficulties, to educational projects for the

public geared to preventive objectives, to training programs for allied professionals and paraprofessionals, to hospitalization and day care facilities for the mentally ill, to rehabilitative and work adjustment programs for the handicapped, to consultation aids to organizations or groups in the community.

There are many existing models in community mental health that deal with how these services may be integrated, and many more will undoubtedly be developed with changing politico-socioeconomic conditions. Caplan (1974) in explicating some of these models states that "since we are grappling with a highly complex multifactorial field, no single model can be expected to do more than focus our attention and pattern our expectations about one aspect of the field." What would be applicable in one community does not necessarily conform with the special problems and conditions of another community. Mental health workers must consequently maintain flexibility and use whatever models seem pertinent, always altering these as new accomodations become necessary. At the Postgraduate Center for Mental Health in New York City we have worked in different communities and with almost 500 different agencies, institutions, and community groups in cities and counties in New York, New Jersey, and Connecticut. We have found that rigid adherence to any one model of operation can cripple a program and that a great deal more innovative flexibility is required than in working with individual and group psychotherapy.

There are times in the career of most psychotherapists when they are called on to apply their mental health skills to the social system. For example, a local school is experiencing an extraordinary increase in droupouts. A community is being plagued with an epidemic of misdemeanors and crimes perpetrated by juvenile delinquents. A center is being organized to provide recreational and rehabilitative services for older people, and the founders insist that it be oriented around sound mental health principles. A social agency wants to know how to start a mental health clinic. A group of ministers needs help in doing more effective pastoral counseling. Vocational rehabilitative workers request a course in the psychiatric and psychological aspects of work readjustment. A parent-teacher's association desires a lecture on child development illustrated by a good film. A

fraternal society is setting up a series of discussion groups dealing with family life education and needs a discussion leader. The roles that psychotherapists will be expected to play in servicing any of these requests go beyond those they conventionally assume in the clinic or their office. They must take on among other responsibilities those of educator, public health expert and mental health consultant. If they have had the traditional residency and post-residency training, they will not be equipped to do this, the focus of their education being more on clinical than on community functions.

It is beyond the scope of this book to explicate the details of community mental health or the full operations of the mental health specialist. Ample literature exists on these subjects. Mannino, MacLennan, and Shore (1975) have compiled an excellent reference guide to the consultation literature as well as a serviceable list of films and tapes. A full bibliography may be found in *Community Mental Health and Social Psychiatry,* prepared by Harvard Medical School and the Psychiatric Service of the Massachusetts General Hospital (Cambridge, Harvard University Press, 1962), and *Community Mental Health, Selected Reading List 1961-1965* (Canada's Mental Health Supplement No. 50; November-December, 1965), as well as Beliak et al. (1969, 1972, 1975) Bindman (1966), Brace-land et al. (1975), Hume (1966), and NIMH (1967-1970). Nevertheless, some guidelines will be indicated in this chapter that therapists may find of practical value.

Assume for illustration that a therapist receives a letter requesting a consultation from the director of a boys' club that has been organized around activities, such as carpentry and other handicrafts, for adolescents from deprived economic areas. The presenting problem is poor staff morale, which the director credits to the fact that the staff members feel themselves to be ineffectual in dealing with psychiatric problems. Delinquency and drug addiction among many of the boys, for example, continue unabated. The director believes that a course on psychopathology would be good for the staff and may help them to function more efficiently. The therapist replies affirmatively to the letter and sets up an appointment with the director. Prior to the conference, the therapist may make several assumptions:

    1. The director's diagnosis of what is needed, namely a course on

psychopathology, may or may not be what is required to resolve the problem.

2. In entering into the picture, the consultant (therapist) most likely will find among different levels of the administration, supervisory group, and staff workers, as well as among the recipients of the service (the adolescents) a hotbed of interlocking psychopathological constellations. The consultant will, with full justification, be tempted to prescribe psychotherapy for the most disturbed individuals. To do this would probably prove fatal. Limited finances, absent motivation, and the dearth of treatment facilities render psychotherapy impractical. Solutions other than therapy will be required.

3. A series of conferences will be needed with the director, the supervisors, and the staff individually and collectively to determine what they believe is wrong and to observe the way that they interact with one another in the work situation.

4. A series of conferences with the adolescents, particularly the leaders, may be desirable at some time once the picture has crystallized.

5. The entry of the consultant into the organization will probably stir up initial anxiety and resistance on all levels of the organization that will require handling.

6. Being involved in the dynamics of a social system, the consultant will have to keep communication channels open between the administrative, supervisory, and staff levels of the organization. The boundaries of the consultant's operations will require explicit definition; i.e., the director may need to be informed about what is going on but may not have to be involved in the project itself; written communications will have to be sent by the consultant to the director outlining what decisions are reached and what the consultant proposes to do; written agreement to proposals must be received by the consultant; a liaison person must be appointed by the director to represent the administration; and a decision must be made in joint conference who the consultant will work with in the project.

With these assumptions in mind, the consultant and director set up an appointment to meet in the consultants office. The director appears to be an intelligent, interested, and

knowledgeable person, a social worker who has had considerable experience in the field of group work. The director is very active in community affairs and has affiliations with many community organizations. The director is sociable and relates well. The consultant, inquiring about the program, discovers that 1000 boys are being worked with who live in the area of the club. During the summer the club runs a camp outside of the city. The activity program is managed by a staff of expert crafts people who have had no mental health orientation. The initial impression of the consultant is that if the staff had some mental health information, they may be able to use this in their work with the adolescents. For instance, many of the boys are expressing the usual defiant gestures of adolescents, and some of the staff, the consultant believes, are responding with feelings of not being appreciated. Moreover, a good number of the adolescents have severe character disturbances and are engaging in antisocial activities that may be upsetting the staff. Clarification about the dynamics would, therefore, seem indicated.

The consultant makes an appointment to visit the club and arranges to meet with the staff and supervisory groups individually. Several meetings are also held jointly with the staff supervisors and director. It soon becomes obvious to the consultant that the relationship of the staff and supervisors with the director leaves much to be desired. They consider the director an autocrat who overrides their decisions and who does not allow them freedom in their work. They respond to this by sullen withdrawal and disinterest in their duties. Most of the staff believe that they might learn something constructive from a course in mental health principles and practices. The consultant, however, is convinced that little will be accomplished until better relationships are established among the personnel. The director is not at all aware of personal shortcomings in managing the staff or of their hostile reactions to this management. From the way the director had communicated in the initial conference, the consultant could not diagnose what was wrong until the work situation and the ongoing interactions had been observed.

In discussion with the staff, the following plan is elaborated: (1) a group process to enable the staff to verbalize feelings and to become aware of self-sabotaging reactions that paralyze their functions and interfere with their relationships with the adolescents, (2)

conferences with the director to give the director an opportunity to express feelings and to test the director's flexibility, (3) group meetings with the staff, supervisors, and director, during which they are encouraged to discuss how they feel about one another in their work roles. Such sessions help the director play a more cooperative role with the staff and encourage them to talk to the director about their "gripes."

The consultant does not consider the staff participants as "patients" for very good reasons. First, they do not regard themselves as patients; second, the consultant is principally concerned with their work problems and not their neuroses; and third, group process, employing principles of group dynamics, is the instrumentality that will be used, not probing techniques into defenses and unconscious conflicts. The upshot may be therapeutic for all participants, but this is a byproduct. The focus is on conscious feelings in relation to the staffs ongoing interactions. Improved morale results in the staff taking greater interest in the boys, even taking them on outings. The effects are registered in dramatic improvements in behavior both within and outside the club.

Another example of how a therapist-consultant may respond to a community need is contained in the request of a suburban psychiatric clinic for staff training in psychotherapy. Upon visiting the clinic, the consultant finds that the problem confronting the clinic is that all of the available time of the staff members is occupied in treating a stationary caseload that does not seem to be going anywhere. The waiting lists are long; intake has more or less been frozen for months due to the absence of available therapeutic hours.

Examining the records of the kinds of patients being treated, the consultant finds that most of them are chronic cases: borderlines, or dependent-personality patients who have fastened themselves onto their therapists and have settled into what is turning out to be a permanent niche. The director of the clinic believes that what is required is more sophisticated training of the staff in depth approaches so that the basic inner problems of their patients may be influenced, in this way "curing the patients" and resolving the stalemate. An interview with the staff reveals frustration and demoralization because of

disappointment that they are unable to effectuate cures and because of pressures on them to open up more time for new patients.

The consultant sets up conferences with the staff members, and what is finally decided is the following: (1) establishment of a special clinic for sicker patients organized around drug therapy and no more than 15-minute supportive interview sessions once weekly or bimonthly, (2) transfer of the bulk of patients to this clinic, (3) development of a social rehabilitative unit in a neighboring church recreational center to which the patients may be referred for adjunctive social programs, (4) organization of a group therapy clinic and training of the staff in group therapeutic techniques, (5) concentration on short-term therapy as standard for the clinic and staff training in brief psychotherapy, (6) since this plan is long-term, requiring a period of years for its full development, a training program in group therapy and short-term therapy, for which the consultant will help recruit appropriately qualified trainers, (7) work by the consultant, if possible, with this group over the 3 or 4 years of transition, since there will be much staff anxiety that will require handling.

A third example will illustrate how psychotherapists engage in community work. A therapist-consultant is called into a school to determine why so large a percentage of the students are failing their college entrance examinations. Upon studying the school program, and after conferences with the principal, the teachers, and some of the students, the consultant comes to the conclusion that what is needed in the school is a school psychologist who can help students with problems in school and personal adjustment. An expanded budget is presented by the principal to the school board, some of whose members accuse the principal of being lax in running the school. They then oppose the recommendations. A group of irate taxpayers organizes itself into a political-action body and argue that a psychologist in the school will "make the students crazy" or give them "new-fangled foolish ideas about sex." The principal of the school is greatly disturbed and realizes that the community will not accept a psychologist to serve the high school population. The consultant and the principal discuss the problem with the teachers, and it is decided that an educational program is needed for the community. The help of the PTA

is enlisted, and an educational program is planned. A series of community lectures is organized employing mental health films, with discussion groups following the lectures around problems of child development and family life. There results a change in attitude, and the psychologist is accepted into the school system.

It will be seen from these illustrations that the operations of community mental health specialists go beyond those of mere psychotherapist. If they are to live up to community responsibility, psychotherapists will need skills not now developed in the traditional residency and postresidency programs. It so happens that by the nature of education and background, psychotherapists may not know as much about the community and their proper role in it as do certain professionals, such as community organizers, public health officers, and other social scientists. Yet the knowledge of human dynamics and of the irrational forces that prompt people and groups qualifies psychotherapists to understand the disorganizing emotional cross-currents that operate in society. What therapists need, as has been mentioned before, is the acquisition of a completely new set of professional talents in addition to psychotherapy, since psychotherapy as such may not be suited to the client group or will require reinforcement with other techniques.

The lines along which this supplementation may be organized is perhaps best conceptualized in an ecological model of community mental health that draws upon theories and techniques from clinical psychiatry, social science, and public health. Since one objective is the control en masse of emotional disturbance, it is essential to bring into the orbit of techniques methods that not only influence individuals but also families and other groups. A network of coordinated services is consequently employed that acts independent of psychotherapy. By the very nature of the work, psychotherapists who work in the community must collaborate with other professionals in the fields of education, medicine, nursing, welfare, correction, law, religion, and other disciplines. This does not mean a watering down of psychotherapy when it is indicated in individual cases; however, the limitations of psychotherapy in dealing with community problems must be acknowledged. Essential is a broadening of the base of operations to include every measure—psychological and sociotherapeutic—that can help people relate better and

function better.

Actually, present knowledge of dynamics and psychopathology has widened the horizons of illness to include deviant behavior in addition to the traditional neurotic and psychotic syndromes. With this insight has come the need to provide services for disorders up to recently not considered within the province of psychotherapeutic concern. As a consequence, it has been necessary to blend therapeutic methodologies with educational, social, and rehabilitative approaches and to modify ideas and methods within the context of the communities' medical and social organizations.

Alterations in line with community need inevitably includes psychotherapy. In extending the benefits of psychotherapy to the masses, however, it becomes necessary to adapt psychotherapeutic tactics to abbreviated objectives. Short-term psychotherapy devoid of ambiguous abstractions and amorphous theoretical concepts that applies itself to the immediate problems of patients becomes essential. The effect of these modified treatment techniques can be both reparative and reconstructive, although goal compromise may be necessary to meet the practical needs of the millions who require aid. Attention to the populations that are now being unserved or underserved, such as the chronically mentally ill, the aged, children, minorities, alcoholics, and substance abusers, is particularly urgent.

In addition to psychotherapy, the total involvement of the community and its resources in a comprehensive program is unavoidable. One form particularly suited for sicker patients is the "therapeutic community" (Edelson, 1964; Kraft, AM, 1966). The therapeutic community is actually an old concept, dating far back in history. But the ways in which therapeutic communities have operated have varied with the level of our understanding of group and interpersonal processes. Mental health specialists will need to know how to help each member of the community achieve as maximal a development as is within the individual's potential.

Because emergencies in the lives of people most commonly motivate them to seek help, some mental health centers have largely devoted their efforts to working with crises.

According to Caplan and Grunebaum (1972), the following points are essential crisis intervention:

1. Timing: Intensive and frequent visits during the first 4 to 6 weeks are mandatory, rather than spacing interviews at weekly intervals over a long-term period.

2. Family orientation: The integrity of the family should be preserved to help support the member in crisis. Interviews with the family at its home may be required.

3. Avoiding dependency: Undue dependency is avoided by dealing with the current situation rather than focusing on past problems.

4. Fostering mastery: All efforts are made to encourage understanding of a problem and modes of coping with it effectively. This may require intensive short-term education.

5. Outside support: Enlisting the help of available outside support (friends, clergy, and other agencies) facilitates treatment.

6. Goals: The objective is to improve adjustment and immediate coping with the current situation rather than "cure." Trained nonprofessionals may be useful in carrying out the therapeutic plan.

Helping people to deal constructively with crises necessitates less a focus on etiology than on encouraging exiting health-promoting forces of an interpersonal and social nature that are present or latent. Ca-plan (1974) points out appropriately that capacities for adaptation of individuals are bolstered by help from their social networks, "which provide them with consistent communications of what is expected of them, supports and assistance with tasks, evaluations of their performance, and appropriate rewards." Although the intensity of stress and the existing ego strength of individuals is important, the quality of the support that the individuals get from their group is even more important in adjusting to the noxious effects of an environment or in coping with crises. Supportive groups are many, the individuals involving themselves consistently with some of these such as in work, church, and political or recreational associations; or groups may be selected and utilized only in times of need, such as self-help groups, physicians, social

workers, ministers, lawyers, nonprofessionals, mental health aides, and concerned friends who have had and perhaps conquered problems similar to those of the individuals. These helping aids may be exploited spontaneously by the individuals or, if a community is lacking in them, organized and stimulated by a knowledgeable professional. Where they exist and the individuals isolate themselves from them, the task of community mental-health workers may be to motivate the clients to make use of them or to deal with the resistances against their use. Adequate support programs are vital in any comprehensive program of community mental health (Caplan and Killilea, 1976).

COMMUNITY PSYCHIATRY

The reduction of psychiatric morbidity through preventive, rehabilitative, and therapeutic measures is the objective of "community psychiatry" or "social psychiatry." Elaboration of community-based treatment and aftercare services draws upon principles of public health and incorporates epidemiological and biostatistical precepts even though psychiatric techniques are ultimately employed. An ample body of literature has accumulated on community psychiatry: Beliak (1964, 1974); Bernard (1954, 1960); Carstairs (1962); Clausen and Kohn (1954); J. V. Coleman (1953); Columbia University School of Public Health (1961); Dax (1961); Dohrenwend et al. (1962); Duhl (1963); Dunhan and Weinberg (1960); Faris and Dunham (1939); Felix (1957, 1961); Forstenzer (1961); L. K. Frank (1957); H. Freeman and Farndale (1963); GAP (Reports 1949, 1956b; Symposium, 1965); Goldston (1965); Greenblatt et al. (1957); Gruenberg (1957); Hanlon (1957); Harvard Medical School (1962); Hume (1964, 1965, 1966); M. Jones (1952); I. Kaufman (1956); Kupers (1981); Lager and Zwerling (1983); Lamb (1984); Lebensohn (1964); Leighton (1960); Leighton et al. (1957, 1963); Lemkau (1955); Lin and Standley (1962); Milbank Memorial Fund (1956, 1957, 1959); Mintz and Schwartz (1964); NIMH (1961); Pepper et al. (1965); Plunkett and Gordon (1960); Redlich and Pepper (1963, 1964); Rennie and Woodward (1948); Ruesch (1965); Stainbrook (1955); Talbot (1984); Weston (1975); and WHO (1960).

PREVENTIVE PSYCHIATRY

Originally, therapy was focused on caring for seriously impaired mental patients. The emphasis on prevention, however, has shifted attention to patients with less severe emotional ailments, i.e., the psychoneuroses, the character disorders, the minor addictions, and even the milder adjustment problems. Caplan (1965) stressed that it was essential to accept responsibility "for helping those of all ages and classes who are suffering from disorders of all types, wherever they occur in the community." His statement makes clear why therapeutic services shifted away from the desperately mentally ill: there just was not enough money to go around.

A public health model of prevention divides such a program into primary, secondary, and tertiary categories (Caplan, 1964; Zusman, 1975). In *primary prevention,* attempts are made both to modify the environment and to reinforce constructive elements within individuals to aid in their coping capacities and to reduce the incidence of mental disorder. In *secondary prevention,* the aim is to diagnose and to treat patients with existing mental disorders to lower the severity and duration of morbidity. In *tertiary prevention,* the object is to rehabilitate people with emotional difficulties so that they may make some kind of adaptation to their environment.

Efforts at prevention require knowledge of community organization and planning as well as cooperation with other productive community programs that are operative within the community. There are relatively few psychotherapists who have gone beyond their clinical training to acquire required skills to work at prevention. But even if mental health workers have had adequate knowledge and training, there are regressive forces within the community that will resist change and will even attempt to restore the prior pathogenic elements once change is effectuated. Indeed, there are professionals who insist that the present-day community mental health movement is geared predominantly toward social control and toward preserving the politico-economic system and that change will be possible only by the assumption of a radical position, with mental health centers becoming politically involved while using methods that reach large masses of people (Kunnes, 1972). Advocated is turning over the control of policies and priorities of services to the citizenry of the community, the "consumers." On the other hand, it is pointed out by

oppositionists that where such a radical position has been taken, the results have been sadly wanting and that, therefore, a more conservative stance is to be preferred. Therapists can only do for a community what it is willing to accept. This should not dampen enthusiasm about what can be accomplished or discourage efforts at public education that can reduce the resistance threshold.

Primary prevention, though "the most desirable and potentially most effective approach to a solution of the problem of mental disorder in our communities, is clearly more a hope than a reality" (Caplan and Grunebaum, 1972). "In regard to preventive programs there seems to be no empirical evidence that any program is capable of preventing abnormal behavior." The provision of adequate health, housing, police, sanitation, educational, welfare, social, and recreational facilities requires outlays of public funds so vast that any effective provision would threaten other priorities. Increasing taxation and the issuing of bonds to bolster flagging budgets have acted like time bombs that threaten fiscal solvency. Accepting the fact that primary prevention is still a dream, some community mental-health operations have served quite successfully to supply services for secondary and tertiary prevention.

THE COMMUNITY MENTAL HEALTH CENTER

Broadening the base of services to the mentally ill and emotionally disturbed and focusing on early treatment and ambulatory services result in a minimal disruption of personal, family, work, and social life. Essentially, therapists function most effectively as consultants both for the management of individual cases and for the development and implementation of programs. Therapists' major areas of competence, diagnosis and treatment, is of great value here.

Two patterns of community psychiatry appear to be emerging. The first is organized around the community mental-health center, which aims at decentralization, regionalization and local service and is not too intimately related to other health services. The second is the integration of psychiatric services centered around the general hospital, which has consultative, outpatient, inpatient, round-the-clock care facilities but which is

relatively isolated from community welfare and educational services.

The assembly under one umbrella of *all* services for the mentally ill was one of the recommendations of the National Congress of Mental Illness and Health, held by the American Medical Association Council on Mental Health in 1962 (NIMH: *The Comprehensive Community Mental Health Center,* Public Health Service Pamphlet No. 1137, 1964; see also *Community Mental Health Advances,* Public Health Services Publication No. 1141). The Joint Commission on Mental Illness and Health, in its report to Congress in 1961, also emphasized the need for community services as a way of prevention and treatment to avert the debilitating effects of long hospitalization. The Joint Commission recommended expanded services in the community, a shift of focus from mental hospital institutionalization to smaller inpatient units as well as increased community care, a concentration on prevention and rehabilitation, greater cooperation among the different professions toward improving mental health research and treatment, and a more intimate coordination of hospital and community resources (*Action for Mental Health: Joint Commission on Mental Illness and Health.* New York, Basic Books, 1961). These recommendations fostered the organization of community mental health centers that promised the following:

1. Inpatient services, including a 24-hour emergency service

2. A day hospital

3. Outpatient clinic services for adults, children, and families without a waiting period

4. Partial hospitalization for day care and night care

5. Consultation services

6. Diagnostic services

7. Rehabilitative services of an educational, vocational, and social nature

8. Precare and aftercare services, such as placement in foster homes and halfway houses

9. Training of all types of mental health personnel

10. Research and evaluation

These instrumentalities were not to be under one roof or one sponsorship but were to be administered so that a continuity of care was achieved (Downing et al., 1966; Dorsett and Jones, 1967; McKinley et al., 1966; NIMH, 1963a & b).

The concentration of services around a general hospital was recommended by some authorities, and a selected annotated bibliography was prepared by the National Institute for Mental Health detailing how a hospital may function as a psychiatric resource (*The Community General Hospital as a Psychiatric Resource,* Public Health Service Publication No. 1484, Public Health Bibliography Series No. 66).

The experience of implementing the community mental health center program has not been an entirely happy one. Glass-cote et al. (1969) believed that the flaw was in the timetable: "Lack of experience, lack of staff, and lack of definition have all played a role, but they have been less of a problem than bad timing." The urgency to spend allocated funds for construction of community mental health centers over a two-year period encouraged the building of centers prior to planning how they would be used in comprehensive statewide designs. Problems also developed in providing for adequate staffing, a prime key to the adequate operation of a center. Psychiatrists, who were in preponderance, now find themselves in the minority in comparison to psychologists, social workers, and nurses. Much of the fault in fulfilling the original purpose of Congress in creating the program lay in the fact that providing for the mental health needs of all people in all parts of each state with adequate preventive, screening, diagnostic, therapeutic, rehabilitative, consultative, educational, research, and training services was a too ambitious, and perhaps unrealistic, goal that awaited a good deal of experiment over many years before it could be even minimally fulfilled. This is perhaps why unfavorable publicity and reports of failure of the community mental health programs have appeared in the literature. For instance, Ralph Nader *(Medical Tribune,* 1972) has claimed that the programs in action have perpetuated a two-class system of care that is sterile in ideas and

operations. An overcommitment to broad social problems at the expense of the immediate needs of clients "wastes professional staff and is both expensive and unfruitful, thus causing public disillusionment and endangering the whole community psychiatry program" (Wachpress, 1972). Under the circumstances it is remarkable that many community mental health centers have functioned as well as they have *(New York Times,* 1972). It is hoped that profiting from what has happened in the past, with adequate governmental funding and more sophisticated staffing, the centers may ultimately bring to fruition some of Congress's original goals. It is hoped, too, that aftercare programs for patients discharged from mental hospitals will become better financed and organized so that readmissions to hospitals are less necessary. Some of the statistics are presented as impressive. The number of hospital beds for mental patients has been more than halved, and the average stay has been reduced from 8 years to 17 months. Without adequate support systems in the community, however, the benefits of deinstitutionalization are questionable.

EXPANDED FUNCTIONS OF THE PSYCHOTHERAPIST

Since diagnostic and treatment resources cannot be deployed for relatively large groups of patients, and patient-therapist contact being limited, other modes of contact are necessary. Preventive methods entail the detection and remedying of *social forces* and *environmental pressures* that have a potentially pathogenic effect. Consequently it is advisable to include in the treatment plan "the active manipulation of the organizational aspect" of patients' lives (Caplan, 1965). This often requires the offering of individual or group consultation to administrators and others in an organization. Advice may be given affecting any phase of organizational functioning, including policy making. In expanding operations, therapists will, as has been mentioned before, have to go beyond habitual clinical theoretical models.

Community work foists onto therapists responsibilities that differ from those of traditional psychotherapy and are in line with the new tools being used (i.e., consultation, in-service training, and general public education). Guiding people in the organization

(executives, foremen, staff workers) with problems is complicated. Exploiting the theory and practice of community psychiatry, the practical implementation of community research methodology, the planning of services in line with the most efficient use of resources, and the development and administration of community programs are functions that will require specialized training beyond that of the psychiatric residency. Such training will undoubtedly be organized in the future as part of a career program and may be as eagerly sought after as psychoanalytic training had been for the past generations of psychotherapists. One design of training was a model offered at the Columbia Presbyterian Medical Center, which was organized and carried out jointly by the Department of Psychiatry and the School of Public Health and Administrative Medicine through an interdepartmental Division of Community Psychiatry (Columbia University, 1961; Bernard, 1960, 1965). Other training programs have been at the Johns Hopkins School of Hygiene and Public Health (Lemkau, 1955), at Harvard (Caplan, 1959), and at Berkeley (Beliak, 1964). There are some who believe that it is possible to teach community psychiatry in a traditional residency training program (Daniels and Margolis, 1965). Some favor the Community Mental Health Center (Sabshin, 1965). Others have developed programs in relationship to state and local health departments and university, state, and private training centers (Kern, 1965).

Comprehensive Training in Community Mental Health

There is disparity in ideas of who should be trained in community psychiatry and community mental health. Some authorities believe that psychiatrists should have the priority; others believe that psychiatric nurses, clinical psychologists, and clinical social workers are fully capable, with training, of learning skills in community psychiatry (Hume, 1966). Community mental health is, according to Lemhkau (1965), of medical concern, but it is not identical or coincident with psychiatry. It is much broader: it is a community-wide responsibility that sponsors the concept that "the program is to be under professional and lay auspices, and that mental health is promoted and fostered not solely through medical treatment, but also through a variety of institutions and agencies with numerous disciplines joining in the effort."

The multidisciplinary accent on community mental health has exacerbated rivalries and hostilities among the disciplines involved whenever adequate financing for services has become available. With expanded funding, arguments of who can practice—and under what auspices and supervision—will perhaps be as vehement as in the practice of psychotherapy. With added information about epidemiology and biostatistics, and with a greater public health orientation, trained psychotherapists in any of the professions can very well adapt to a community-based design for the mentally ill and, if creative and experienced, may be able to organize, direct, and execute projects of public education in mental health. To do consultation, however, and the in-service staff training and education of allied professionals (ministers, nurses, social workers, physicians, rehabilitation workers, speech therapists, and teachers) in therapeutic techniques (counseling, group process, and so on), even experienced therapists will need to fulfill certain requirements. They will preferably, following their residencies, have completed postgraduate work in a psychoanalytic or psychotherapeutic training center. They will ideally also have completed a structured course in community mental health that draws upon the public health and behavioral science fields. Work in community projects under supervision will have taught them the fundamentals of mental health consultation and how to gear teaching methods to the needs of the different professionals who handle people experiencing problems. It is hardly conceivable that a mental health consultant and professional trainer can be on a level below that of supervising psychotherapist.

One of the chief difficulties for most psychotherapists launching into the field of mental health is that, with the possible exception of social workers, their training, experience, and hence conceptual framework is largely clinical. Although this framework may operate effectively in psychotherapy, it does not apply to many, perhaps most, of the problems encountered in the community. An ideal community mental health worker should in part be a sociologist, anthropologist, psychologist, educator, political scientist, community organizer and planner, psychoanalyst, psychiatrist, physiologist, social worker, historian, pubic health specialist, biologist, social philosopher, researcher, and administrator. Since no therapist has or will ever have a complete combination of skills relating to the above professions, therapists will have to accommodate existing talents to a

complex, difficult, and constantly changing community atmosphere, utilizing themselves as constructively as possible while preserving the open mind of a student and scholar who is in constant search for new information and knowledge. Training is helpful within a community mental health center to equip therapists with the specialized abilities required to work in the community. When therapists have the motivation and are fortunate enough to live in an area where there is a training course in community mental health, the experience may be very profitable.

The kind of training that is most suited for community mental health specialists is, in addition to psychotherapy, experience with group processes and group dynamics, research design and methods, community organization and planning, communication techniques, teaching, various rehabilitation procedures, administration, and legal and legislative processes. A knowledge of public health objectives and measures is also helpful. It is rare that an individual can be interested in all of these fields. Generally therapists concentrate on a special area, such as mental health education, but comprehensive knowledge will enhance functioning even though greatest weight is given one kind of activity. Work in such fields as rehabilitation, law enforcement, industry, recreation, and religion, requires an extensive repertoire of techniques. The broader the education of therapists, the more effective they will be as consultants.

Since substantial therapeutic impact may be made during periods of crisis, contact with individuals in trouble may be of incalculable help if therapists have fundamental information about how to recognize an emotional problem, how to interview, how to conduct themselves constructively in therapeutic relationships, and how to make referrals. Educating such individuals presupposes an understanding of teaching method.

TECHNIQUES IN COMMUNITY MENTAL HEALTH

Mental Health Consultation

Consultation is a basic tool of mental health specialists. It consists of an interaction between a specialist or consultant and one or more consultees (usually agency

professionals) aimed at the mental health components of their work, including program and practices of the consultee organization. In the course of such consultation the consultee is also, according to Gerald Caplan, "being educated in order that he will be able in the future to handle similar problems in the same or other clients in a more effective manner than in the past" (U.S. Public Health Service, 1962).

Mental health consultation must be differentiated from psychotherapy, supervision, professional education, in-service training, and collaboration (Haylett and Rapaport, 1964). In psychotherapy, the interaction is with patients toward resolving symptoms and strengthening personality assets; in consultation, the relationship is with consultees and is geared toward enhancing their knowledge and skills. In supervision, supervisors assume an administrative in addition to an educative role; in consultation, consultants do not play an administrative authority role. In professional education, students are schooled in a skill that equips them to enter a certain profession; in consultation the consultees have already fulfilled the minimum requirements for their profession. In in-service training, the focus is on improving competence in the tasks for which therapists have been hired; in consultation new tasks are envisioned to expand the consultees' functions in mental health areas.

Consultation is usually offered to individuals in key administrative and supervisory positions to maximize the effect and reach the greatest numbers of people, i.e., the working staffs. It is generally done at the consultees' place of work unless consultants possess or arrange for special facilities.

Stages of consultation may be divided into a beginning or "entry" phase, a problem-solving phase, and a termination phase. It is assumed that the consultee is acquainted with the consultant or the consultant's work and is oriented regarding the nature of consultation services. If not, a preparatory interpretive meeting or group of meetings may have to be arranged. A contract is drawn up either verbally or, preferably, in the form of an exchange of letters. The consultant and consultee agree on details about participating personnel, the extent of time of the project, and physical arrangements. It may be

necessary to clarify the consultant's role—for instance, that services are not given directly to the consultee's clients. The next phase is that of problem solving, which is the core of the consultation process. Here the consultee's motivations and readiness for change mingle with the consultant's skill, experience, and capacity to handle emotional aspects of the relationship. This interaction will determine the rapidity with which movement and change are registered. The final phase is that of a mutually agreed upon termination.

The methods employed by the mental health consultant will have to be adapted to the special needs and problems of the agency, group, or individual who is seeking help. Generally, methods derived from the clinical model, i.e., therapeutic work with individuals, are not too applicable to consultation. As an example, suppose that the specialist is engaged by a social agency as a consultant in making their functions more effective. The first step is the "entry process" into the agency—"consultee system," or "client-system" as R. Lippitt et al. (1958) call it. This entails a proper diagnosis of the problem determined by setting up a series of meetings with key personnel. The objective is to help the consultee arrive at an understanding of what is needed and which aspects of the problem to approach immediately and which later on. A problem-solving plan is evolved, and the consultant then focuses on facilitating and enhancing the problem-solving skills of the individuals who will execute the plan. Communication channels are opened up between the various levels of the agency (executive, supervisor, and staff) to handle the effects of feedback, and resistances to change and to learning. The consultant then continues to work with the agency until the plan is proceeding satisfactorily. If the agency is large, the consultant may restrict efforts just to training the supervisory staff, expanding their information and skills so that they may by themselves manage and continue the program that has been instituted. The consultant may have to use some research techniques and engage in 9 or 10 group conference services, getting details of work habits, studying records, and becoming familiar with the functions of the organization. Then attention may be directed to training. If the consultant cannot personally enter into the problem-solving process, help may be obtained from the proper outside resources for this task. Finally, the consultant withdraws from the agency or "consultee system" (Wolberg A and Padilla-Lawson, 1965).

Considerable numbers of writings have accumulated detailing theory and method in mental health consultation. Recommended readings are the following: Argyris (1961); Berlin (1956, 1960, 1964); Bindman (1959, 1960, 1966); Boehme (1956); Brashear et al. (1954); Caplan (1961b, 1963, 1964, 1970); L. D. Cohen (1966); J. V. Coleman (1947); Cooper and Hodges (1983); Covner (1947); Croley (1961); Davies (1960); W. E. Davis (1957); GAP (1956a); Garrett (1956); Gibb (1959); Gibb and Lippitt (1959); Gilbert (1960); Gilbertson (1952); Glidewell (1959); Gordon DE (1953); Greenblatt (1975); Halleck and Miller (1963); Kazanjian et al. (1962); Lamb and Peterson (1983); Leader (1957); Lifschutz et al. (1958); G. Lippitt (1959); R. Lippitt et al. (1958); Maddux (1953); Malamud (1959); Mannino et al. (1975); Mental Hygiene Committee (1950); Nunnally (1957); K. B. Oettinger (1950); Parker (1958, 1962); L. Rapaport (1963); Rogawski (1979); M. J. Rosenthal and Sullivan (1959); San Mateo County (1961); G. S. Stevenson (1956); Valenstein (1955); A. Wolberg and Padilla-Lawson (1965); Zander (1957).

More specifically, the entry phase is characterized by an exploration during conferences of the manifest problems and needs of the consultee. During this phase relationships will be established. If possible, a personal interview is arranged by the consultee for the consultant with the head of the agency to affirm the agency's support for the project. Answers are needed to the following:

1. What is the structure of the agency, including the history, budget, and financing?

2. What is the organizational structure involving the personnel in the agency? What are the authority lines and policy-making bodies?

3. What are the supervisory policies?

4. Are there any apparent personality problems of, and conflicts in relation to, the leadership?

5. Are there any apparent conflicts in policies and aims?

6. What are the existing functions of the agency and are these being fulfilled?

7. What are the proposed future functions, if any, and are these realistic?

8. What is the community setting in which the agency operates? Are there conflicts between policies and functions of the agency and the community? What are the -areas of community support and the areas of opposition? (For example, a school may wish to focus its resources and energies on the most gifted children who are showing learning blocks. The parents' association may be pressing for better tutoring to prepare the students for college boards. Some community organizations, courts, and social agencies, in contrast, may be insistent that juvenile delinquents and retarded children receive special attention, which will conflict with a program for brighter students.)

9. What is the community organization; is there now or will there be a duplication of services? Is there cooperation with other agencies?

10. What are the existing and anticipated conflicts regarding programming and policy changes?

11. What were the previous experiences of the agency with consultants?

During the next (problem-solving) phase of the consultation there is an ordered gathering of informaation about the consultee system, including needs and difficulties. A true working relationship begins to develop. Diagnostic assessments are made and a plan of action is agreed upon. It will be essential for consultants to educate the consultees in handling anxieties and resistances. A periodic review of services and problems may be required and role limitations defined. It is to be expected that some untoward reactions will crop up among the staff, supervisors, and administration when program changes are proposed or implemented. Great tact must be exercised in dealing with these. It may that the staffs proposals for change may not be consonant with the personal philosophies of the administrator, in which case exploratory conferences will be necessary.

In the course of problem solving, transference and countertransference will come into evidence. The consultants' own analysis and experience as psychotherapists will help the consultants deal with these contingencies. Obviously, psychotherapy will not be done; however, inimical reactions may tactfully be interpreted on the "here-and-now" level. Temptation to fall back on clinical methods must be resisted. If the consultees recognize an emotional problem in themselves and request help for this, the consultants may offer

advice about resources. Plunging in blindly and trying to get consultees to accept personal therapy without their desire for this may destroy the working relationship.

What is discouraging to most consultants is the slowness with which attitude change can be brought about. Personality difficulties among the personnel in an agency are the greatest deterrents to change and constructive action, and consultants will have to work with these obstructions painstakingly. Honest, frank communication in the matrix of a working relationship is the best way of dealing with emerging resistances and problems. Consultants must expect that some of the intrusions proffered will be challenged and that discrimination may be exercised that will not always be in the consultants' favor. Questions consultants ask about the organization and its functions may arouse suspicions of "trespassing" and may mobilize guilt feelings in those who fear that their negligence in duty will be discovered. Some may resent being told how to do their jobs. The consultants during conferences should convey no implication of blame or criticism, no "eyebrow lifting." A casual reassuring manner is best punctuated by occasional approving remarks for praiseworthy tasks the consultees are doing. Attempts should be made to build up confidence and trust, realizing that no matter how meritorious or urgently changes are needed, they are bound to be resisted. Even a poorly functioning organization has achieved a shaky equilibrium, which will be defended.

Among the rules to follow are these:

1. Do not be hasty with advice. Community problems are complex and a thorough exploration will be essential before conclusions are valid.

2. Consider carefully the ideas and opinions of the people with whom you are working.

3. Expect power groups to try to involve you; avoid taking sides.

4. Try to see all aspects of a question if there is conflict. Verbalize how the opponents must feel. Let them offer suggestions regarding proposed courses of action.

5. Try to exhibit tact and to retain a sense of humor.

The withdrawal phase of consultation will take place after the problem for which the consultants was retained has been solved, or prior to its solution by mutual consent. An evaluation of the service and plans for future cooperation (e.g., reports, personal contact) are made.

It is apparent that the consultants will need to know something about community organization and planning for mental health, social planning, organizational management, administration, public relations, public health, individual and group dynamics, research, law, teaching, supervision, social psychology, cultural anthropology, sociology, and political action.

At the Postgraduate Center for Mental Health in New York City, an interdisciplinary specialty program trained psychiatrists, psychiatric social workers, and clinical psychologists to function as community mental health consultants only after they had completed a postgraduate psychoanalytic training program (which requires an average of 4 years of didactic courses, personal psychoanalysis, and intensive supervision) and who thereafter spent an additional 2 years, part time, in active consultative work in the community under supervision (Hamburger, 1976; Wolberg A, and Padilla-Lawson, 1962). In practically all cases, students have become so interested in community work that they have participated substantially as community workers after completing their course in addition to operating as therapists in private practice. The model for the consultation process taught has been developed and organized in part around the paradigms of G. Lippitt (1959) and Gibb and R. Lippitt (1959), which emphasize systems theory and group dynamics, and in part around concepts of a mental health "multilevel-planning-activity group (MPAG)" developed by A. Wolberg and Padilla-Lawson (1959), an outline of which is given in Table 67-1.

To apply themselves most effectively in the community, therapist-consultants will have to fulfill a number of roles. Ideally, they should be able to plan, develop, and implement programs for prevention of mental illness, for reduction of psychiatric morbidity, for training of mental health personnel, for agency evaluation and

reorganization, for education of professionals (e.g., physicians, teachers, ministers, lawyers, correctional workers) who deal with people blocked in learning, work, and interpersonal and social relationships, for upgrading of skills of institutional staffs (e.g., schools, industry, social agencies), and for public education in mental health. Obviously, neither the consultants' backgrounds nor available time will enable consultants to be equally effective as community mental health consultant, professional trainer, and public health educator. Consequently, it will be necessary to restrict efforts to areas within the consultants' competence while acquiring further training that will equip consultants to play an expanded mental health role. Thus if zones of interest and ability are in the field of treatment, administration, research, or teaching, therapist-consultants will most likely seek out and be sought for selective projects in line with this expertise.

In some of these projects the consultants will become involved in organizing, administrating, and supervising a variety of other services, some of which they can do better than others. These include preventive care, home treatment, walk-in clinics, admission procedures, partial hospitalization, work programs, social rehabilitation, planning development of the locus of care, rural program development, metropolitan mental health center development, legal issues in establishment and operation, record keeping and research, and so on (Grunebaum H, 1970).

The Training of Mental Health Personnel

Mental disorders constitute a major public health problem resulting not only in syndromes that totally incapacitate a large section of the population, but also, in their early stages and incipient forms, directly or indirectly influencing the happiness and efficiency of every individual alive. Because of the ubiquity of the problem, psychotherapists are being increasingly drawn into programs of training on federal, state, and local levels. The broadening of vistas of mental health to penetrate into every nook and cranny of the community and diffusion of psychological knowledge into programs of education, correction, health, and welfare have resulted in an enlistment of psychotherapists toward planning programs and participating in their development in

accordance with the needs, readiness, and practical limitations existing in a specific area of the country. Psychotherapists are also playing a vital role in the recruitment of mental health personnel.

In view of the great shortage of mental-health workers, training programs are being sponsored with federal and state support, which include not only professional groups such as general practitioners, nurses, social scientists, health officers, health educators, ministers, teachers, social workers, occupational therapists, recreational therapists, speech therapists, and vocational counselors, but also subprofessional and technical personnel such as psychiatric aides and paraprofessionals. While it is difficult to estimate the precise personnel requirements, it is safe to assume that at least twice the number of mental health professionals will be needed to cope even minimally with the existing demand for services. In recognition of these needs, the Surgeon General's Ad Hoc Committee on Mental Health Activities (NIMH, 1962) encouraged the in-service training in mental health of professional personnel in organizations that deal with problems confronting human beings on every level of functioning, the introduction of mental health courses in schools of public health, more intensive exposure of psychiatric residents to social science and public health methods, and support for the training of greater numbers of high-level professional mental health personnel, particularly for work in community mental health programs.

In designing a training program for an agency or organization, the therapist-consultant will need to use some of the processes of consultation. This may be illustrated by a problem presented to the Postgraduate Center by the casework staff of the case study unit of one of the bureaus of a school system (Wolberg A, 1964). The staff was concerned with the need to learn new techniques to approach the hard-to-reach children expressing their emotional problems in poor school attendance. Home visits, referrals to community agencies, supervision of the children, consultation with community agencies, and appearances in court constituted the work done by the social work staff. After a series of conferences of the consultees with the casework staff, it was agreed that some of the children might benefit from group approaches. It was decided to organize a training

program to teach the social workers the group-counseling method within casework process.

Four broad phases in this program were planned: (1) Six to eight exploratory sessions with the case study supervisors of the bureau and the consulting supervisory staff of the Postgraduate Center to discuss typical cases handled by the bureau, with the hope (a) of developing a set of criteria for the choice of clients who would participate in the groups and (b) of developing group techniques appropriate to this situation. (2) A regular 15-session seminar in group process for the case-study supervisory staff of the bureau and for the three caseworkers who were to handle the first three trial groups. (3) Three consultants assigned to the first trial groups were to teach the caseworkers how to use group dynamic methods in handling their groups of children, and to teach the supervisors how to supervise this group process. Other supervisors and social workers were to observe the supervision of the worker. This phase was to continue for 2 or 3 years in a progressively diminishing manner as the bureau staff acquired greater skills. (4) In 4 or 5 years the project was to be expanded to train social workers in the bureau to assume responsibility for a citywide group program in the schools. After this the Postgraduate Center was to withdraw and the consultation program was to be terminated. According to the plan, each caseworker (attendance teacher) carried 2 groups of 8 children each, weekly, over a period of 1 semester (15 weeks), in addition to the caseworker's regular work. The objective was not to make group therapists out of the social workers, but to adapt group methods to casework procedure to enhance the mental health of the children.

The value of this program was proven by the marked improvement by the participant children in actual school attendance (complete cessation of absenteeism in 53 percent, marked reduction in 20 percent), in scholastic achievement, in attitudes toward school, and in general attitudes toward their classmates and adults. The school personnel expressed enthusiasm regarding the results of the program. A total of 25 attendance teachers was trained to manage groups, most of whom became supervisors and in turn began to train others.

Training programs must be tailor-made, designed for the specific needs of the professionals who are seeking further tutelage, taking into consideration their present education and the functions that they intend to fulfill. Generally, a consultation process will be required to assess what the training requirements are and the best means of executing the proposed goals. It is essential that the training equip the individuals to work more effectively within their particular profession and not be geared to making the "trainees" psychotherapists. Didactic lectures are secondary to case discussions and supervised work with clients. A group process is often helpful for the the professionals themselves, enabling them to become aware of some of their personal problems and resistances.

Public Education in Mental Health

The great need for public education in mental health was pointed out by Braceland (1955): "public information on what constitutes illness and health is a hodgepodge of folklore, information, and misinformation." He appropriately warned, moreover, that the techniques and particularly the use of mass propaganda methods may present a distorted picture of any public health problem. Data about mental and emotional disease may easily arouse fears and anxieties. The ineffectiveness of intensive educational programs using a wide variety of materials is, unfortunately, not too uncommon an experience, established attitudes rarely being changed. Braceland affirmed the need to avoid calling attention to the ravages of mental illness; rather it is essential, he noted, to stress hope and the promise of recovery with early diagnosis and treatment "to reassure rather than to threaten or frighten" and "the audience . . . spared technical language and abstruse, complex material that they are not prepared to handle." What requires emphasis is normal behavior, the fluctuations in emotional well-being, the universality of anxiety and some of its common manifestations, the determining (but not necessarily irreversible) influences of past experiences, the impact of social and cultural factors on personality development and functioning, the psychological needs at various developmental phases, the stress situations that create emotional insecurity at different age periods, and a description of how emotions influence humans toward unrealistic goals and immature behavior.

Mass approaches to public education in mental health must await the development of television and radio programs as well as the kinds of press reporting and magazine writing that does not emphasize the destructive, dramatic, and violent aspects of mental illness and emotional disturbance. If the sponsors of programs and the controlling forces in the publication field were to apply the organizational and creative skills they use to sell advertised products, they undoubtedly would be able to adapt mental health materials that would change attitudes. This would necessitate a shift in the content of mass media away from preoccupations with violence and disturbed relationships among people.

In the meantime, mental health workers may have to confine themselves to the influencing of small, motivated groups who need and ask for special kinds of information. Materials pertinent to the topics of interest may be procured, and leads regarding appropriate films, pamphlets, plays, and other audiovisual and graphic aids may be obtained, from such educational organizations as the Mental Health Materials Center, 30 E. 29th St., New York, NY 10016. There is a useful Public Health Service Publication (No. 218, Washington, D. C., 1960) titled *Mental Health Motion Pictures: A selective Guide.* A film guide, *Index to 16 mm Educational Films,* is published by NI-CEM, University of Southern California, National Information Center for Educational Media, University Park, Los Angeles, CA 90024. The Library of Congress publishes a catalogue of motion pictures and filmstrips on many educational topics. Films may also be obtained from Psychological Cinema Register, Audiovisual Service, Pennsylvania State University, University Park, PA 16802; and New York University Film Library, Washington Square North, New York, NY 10003. If audio materials alone would be sufficient, a catalogue with a full listing may be obtained from The Center for Casette Studios, 8110 Webb Avenue, North Hollywood, CA 91605; and from Xerox University Microfilms, 300 North Zeeb Road, Ann Arbor, MI 48106.

In the section on Bibliotherapy, books and pamphlets on different subjects written for the general public will give educators ideas of content and methods of presentation.

A brief outline of suggested methods of working with films and conducting discussion groups follows.

SUGGESTIONS ON METHODS OF INTRODUCING AND DISCUSSING MENTAL HEALTH FILMS (OR VIDEOTAPES)

1. *General.* Mental health films presented to lay groups are mainly informational in objective. This means that the discussion leaders function as "experts." They must make the largest contributions elaborating on the theme of the film and clarifying the questions brought up by the audience. Nevertheless, audience participation must be encouraged. This can be done by stimulating discussion on several points illustrated by the film.

   Many members of the audience will identify with characters in the film. Consequently, the tone of the discussion must always be sympathetic and reassuring. *Never* belittle or ridicule any character; *never* say a condition is hopeless or incurable.

2. *Previewing the film.* If possible, preview the film, preferably at least an hour before the actual showing. Make a notation in writing of the following: (a) What is the theme of the film? (b) What three or four points does it illustrate? The discussion that follows the film may be organized around these points.

   If a preview of the film is not possible, study the *leader's guide* issued with the film, if there is such a guide, at least an hour before the showing. Make notations in writing of the film theme and of several psychiatric points that are illustrated.

   If a preview of the film is not possible and if there is no leader's guide, make a mental note of the theme and points raised while watching the film at the actual showing.

3. *Starting the class or meeting.* The class or meeting must be started sharply on time. Latecomers will probably come on time at the next meeting if this is done.

4. *Introducing the film.* There are two methods of introducing the film: Method 1—Give a brief lecture (10 to 15 minutes) on the general topic illustrated by the film, indicating which points the audience is to observe. Method 2—Describe the film briefly (1 to 5 minutes), indicating the general theme and the points the audience is to watch for especially.

5. *Film showing.* Arrangements will probably have been made with a projector operator so that the film is ready for showing on a signal from you. Since

breakdowns in equipment are common, you should determine in advance if the projector is in good working order. Do this also with the videotape recorder if a tape is to be shown.

6. *Discussing the film.* After reviewing the film, you may proceed along several lines:

   a. *Lecture.* If there is to be a lecture, this should last no more than 15 minutes. The points in the film are introduced in the context as illustrative material. Following this, the meeting is opened to discussion.

   b. *Presentation of the salient points of the film.* The chief points illustrated by the film are mentioned, following which there is discussion.

   c. *Asking pertinent questions about the film.* The points illustrated by the film are presented as questions. This is a very good way to get audience participation.

7. *Handling group situations.*

   a. *Group failing to participate.* When the group fails to enter into the discussion, ask one or two provocative questions. If no one responds, call on one member of the group.

   b. *A member arguing too much.* Simply say, "I understand your reaction; perhaps other people here would like to comment on it." The group usually has a way of subduing the the disturbed member. If this does not work, invite the person to discuss matters with you after the meeting.

   c. *One member talking too much.* At a pause in his talk, cut the person off with a summarizing statement and direct a question at someone else.

   d. *A member persisting on talking off the subject.* Cut the person off with the statement, "That is interesting, and we may come back to that later." Direct a question at someone else.

8. *Terminating meeting.* The meeting should be terminated after about one hour of discussion, or lecture and discussion. A brief summary is sometimes helpful, as is assignment of reading material.

SUGGESTIONS ON CONDUCTING A DISCUSSION GROUP

1. *General.* A discussion group provides the participants with perhaps the best opportunity for learning. Sharing ideas and experiences promotes an exchange of information. Verbalizing attitudes and doubts helps to resolve resistances and learning blocks. Furthermore, the discussion group may serve a therapeutic function, enabling individuals to gain a measure of assuredness in expressing their ideas and opinions and in working through fears, hostilities, and other disabling attitudes in relation to a group.

2. *Physical arrangements.*

    a. *Size of group.* The ideal size of the group ranges from 6 to 10 people. This number makes it possible for all members to contribute actively. In exceptional or unavoidable instances, a larger group may be handled, though this will involve some sacrifice in individual activity.

    b. *Position of chairs.* Seating arrangement is important to avoid your being placed in too prominent a position, which is apt to stifle discussion. Members may be seated facing you and one another around a table, or, if this is impractical, in chairs placed in a circle or semicircle. It goes without saying that proper ventilation, comfortable lighting and where smoking is permitted ash trays add to the relaxed atmosphere that is most conducive to good discussion.

    c. *Length of discussion sessions.* This will vary depending on the circumstances, but a good average is *H* hours.

    d. *Starting the session on time.* The session should begin on time. Latecomers will probably come on time at the next session if this is done.

3. *The first session.*

    a. Once members are seated, a good way to start is to ask members to introduce themselves to the group by stating their names, disciplines, (if they have one, and the organization, if any, with which they are associated. This serves to "break the ice" and to introduce an air of informality into the atmosphere.

b. Next introduce the general subject to be discussed and relate it to the interests of the group members. A distributed outline designating material to be considered is a very helpful adjunct.

c. If essential information needs to be conveyed to the members before discussion begins, a short talk is in order. If desired, introduce an auxiliary lecturer, or a movie, filmstrip, or other audiovisual aid. Make this preliminary presentation as brief as possible.

d. Following this, begin the discussion. If there is any doubt in the minds of the members about procedure, inform them that no one will be called on formally, that anyone may speak up whenever desired, and that members should limit their comments to 2 or 3 minutes at most.

e. Encourage the group to participate by any of the following methods:

(1) Ask a provocative question relating to the outline or to the material under discussion.

(2) If there are two points of view on a topic germane to the discussion, call for a show of hands of those who share the different viewpoints. Then ask a question as to why one or the other point of view is taken.

(3) Select a topic related to the general subject and ask if there is anyone in the group who has had experience with this topic.

(4) Using a blackboard, list the different opinions or ideas of the members about a topic, or possible approaches to the topic. Group these into specific categories, and then ask questions about the various listings.

4. *Subsequent sessions.* At the start of each subsequent session, you may summarize the salient points about the previous session and then bring up the topic for the present session. If new information is to be introduced, this may be done by, for example, assigned readings, written reports from the members, an informative talk by an expert, or films.

5. *Activity of the leader.* Your function as leader in a discussion group is to help the members verbalize their ideas and integrate their thinking about a specific subject. Your role is to participate in the discussion only when the members stop talking, when they deviate from the topic under

consideration, or when they are not able to think things through for themselves. Such participation does not mean delivering a lecture, giving advice, or showing off knowledge.

To fulfill this function, there must be respect for all the members in the group and for their opinions, resistances, and resentments. The fact must be accepted that the learning process requires time and that people must resolve their doubts and suspicions before they can accept ideas, no matter how logical these may seem. This will necessitate great tolerance and the ability to handle aggression that is projected by some members toward the group and toward you. Required is an informal manner and a sense of humor. Essential also is an ability to talk the same down-to-earth language as the group, eschewing complicated formulations and avoiding impressing the members with abstruse talk.

From time to time, clarify the material presented, particularly conflicting issues, and summarize the contributions that have been made by the members. If certain points are not covered, ask questions about these. Never argue, belittle, or disagree with anyone. If you have a contribution to make yourself, make it briefly, saying, "This is what I have come to believe," or "This is what is generally believed."

Handling special situations. This is, on the whole, handled as done in this category under the section on discussing films.

a. *Group fails to participate.* When the group fails to enter into discussion, ask one or two provocative questions. If no one responds, call on one member of the group. If, after this person comments, nobody else volunteers, say, "Perhaps someone has a different slant on this."

b. *A member arguing too much.* Simply say, "I can understand your reaction; perhaps other people here would like to comment on it." The group usually has a way of subduing the disturbed member. If this does not work, invite the person to discuss matters with you after the meeting.

c. *One member talking too much.* At a pause in this talk, cut the person off with a summarizing statement and direct a question at the group.

d. *A member persisting on talking off the subject.* Cut the person off with the statement, "That is interesting, and we may come back to that later." Direct a question at the group.

e. *A side argument developing between two or more members.* Rap on the table or chair and say, "May I interrupt please. Perhaps others here would like to comment on this question that is causing controversy." If this does not stop the argument, or if the argument spreads, say, "Obviously there are several points of view; perhaps I can help integrate them." Attempt then to explain why the differences exist and how they can be resolved. If no resolution is possible, say, "Let us think about this matter further, and we may have a chance to come back to it later." Following this, ask another question, directing the discussion into another channel.

f. *One member constantly interrupting the comments of others.* Firmly say to the person at each interruption, "X [the person interrupted] has not finished talking, let us permit X to continue." If this does not stop the person from interrupting, say, "There is something that is bothering you, and it may be helpful for you to see me after the session." Arrange then to have a talk or talks with the person, and if the disruptive activity does not halt, suggest that the person drop out from the group.

g. *Side conversations.* Rap on the table or chair and say, "Please let us all concentrate on what is being said."

h. *The discussion straying too far afield from the subject.* Say, "This is interesting, but how does it apply to the subject we are discussing?"

i. *A member refusing to budge from an opinionated and obviously erroneous point of view.* Do not take issue directly. Merely say, "Perhaps Y would like to bring in source material next time to back up that point of view." Then pass on to another person.

j. *A member refusing to participate.* Respect the person's silence. After a number of sessions, if the person asks to speak, respond positively immediately. Rarely you may say, "Perhaps Z may want to comment on this subject." If the person indicates no or remains silent, gloss this over with, "Not at this time; well, perhaps later."

k. *Lags in the discussion.* Point out the differences in ideas or opinions that have been presented, and ask how these differences may be reconciled.

l. *Unnecessary repetition.* Summarize what has been said, point out

important aspects and highlights; then introduce a different question.

7. *The recorder and observer.* In some discussion groups it is helpful to appoint a volunteer who will record the salient features of the discussion for purposes of transcription or for summarization at the end of the present or at the beginning of the next session. Another volunteer, an observer, may be appointed to record the activity or passivity of the various members and leaders, the interpersonal reactions, and perhaps the dynamics of the group process, if trained in dynamics, which may also be prepared at the end of the session or at the beginning of the next session.

8. *Summarizing the discussion.* Before the session ends, it may be helpful to summarize the discussion, mentioning the salient points that have been covered, relating the material to what has gone on in previous sessions, restating differences of opinion, tying together topics that have not been coordinated, and adding suggestions about procedure and areas of future exploration. It is essential that the summary contain the conclusions of the group rather than your own conclusions. If the group conclusions are in your opinion inadequate or erroneous, a statement may be made to the effect that further discussion on the subject will open up areas that may yield important data.

9. *Reading assignments and reports.* Assigned readings, and verbal or written presentations by the members, are helpful as teaching aids. They serve also to introduce new material for group consideration. Suggestions regarding readings may be obtained in the Bibliotherapy section in Chapter 56.

VI
Addenda

Selected Texts for Special Situations and Problems

The literature in the field of psychotherapy flourishes with ever increasing contributions from all divisions of the behavioral sciences. Accordingly, the selection of recommended reading becomes progressively more difficult as new books and periodicals accumulate. The present section contains a representative sampling of the most popular texts among students and reviewers. A more complete bibliography explicating specific topics will be found in the various chapters of this book. Obviously it will be difficult or impossible for any therapist to read or even to acquire all the recommended texts, which will undoubtedly be found on the shelves of any good psychiatric library. Readers, nevertheless, will be able discriminately to cull from the suggested lists items that suit their interests and needs. New books, as well as revisions, will undoubtedly appear as time goes by. Nevertheless, many of the present texts will in all probability continue to survive as classics.

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Appendix A

Statistical Data[14]

PATIENT'S NAME   Date:

ADDRESS   Interviewer:

HOME TELEPHONE   Referred by:

BUSINESS PHONE

            Informant (*if any*): Name and Address

            With whom is patient now living? (*list people*):

Age of Patient	Sex	Religion
Education	Occupation	Salary
If unemployed, sources of income		
Marital Status	How long married?	Any previous marriages? when?
Age of mate	Occupation of mate	Salary of mate
Military Record		
Miscellaneous		

---

[14]Short form: To be filled out by therapist, initial interviewer, or intake worker in a clinic set up.

Appendix B

Statistical Data

Patient's Name:
Case No.:

1.GENERAL DATA:

a.	Age	Date of Birth:

b. Sex (M, F)

c. Race

d. Religion

e. Birthplace

f. If foreign-born, date of arrival in U.S.

g. Naturalization dates: 1st Papers   2nd Papers

h. Education

i. Occupation

j. Employed (yes, no)

k. Salary

l. Yearly income, all sources

m. If unemployed, on what sources of income, or on what person is patient dependent, giving occupation and relationship to patient of this person.

n. Military Service (yes, no) dates:

o. Name and address of nearest relative or friend

p. With whom is patient living at present?

2. RESIDENTIAL DATA:

a. Address

b. Character of Residence   ( )house ( )apartment ( )room
                                        ( )self-owned ( )rented, rental cost:

c. Place of legal settlement

d. Length of residence in this town or city

e. Length of residence in state

f.   Home phone   Other phone

g.   Previous addresses (*include dates*)

3. MARITAL STATUS:

a.   M, S, W, Div, Sep

b.   Date of marriage

c.   Date termination of marriage

d.   Name of mate, if any

e.   Dates of previous marriages, if any

f.   Dates of termination of previous marriages and reasons

g.   Names and ages of children

4. FAMILY IDENTIFICATION DATA:

a.   Father's name   Living or dead?

Age at present or, if dead, age at death and year of death

Birthplace

If foreign-born, date arrival U.S.   Citizenship

b.   Mother's maiden name   Living or dead?

Age at present or, if dead, age at death and year of death

Birthplace

If foreign-born, date arrival U.S.   Citizenship

c.   Siblings (list names, ages, and sex)

5. SOCIAL SERVICE EXCHANGE (for clinic patients):

(Long form: Complete statistical data outline to be filled out by therapist or social worker)

Appendix C

Initial Interview
(to be filled out by initial interviewer)

PATIENT'S NAME   Date:

ADDRESS   Interviewer:

HOME TELEPHONE   Referred by:

BUSINESS PHONE

Informant (*if any*): Name and Address

With whom is patient now living? (*list people*):

| Age of Patient | Sex | Religion |

| Education | Occupation | Salary |

If unemployed, sources of income

| Marital Status | How long married? | Any previous marriages? |
| | | when? |

| Age of mate | Occupation of mate | Salary of mate |

Military Record

Miscellaneous

(Use additional blank sheets if necessary indicating item number)

1. CHIEF COMPLAINT *(patient's own words)*

2. HISTORY AND DEVELOPMENT OF COMPLAINT *(from onset to present)*

3. DREAMS *(patient's own words)*

4. OTHER SYMPTOMS AND CLINICAL FINDINGS AT PRESENT

( ) Tension   ( ) Depressed   ( ) Severe depression

( ) Suicidal   ( ) Severe anxiety   ( ) Hallucinations

( ) Delusions   ( ) Dangerous   ( ) Excited

( ) Physical symptoms   ( ) Fatigue   ( ) Exhaustion

( ) Headaches   ( ) Dizziness   ( ) GI Symptoms

( ) Sexual problems   ( ) Impotency   ( ) Homosexuality

( ) Phobias   ( ) Obsessions   ( ) Compulsions

( ) Excessive sedatives   ( ) Excess alcohol   ( ) Insomnia

( ) Nightmares   ( ) Other symptoms (specify)   ( ) Present medications (dosage and how long taken)

Description of above

5. FAMILY DATA *(health and personality of mother, father, siblings, spouse, children, and patient's attitudes toward them)*

6. PREVIOUS EMOTIONAL UPSETS *(from childhood to present illness)*

7. PREVIOUS TREATMENT *(including hospitalization)*

8. PSYCHOLOGIC TESTS

9. TENTATIVE DIAGNOSIS

10. TENTATIVE DYNAMICS

_____

11. TENTATIVE PROGNOSIS

_____

12. PATIENT'S RESPONSE TO INTERVIEWER ( )cooperative ( )fearful ( )suspicious ( )hostile

_____

13. INTERVIEWER'S RESPONSE TO PATIENT ( )positive ( )ill-defined ( )negative

_____

14. PHYSICAL APPEARANCE ( )meticulous ( )presentable ( )untidy ( )disheveled

_____

15. PATIENT'S ESTIMATE OF PRESENT PHYSICAL HEALTH ( )satisfactory ( )poor

_____

16. COMMUNICATIVENESS ( )garrulous ( )satisfactory ( )underproductive ( )answers questions only

_____

17. INSIGHT AND MOTIVATION

( ) aware of a problem   ( ) desires to correct problem

( ) aware of emotional nature of problem   ( ) willing to accept psychotherapy

( ) accepts present therapist   ( ) accepts conditions of therapy

( ) can arrange time for therapy   ( ) can afford treatment

18. DISPOSITION

( ) Case accepted	Hours Patient Can Come for Treatment	FEE:
( ) Case referred		Initial interview
( ) Case closed		Testing
		Therapy
( ) Emergency	( ) Appointment given patient	( ) Paid

( ) $ Urgent	( ) Notify patient of appointment	( ) Charge
( ) 5 Not urgent	( ) Patient will call for appointment	( ) Send Bill

TYPE OF THERAPY

CORRESPONDENCE REQUIRED

RECOMMENDATIONS AND REMARKS

Personal Data Sheet

Please fill out the following blank as completely as possible. This will save time and make it unnecessary to ask you routine questions. All material is confidential and will not be released except on your written request.

Name

Address

(Will it be all right to write to you at the above address for billing, changes of appointment, etc.?)

Home phone_____ Other phone_____

Can we call you at either of these?

In the event of a change in appointment, at what time can we reach you at these numbers?

Age _____ Birthday _____ Sex (M, F)_____

Birthplace _____

If foreign-born, date of arrival in U.S.? _____

If foreign-born, are you a citizen? _____

Approximately how long have you lived in this city? _____

Marital status (Single, Married, Separated, Divorced) _____

If married, how long ago? _____ If separated or divorced, when?_____

If married more than once, list dates of marriage, length of time married, whether marriage terminated by divorce, annulment, death
_____

List number and ages of children, if any _____

Occupation _____ Approximate gross yearly salary _____

How long have you been doing your present kind of work? _____

If unemployed, source of income at present _____

How far through school did you go? _____

Name and address of nearest relative or friend _____

Any military service? _____

Whom are you living with at present? _____

Who referred you here? _____

How strongly do you want treatment for your problem (check)
( )very much ( )much ( )moderately ( )could do without it, if necessary ( )do not want treatment

What days and times can you come here for treatments?_____

If your answer to above is after 5 p.m., can you, if necessary, get away for an hour once weekly during the day? _____

If psychologic or other tests are necessary to help your condition, would you object to them for any reasons? _____

Do you know what psychotherapy is? _____

APPENDIX E

Family Data Sheet
(to be filled out by patient)

NAME:

Please fill out the following blank as complete as possible. This will save time and make it unnecessary to ask you routine questions. All material is confidential and will not be released except on your written request.

1. List the first names of your father, mother, brother, and sisters, in chronologic order, and supply the following information about each:

List first names	Age	Live in what city?	If dead, year and cause	Marital status —M, Div, Sep, Wid	Do you see them often or write often to them (yes, no)	Personality adjustment (good, fair, poor)	How do (or did) you get along with them (good, fair, poor)?
Father:							
Mother:							
Sisters:							
Brothers:							

2. If married, age of mate:_____ Are you living with spouse now? _____

Occupation of spouse:_____

How are you getting along with spouse (good, fair, poor)? _____

3. List all of your children both present and previous marriages, by first names in chronologic order, giving the following information on each:

Name	Living or dead	Ages	Living with whom at present?	Check if by previous marriage	Personality adjustment (good, fair, poor)	How do you get along with child (good, fair, poor)?

Examiner	Daily Progress Note15	Date

PATIENT'S NAME

At each visit enter (1) present state of symptoms or complaints (absent, improved, the same, worse), (2) how patient feels (anxious, placid, depressed, happy), (3) important life situations and developments since last visit and how they were handled, (4) generate content of session, (5) significant transference and resistance reactions, (6) dreams.

15 On the standard form, this Daily Progress Note is given two full sides of an 8½ by 11 inch sheet, to allow for as complete a report as is required.

Monthly Progress Summary

This form will be found helpful in clinics where there is routine supervision of the entire case load. It is turned over monthly to supervisor.

Month covered in this report:

(Fill out this side and on back of sheet elaborate on any checked items as well as other items of importance, using additional sheets if necessary.)

NAME OF PATIENT   NAME OF THERAPIST

NUMBER OF SESSIONS THIS MONTH   TOTAL NUMBER OF SESSIONS TO DATE

PATIENT'S RESPONSE TO THERAPY:

---

1. General progress to date:

    ( )excellent ( )satisfactory ( )poor

    Symptoms are ( )better ( )the same ( )worse

2. Appointments:

    ( )comes on time ( )comes early ( )comes late

3. Communicativeness:

    ( )satisfactory ( )overproductive ( )incoherent ( )underproductive ( )responds on to questions ( )long periods of silence ( )other, describe:_____

4. Relationship with therapist/Working relationship:

    ( )good ( )fair ( )poor ( )intense dependency ( )sexual feelings ( )fear ( )detachment ( )negativism ( )hostility ( )other, describe: _____

5. Resistance:

    ( )low ( )moderate ( )strong ( )interferes with progress ( )"acting-out" tendencies

6. Insight:

    ( )achieving insight ( )curiosity about dynamics ( )intellectual, but not emotional, insight ( )resists insight

7. Translation of insight into action:

    ( )excellent ( )satisfactory ( )poor

8. Present symptoms: (Describe any checked items on back.)

( )new physical symptoms or complaints	( )sexual disturbance	( )intense anxiety
( )exaggerated old	( )intense	( )hallucinations

physical symptoms	depression	
( )work disability	( )suicidal threats	( )delusions
( )marked insomnia	( )suicidal attempts	( )excess alcohol
( )overactivity	( )destructive tendencies	( )excess sedatives/drugs
( )other, describe:		

9. Severe environmental problems

( )finances ( )work ( )family ( )other

REMARKS

1.   ( ) Supervisory Conference Needed:

      ( )emergency foreseen ( )dynamics not clear ( )treatment going poorly ( )patient wants to discontinue ( )may need medication ( )therapist considering closing ( )other, describe:_____

2.   ( ) Consultation Needed:

      ( )with caseworker ( )with psychologist ( )with medical consultant ( )with psychiatric consultant ( )other, describe:_____

3.   Other (describe briefly on back of sheet what has been going on in treatment during the last month):

Termination Note

---

1. NAME OF PATIENT

2. DATE OF INITIAL INTERVIEW

3. DATE OF TERMINAL INTERVIEW

4. TOTAL NUMBER OF SESSIONS

5. REASON FOR TERMINATION

    ( )planned termination   ( )withdrawal by patient (explain)

6. CONDITION AT DISCHARGE

    a.   ( )Recovered: Asymptomatic with good insight

    b.   ( )Markedly improved

           ( )Asymptomatic with some insight

           ( )Asymptomatic with no insight

    c.   ( )Moderately improved

           ( )Partial reduction of symptoms with good insight

           ( )Partial reduction of symptoms with some insight

    d.   ( )Slightly improved: Partial reduction of symptoms with little or no insight

    e.   ( )Unimproved

    f.   ( )Worse (describe)

7. AREAS OF IMPROVEMENT (use back of sheet, if necessary):

    a.   Symptoms

    b.   Adjustment to environment: (work, community, etc.)

    c.   Physical functions: (appetite, sleep, sex, etc.)

    d.   Relations with people

8. PATIENT'S ATTITUDE TOWARD THERAPIST AT DISCHARGE (use back of sheet, if necessary)

    ( )friendly ( )indifferent ( )unfriendly

9. WOULD PATIENT OBJECT TO A FOLLOW-UP LETTER INQUIRING ABOUT PROGRESS?

    ( )Yes ( )No

10. RECOMMENDATIONS TO PATIENT AT DISCHARGE (if any, Use back of sheet if necessary)

11. DIAGNOSIS AT DISCHARGE

10. ADDITIONAL COMMENTS (use back of sheet)

Summary[16]

PATIENT'S NAME		
Date of Summary:		Therapist:
Prepared by:	Total Treatment Sessions:	Initial Interview Date:

I. CHIEF COMPLAINT

II. HISTORY AND DEVELOPMENT OF COMPLAINT

III. OTHER COMPLAINTS AND SYMPTOMS

IV. MEDICAL, SURGICAL, AND GYNECOLOGIC HISTORY

V. ENVIRONMENTAL DISTURBANCES (at onset of therapy)

VI. RELATIONSHIP DIFFICULTIES (at onset of therapy)

VII. HEREDITARY, CONSTITUTIONAL, and EARLY DEVELOPMENTAL INFLUENCES

VIII. FAMILY DATA

IX. PREVIOUS ATTACKS OF EMOTIONAL ILLNESS

X. INITIAL INTERVIEW (brief summary of condition of patient)

XI. LEVEL OF INSIGHT AND MOTIVATION (at onset of therapy)

XII. CLINICAL EXAMINATION (significant physical, neurologic, psychiatric, and psychologic findings)

XIII. DIFFERENTIAL DIAGNOSIS

XIV. ESTIMATE OF PROGNOSIS

XV. PSYCHODYNAMICS AND PSYCHOPATHOLOGY

XVI. COURSE OF TREATMENT (type of therapy employed, frequency, total sessions, significant events during therapy, nature of transference and resistance, progress in therapy, insight, change in symptoms, attitudes, and relationships with people.)

XVII. CONDITION ON DISCHARGE

XVIII. RECOMMENDATIONS TO PATIENT

XIX. STATISTICAL CLASSIFICATION

16 Retype this form, if possible, before use. Use and attach additional blank sheets in the event space for any item to be sufficient, carrying over the same item number. Note: This form has been condensed (ordinarily four full pages with considerable space between items.)

Case Folder

NAME OF PATIENT:
NAME OF THERAPIST:
(L—Late, B—Broken, C—Cancelled)

	Date:	L, B, or C	Billing
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			

Date:	Form:
	Personal Data Sheet
	Family Data Sheet
	INITIAL INTERVIEW
	Personality Inventory
	Rorschach Responses
	Man-Woman Drawing
	Consultations
	Psychiatric
	Medical
	Neurological
	Psychological
	Casework
	TERMINAL NOTE
	SUMMARY
	Transfer
	Follow-up 1 yr.
	Follow-up 2 yrs.
	Follow-up 5 yrs.
	Case re-opened

1	13	25
2	14	26

24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32.			
33.			
34.			
35.			
36.			

3	15	27
4	16	28
5	17	29
6	18	30
7	19	31
8	20	32
9	21	33
10	22	34
11	23	35
12	24	36

This form is printed on the front of a heavy manila folder and the numbered list of appointments is continued in two columns on the back for 165 appointments. (9 x 11¾ inch folder)

Date	Supervisor	Date	Supervisor

Outline for Case Presentation

---

1. Sex

3. Marital status

4. How long married?

5. Number and ages of children

6. Age and occupation of mate

7. Any previous marriages? When?

8. Relgion

9. Education

10. Occupation

11. Employed? Salary

12. If unemployed, source of income

13. Chief Complaint
(in patient's own words)

14. History and Development of Complaint
(date of onset, circumstances under which complaint developed, progression
rom the onset to the time of the initial interview)

15. Other Complaints and Symptoms
(physical, emotional, psychic, and behavioral symptoms other than those of the
complaint factor.)

16. Medical, Surgical, (and in Women Gynecologic History)

17. Environmental Disturbances at onset of Therapy
(economic, work, housing, neighborhood, and family difficulties)

18. Relationship Difficulties at onset of Therapy
(disturbances in relationships with people, attitudes toward the world, toward
authority, and toward the self)

19. Hereditary, Constitutional, and Early Developmental Influences
(significant physical and psychiatric disorders in patient's family, socioeconomic
status of family, important early traumatic experiences and relationships,
neurotic traits in childhood and adolescence)

20. Family Data
(mother, father, siblings, spouse, children—ages, states of health, personality
adjustment, and patient's attitudes toward each)

21. Previous Attacks of Emotional Illness
(as a child and later. When did patient feel himself to be completely free from
emotional illness?)

22. Initial Interview

(brief description of condition of patient at initial interview, including clinical findings)

23. Level of Insight and Motivation at onset of Therapy
(How long ago did the patient feel that he needed treatment? For what? Awareness of emotional nature of problem, willingness to accept psychotherapy)

24. Previous Treatments
(When did the patient first seek treatment? What treatment did he get? Any hospitalization?)

25. Clinical Examination
(significant findings in physical, neurologic, psychiatric, and psychologic examinations)

26. Differential Diagnosis
(at time of initial interview)

27. Estimate of Prognosis
(at time of initial interview)

28. Psychodynamics and Psychopathology

29. Course of Treatment
(up to time of presentation)

   a. Type of therapy employed, frequency, total number of sessions, response to therapist

   b. Significant events during therapy, dynamics that were revealed, verbatim report of important dreams, nature of transference and resistance

   c. Progress in therapy, insight acquired, translation of insight into action, change in symptoms, attitudes, and relationships with people

   d. Verbatim account of all or part of a typical session, if desired

30. Statistical Classification

Application Blank for New Staff Members

NAME

ADDRESS

AGE

MARITAL STATUS

TELEPHONE

DEGREES (where obtained and dates—undergraduate and postgraduate):

DIDACTIC INSTRUCTION

Basic Courses	Where Taken	Year	Instructor
Psychosocial Development			
Psychopathology			
Psychodynamics			
Techniques of Interviewing			
Basic Neuropsychiatry			
Readings in Psychiatric Literature			
Techniques in Psychotherapy			
Clinical Conferences			
Continuous Case Seminars			
Child Psychiatry			
Group Psychotherapy			

What schools of psychotherapy or psychoanalysis have you attended as a matriculated student?

Dates:

Were you ever certified?

Have you been qualified by any Board?

Date of license, if any, to practice profession:

Membership in which professional societies?

PERSONAL PSYCHOANALYSIS OR PSYCHOTHERAPY

When started

With whom

Number of sessions per week

Total number of sessions

Additional therapy

CLINICAL EXPERIENCE (indicate names of therapeutic centers, clinics, institutions, or agencies; date of affiliation; capacity in which you have functioned)

CASE EXPERIENCE

When did you begin practicing psychotherapy?

Can you estimate the total number of patients treated?

Can you estimate the total number of patient sessions to date?

Underline the kinds of problems you have handled:
character disorder, psychopathic personality, anxiety neurosis, anxiety hysteria, conversion hysteria, obsessive compulsive neurosis, psychosomatic problem, alcoholism, drug addiction, borderline case, schizophrenia, psychoneurotic depression, manic-depressive psychosis, involutional melancholia, paranoid condition, marital problem, childhood behavior problem, childhood psychoneurosis, childhood psychosis, convulsive disorder

SUPERVISED CLINICAL EXPERIENCE
give names of supervisors, place of supervision, dates, total number of sessions with each supervisor

SUPERVISORY EXPERIENCE

Have you ever supervised therapists in psychotherapy?

If yes, how many therapists?

Total number of supervisory sessions

Have you ever had a course of instruction in psychotherapeutic supervision?

GROUP THERAPY

Have you ever done group therapy?

If so, underline types:
inspirational and supportive groups, educational groups, discussion groups, analytic groups, social and activity groups, psychodrama, other:_____

Total number of group therapy sessions

PSYCHOTHERAPEUTIC TEACHING EXPERIENCE
(courses taught, dates, places)

HAVE YOU EVER PUBLISHED ANY MATERIAL ON PSYCHOTHERAPY *(papers, pamphlets)*
If so, list:

Questions You May Have about Psychotherapy[17]

DO I NEED PSYCHOTHERAPY?

If you have nervous symptoms such as tension, depression, fears, fatigue, and certain physical complaints for which your doctor finds no physical basis; if you find it difficult to get along in your work or in your relations with people, if you have a school, sex, or marital problem; of if you merely feel irritable, unhappy, and believe you are not getting the most out of life, psychotherapy will be of help to you

HOW DOES PSYCHOTHERAPY WORK?

Nervous symptoms and unwarranted unhappiness are the product of inner emotional troubles. In psychotherapy you are helped to understand your problems. In this way it is possible for you to do something constructive about solving them.

CAN PHYSICAL SYMPTOMS BE CAUSED BY EMOTION?

Many physical symptoms are psychosomatic in nature, which means that they have an emotional or nervous basis. When you come to think of it, it is not really so strange that emotional strain or worry should produce physical symptoms. After all, every organ in your body is connected with your brain by nerve channels; and so it is logical that when your nervous system is upset by some crisis or conflict, you may feel the effects in various organs of the body.

IF I CANNOT SOLVE MY PERSONAL PROBLEMS WITHOUT HELP, DOES THAT MEAN THAT I HAVE A WEAK WILL OR AM ON THE WAY TO A MENTAL BREAKDOWN?

No. Even if you have no serious symptoms, it is difficult to work out emotional problems by yourself because you are too close to them and cannot see them clearly. More and more people, even those with a great deal of psychologic knowledge, are seeking help these days because they realize this. The fact that you desire aid is a compliment to your judgment and is no indication that you are approaching a mental breakdown. Psychotherapy has helped countless numbers of people to overcome serious emotional symptoms and has enabled many others to increase their working capacities and to better their relationships with people.

WHAT KIND OF TREATMENT WILL I NEED?

The kind of treatment best suited for you can be determined only by a careful evaluation of your problem by a professional therapist.

In scientific work records are necessary, since they permit a more thorough dealing with one's problems. It is understandable that you might be concerned about what happens to the information about you, because much or all of this information is highly personal. Case records are confidential. No outsider, not even your closest relative or family physician, is permitted to see your case record without your written permission.

HOW CAN I HELP TO COOPERATE WITH THE TREATMENT PLAN?

The general practitioner has medications; the surgeon works with instruments; the heart specialist has x-rays and delicate recording apparatus. But for the most part, the psychotherapist has only one aid besides knowledge—YOU. Your cooperation and trust in the therapist are essential. You must feel free to take up with your therapist anything about the treatment process that disturbs you or puzzles you in any way. By doing this you have the best chance of shortening your treatment and insuring its fullest success.

17 This form is useful in determining the didactic and experimental equipment of an applicant for a clinic position.

Personal History Sheet[18]

Last Name:
First Name:
Date:

This material is necessary for the completion of your records. In answering the questions use extra sheets if required, noting the number of the question that is being answered. This, as all other information, will be kept confidential. If you are particularly troubled by any question and do not desire to answer it, merely write in "Do not care to answer."

1. How would you describe your health (excellent, good, fair, poor)?

   a. Physical

   b. Emotional

2. What physical illnesses have you had? When?

3. When was your last examination by a physician?

   a. For what condition?

4. Have you in the last 2 years had:

   a. Chest x-ray

   b. Urine examination

   c. Blood tests

5. Have you ever been turned down for life insurance?

   a. If yes, why?

6. Have you ever been in a hospital? _____ If yes:

   a. Name of hospital

   b. Nature of illness

   c. Date and length of hospitalization

7. When was the last time you felt well both physically and emotionally for a sustained period?

8. Have you received treatment for "nervous" or emotional difficulties? If so:

   a. Date

   b. Frequency of visits

   c. Nature of treatment

d.   Whom treated by

9.   Does your present job satisfy you?
     If not, in what ways are you dissatisfied?

10. Do you think you could handle a job more difficult than those you have held?
     If yes, describe.

11. What is your ambition?

12. Do you make friends easily?   Do you keep them?

13. Are most of your friends of one gender?   Which?

14. Can you confide in your friends?

15. How is most of your free time occupied?

16. What medications (and dosages) are you taking at the present time?

17. Check any of the following that apply to you

( )	headaches	( )	depressed
( )	dizziness	( )	suicidal ideas
( )	fainting spells	( )	always worried about something
( )	palpitations	( )	unable to relax
( )	stomach trouble	( )	unable to have a good time
( )	no appetite	( )	don't like weekends and vacations
( )	bowel disturbances	( )	over-ambitious
( )	fatigue	( )	sexual problems
( )	insomnia	( )	shy with people
( )	nightmares	( )	can't make friends
( )	take sedatives	( )	can't make decisions
( )	alcoholism	( )	can't keep a job
( )	feel tense	( )	inferiority feelings
( )	feel panicky	( )	home conditions bad
( )	tremors	( )	financial problems

Medical Form

RE:_____

Dear Dr._____

  The above patient has given me (us) permission to ask you for the results of his recent physical examination. I would appreciate your filling out this form and returning it in the enclosed envelope. (The patient's signed released is attached.)

Head: EENT

Cardiovascular:

Pulmonary:

Genito-urinary:

Neurologic:

Additional:

Diagnosis:

From your findings is there any evidence of physical illness which requires treatment at this time?
NO_____ YES_____

If yes, what medical treatment do you recommend?

<div align="right">

Sincerely,

_____

Address: _____

Phone:_____

</div>

APPENDIX P

Physical, Neurologic, and Laboratory Examinations

(Check items in which abnormality exists and explain below.)

I. Physical Examination

( )	Stature	( )	Tongue	( )	Abdomen
( )	Nutrition	( )	Gums and teeth	( )	Hernia
( )	Weight	( )	Pharynx	( )	Genitals
( )	Skin	( )	Tonsils	( )	Muscles
( )	Hair	( )	Neck	( )	Bones
( )	Scalp	( )	Thyroid gland	( )	Joints
( )	Eyes	( )	Chest	( )	Spine
( )	Nose	( )	Breasts	( )	Extremities
( )	Sinuses	( )	Lungs	( )	Nails
( )	Ears	( )	Heart	( )	Lymphatic glands
( )	Lips	( )	Blood vessels	( )	Other (explain below)
( )	Mouth	( )	Blood pressure		

II. Neurologic Examination

( )	Station	( )	Oculomotor, trochlear, and abducens nerves
( )	Gait	( )	Trigeminal nerve
( )	Tactile sense	( )	Facial nerve
( )	Pressure sense	( )	Auditory nerves
( )	Temperature	( )	Glossopharyngeal nerve
( )	Pain	( )	Vagus nerve
( )	Muscular sense	( )	Spiral accessory nerve
( )	Stereognostic nerve	( )	Hypoglossal nerve
( )	Olfactory nerve	( )	Knee jerk
( )	Optic nerve	( )	Abdominal and epigastric reflexes
( )	Achilles reflex	( )	Sphincteric reflexes

( )	Wrists, biceps, triceps reflexes	( )	Motor disturbances
( )	Babinski reflex	( )	Paresis
( )	Oppenheim's reflex	( )	Hypotonia
( )	Gordon reflex	( )	Tremors, tics, spasms
( )	Cremasteric reflex	( )	Other (explain below)

III. Miscellaneous Examinations

( )	Urinalysis	( )	X-ray examiniation
( )	Blood analysis	( )	Electrocardiogram
( )	Endocrine analysis	( )	Electroencephalogram
( )	Other (specify)		

IV. Summary of Physical, Neurologic, and Laboratory Examiniations

If examinations are essentially negative, check below. Explain items that have been checked above.

( )   Physical examination negative

( )   Neurologic examination negative

( )   Miscellaneous examinations negative

APPENDIX Q

Mental Examination

NAME OF PATIENT

(Check the following and elaborate below.)

I. Attitude and General Behavior

a. Physical appearance ( )disheveled ( )untidy ( )unkempt

b. Degree of cooperativeness ( )fair ( )poor

c. General manner ( )mistrustful ( )suspicious ( )antagonistic
( )negativistic ( )defiant ( )preoccupied

d. General activity ( )motor retardation ( )hyperactivity
( )stereotype ( )mannerisms
( )tics ( )echolalia
( )echopraxia ( )preservation
( )compulsion

II. Stream of Mental Activity

a. Accessibility ( )indifferent ( )self-absorbed ( )inaccessible

b. Productivity ( )voluble ( )circumstantial ( )flight of ideas
( )under-productive ( )retarded ( )mute

c. Progression of thought ( )illogical ( )suspicious ( )irrelevant
( )incoherent ( )verbigeration ( )blocking

d. Neologisms

III. Emotional Reactions

a. Quality of affect ( )elation ( )exhilaration ( )exaltation
( )euphora ( )mild depression
( )moderate depression ( )severe depression
( )apprehension ( )fear ( )anxiety
( )irritability ( )morbid anger
( )apathy ( )emotional instability

b. Appropriateness ( )incongruity with thought content ( )ambivalence
of affect ( )emotional deterioration

IV. Mental Trend—Content of Thought

a. Thinking ( )phobias ( )obsessive ideas
disorders ( )psychosomatic complaints ( )persecutory trend
( )ideas of reference ( )grandiose ideas
( )depressive delusions ( )nihilistic delusions
( )hypochondriac ideas ( )ideas of unreality

( )deprivation of thought ( )delusions of influence
( )autistic thinking

b. Perceptive   ( )auditory hallucinations ( )visual hallucinations
    disorders

c.   ( )olfactory hallucinations ( )tactile hallucinations
                             ( )reflex, microptic, hypnagogic, or psychomotor
                             hallucinations ( )illusions

V. Sensorium, Mental Grasp, and Capacity

a. Disorders of consciousness   ( )confusion ( )clouding ( )dream state
                             ( )delirium ( )stupor

b. Disorders of apperception   ( )mild ( )severe

c. Disorders of orientation   ( )time ( )place ( )person

d. Disorders of personal   ( )general amnesia ( )circumscribed amnesia
    identification and memory   ( )confabulation ( )retrospective
                             ( )falsification hypermnesia

e. Disorders of retention and   ( )mild ( )severe
    immediate recall

f. Disorders of counting and   ( )mild ( )severe
    calculation

g. Disorders of reading   ( )mild ( )severe

h. Disorders of writing   ( )mild ( )severe

i. Disorders in school and general ( )mild ( )severe
    knowledge

j. Disorders in attention,   ( )mild ( )severe
    concentration, and thinking
    capacity

k. Disorders in intelligence   ( )inconsistent with education
                             ( )mild ( )severe

l. Disorders in judgment   ( )mild ( )severe

m. Disorders in insight   ( )mild ( )severe

VI. Summary of Mental Examination

(check and describe abnormality, if any):

( )   Mental examination essentially negative

( )   Disturbance in attitude and general behavior

( )   Disturbance in stream of mental activity

( )   Disturbance in emotional reaction

( )   Disturbance in mental trend—content of thought

( )   Disturbance in sensorium, mental grasp and capacity

APPENDIX R

Authorization for Release of Medical Records

TO:_____

ADDRESS:_____

I would appreciate your releasing to _____ all records
or abstracts pertaining to my case. I herewith grant permission for this release.

SIGNED:_____

Witness:_____

Date:_____

Progress Report[19]

NAME:

DATE:

At the beginning of each month, it would be helpful if you would write a brief report on how you feel and what you believe has been accomplished in the past month.

Check the following:

The symptoms or complaints for which I sought treatment originally are:

( ) the same

( ) better

( ) worse

My understanding of my condition is:

( ) excellent

( ) good

( ) fair

( ) poor

I believe my relationship with my therapist to be:

( ) good

( ) fair

( ) in need of improvement

I would consider my progress to be:

( ) excellent

( ) good

( ) fair

( ) poor

Additional Comments:

19 This sheet may be given monthly to selected patients for a progress report.

Antidepressant Medications: Special Instructions for Patients[20]

TYPE OF MEDICINE

These medications properly taken can relieve depression *immediately or take up to 4 weeks of continuous medication.* The percentage of success with these medications is very high, and if the patient cooperates by not skipping medication and not under or overdosing hospitalization is rarely (less than 5%) necessary. The average time for signs of recovery to appear is 1 to 4 weeks.

DOSAGE

It cannot be overstressed that the medication should be taken as prescribed and not skipped. It is common for depressed persons to be their own worst enemies and thus, on one pretext or another, not take the medication as prescribed or most frequently to skip doses or days.

SIDE EFFECTS

Almost all good modern medicines have some mildly undesirable or minor reactions which are usually unimportant. Do not become alarmed. Usually it is best to tell the doctor if you do get them.

1. Dryness of the mouth is probably the most frequent. Ignore it, or chew gum, keep hard candy in the mouth, or take liquids often.

2. Blurring of vision—is usually due to a temporary enlargement of the pupil. If it bothers you a great deal or interferes with your work, tell the doctor.

3. Lowered blood pressure—*Do not stand suddenly*. If you should forget and stand suddenly after having been on the medicine for some time, you get nauseous or dizzy. If you are afraid of fainting, lie flat. Get an elastic bandage to wrap tightly around the abdomen (belly). The wrapping should be at least 8 inches wide. A tight girdle or similar support may be enough. An abdominal support purchased in a surgical supply house or drugstore is best. Put the support on before getting out of bed in the morning and continue to wear it daily until the doctor says you may stop. It is rarely necessary to wear elastic stockings or wrap elastic bandages around the legs to the hip. The belly support tightly and properly applied is usually adequate. If it is not, tell the doctor and have him check your blood pressure *in the standing position*. The doctor can also use additional medicines to raise your

pressure.

4. Constipation—Your body can adjust to bowel movements occurring every 2-3 days, and, thus, if medication or depression does this, laxatives are not required. Do not take any laxative but mineral oil or milk of magnesia except with the doctor's advice.

5. Minor and rare inconveniences—never reason for stopping medication.

a. Sweating—excessive perspiration may occur in some persons. This is usually a sign that an adequate dosage is being used. Excessive sweating may also be caused by nervousness, so do not stop medication under these circumstances; discuss it with your doctor.

b. Sleepiness—most fatigue and sleepiness is due to emotional problems. Rarely, temporary sleepiness of a week's duration is caused by medication. Under no circumstances stop the medication entirely because of this. Dose may be taken more toward bedtime, decreased with doctor's consent, or sleepiness will stop after a week on the medication.

c. Shakiness—most shakiness is due to the emotional problem. Rarely is it due to medication. Discuss this with your doctor.

**IMPORTANT! Most antidepressants will mix well with foods or other medicines. However, if you are treated by another doctor for anything, even a cold, you should remind him that you are taking an antidepressant or have been in the last two weeks

d. DO NOT USE ALCOHOL IN ANY FORM

e. Do not take any medication without the doctor's knowledge, especially over-the-counter medicines with the exception of aspirin, mineral oil, or milk of magnesia. In particular, avoid cold and cough medicines, antihistamines, and reducing or sleeping medicine. It is also well to avoid coffee and "colas" as they increase nervousness.

**MOST IMPORTANT—For those on MAO antidepressants only. If the doctor tells you that you are on an especially strong antidepressant, such as an MAO (monoamine oxidase inhibitor) for depression, then:

f. Do not use alcohol in any form, especially Chianti wine.

g. Do not eat cheese, except cottage cheese

h. Do not eat prepared herring or similar products, no wax beans, or other foods that the doctor may prohibit.

Almost all people get the "blues" or are depressed for some period of time. You have a longer period of depression than is healthy. You may usually feel that there is no hope for you …that you're not worth taking the time and money to cure …that you're too tired to make any effort …or that you're the one person who can't be cured. Usually your concentration and memory have temporarily declined. You may have little feeling for those you have loved before, even in your own family, and you may have little interest in sex. These and some other things are characteristic of depression. *They respond easily to treatment—do not give up hope.*

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APPENDIX U

Questions You May Have about Hypnosis

Exactly What is Hypnosis?

Hypnosis is a state of altered consciousness that occurs normally in every person just before one enters into the sleep state. In therapeutic hypnosis we prolong this brief interlude so that we can work within its bounds.

Can Everybody be Hypnotized?

Yes, because it is a normal state that everybody passes through before going to sleep. However, it is possible to resist hypnosis like it is possible to resist going to sleep. But even if one resists hypnosis, with practice the resistance can be overcome.

What is the Value of Hypnosis?

There is no magic in hypnosis. There are some conditions in which it is useful and others in which no great benefit is derived. It is employed in medicine to reduce tension and pain that accompany various physical problems and to aid certain rehabilitative procedures. In psychiatric practice it is helpful in short-term therapy and also, in some cases, in long-term treatment where obstinate resistances have been encountered.

Who Can Do Hypnosis?

Only a qualified professional person should decide whether one needs hypnosis or could benefit from it. In addition to other experience, the professional person requires further training in the techniques and uses of hypnosis before being considered qualified.

Why Do Some Doctors Have Doubts About Hypnosis?

Hypnosis is a much misunderstood phenomenon. For centuries it has been affiliated with spiritualism, witchcraft, and various kinds of mumbo jumbo. It is a common tool of quacks who have used it to "cure" every imaginable illness, from baldness to cancer. The exaggerated claims made for it by undisciplined persons have turned some doctors against it. Some psychiatrists too doubt the value of hypnosis because Freud gave it up 60 years ago and because they themselves have not had too much experience with its modern uses.

If Hypnosis is Valuable, Shouldn't it be Employed in all Psychological or Psychiatric

Most psychological and psychiatric problems respond to treatment by skilled therapists without requiring hypnosis. Where blocks in treatment develop, a therapist skilled in hypnosis may be able to utilize it effectively. But only a qualified professional person can decide whether this is necessary or desirable.

Is the Use of Hypnosis Endorsed by the Proper Authorities?

Both the American Medical Association and the American Psychiatric Association have qualified hypnosis as a useful form of treatment in the hands of skilled doctors who have had adequate training and who employ it in the context of a balanced treatment program.

Can Hypnosis be Dangerous?

The hypnotic state is no more dangerous than is the sleep state. But unskilled operators may give subjects foolish suggestions, such as one often witnesses in stage hypnosis, where the trance is exploited for entertainment purposes. A delicately balanced and sensitive person exposed to unwise and humiliating suggestions may respond with anxiety. On the whole, there are no dangers in hypnosis when practiced by ethical and qualified practitioners.

I Am Afraid I Can't be Hypnotized?

All people go through a state akin to hypnosis before falling asleep. There is no reason why you should not be able to enter a hypnotic state.

What Does it Feel Like to be Hypnotized?

The answer to this is extremely important because it may determine whether or not you can benefit from hypnosis. Most people give up hypnosis after a few sessions because they are disappointed in their reactions, believing that they are not suitable subjects. The average person has the idea that he will go through something different, new and spectacular in the hypnotic state. Often he equates being hypnotized with being anaesthetized, or being asleep, or being unconscious. When in hypnosis, he finds that his mind is active; that he can hear every sound in the room; that he can resist suggestions if he so desires; that his attention keeps wandering, his thoughts racing around; that he has not fallen asleep; and that he remembers everything that has happened when he opens his eyes, and thus he believes himself to have failed. He imagines then that he is a poor subject, and he is apt to abandon hypnotic treatments. *The experience of being hypnotized is no different from the experience of relaxing and of starting to go to sleep.* Because this experience is so familiar to you, and because you may expect something startlingly different in hypnosis, you may get discouraged when a trance is induced. Remember, you are not anaesthetized, you are not unconscious, you are not asleep. Your mind is active, your thoughts are under your control, you perceive all stimuli, and you are in complete

communication with the operator. The only unique thing you may experience is a feeling of heaviness in your arms and tingliness in your hands and fingers. If you are habitually a deep sleeper, you may doze momentarily; if you are a light sleeper, you may have a feeling you are completely awake.

How Deep Do I Have to Go to get Benefits from Hypnosis?

If you can conceive of hypnosis as a spectrum of awareness that stretches from waking to sleep, you will realize that some aspects are close to the waking state, and share the phenomena of waking; and some aspects are close to sleep, and participate in the phenomena of light sleep. But over the entire spectrum, suggestibility is increased; and this is what makes hypnosis potentially beneficial, provided we put the suggestibility to a constructive use. The depth of hypnosis does not always correlate with the degree of suggestibility. In other words, even if you go no deeper than the lightest stages of hypnosis and are merely mildly relaxed, you will still be able to benefit from its therapeutic effects. It so happens that with practice you should be able to go in deeper, but this really is not too important in the great majority of cases.

How Does Hypnosis Work?

The human mind is extremely suggestible and is being bombarded constantly with suggestive stimuli from the outside, and suggestive thoughts and ideas from the inside. A good deal of suffering is the consequence of "negative" thoughts and impulses invading one's mind from subconscious recesses. Unfortunately, past experiences, guilt feelings, and repudiated impulses and desires are incessantly pushing themselves into awareness, directly or in disguised forms, sabotaging one's happiness, health, and efficiency. By the time one has reached adulthood, he has built up "negative" modes of thinking, feeling, and acting that persist like bad habits. And like any habits they are hard to break. In hypnosis we attempt to replace these "negative" attitudes with "positive" ones. But it takes time to disintegrate old habit patterns; so do not be discouraged if there is no immediate effect. If you continue to practice the principles taught you by your therapist, you will eventually notice change. Even though there may be no apparent alterations on the surface, a restructuring is going on underneath. An analogy may make this clear. If you hold a batch of white blotters above the level of your eyes so that you see the bottom blotter, and if you dribble drops of ink onto the top blotter, you will observe nothing different for a while until sufficient ink has been poured to soak through the entire thickness. Eventually the ink will come down. During this period while nothing seemingly was happening, penetrations were occurring. Had the process been stopped before enough ink had been poured, we would be tempted to consider the process a failure. Suggestions in hypnosis are like ink poured on layers of resistance; one must keep repeating them before they come through to influence old, destructive patterns.

How Can I Help in the Treatment Process?

It is important to mention to your therapist your reactions to treatment and to him

or her, no matter how unfounded, unfair, or ridiculous these reactions may seem. Your dreams may also be important. If for any reason you believe you should interrupt therapy, mention your desire to do so to your doctor. Important clues may be derived from your reactions, dreams, and resistances that will provide an understanding of your inner problems and help in your treatment.

Wouldn't Hypnotic Drugs be Valuable and Force Me to Go Deeper?

Experience shows that drugs are usually not necessary. Often they complicate matters. If you should require medications, these will be employed.

What about Self-Hypnosis?

"Relaxing exercises," "self-hypnosis," and "auto-hypnosis" are interchangeable terms for a reinforcing process that may be valuable in helping your therapist help you. If this adjunct is necessary, it will be employed. The technique is simple and safe.

Relaxing Exercise

These exercises may be performed the first thing in the morning before getting out of bed. They may be repeated during the day if desired. They should always be done at night prior to retiring; relaxing suggestion will eventually merge into sleep. The total time for each session should be at least 20 minutes.

After shutting your eyes, proceed with the following steps:

1. Deep slow breathing for about 10 breaths.

2. Progressive muscle relaxation from forehead, face, neck to fingertips; from chest to toes, visualizing and purposefully loosening each muscle group.

3. Visualizing a wonderfully relaxed scene or simply a blank white wall.

4. low counting to self from 1 to 20 while visualizing the relaxed scene (or white wall).

5. Relaxing or sleeping from 1 to 2 minutes during which visualization of the relaxed scene continues.

6. Make the following suggestions to yourself (using the word "you").

a. *Symptom relief* (disturbing symptoms, like tension, etc., will get less and less upsetting).

b. *Self-confidence* (self-assuredness will grow).

c. *Situational control* (visualize impending difficult situations and successful mastery of them).

d. *Self-understanding* (make connections if possible between flare-ups of symptoms and precipitating events and inner conflicts).

7. Relax or sleep for several more minutes.

8. During daytime arouse yourself by counting from one to five. At night do not arouse yourself; continue relaxing until sleep supervenes.

If sleep begins developing during the 4th step before the count comes to an end,

interrupt counting and proceed immediately to suggestions (6th step above). Then continue with count and go as deeply as you wish. A racing of the mind and a tendency to distraction are normal. When this occurs force your attention back to the exercises.

Remember, you will not really be asleep during these exercises. You will be aware of your thoughts and of stimuli on the outside. If, for any reason, before you finish you want to bring yourself out of the relaxed state, tell yourself that at the count of 5 you will be out of it. Count from 1 to 5 and say to yourself: "Be wide awake now, open your eyes." If negative thoughts crop up, bypass them, and continue with the steps outlined above. *Results are rarely immediate.* It takes a while to neutralize negative suggestions you have been giving yourself all your life. So be patient. Persistence is the keynote to success.

Tables & Figures

Table 2-1 Varieties of Psychotherapy

Type of Treatment	Objectives	Illustrative Therapies
Supportive Therapy	Strengthening of existing defenses. Elaboration of new and better mechanisms of maintaining control. Restoration to an adaptive equilibrium.	Guidance, Environmental Manipulation, Externalization of Interests, Reassurance, Pressure and Coercion, Persuasion, Emotional Catharsis and Desensitization, Prestige Suggestion, Suggestive Hypnosis, Inspirational Group Therapy, Supportive Adjuncts (Somatic Therapy, Muscular Relaxation, Hydrotherapy)
Reeducative Therapy	Deliberate efforts at readjustment, goal modification, and the living up to existing creative potentialities, with or without insight into conscious conflicts.	Behavior and Conditioning Therapy, "Relationship Therapy," "Attitude Therapy," "Interview Psychotherapy," Client-centered Therapy, Directive Therapy, Distributive Analysis and Synthesis (Psychobiologic Therapy), Therapeutic Counseling, Casework Therapy, "Rational Therapy," Reeducative Group Therapy, Marital Therapy, Family Therapy, Psychodrama, Semantic Therapy, Philosophic Approaches (Existential, Zen Buddhist), Strategic Therapy, Cognitive Therapy
Reconstructive Therapy	Insight into unconscious conflicts, with efforts to achieve extensive alterations of character structure. Expansion of personality growth with development	Freudian Psychoanalysis, Ego Analysis, Kleinian Analysis, Object Relations Therapy, Neo-Freudian Psychoanalysis (Adler, Jung, Stekel, Rank, Ferenczi, Reich, Fromm, Sullivan, Horney, Rado), Psychoanalytically Oriented Psychotherapy, Transactional Approaches, Existential Analysis, Analytic Group Therapy, Adjunctive Therapies (Hypnoanalysis, Narcotherapy, Play Therapy, Art Therapy)

of new
adaptive
potentialities.

Table 2-2 Approaches to Mental Illness

Approach	Principal Fields Involved	Affiliated Professionals and Workers	Illustrative Treatment Methods
Biological	Neuroanatomy, Neurophysiology, Neurology, Biochemistry, Ethology, Genetics, Behavioral Genetics	Neuroanatomists, Neurophysiologists, Neurologists, Geneticists, Physiologists, Biologists, Biochemists, Ethologists, Physicans, Nurses	Somatic Therapies (Drug Therapy, Sleep Therapy, Electroconvulsive Therapy, Insulin Coma, Psychosurgery)
Psychological	Conditioning and Learning Theory, Developmental Theory, Personality Theory, Psychoanalytic Theory	Psychiatrists, Psychologists (experimental, educational, developmental, clinical), Educators, Psychiatric Social Workers, Psychiatric Nurses	Psychotherapy (Psychoanalysis, Behavioral Therapy, Therapeutic Counseling, Gestalt Therapy, Hypnotherapy, etc.)
Sociological	Social Theory, Role Theory, Field Theory, Ecology, Cultural Anthropology, Group Dynamics	Sociologists, Social Workers, Social Psychologists, Anthropologists, Mental Health Aids, Paraprofessionals	Casework, Environmental (Milieu) Therapy, Rehabilitation, Group Therapy, Psychodrama, Sociodrama, Family Therapy, Social Therapy, Transactional Therapy
Philosophic	Religion, Philosophy	Clergymen, Philosophers, Psychotherapists	Religious Therapy, Transcendental Meditation, Existentialism, Zen Buddhism, Yoga, Cognitive Therapy

Table 7-1 Helping, Counseling, and Psychotherapeutic Relationships

	Helping Situation	Counseling Supportive Psychotherapy	Psychotherapy (Reeducative and Reconstructive Goals)
Objectives	Symptom relief	Correction of situational problem, rectification of deviant behavior, expansion of personal abilities and skills, restoration of defenses, prevention of emotional breakdown	Alteration of defenses, facilitation of interpersonal and social adjustment, personality growth and development
Interview focus	Manifest complaints and interpersonal problems	Symptoms, situational problems, conflicts, attitudes	Underlying roots of complaints and conflicts, defenses, coping mechanisms, fantasies, symbolisms
Psychic arena	Conscious processes	Conscious processes	Conscious, preconscious, and in psychoanalysis, unconscious processes
Temporal focus	Immediate present	Immediate present	Immediate present and historical past
Technical processes	Support, reassurance, emotional catharsis, placebo influence, group dynamics	Guidance, clarification, suggestion, environmental manipulation, use of community resources	Inculcation of insight, pattern reinforcement and extinction, and in psychoanalysis, dreams and free association
Transference	Positive transference encouraged and utilized	Positive transference encouraged and utilized, negative transference discouraged	Transference interpreted when it acts as resistance
Transference neurosis	Avoided	Avoided	In psychoanalysis purposefully promoted to release repressions and to detect sources of inner conflict, otherwise circumvented if possible
Countertransference	Positive feelings utilized to promote supportive process	Positive feelings utilized, negative feelings controlled	Constantly examined, analyzed, and resolved

Table 8-1 Course of Psychotherapy

(in relation to symptom relief, behavior change, and reconstructive personality change)

	Early Phases			Middle Phases	Late Phases
Negative Factors	Defective motivation↓	Continuing Conflict ↓	Secondary gains ↓	Resistance, Transference, ↓ Transference Neurosis	Dependency ↓
1. Symptom relief					
2. Behavior Change					
3. Reconstructive personality change					
Positive Factors	Placebo influence Emotional catharsis Idealized relationship Suggestion	Insight Interpretation	Working-through Process	Corrective relearning experience	Resolution of Dependency
	Group dynamics	Supportive	Educative and Adjunctive		Techniques

During early phases of therapy there is often an immediate and dramatic relief of symptoms brought about by such positive factors as the placebo influence, emotional catharsis, idealized relationships, suggestion, and group dynamics. There is some attitude and behavior change, but little or no reconstructive personality change. Therapy interrupted at this point – as it is in short-term therapy – will show a considerable degree of symptomatic improvement. However, if therapy continues, and particularly where habitual behavior patterns are challenged, resistance and transference will erupt and will reduce or temporarily eliminate symptomatic and behavioral improvement. Treatment stopped in the middle phases will then tend to show a poorer response than if it had been discontinued before. However, as working-through of transference and resistance goes on, and, as corrective relearning takes place, symptomatic and behavioral improvement will rise accompanied by reconstructive changes. A propitious experience during short-term therapy may initiate reconstructive changes that will still require protracted time span outside of the therapeutic situation before they become manifest. This eventuality is not as consistent as it might be in properly motivated patients, who are able to endure the rigors of long-term depth therapy conducted by "effective" therapists.

Table 8-2 Estimated Results in Psychotherapy

Estimates of symptom improvement, behavioral and reconstructive personality change with various kinds of approaches

Area of change	"Spontaneous" Improvement	Helping Situation with a Non-trained Helper*		Counseling Situation (trained counselor)		Therapeutic Situation (trained therapist)	
Symptom relief or cure		"Effective" Helper	"Ineffective" Helper	"Effective" Counselor	"Ineffective" Counselor	"Effective" Therapist	"Ineffective" Therapist
	60%	70%	30%	80%	30%	80-90%	30%
Behavior change	40	50	20	60-70	20	70-80	20
Reconstructive personality change	10	15	5	20	5	40**	5

* The same results will be obtained with untrained and unskilled counselors and therapists.

** Where therapist is not trained in depth techniques the figure will approximate 20%

The average person with an emotional problem will spontaneously seek out solutions for one's problems that will result in a certain degree of symptomatic and behavioral improvement, as well as of personality change. Opportunity for the *greatest improvement* above that of the "spontaneous" rate in all three areas will be afforded one with an "effective" psychotherapist, for *considerable improvement* with an "effective" trained counselor, and for *some improvement* with an "effective" helping agency. In the hands of an "ineffective" helping agency, counselor, or psychotherapist, changes for improvement will be approximately half that of the spontaneous rate.

Table 9-1
Brain Functioning and Psychoactive Drugs

Brain Area	Function	Chemical Effect	Drug
Neocortex	Thinking; reasoning	Stimulation	Caffeine, Amphetamine (1), Methylphenidate (10)
		Depression	Barbiturates (3), Nonbarbiturate Hypnotics (11)
Thalamus	Integrating sensation; transmitting and modulating alerting impulses	Stimulation	Barbiturates (3), Phenothiazines (13)
		Depression	Meprobamate (9)
Reticular formation	Alerting; integrating emotional responses to stimuli	Stimulation	Rauwolfia derivatives (14) (small doses)
		Depression	Phenothiazines (13), Barbiturates (3), Rauwolfia derivatives (14) (large doses). Amitriptyline (2), Imipramine (7), Methylphenidate (10), Nonbarbiturate Hypnotics (11), Thioxanthenes (16), Butyrophenones (17)
Limbic System	Regulating emotions	Stimulation	Phenothiazines (13), Rauwolfia derivatives (14), Thioxanthenes (16), Butyrophenones (17)
		Depression	Meprobamate (9), Barbiturates (3), Chlordiazepoxide (4), Diazepam (5), Oxazepam (12), Tybamate (15), Hydroxyzine (6)
Hypothalamus	Controlling autonomic and endocrine functions	Stimulation	*MAO inhibitors (hydrazines)(8). Amphetamine (1)
		Depression	Phenothiazines (13), Rauwolfia derivatives (14), Barbiturates (3), Thioxanthenes (16), Butyrophenones (17)
Synapses	Transmitting nerve impulses	Stimulation	Rauwolfia derivatives (14), Acetylcholine
		Depression	Epinephrine, Amphetamine (1), Mescaline, LSD, Imipramine (7), Amitriptyline (2), Gamma Aminobutyric Acid
Interneuronal circuits	Coordinating neuronal masses	Depression	Meprobamate (9)
Neurohormonal depots (serotonin, norepinephrine.	Regulating brain metabolism	Stimulation	MAO inhibitors (8), Imipramine (7)
		Depression	Phenothiazines (13), Rauwolfia derivatives (14) Benzoquinolizenes,

etc.)	Thioxanthenes (16), Butyrophenones (17)

* Electroconvulsive Therapy is said to stimulate the posterior hypothalamus (Gellhorn et al. 1963).

(1) Amphetamine (Benzedrine. Dexedrine, etc.); (2) Amitriptyline (Elavil); (3) Barbiturates (Phenobarbital. Pentothal. Seconal, etc.); (4) Chlordiazepoxide (Librium); (5) Diazepam (Valium); (6) Hydroxyzine (Vistaril); (7) Imipramine (Tofranil), Desipramine (Norpramin, Pertofrane); (8) MAO inhibitors (Nardil, Marplan), Niacin, etc.; (9) Meprobamate (Equinal. Miltown); (10) Methylphenidate (Ritalin); (II) Nonbarbiturate Hypnotics (Doriden. Noludar, etc.); (12) Oxazepam (Serax); (13) Phenothiazines (Thorazine. Stelazine. Mellaril, Trilafon, Permitil. etc.); (14) Rauwolfia derivatives (Reserpine etc.); (15) Tybamate (Solacen); (16) Thioxanthenes (Taractan. Navane); (17) Butyrophenones (Haldol).

From Wolberg LR: Psychotherapy and the Behavioral Sciences. Orlando, FL, Grune & Stratton, 1966.

Table 9-2
Symptomatic Uses of Psychoactive Drugs

Desired Drug Effect	Drug
Enhancing cortical activity (facilitating alertness and thinking)	Amphetamine (Benzedrine, Dexedrine, Dexamyl), Methylphenidate (Ritalin), Caffeine
Diminishing excessive cortical activity (producing calming and sedation)	Barbiturates (Phenobarbital), Nonbarbiturate hypnotics (Doriden), Bromides (Triple Bromides)
Controlling anxiety and tension	Diazepoxides (Valium, Librium)
Elevating mood (overcoming depression)	Amphetamine (Benzedrine, Dexedrine, Dexamyl), Methylphenidate (Ritalin), Mono-aminooxidase inhibitors (Nardil, Parnate, Marplan), Amitriptyline (Elavil), Imipramine (Tofranil), Desipramine (Pertofrane, Norpramin)
Eliminating apathy (especially in borderline or schizophrenic states)	Phenothiazines with a piperidine or piperazine ring on side chain (Mellaril, Stelazine, Trilafon)
Inhibiting excitement, confusion, tension, and anxiety (especially in schizophrenic and manic states)	Phenothiazines (Thorazine, Mellaril), Thioxanthenes (Taractan, Navane), Butyrophenones (Haldol)
Restoring mental integration (controlling hallucinations and delusions)	Phenothiazines (Thorazine, Mellaril, Stelazine, Permitil, Trilafon, etc.). Rauwolfia derivatives (Reserpine), Butyrophenones (Haldol)
Producing "model psychoses" (for abreactions and hypermnesia)	LSD, Mescaline, Psilocybin

From Wolberg LR: Psychotherapy and the Behavioral Sciences. Orlando, FL. Grune & Stratton. 1966.

Table 13-1
Technical Psychotherapeutic Similarities and Differences

	Supportive Therapy	Reeducative Therapy	Classical Psychoanalysis	Non-Freudian Psychoanalysis	Psychoanalytically Oriented Psychotherapy
Duration of therapy	One to several hundred sessions	Several sessions to several hundred sessions	2-5 years or longer	1-5 years or longer	Several sessions to several hundred sessions
Frequency of visits	1-3 times weekly	1-2 times weekly	4-5 times weekly	2-4 times weekly	1-3 times weekly
Detailed history taking	Usually	Often	Rarely	Occasionally	Often
Psychologic examinations	Intelligence testing, Vocational battery	Intelligence testing, Vocational battery, Projective testing	Projective testing may be employed	Projective testing may be employed	Projective testing often employed
Patient's communications	Interviews focused on symptoms and environmental disturbances	Interviews focused on daily events and interpersonal relationships	Unguided free associations	Interviews focused on current situations, interpersonal relationships, and other conflictual sources Free associations sometimes used	Interviews focused on current situations, interpersonal relationships, and other conflictual sources Free associations sometimes used
General activity of therapist	Toward strengthening of existing defenses	Challenging of existing defenses Activity - directiveness to nondirectiveness	Challenging of existing defenses Passivity, anonymity, nondirectiveness Constant analysis of transference and resistance	Challenging of existing defenses Activity - moderate directiveness to nondirectiveness Constant analysis of transference and resistance	Challenging of existing defenses Greater activity - directiveness to relative nondirectiveness Constant analysis of transference and resistance
Advice giving to patient	Often	Occasionally	Never	Rarely	Rarely
Transference	Positive transference encouraged and utilized to promote improvement	Positive transference controlled, and if possible utilized to promote improvement Negative transference analyzed as it develops in terms of the reality situation	Transference encouraged to point of development of transference neurosis Transference analyzed in terms of genetic origins	Transference encouraged to point of awareness of repressed attitudes and feelings Transference neurosis avoided by some analysts Transference analyzed in terms of	Transference encouraged to point of awareness of repressed attitudes and feelings Transference neurosis avoided as a rule Transference analyzed in terms of character

				character structure or genetic origins	structure and occasionally genetic origins
General relationship of patient to therapist	Positive relationship fostered and utilized	Positive relationship fostered and utilized	Relationship permitted to develop spontaneously	Relationship permitted to develop spontaneously	Relationship permitted to develop spontaneously Positive relationship occasionally fostered and utilized
Physical position of patient during therapy	Sitting up, face to face	Sitting up, face to face	Recumbent on couch	Sitting up, face to face or Recumbent on couch	Sitting up, face to face or Occasionally recumbent on couch
Dream material	Not utilized	Not utilized	Constantly utilized	Constantly utilized	Constantly utilized
Adjuncts utilized during therapy	Bibliotherapy Art therapy Group therapy Physical therapy Somatic therapy Hypnotherapy Occupational therapy etc.	Group therapy Bibliotherapy Other adjuncts occasionally used	None	Few or none	Analytic group therapy Hypnoanalysis Narcotherapy Play therapy occasionally Art therapy occasionally Drug therapy occasionally

Table 16-1
Traditional Specialized Functions of Various Team Members in a Community Psychiatric Clinic

Psychiatrist	Caseworker	Psychologist
1. Establishing a psychiatric diagnosis 2. Physical examination where needed 3. Neurologic examination where the psychiatrist is qualified 4. Administration of somatic therapy (drugs, ECT, etc.) 5. Arranging for commitment and hospitalization where necessary 6. Handling routine physical and neurologic check-ups on patients with physical and psychosomatic problems 7. Handling of psychiatric emergencies, such as severe depression, suicidal tendencies, excitement, psychotic manifestations etc. 8. Supervision of non-medical therapists in the management of emergencies	1. Intake interviewing (clarification of services to prospective patients and determining if services are consonant with the needs of the patient) 2. Preparation of patients for psychotherapy, dealing with resistances to treatment and establishing the proper motivation for treatment 3. Exclusive handling of, or acting as a consultant for, problems in patients relating to finance, health, employment, recreation, housing, exercise, companionship, and special training. Acquainting patients with, and aiding them to utilize most effectively, available community resources 4. Acting as a casework consultant to other team members where environmental manipulation in their patients is essential in addition to psychotherapy 5. Acting as liaison between the patient and the family, employer, teacher, etc. when it is essential to interpret the patient's illness to them, to give them reassurance or to enlist their interest and cooperation. 6. Handling of parents, mate, or children of patients who are being treated by team members and who require counseling or psychotherapy as an aid to the treatment of the patient 7. Handling of children with primary behavior disorders 8. Organizing and handling administrative details of educational projects of team. Interpreting the work of the clinic to the community, securing cooperation of the community in the work of the clinic, acting as liaison between the clinic and community organizations that are implementing community programs related to health, welfare, and social security	1. Diagnostic testing: intelligence, educational, achievement, vocational, projective personality traits 2. Exclusive handling of, or acting as consultant for: a. Problems of school adjustment, maladjustment and placement b. Corrective work in educational field: therapy of reading or other educational disabilities c. Career planning, vocational guidance d. Rehabilitative work for physical and sensory defects particularly in educational and vocational areas e. Speech disturbances 3. Organizing and handling administrative details of research projects of team 4. Behavioral techniques and biofeedback

Table 19-1
Activities of the Therapist

I. Opening the Interview

II. Maintaining the Flow of Verbalizations

      A. Managing pauses

      B. Managing silence

III. Directing the Flow of Verbalizations: The Principle of Selective Focusing

      A. Identifying an important theme

      B. Reading between the lines

      C. Guiding the theme into a goal-directed channel

      D. Guiding the theme into a goal-directed channel

IV. Inculcating Insight

      A. Accenting

      B. Summarizing

      C. Restating

      D. Reflecting

      E. Establishing connections

      F. Maintaining tension in the interview

      G. Extending measured support

      H. Confrontation

      I. Making interpretations

V. Terminating the Interview

Table 21-1
An Outline of Psychotherapy

	Beginning Phase	Middle Phase		End Phase
Phases	I	II	III	IV
Objectives	Establishing a working relationship with patient	Exploring the causes and consequences of the patient's disorder	Translating understanding into action. Instituting corrective measures	Terminating Therapy
Therapeutic tasks	1. Motivating patient to accept therapy. 2. Clarifying misconceptions about therapy. 3. Convincing patient that therapist understands his or her suffering and is capable of helping. 4. Tentative defining of goals in therapy and of the therapeutic situation.	1. Delineating and exploring environmental frustrations and maladaptive interpersonal drives through interviewing. 2. In cognitive therapy, searching for false self-statements. 3. In dynamic psychotherapy, probing for unconscious conflicts that mobilize anxiety and vitiate basic needs through psychoanalytic techniques of free association, dream interpretation, analysis of the transference, and the exploration of genetic material. 4. In behavior therapy, appraising factors that need reinforcement and symptoms that require extinction.	1. Creating incentives for change. 2. Dealing with forces that block action. 3. Helping patient to master anxieties surrounding normal life goals. 4. Correction of remediable environmental distortions. 5. Helping patient to adjust to irremediable conditions. 6. Symptom removal if desirable when immediate correction is urgent. 7. Adjustment to those symptoms and abnormal character patterns that for one reason or another cannot be removed during present therapeutic effort.	1. Analyzing the dependency elements of the therapist-patient relationship. 2. Redefining the treatment situation with the aim of encouraging patient to make independent decisions and to establish individual values and goals. 3. Helping patient to achieve as much independence and assertiveness as possible.
Resistances in patient	1. No motivation for therapy or inability to accept the fact	1. Guilt in acknowledging environmental disturbance or interpersonal	1.Resistance to abandoning primary and secondary neurotic gains.	1. Refusal to yield dependency. 2. Fear of assertiveness.

	that he or she can be helped. 2. Refusal to accept therapist's definition of the treatment situation 3. Hostility, aggression, detachment, intense dependency, sexual demands, and other resistances to a warm working relationship.	difficulties. 2. Unwillingness and, in the instance of a weak ego, an inability to face and to master anxieties related to unconscious conflicts, strivings, and fears.	2. Resistance to normality. 3. Resistance to activity through own resources.	
Counter-transference problems in therapist (manifestations)	1. Inability to sympathize with patient and to communicate in understandable terms with him or her. 2. Irritability with resistances of patient to accepting therapy and therapist 3. Inability to extend warmth toward patient and to show acceptance of the problems.	1. Avoidance by therapist of those problems in patient that inspire anxiety in therapist. 2. Desire to probe too deeply and rapidly at the start. 3. Irritation with resistance of patient toward gaining understanding of the problems.	1. Frustration, hostility, and discouragement in therapist to patient's refusal to use insight in the direction of change 2. Tendency to push patient too hard and too rapidly toward normal objectives. 3. Fear of being too directive, with resultant excessive passivity. 4. Resentment at patient's inability or refusal to cooperate with corrective procedures.	1. Tendency to overprotect or to domineer patient. 2. Inability to assume a nondirective therapeutic role.

Table 24-1 Personal Data Necessary from Patient

Statistical Data

       Name

       Address

       Telephone number

       Age

       Sex

       Marital status

       Education

       Occupation

       Employment status and income

Complaint Factor

1.   Chief complaint (in patient's words)

2.   History and development of the complaint

   a.   When did the complaint begin?

   b.   Under what circumstances?

   c.   What does the patient believe produced the complaint?

   d.   What treatment has been given?

3.   Other complaints or symptoms

   a.   Physical

   b.   Emotional

   c.   Psychic

   d.   Behavioral

4.   Previous attacks of emotional illness

   a.   As a child

   b.   Later attacks

   c.   Any hospitalization?

   d.   At what period does the patient believe him or herself to have been completely free from emotional illness?

5.   Effect of emotional illness on present functioning

   a.   Effect on physical health, appetite, sleep, and sexual functions

   b.   Effect on work

    c.   Effect on family and other interpersonal relationships

    d.   Effect on interests and recreations

    e.   Effect on community relations

6.   Evaluation of complaint factor

    a.   What evidence is there of adaptational breakdown, such as anxiety, depression, psychosomatic symptoms?

    b.   Are the defensive elaborations adaptive or maladaptive?

    c.   What are the patient's ideas and attitude about the problem?

Etiological Factors

1.   History of hereditary family illness

2.   Family data: relationships with parents and siblings

3.   Significant events in the past history

4.   Precipitating factors in present environment: assay of present environment to determine extent of stress on patient

5.   Other factors, including inner conflicts as revealed by dreams and symptoms

Assay of Personality Strengths and Weaknesses

1.   Level of maturation: physical growth, educational achievement and school progress, resolution of dependence, sexual maturity, marriage, parenthood, social relationships, and community participation

2.   Neurotic disturbances in childhood

3.   Interests, hobbies, ambitions

4.   Character structure: security feelings, attitudes toward authority, interpersonal relationships, attitudes toward self, and methods of handling conflict

5.   Motivational factors and level of insight

Table 27-1
Summary of Positive and Negative Prognostic Signs in the Patient

	Positive	Negative
1.	The age of the patient is not too advanced	Patient has advanced to an age when learning is not so easy, patterns are set, and considerable rigidity exists.
2.	Problems are of recent duration.	Problems date back to childhood or are of a long-standing nature.
3.	Patient's symptoms or behavior patterns are incapacitating or inconvenient or arouse resentments in the patient.	Patient's symptoms or behavior patterns cause no inconvenience and are not incapacitating. Symptoms are strongly protective in nature and yield positive dividends, such as support, attention, and monetary compensation. Symptoms satisfy a masochistic need in the patient.
4.	The patient is suffering from a stress, anxiety, phobic, conversion, or mild somatoform disorder.	The patient is suffering from an organic brain disorder, schizophrenia, manic-depressive reaction, involutional psychotic reaction, chronic anxiety reaction, chronic obsessive-compulsive reaction, drug addiction, sexual perversion, or severe personality disorder.
5.	The patient has a normal or high intelligence.	The patient has a borderline or low intelligence.
6.	The patient has a strong motivation for therapy. The patient applies for therapy and sees the need for it.	The patient has little or no motivation for therapy. The patient is brought into therapy by another person and does not see a need for it.
7.	The patient has insight into the emotional nature of the problem.	The patient has no idea that the problem is emotionally inspired.
8.	Elements of secondary gain are relatively lacking.	Secondary gain elements are present.
9.	There is no hereditary history of mental illness.	There is a hereditary history of mental illness.
10.	The patient has no constitutional abnormal stature or physique or endocrine disorder.	A constitutional disturbance is present.
11.	The patient was not subject to severely traumatizing influences in childhood.	Severe traumatic influences existed in the patient's childhood.
12.	Few or no distortions existed in the relationship of the parents with the patient.	There was severe disharmony in the home, severe difficulties between patient's mother and father, or severe distortions in the patient-parent relationship.
13.	The developmental history shows no serious defects in physical development, habits, school adjustment, emotional maturation, or sexual	The developmental history shows a serious maladjustment during infancy and childhood.

development.

14.	Adjustment failures in childhood were minimal: childhood neurotic disturbances were absent.	There was failure of adjustment in childhood; patient had childhood neurotic disturbances.
15.	Patient's relationships with people in general are good. There is plasticity in personality traits and defenses. The patient is able to establish a good relationship with the therapist.	The patient has severe disturbances in interpersonal relations. There is rigidity in personality traits and defenses. Transference elements are disturbing and interfere with a good relationship with the therapist.
16.	Assertiveness is present, and self-esteem is good.	Assertiveness is lacking, and self-esteem is diminutive.
17.	The patient's conscience is not too severe or too diminutive	The patient's conscience is excessively severe, is diminutive, or exerts an uneven pressure.
18.	The patient is capable of handling reasonable stress or of enduring reasonable anxiety without repressive or regressive reactions.	The patient tends to handle stress or anxiety by reactions of physical withdrawal, emotional detachment, fantasy, acting-out, aggression, sadism, alcoholic overindulgence, excess sedation, intense dependency, self-punishment, self-aggrandizement, intellectual confusion, emotional shattering, physical sickness, compulsions, depression, and feelings of unreality.
19.	The patient is capable of gratifying vital biologic and social needs in conformity with the mores of the group.	Patient is unable to gratify personal needs or does so in opposition to accepted mores.
20.	The patient's symptoms consist of anxiety, tension, mild depression, or mild psychophysiologic reactions or phobias.	Symptoms consist of stammering, sexual perversions, deep depression, violent rages, euphoria, apathy, various obsessions and compulsions, ideas of reference, delusions, hallucinations, impaired reality sense, depersonalization, alcoholism, drug addiction, and criminality.
21.	Immediate environmental precipitating factors are strong.	Immediate environmental precipitating factors are not intense.
22.	The patient's adjustment prior to illness was good.	Maladjustment was present since early childhood.
23.	The patient has achieved social maturity. There are no defects in physical growth, educational achievement and school progress, resolution of dependence, sexual maturity, marriage, parenthood, social relationships, and community participation.	The patient has been delayed in achieving social maturity. There are defects present in the patient's physical growth, educational achievement and school progress, resolution of dependence, sexual maturity, marriage, parenthood, social relationships, and community participation.
24.	The patient has adequate interests, hobbies, and recreational pursuits.	Patient has few or no interests, hobbies, or recreational activities.
25.	The patient's life situation will compensate for the	The abandonment of symptoms or the development of new patterns of behavior bring

	abandonment of symptoms and reward the development of new patterns.	negative results or expose the patient to dangers of a strongly threatening nature.
26.	Habitual environmental pressures on and responsibilities of the patient are average.	Habitual environmental pressures on and responsibilities of the patient that must be adjusted to are severe and irremediable. The patient will have to live in a disturbed or depriving environment (neurotic parents or mate, poor economic circumstances, harsh culture, and so on).
27.	Ambitions are in line with aptitudes and the reality situation.	Ambitions are out of line with aptitudes or reality.
28.	The patient has had no previous attacks of emotional illness.	The patient has had previous attacks of emotional illness.
29.	The patient has received no psychotherapy in the past.	The patient has received psychotherapy in the past that was unsuccessful.
30.	Therapy and the therapeutic situation do not impose too great hardships on the patient in terms of expense, time, travel, and so on.	Therapy and the therapeutic situation impose great hardships on the patient.
31.	Patient has no problems in communication.	Patient has problems in communication.

Table 27-2
Summary of Prognostic Signs Relating to the Therapist

	Positive	Negative
1.	The therapist is capable of understanding the dynamics of the patient's illness. The therapist is well trained and skilled.	The therapist is confused about the existing dynamics. The therapist is not well trained and lacks skills.
2.	The therapist is sufficiently sensitive to perceive what is happening in the treatment process.	The therapist is insensitive to what is going on within the patient and within himself or herself.
3.	The therapist is aware of his or her own feelings and is capable of remaining objective irrespective of the attitudes and behavior manifested by the patient.	The therapist is incapable of maintaining satisfactory objectivity.
4.	The therapist is flexible in the approach used.	The therapist is rigid in the approach used.
5.	The therapist has a capacity for empathy with the patient.	The therapist lacks empathy with the patient.
6.	The therapist tends to treat the patient in a respectful and cooperative manner.	The therapist is domineering, pompous, and authoritarian.
7.	The therapist is capable of being firm on occasion.	The therapist is too passive and submissive.
8.	The therapist is capable of establishing a working relationship with the patient.	The therapist is detached.
9.	The therapist is well adjusted and is satisfying basic needs.	The therapist tends to use the patient for the vicarious gratification of repressed or suppressed impulses, such as sexuality, the expression of hostility, and the gaining of prestige.
10.	The therapist is capable of tolerating the expression of varied impulses in the patient.	The therapist is incapable of tolerating such impulses in the patient as sexuality, hostility, or assertiveness.
11.	The therapist has no neurotic attitudes toward money.	The therapist's insecurity reflects itself in anxiety about fees and payments.
12.	The therapist is able to tolerate the vicissitudes	The therapist is unable to tolerate blows to personal self-esteem by the patient's acting-out tendencies, by

	inevitable in therapy.	manifestations of resistance and transference, and by the inevitable failures and frustrations in treatment.
13.	The therapist feels personally secure.	The therapist has a neurotic need to be liked, a compulsive tendency toward perfectionism, inordinate hostility, lack of creativity, no sense of humor, an inability to take criticism, low personal integrity, a diminished respect for people, a failure to acknowledge self-limitations, a low energy level, or poor physical health.
14.	The therapist is capable of giving the patient support in accordance with the patient's needs without overprotecting or dominating the patient.	The therapist rejects the patient or refuses to or is unable to extend to the patient measured support.

Figure 37-1 Outline of Personality Operations

Fig. 37-1. Outline of Personality Operations

Figure 44-1 Personality Mechanisms

Fig. 44-1. Personality Mechanisms. From Wolberg LR, Kildahl J: The Dynamics of Personality. Orlando, FL, Grune & Stratton, 1970. p. 215, with permission.

THE FIVE MOTORS

MOTOR ONE

HIGH DEPENDENCE

"I want you to be perfect, like a God; to be accepting and loving; to be wise and strong."

MOTOR TWO

RESENTMENT HOSTILITY

"I resent my need to be dependent on you. When you show any weakness, I am furious. I feel guilty and upset about my feelings. I feel like killing anybody who controls me."

MOTOR THREE

LOW INDEPENDENCE

"I know I must face responsibility, but I feel too weak, and unmasculine," (in females: "If I were a man, I would be strong and independent.")

MOTOR FOUR

DEVALUED SELF-IMAGE

"I feel like a shit and hate myself. I am a nothing and I'd like to be a somebody, but I can't."

MOTOR FIVE

DETACHMENT

"I am constantly running away. I get so angry at people. I don't want to see anybody. I'm so upset about myself. I try not to feel."

Table 56-1 Self-help Relaxation Methods

I. *Letting Go:* For most, it is a mistake to "try to relax." Just tense the muscle group and then visualize and verbalize to the muscle group "let go and keep on letting go."

II. *Breathing:* A Yogic style of deep slow breathing (6000 years old). Fill up with air from the lower belly (abdomen and diaphragm) toward the chest, like filling a glass of water, and *exhale slowly* thru the nostrils. You can first tense, or suck in the belly and feel tension in these muscles, and then say, "I will allow these muscles to let go," visualizing letting go on exhalation. Place hand below "belly button" and feel area move up on inhalation and down on exhalation. Relaxed breathing should continue throughout remaining exercises of tensing and relaxing.

III. *Forearm:* Many people can most quickly be aware of tensing the forearm and relaxing it on exhalation. Making a fist is one way of tensing and visualizing.

IV. *Face and Forehead:* Wrinkle forehead as tightly as possible, and then say to muscles, "Let go and keep on letting go." Practice this often. Furrow between the brows often and say, "Let go and continue to let go." Clench teeth, feel jaw muscles tighten, and let go with lips and teeth slightly parted. Show teeth and relax these muscles. *Push* tongue against upper palate (top of mouth) and let it relax between lower teeth (just almost touching bottom teeth). Close eyelids tightly and let go slowly. *IMPORTANT:* Look as far to left as possible with eyes closed, lids relaxed, and then let go and let eyes go and drift. Same to right and up and down. (Rolling eyeballs up with Yogic breathing and keeping them up is one way to be helpful for inducing self-hypnotism and later sleep in insomniacs.) Visualize and let the entire face smooth out as though you are smoothing it with both hands and let it stay smooth. (*Relaxation of eyes and tongue often controls unwanted thoughts and helps with insomnia.)*

V. If mind wanders, get it back to thinking of breathing and muscle group pictures as best you can. Tighten on inhalation and let go on exhalation.

VI. *Repetition:* Do not become discouraged since tension patterns have existed all of your life. Practice whenever possible. Soon shortcuts such as deep

breathing and words "calm," or "let go," or "relax" or words or pictures of your choosing may help form relaxing a habit. You may find for yourself certain muscle groups, such as face, shoulders, or breathing muscles, that allow you to relax most adequately.

VII. *Neck Practice:* The same procedures of breathing and tensing muscle groups apply to all part of body. You can, especially in the beginning, bend head back, relax. Head to the left and right.

VIII. *Shoulders:* Hunch up as far as possible and let go. Backward and forward also.

IX. *Lower Extremities:* Pinch buttocks together; feel tension and let go. Tighten and let go toes.

General: Practice at every available moment to do things in a relaxed fashion: then let yourself consciously breath deeply and relax in situations ordinarily causing tension. If possible, condition or habituate the relaxation of the entire musculature or letting go to deep breathing and the same key words or words that seem to suit you.

Time: Persistence and review are worthwhile since everyone agrees on the desirability and harmlessness of relaxation.

Table 56-2 Relaxation Training Procedure

Part 1

Sit quietly in a comfortable position.

Take a deep, slow breath.

Hold the breath for several seconds.

Slowly exhale.

Take another deep, slow breath.

Hold the breath and pull your toes toward your head, tightening your leg and calf muscles. Feel the tension.

Breathe out and let go completely.

Take another deep, slow breath.

Hold the breath and make a fist with both hands, tightening your arm and shoulder muscles.

Feel the tension.

Breathe out and let go completely.

Take another deep, slow breath.

Hold the breath and bit down as hard as you can, tightening your jaw muscles.

Feel the tension.

Breathe out and let go completely.

Take another deep, slow breath.

Hold the breath while tightening your stomach and neck muscles.

Feel the tension.

Breathe out and let your muscles go limp.

Take another deep, slow breath.

Hold the breath and tighten every muscle in your body until you feel your whole body start to tremble with tension.

Now breathe out and let go completely.

Take another deep, slow breath.

Hold the breath and tighten every muscle in your body.

Hold on to the tension.

Now breathe out and let go completely.

Take another deep, slow breath.

Hold the breath and tighten every muscle in your body.

Hold the tension.

Now breathe out and let go, relaxing completely.

Part II

Concentrate on slow, deep breathing throughout this entire section.

Slowly repeat each of these phrases to yourself as you hear them.

I feel very calm and quiet.

I feel very comfortable and quiet.

I am beginning to feel quite relaxed.

I am beginning to feel quite relaxed.

My feet feel heavy and relaxed.

My feet feel heavy and relaxed.

My ankles feel heavy and relaxed.

My ankles feel heavy and relaxed.

My knees feel heavy and relaxed.

My knees feel heavy and relaxed.

My hips feel heavy and relaxed.

My hips feel heavy and relaxed.

My feet, my ankles, my knees and my hips all feel heavy and relaxed.

My feet, my ankles, my knees and my hips all feel heavy and relaxed.

My neck, my jaws and my forehead all feel heavy and relaxed.

My whole body feels heavy and relaxed.

My stomach and the whole center portion of my body feel heavy and relaxed.

My stomach and the whole center portion of my body feel heavy and relaxed.

My hands feel heavy and relaxed.

My hands feel heavy and relaxed.

My arms feel heavy and relaxed.

My arms feel heavy and relaxed.

My shoulders feel heavy and relaxed.

My shoulders feel heavy and relaxed.

My hands, my arms and my shoulders all feel heavy and relaxed.

My hands, my arms and my shoulders all feel heavy and relaxed.

My neck feels heavy and relaxed.

My neck feels heavy and relaxed.

My jaws feel heavy and relaxed.

My jaws feel heavy and relaxed.

My forehead feels heavy and relaxed.

My forehead feels heavy and relaxed.

My neck, my jaws and my forehead all feel heavy and relaxed.

My left elbow, my left shoulder feel warm and heavy.

My whole body feels heavy and relaxed.

My breathing is getting deeper and deeper.

My breathing is getting deeper and deeper.

I can feel the sun shining down on me warming the top of my head.

The top of my head feels warm and heavy.

The top of my head feels warm and heavy.

The relaxing warmth flows into my right shoulder.

My right shoulder feels warm and heavy.

My right shoulder feels warm and heavy.

My breathing is getting deeper and deeper.

The relaxing warmth flows down to my right hand.

My right hand feels warm and heavy.

My right hand feels warm and heavy.

The relaxing warmth flows back up to my right arm.

My right arm feels warm and heavy.

My right arm feels warm and heavy.

The relaxing warmth spreads up through my right elbow into my right shoulder.

My right elbow, my right shoulder feel warm and heavy.

My right elbow, my right shoulder feel warm and heavy.

The relaxing warmth flows slowly throughout my whole back.

I feel the warmth relaxing my back.

My back feels warm and heavy.

My back feels warm and heavy.

The relaxing warmth flows up my back and into my neck.

My neck feels warm and heavy.

My neck feels warm and heavy.

The relaxing warmth flows into my left shoulder.

My left shoulder feels warm and heavy.

My left shoulder feels warm and heavy.

My breathing is getting deeper and deeper.

The relaxing warmth flows down to my left hand.

My left hand feels warm and heavy.

My left hand feels warm and heavy.

The relaxing warmth flows back up to my left arm.

My left arm feels warm and heavy.

My left arm feels warm and heavy.

The relaxing warmth spreads up through my left elbow into my left shoulder.

My whole body is heavy, warm, relaxed.

My left elbow, my left shoulder feel warm and heavy.

The relaxing warmth flows to my heart.

My heart feels warm and easy.

My heart feels warm and easy.

My heartbeat is slow and regular.

My heartbeat is slow and regular.

The relaxing warmth flows down into my stomach.

My stomach feels warm and quiet.

My stomach feels warm and quiet.

My breathing is deeper and deeper.

My breathing is deeper and deeper.

The relaxing warmth flows down into my right thigh.

My right thigh feels warm and heavy.

My right thigh feels warm and heavy.

The relaxing warmth flows down into my right foot.

My right foot feels warm and heavy.

My right foot feels warm and heavy.

The relaxing warmth flows slowly up through my right calf, to my right knee, to my right thigh.

My right leg feels warm and heavy.

My right leg feels warm and heavy.

My breathing is deeper and deeper.

My breathing is deeper and deeper.

The relaxing warmth flows down into my left thigh.

My left thigh feels warm and heavy.

My left thigh feels warm and heavy.

The relaxing warmth flows down into my left foot.

My left foot feels warm and heavy.

My left foot feels warm and heavy.

The relaxing warmth flows slowly up through my left calf, to my left knee, to my left thigh. My left leg feels warm and heavy.

My left leg feels warm and heavy.

My breathing is deeper and deeper.

My breathing is deeper and deeper.

The relaxing warmth flows up through my abdomen, through my stomach and into my heart.

My heart feels warm and easy.

My heart feels warm and easy.

My heart pumps relaxing warmth throughout my entire body.

My whole body is heavy, warm, relaxed.

My whole body is heavy, warm, relaxed.

(*continued*)

I am breathing deeper and deeper.

I am breathing deeper and deeper.

My whole body feels very quiet and very serene.

My whole body feels very comfortable and very relaxed.

My mind is still.

My mind is quiet.

My mind is easy.

I withdraw my thoughts from my surroundings.

Nothing exists around me.

I feel serene, secure, still.

My thoughts are all turned inward.

I am at ease, completely at ease.

Deep within my mind I can visualize and experience myself as relaxed.

I am comfortable and still.

My mind is calm and quiet.

I feel an inward peace.

I feel a new sense of well being.

I am breathing more and more deeply.

Part III

Now lift your arms slowly, high over your head.

Take a deep, deep breath.

Hold the breath and slowly lower your arms and hands.

When your arms and hands touch your chair breathe out and go completely limp.

Hold your hands in front of you as if you were praying.

Take a deep, deep breath.

Press your hands together until you feel your arm muscles tremble.

Breathe out and go completely limp.

Take a deep, deep breath.

Hold the breath and slowly draw your hands toward your face.

When your hands touch your face, breathe out and let go.

Go completely limp.

You are breathing deeper and deeper.

You are breathing deeper and deeper.

Slowly say the following phrases to yourself.

My whole body feels quiet, comfortable and relaxed.

My hands and arms feel heavy, warm and relaxed.

My legs feel heavy, warm and relaxed.

My mind is quiet.

I withdraw my thoughts from my surroundings.

I feel serene and still.

My thoughts are turned inward.

I am at ease.

Deep within my mind I can visualize and experience myself as comfortable and still. My mind is calm and quiet.

I feel an inward peace and quiet.

I am now relaxed and alert. *[If biofeedback training is to be utilized, simply say:* I am now ready to begin my training session.]

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Table 56-3 Uses, Characteristics, and Doses of Psychotropic Drugs

d=daily; bid = 2 times daily; tid= 3 times daily; qid = 4 times daily.

T=tablets; P=parenteral; S=spansules; caps=capsules; IM=intramuscularly; IV=intravenously; SR=sustained release;

max=maximum; av=average; gr=grain; mg=milligrams; cc=cubic centemeters

Psychostimulants

Drug (How Dispensed)	Uses	Dosage	Misc.
1. Sympathetic amines a. dextroamphetamine (Dexedrine; S 5, 10, 15 mg; T 5) b. methamphetamine (Desoxyn: T5 mg, Gradumet T 5, 10, 15 mg)	1. Very mild depression; appetite control; oversedation and fatigue; enuresis; attention deficit disorder with hyperactivity in children, narcolepsy	a. 5-15 mg at 9 am & 2 pm; (S) 10-15 mg at 9 am. b. 5 mg at start, raise 5 mg weekly. Usual dose 20-25 mg d	1. Rapid action. Do not use in schizophrenia, agitation and hypertension. Can cause irritability and insomnia. Habituation danger serious; user for no more than 3 months. Monitor blood pressure, especially in hypertension.
2. Methylphenidate (Ritalin: T 5, 10, 20 mg; SR 20 mg)	2. As in (1) but effects are weaker.	2. 10-20-30 mg(T) at 9 am & 2 pm. In children start with 5 mg(bid) gradually raised.	2. As in (1). Do not use in anxiety, Tourette's syndrome, drug dependent patients.
3. Pemoline (Cylert: T 18.75, 37.5, 75 mg; chewable T 37.5 mg)	3. Attention deficit disorders	3. Single morning dose – start with 37.5 mg/day, increase by 18.75 mg at 1 wk intervals until desired effect.	3. Clinical improvement is gradual. May require 3-4 weeks for good effects. Do not use in psychotic children or in kidney disease.

Anitdepressants

Drug (How Dispensed)	Uses	Dosage	Misc.
1. Tricyclics			

a. imipramine (Tofranil: T 10, 25, 50, 50 mg; P 25 mg in 2 cc; Tofranil PM, 75, 100, 125, 150 mg sustained action	a. For retarded endogenous depression	a. 25 mg qid increased to 50 mg qid. Max. 250 mg d. Use the 10 mg size in older patients. P-IM-to 100 mg in divided doses	a. Action in 7-21 days. Do not give with MAO inhibitors. Do not use in schizophrenia, epilepsy, glaucoma, urinary retention. Use cautiously in cardiovascular illness. Avoid cimetidine. Dryness of mouth and perspiration are side effects. Insomnia and hypotension seen occasionally. Desipramine not recommended for children.
desipramine (Norpramine: T 10, 25, 50, 75, 100, 150 mg. Pertofrane: caps 25, 50 mg)		100-200 mg daily. In elderly 25-100 mg.	
b. amitriptyline (Elavin: T 10, 25, 50, 75, 100, 150 mg: P 10 mg per cc	b. A sedating antianxiety antidepressant; for agitated depression	b. 25 mg tid increased to 50 mg tid; max. 250 Use the 10 mg size older patients. Maintenance 50-100 mg.	b. As in (a) but with more sedative features. Action in 10-30 days. Potentiates alcohol and barbiturates.
nortriptyline (Aventyl: T 10, 25 mg; liquid 10 mg per 5 cc)		10 mg bid increased to 10 mg qid; in 1 week 25 mg bid increased to 25 mg qid.	Avoid in cardiovascular disease. Not recommended for children.
c. doxepin (Sinequan: caps 10, 25, 50, 75, 100, 150 mg; oral concentrate 10 mg per cc) (Adapin: caps 10, 25, 50, 75, 100 mg)	c. For neurotic, alcoholic, and psychotic depression especially when accompanied by anxiety.	c. 25 mg tid increased to 50 mg tid (for mild or moderate depression) 50 mg tid increased to 100 mg tid (for severe depression)	c. Side effects less than other tricyclics. A preferred drug for cardiac patients. Action in 10-21 days.
d. protriptyline (Vivactil: T 5, 10 mg)	d. Slight stimulant qualities.	d. 5 to 40 mg daily divided into 3 or 4 doses. Max 60 mg. Lower dose in adolescence and elderly.	d. Potentiates response to alcohol and barbiturates.
e. amoxapine (Asendin: T 25, 50, 100, 150 mg)	e. Slight sedative qualities	e. 50 mg bid or tid raised to 200 to 300 mg daily; max. 400 mg. In	e. Somewhat more rapid action than imipramine or amitriptyline. Has neuroleptic advantages and dangers. Use cautiously in cardiac and convulsive disorders.

		elderly ½ this dosage.	
f. trimipramine (Surmontil: caps. 25, 50, 100 mg)	f. Antianxiety sedative antidepressant.	f. 25mg tid gradually increased to 150 mg. daily. Max. 300 mg d. Maintenance 50 to 150 mg daily.	f. Not recommended for children. Avoid in cardiovascular disease. Anticholinergic side effects.
2. MAO Inhibitors	2. For neurotic and atypical depression		2. Action in 1-4 weeks.
a. phenelzine (Nardil: T 15 mg)		a. 15 mg tid (max d 90 mg) reduce slowly; maintenance d 15 mg.	a. Potentiates amphetamines, alcohol and barbiturates. May intensify schizophrenia. Produces hypotension, dry mouth, blurred vision, dizziness. Do not use in liver, kidney, or heart diseases. Sexual dysfunction may occur. Avoid tyramine foods and over-the-counter medicaments. Avoid in hypertension, cardiovascular disease.
b. tranyleypromine (Parnate: T 10 mg)		b. 10 mg at 9am & 2pm; in 2 weeks , 20 mg at 9 am & 10 mg at 2 pm.	b. Action in 2-21 days. As in (a).
3. Trazodone (Desyrel: T 50, 100, 150 mg)	3. Serotonin uptake inhibitor. Sedative qualities. No anticholinergic side effects, which is of advantage in glaucoma, urinary retention, constipation, or for elderly.	3. 50 mg tid increase by 50 mg/day every 3 days to max. of 400 mg d.	3. Side effects occasionally of priapism and cardiac arrhythmia may require cessation of drug. Generally less cardiotoxic than tricyclics.
4. Maprotiline (Ludiomil: T 25, 50, 75 mg)	4. A tetracyclic drug that helps depressions with anxiety, dysthymic disorders (neurotic depression), and major depressive disorders.	4. Start with 25 tid, after 2 weeks, gradually increase to 150 mg (max. 225) In elderly start with 25 mg increased to 75 mg if necessary.	4. Avoid in seizure disorders. Anticholinergic side effects. Caution in patients with cardiac disease, urinary retention, glaucoma. Long half-life. Avoid in patients on thyroid medication.
5. Wellbutrin	5.	5. 75 mg tid,	5. Low incidence of daytime

		increase by 75 mg every 3 days to 450 mg max d.	drowsiness, anticholinergic effects, or sedation. Little effect on weight, heart rate, and blood pressure. Avoid in seizure disorders, psychotic depression, history of psychosis.
(Buprion T 75 mg)	antidepressant with little cardiovascular effect.		
6. Combination drugs perphanzine + amitriptyline (Triavil: 2-10, 2-25, 4-10, 4-25, 4-50 mg. Etrafon 2-10, 2-25, 4-10, 4-25mg.)	6. For anxious and agitated depression as well as depression in schizophrenia.	6. One T tid or qid., (max d. 2 T tid); maintenance 1 T bid, tid or qid.	6. Contraindicated in glaucoma, urinary retention. Action in a few days or a few weeks. See amitriptyline and perphenazine. Some authorities feel combination drugs are unnecessary and even contraindicated.

Neuroleptics

Drug (How Dispensed)	Uses	Dosage	Misc.
1. Phenothiazines			
a. chlorpromazine (Thorazine: T 10, 25, 50, 100, 200 mg; S 30, 75, 150, 200, 300 mg; P 25 mg in 1 cc, 50 mg in 2 cc, 250 mg in 10 cc; syrup, 10 mg in each tsp; suppositories 25, 100 mg; concentrate 30 mg in 1 cc and 100 mg in 1 cc.)	a. The sedative phenothiazine for paranoidal, agitated, confused, and hyperactive reactions in schizophrenia, manic-depressive reactions, agitated senile dementia. Safest for children and young adults.	a. 10-25 mg tid; after 1-2 days increase by 2-=25 mg semiweekly to 1000 mg if necessary. P 25 mg for excitement IM, repeat in 1 hr if necessary then oral 25-50 mg tid.	a. Action in a few days. Potentiates barbiturates. Drowsiness, dryness of mouth, stuffiness of nose, tachycardia, hypotension, photosensitivity, allergic skin reactions, jaundice may occur. Use cautiously in atherosclerosis, cardiovascular diseases. Rarely skin pigmentation, ocular changes, blood dyscrasias. Parkinsonism requires Cogentin, Artane, or Kemadrin (qv below).
b. thioridazine (Mellaril: T 10, 15, 25, 50, 100, 150, 200 mg; concentrate 30 mg per cc and 100 mg per cc)	b. Excellent sedative phenothiazine for ambulatory out-patient treatment of hyperkinetic and agitated psychoses. Helps some depressive reactions and hyperactive disturbed children.	b. Nonpsychotic patients: 10-25 mg tid or qid. Psychotics: 100 mg tid or qid (Max. 800 mg d)	b. Minimum of side extra pyramidal reactions. Action is rapid. High doses may cause pigmentary retinopathy. Use in neurological problems and in elderly. Avoid in severe cardiac illness.
c. trifluoperazine (Stelazine: T 1, 2, 5, 10 mg; P 2 mg per cc; concentrate 10 mg per cc)	c. For apathetic, depressed, withdrawn schizophrenics. Low dosage relieves tension and agitation. High dose for manic states, agitated depression, active schizophrenia.	c. Office patients: 1-2 mg bid or tid. Hospital patients: 5 mg tid or qid (max. 40-50 mg d) P 1-2 mg IM repeated 4-6 hours. In	c. Side effects in high dosage are common, namely extrapyramidal reactions – dystonia and parkinsonism require Cogentin, Artane, or Kemadrin (qv below). Lower anticholinergic effects.

		nonpsychotic anxiety up to 5 mg d. max. 12 weeks.	
d. perphenazine (Trilafon: T 2, 4, 8, 16 mg; repetabs 8 mg; concentrate 16 mg per 5 cc; P 5 mg in 1 cc)	d. For psychotic disorders with apathy, and control of severe nausea and vomiting in adults	d. 2-4 mg tid; increased to 4 mg qid, max. 8 mg tid. 1-2 repetabs bid.	d. As above (c). Tolerated by elderly.
e. fluphenazine (Permitil: T 0.25, 2.5, 5, 10 mg; oral concentrate 5 mg per cc)	e. For psychotic agitation, hostility, aggression, behavior problems in children, and senile agitation.	e. Office patients: 0.5 mg d to 10 mg. Hospital patients 2-5 mg bid (max. 20 mg d). (Children and elderly: 0.25-0.5 mg d; max. 1 mg)	e. As above (c)
(ProlixinL T 1, 2.5, 5, 10 mg; elixir: 0.5 mg per cc; P 2.5 mg per 5 cc IM only)		Same as above. Divided doses at 6-8 hour intervals. Maintenance 1-5 mg. d; P 1.25 mg increased 6-8 hr intervals to total of 10 mg.	As above. After IM injections for emergencies, continue on 2-3 times P does with oral T.
f. fluphenazine enanthate (Prolixin Enanthate: P 25 mg in 1 cc preassembled syringes; vials of 5cc)	f. Potent long-acting injectable phenothiazine derivative for psychotic disorders	f. 25 mg (1cc.) IM or subcutaneous every 2 weeks. Adjust dose according to response from 12.5-100 mg every 2 weeks	f. Action in 24-48 hours, lasting about 2 weeks. Useful where oral medication cannot be depended on. Extrapyramidal reactions frequent, which can be controlled with antiparkinsonian drugs. Contraindicated in subcortical brain damage.
g. fluphenazine decanoate (Prolixin Decanoate: P 25 mg in 1 cc preassembled syringes; vials of 5 cc)	g. Potent long-lasting injectable phenothiazine derivative for schizophrenia	g. 12.5 -25 mg IM or subcutaneous every 4 weeks. Adjust does in small increments to 50 or 100 mg.	g. Action in 24-72 hours, lasting about 4 weeks. Useful where oral medication cannot be depended on. Extrapyramidal reaction frequent and will require antiparkinsonian drugs.

2. Dibenzoxaxepines

a. loxapine succinate (Loxitane: C 5, 10, 25, 50 mg; concentrate 25 mg per cc; P 50 mg per cc, IM)	a. Tranquilizes and suppresses aggressive activities in schizophrenia.	a 10-25 mg bid, usual maintenance dose 60-100 mg d.	a. Action in ½ to 2 hours for 12 hours. Contraindicated in drug-induced depressive states (alcohol, barbiturates). Lowers convulsive threshold. Fewer anticholinergic and

			hypotensive effect but use cautiously in cardiovascular disease. Extrapyramidal reactions frequent.
3. Butyrophenones			
a. Haloperidol (Haldol: T ½, 1, 2, 5, 10 mg; concentrate 2 mg per cc; P 5 mg per cc)	a. For psychotic disorders and severe tics. Use where sedation is undesirable. Good for paranoidal patients, manic excitement, assaultive behavior, alcoholic delirium, neurological disorders, torticollis, intractable hiccups and vomiting, and confused negativistic geriatric patients.	a. Moderate symptoms and older patients ½ to 2 mg bid or tid. Severe symptoms: 3-5 mg bid or tid (max. 100 mg); P 2-5 mg repeated if necessary.	a. May be tolerated in some patients better than phenothiazines. Extrapyramidal reactions common. Low anticholinergic and cardiac complications.
b. (Haldol Decanoate P 50 mg per cc)	b. Sustained protection against schizophrenic relapses	b. Start with 10-15 times previous oral dosage of Haldol (max 100 mg) adjust dose required as needed. Give by deep intramuscular injection into gluteal region. In exacerbation of symptoms, supplement with oral Haldol.	b. Peak level in 6 days; half-life 3 weeks. Before starting convert to and stabilize pt on oral Haldol from any other neuroleptic being taken.
4. Thioxanthenes			
a. thiothixene (Navane: C 1, 2, 5, 10, 20 mg; concentrate 5 mg per cc; P 2 mg per cc)	a. For psychotic disorders; esp. with depressive and anxiety symptoms.	a. Mild symptoms: 2 mg tid (max d 15 mg). More severe symptoms: 5 mg bid to 30 mg (max d 60 mg).	a. May be tolerated in some cases better than phenothiazines. Less sensitivity to sunlight. Lower extrapyramidal and myocardial effects.
b. chlorprothixene (Taractan: T 10, 25, 50, 100 mg; concentrate100 mg per tsp; P 25 mg in 2cc)	b. Agitated, anxious, depressed schizophrenics.	b. 25-50 mg tid or qid. Max. 600 mg d. P 25-50 mg up to tid or qid.	b. Avoid in cardiac and respiratory disease.

5. Dihydroindolones

a. molindone (Moban: T 5, 10, 25, 50 , 100 mg; concentrate 20 mg per cc)	a. For psychotic disorders.	a. 50-75 mg/d increased to 100 mg/d in 3-4 days. Mild symptoms 5-15 mg tid or qid; moderate 10-25 mg tid or qid. Severe symptoms: up to 225 mg total.	a. Side reactions less than phenothiazines.

6. Dihydroindolones

a. Lithium carbonate (T 300 mg) (See also Haldol, Thorazine, and Mellaril above).	a.–d. For control and prophylaxis of manic episodes in manic-depressive psychosis (Bipolar disorder – manic)	a. Usual dose, 300-600 mg tid. Adjust dosage to maintain serum levels between 1-1.5 mEq/l.	a-d. Action in 1-3 weeks. Contraindicated in colitis and severe renal and cardiovascular disease, or where diuretics are taken. Test serum levels twice weekly acute phase; in maintenance therapy at least every 2 months. Some skin eruptions and renal impairment possible in long term therapy.
b. Lithane T 300 mg.		b. As above	
c. Lithobid: slow release T 300 mg.		c. 1800 mg/d; maintenance 900-1200 mg/d	
d. Cibalith- S: Syrup 300 mg per tsp.		d. 2 tsp tid; maintenance 1 tsp tid or qid.	

7. Anti-Parkinson Drugs

a. Cogentin (T 0.5, 1.2 mg; P 1 mg in 1 cc)	a-d. For dystonia, akithisia, parkinsonism. Do not use prophylactically.	a. Usual dose 1-2 mg d. or P 1-2 mg	a-d. After symptoms disappear for 1-2 weeks, withdraw to determine need for drug. For temporary use only; withdraw within 4-12 weeks.
b. Artane (T 2.5 mg; elixir 2 mg each tsp; sustained release C 5 mg)		b. 1 mg 1st day; 2 mg 2nd day; increased if necessary to 5-15 mg d.	
c. Kemadrin (T 5 mg)		c. 2.5 mg tid increased to 5 mg tid or qid.	
d. Synmetral (C 100 mg; Syrup 50 mg per tsp)		d. 200 mg d.	

Axiolytics

Drug (How Dispensed)	Uses	Dosage	Misc.
a. diazepam	a. Anxiety, muscle	a. 5 mg d to	a. Avoid in glaucoma and

(Valium: T 2. 5. 10 mg; P 5 mg per cc)	spasms, drug and alcohol withdrawal, insomnia due to anxiety, status epilepticus.	tid. Severe anxiety 10 mg tid or qid; P: IM or IV 2-20 mg repeated if necessary in 3-4 hours.	epilepsy. Drowsiness possible. Reduce dose in elderly patients. Avoid alcohol. Long half-life.
b. cholordiazepoxide (Librium: caps 5, 10, 25 mg; P 100 mg in 5 cc)	b. Excellent tranquilizer with palliating qualities for anxiety, alcoholism, muscle spasms. IV in delirium tremens and as an anticonvulsive.	b. 10 mg tid or qid. Severe anxiety: 20-25 mg tid or qid; P 50-100 mg IM or IV repeated if necessary in 2-6 hours.	b. Ataxia, especially in older persons. Avoid alcohol
c. alprazolam (Xanax: T 0.25, 0.5, 1 mg)	c. Anti-anxiety agent with antidepressant qualities	c. 0.25 to 0.5 mg tid Max d. 4 mg. In elderly start with 0.25 mg bid or tid. Increase or reduce as necessary. Larger doses needed to prevent panic attacks.	c. Short half-life. Temporary drowsiness and lightheadedness may occur. Avoid alcohol.
d. oxazepam (Serax: caps 10, 15, 30 mg; T 15 mg)	d. Anxiety, alcoholic withdrawal, senile agitation	d. Mild anxiety: 15 mg qid. Severe anxiety: 30 mg tid or qid. Older patients: 10 mg tid.	d. Initial drowsiness usually passes.
e. lorazepam (Activan: T 0.5, 1.0, 2.0 mg; P 2 & 4 mg per cc)	e. Short-term relief of anxiety and neurotic depression. IV and IM used prior to surgical procedures.	e. 2-6 mg daily in divided doses; no more than 2 mg in elderly in divided doses. IV 2 mg; IM 4 mg.	e. Sedation in 16 percent of patients; dizziness less frequently. Avoid alcohol. Short half-life.
f. hydroxyzine (Vistaril: caps 25, 50, 100 mg; P 25-50 mg in 1 cc; oral suspension 25 mg per tsp)	f. Mild anxiety, psychophysiological reactions. IM or IV for extreme anxiety and alcoholic withdrawal.	f. 25-100 mg tid or qid. P & IM: 50-100 mg repeated as necessary, 4-6 hours.	f. Side effects mild. May be used with psychotherapy. Potentiates barbiturates and narcotics.
(Atarax: T 10, 25, 50 mg; syrup 10 mg per tsp)	Antihistamine antipruritic, antiemetic properties. For chronic urticaria and dermatitis.		

g. clorazepate dipotassium (Tranxene: 3.75, 7.5, 15 mg; Tranxene SD: 11.25 and 22.5 mg)	g. Anxiety	g. 15-60 mg d. Elderly or debilitated patients: 7.5-15 mg d.	g. Avoid in depression or psychosis.
h. meprobamate (Miltown, Equanil: T 200, 400, 600 mg)	h. Anxiety, tension headache, muscle spasms, insomnia. Use is diminishing in favor of benzodiazepines.	h. Adults: 400 mg d to tid (max. 2400 mg d) Children: 100-200 mg bid.	h. Potentiates alcohol and sedatives. Hypotension possible, esp. in older persons. Habituation with prolonged use. Avoid driving until drug dose is stabilized. Avoid rapid withdrawal of drug. Drowsiness, allergic reactions possible. Tolerated by older persons.
i. busiprone (BuSpar T 5, 10 mg)	i. a non-benzodiazepine anxiolytic useful in generalized anxiety reactions. Relatively non-sedating and non-additive with few side effects	i. 5 mg tid. Increase by 5 mg over 2-3 days up to 60 mg max. Optional 20-30 mg d.	i. Does not potentiate alcohol sedation or impair psychomotor skills.

Sedatives and Hypnotics

Drug (How Dispensed)	Uses	Dosage	Misc.
1. Barbiturates	1. Helpful in short-term allaying of tension, anxiety, and insomnia. P: Iv or IM for convulsions		1. Use with caution in liver disease. Habituation, tolerance, and addiction possibilities great; not for prolonged use.
a. phenobarbital sodium (T 15, 30, 60, 100 mg; P 30, 60, 130 mg; Elixir 20 mg in tsp)	a. Short-term sedative and hypnotic.	a. Sedation: 15-40 mg tid. Hypnotic: 100-200 mg.	a. Slow acting; long duration.
b. amobarbital sodium (Amytal: T 15, 30, 50, 100 mg; P 250, 500 mg)	b. (as in a) IV amytal solution useful in narcosynthesis	b. Sedation: 65-200 mg d. Hypnotic: 100-200 mg P (IV or IM) 60-500 mg (10% sol) 0.5 to 1.0 cc per minute.	b. Moderately rapid acting; medium duration.
c. butabarital (Sodim Butisol: T 15, 30, 50 , 100 mg. Elixir 30 mg per tsp.)		c. Sedation 15-30 mg tid or qid. Hypnotic: 50-200 mg.	c. Rapid acting, short duration.
d. pentobarbital		d. Hypnotic: 50-100	d. Moderately rapid

sodium (Nembutal: caps 50-100 mg. P 50 mg per cc. Suppositories 30, 60, 120, 200 mg.)		mg; P 150-200 mg IM, 100-500 mg IV. Suppositories: children 30-60 mg; Adults 120-200 mg.	acting; short duration.
e. secobarbital sodium (Seconal: pulvules 50-100 mg. P 50 mg in 1 cc)		e. Hypnotic: 100 mg; P (IV or IM) 50-100 mg.	e. Moderately rapid acting; short duration.
f. amobarbital and secobarbital sodim (Tuinal: caps 50, 100, 200 mg)		f. Sedation: 50 mg; Hypnotic: 50-200 mg.	f. Moderately rapid acting; medium duration
2. Nonbarbituates			
a. flurazepam hydrochloride (Dalmane: caps 15-30 mg)	a. Effective hypnotic for all types of insomnia.	a. 15-30 mg before retiring	a. Low incidence of dependence, but avoid too longed administration. Avoid in pregnancy.
b. temazepam (Restoril C 15, 30 mg)	b. A short acting benzodiazepine. Anti insomniac agent.	b. 15-30 mg; 15 mg in elderly.	b. Avoid in pregnancy
c. triazolam (Halcion T 0.25, 0.5 mg)	c. A very short acting anti-insomniac agent.	c. 0.25 to 0.50 mg; 0.125 to 0.25 in elderly.	c. Avoid in pregnancy
d. glutethimide (Doriden: T 250, 500 mg; caps 500 mg)	d. Useful in elderly and chronically ill patients. For 3-7 days only.	d. Sedation: 250 mg. Hypnotic: 500 mg.	d. Onset in 15-30 minutes; duration 6 hours. Occasional skin rash. Avoid in chronic insomnia.
e. methyprylon (Noludar: T 50, 200 mg; caps 300 mg)	e. Well tolerated and effective. For short-term use.	e. Sedation: 250 mg Hypnotic: 500-1000 mg	e. Onset in 15-45 minutes; duration 5-8 hours. Avoid in chronic insomnia.
f. chloral hydrate (Noctec: caps 250-500 mg; syrup 500 mg per tsp)	f. Low toxicity; well tolerated in chronic illness.	f. Sedation: 250 mg tid Hypnotic: 500-1000 mg	f. Onset in 20 minutes. Avoid in cardiac, kidney, and liver disease.
g. ethchlorvynol (Placidyl: caps 200, 500, 750 mg)	g. Insomnia due to anxiety or excitement. 3-7 days only.	g. Hypnotic: 500-1000 mg	g. Do not give to patients with suicidal tendency Avoid in chronic insomnia.
h. paradehyde	h. A safe hypnotic and anticonvulsant in psychotic patients.	h. ½ to 1 ½ tsp in iced fruit juice or milk; 2 tsp in agitation. P 1-2 cc IM (Sterile sol)	h. Onset in 20 minutes. Avoid in gastrointestinal and liver disease

Table 57-1 Therapeutic Focus, Goals and Selection of Modality

(A) COMPLAINT FACTOR (target symptoms)	(B) SYNDROMES	(C) AREAS OF PATHOLOGY	(D) GOALS	(E) THERAPEUTIC FOCUS (implicated links)	(F) APPLICABLE FIELDS	(G) EFFECTIVE THERAPEUTIC MODALITIES
Depression Hyperactivity Hallucinations Severe anxiety Panic attacks Impulsivity and inattention Binge eating Obsessions and compulsions Phobias	1. Major depression 2. Bipolar disorder a. depressed b. manic 3. Atypical depression 4. Schizophrenic disorder 5. Schizophreniform disorder 6. Generalized anxiety disorder 7. Panic disorder 8. Attention deficit disorder 9. Bulimia 10. Obsessive-compulsive disorder 11. Agoraphobia	Neurotransmitter systems	Restoring balance in neuro-transmitter systems	Biochemical link	Bio-chemistry	1. 2a, 7, 9, 11: Antidepressants Interpersonal therapy Cognitive therapy 2. Lithium 3. MAO inhibitors 4. 5. Neuroleptics 6. Anxiolytics 8. Psychostimulants 10. Clomipramine 1. ECT (for uncontrollable suicidal gestures and excitement) 4. Hospitalization, rehabilitation
Poor emotional and impulse control; incoordination;	Organic brain syndrome	Neuronal masses of brain	Resolving affective and autonomic dysregulations	Neuro-physiological link	Neurophysiology	Pharmacotherapy Relaxation therapy

(A) COMPLAINT FACTOR (target symptoms)	(B) SYNDROMES	(C) AREAS OF PATHOLOGY	(D) GOALS	(E) THERAPEUTIC FOCUS (implicated links)	(F) APPLICABLE FIELDS	(G) EFFECTIVE THERAPEUTIC MODALITIES
personality change; tension; defective information processing; paranoidal attitudes; neurological impairments; delirium; amnesia; dementia	Organic mental disorder (primary degenerative dementia; multi-infarct dementia)					Psychosocial therapies Counseling
	Substance-induced intoxications (alcohol, amphetamine, barbiturate, cannabis, cocaine, opioid, PCP, other)		Removal of abused toxic substances		Toxicology	
Physical complaints of various organ systems (e.g. severe pain; headache; indigestion; backache; hypertension; colitis; etc.)	Organic physical disease	Implicated organ systems	Relieving or resolving organic and functional pathology	Somatic link	Medicine Psychiatry	Medicinal & surgical interventions Relaxation therapy, biofeedback Supportive psychotherapy Individual & group counseling

(A) COMPLAINT FACTOR (target symptoms)	(B) SYNDROMES	(C) AREAS OF PATHOLOGY	(D) GOALS	(E) THERAPEUTIC FOCUS (implicated links)	(F) APPLICABLE FIELDS	(G) EFFECTIVE THERAPEUTIC MODALITIES
Conditioned behavioral disturbances and poor adjustment following an identifiable psychosocial stressor Depression; jitteriness; conduct disorder (truancy, vandalism, reckless driving, fighting) work or academic failure; phobic avoidance	Adjustment disorder (with depressed mood; with various emotional features; with disturbances of conduct; with academic or work inhibitions; with withdrawal; with atypical features) Phobic disorders	Conditioned anxieties	Reconditioning anxiety responses	Conditioning link	Learning theory	Behavior therapy Hypnosis Cognitive therapy
Anxiety; panic attacks; obsessions; compulsions; depression; somatic symptoms; sensory and motor disturbances; fugue states; multiple personality; depersonalization; sexual dysfunction; phobias	Panic disorder Generalized anxiety disorder Obsessive-compulsive disorder Dissociative disorder Conversion disorder Dysthymic disorder Psychosexual disorder Agoraphobia Simple phobia Social phobia Posttraumatic stress disorder	Unconscious conflicts	Recognition, understanding, and resolution of conflicts	Intrapsychic link	Psychoanalytic theory	Psychoanalysis Psychoanalytically oriented therapy Hypnoanalysis Guided imagery

(A) COMPLAINT FACTOR (target symptoms)	(B) SYNDROMES	(C) AREAS OF PATHOLOGY	(D) GOALS	(E) THERAPEUTIC FOCUS (implicated links)	(F) APPLICABLE FIELDS	(G) EFFECTIVE THERAPEUTIC MODALITIES
Disturbed relationships with people [paranoidal, oppositional, hostile, defensive, stubborn, power driven, hypersensitive, eccentric, seclusive, aggressive, indifferent, excitable, irrational, overactive, exhibitionistic, exploitative, self-centered, impulsive, explosive, manipulative] Antisocial behavior Academic problems Marital problems Family problems Substance abuse and dependence	Personality disorder [paranoid, schizoid, schizotypal, histrionic, narcissistic, antisocial, borderline, avoidant, dependent, compulsive, passive-aggressive, atypical] Substance abuse/dependence [alcohol, barbiturates, other hypnotics, opioids, cocaine, amphetamine, PCP, hallucinogens, cannabis, tobacco] Identity disorder Adjustment disorders	Interpersonal relationships Developmental arrest [impaired separation-individuation]	Personality maturation Improved relationships with authority and peers Enhanced self-esteem Improved identity	Developmental interpersonal link	Develop-mental theory Psycho-analytic theory Role theory Group dynamics Social psychology Self-psychology Object relations theory Systems theory	Psychoanalytic psychotherapy Psychodrama Group therapy Marital [couples] therapy Family therapy Rehabilitaion
Situational problems [e.g. education, health, housing, neighborhood, finances, cultural differences, pollution, international	Phase of life problem Environmental problem Occupational problem Adjustment problem	Environmental stress	Rectification of or adaptations to environmental stress	Social link	Sociology Anthropology Economics Political science	Environmental manipulation Milieu therapy Social casework Counseling Social therapy Rehabilitation therapy

(A) COMPLAINT FACTOR (target symptoms)	(B) SYNDROMES	(C) AREAS OF PATHOLOGY	(D) GOALS	(E) THERAPEUTIC FOCUS (implicated links)	(F) APPLICABLE FIELDS	(G) EFFECTIVE THERAPEUTIC MODALITIES
tensions]						
Distorted values and standards Maladaptive belief systems	Multiform adaptational difficulties	Cognitive distortions	Reeducation Cognitive restructuring	Philosophical spiritual link	Philosophy Theology Meta-psychiatry	Cognitive therapy Education Existential therapy

Target symptoms (A) characteristic of different syndromes (B) may often be expediently resolved by dealing directly with specific responsible areas of pathology (C). Goals in therapy here (D) are directed at such distortions. Looking at behavior as a chain of interrelated systems (biochemical, neurophysiological, somatic, conditioned, intrapsychic, developmental-interpersonal, social-environmental, philosophic-spiritual) a suitable focus is on the implicated links of this chain (E). Distinctive fields of interest (F) and special theories related to each link inspire a number of therapeutic modalities (G) that may be preferred approaches in certain syndromes even though through feedback interventions bracketed to other links may also be effective.

Table 61-1 Outline of Evaluation for Certification

Technical Skill

1. Diagnostic skill

   a. Ability to establish diagnosis and tentative psychodynamics after one or two sessions with the patient

   b. After six weeks, the ability to describe the patient's character manifestations and how they will most likely work out in relation to the therapist.

   c. After six weeks, ability to write an organized case report including diagnosis, psychodynamics and estimate of rate of progress.

2. Treatment planning:

   a. Formulation of a plan of treatment consistent with some theoretical orientation.

   b. Estimation of areas of difficulty.

   c. Estimation of which stage of therapy a patient is in and formulation of what to do accordingly.

   d. Estimation of when the patient is ready to discuss transference.

   e. Judgment in management and timing of interpretations and communications.

3. Session-to-session handling of the patient.

   a. Perception and understanding of continuity and discontinuity of communications of the patient within a session and from session to session.

   b. Recognition of manifestations of resistance.

   c. Judgment about when to give ego support and ability to do so.

4. Skill in handling the middle phases of therapy

   a. Judgment in the use of dreams in the best interests of the patient's therapy.

   b. Judgment in the use of transference in the patient's best interest

   c. Awareness and use of countertransference

   d. Ability to recognize acting-out and to help the patient recognize this either in what patient does in the session or between sessions, including the desire to terminate therapy prematurely.

5. Skill in handling emergencies, including the recognition of the severity of a crisis.

6. Skill in handling problems of termination.

   a. Recognition of when termination should be planned for.

   b. Preparation of the patient for this.

Personality of the Therapist

1. Ways of relating to the patient.

   a. Genuine interest in and empathy for the patient.

   b. Readiness and capacity to relate emotionally to the patient in a healthy way, that is:

      i. To disengage from neurotic involvements

      ii. Be aware when it is productive to express feelings, positive and negative.

      iii. Be able to estimate the attitudes and role that are assumed in the therapeutic sessions(awareness of roles that may hurt the patient, such as putting up a front, being managerial, rigid, detached, overconcerned, not showing respect).

   c. Appraising factors in the previous experience of the patient.

      i. Sorting out real hardships from neurotic ones in the life of the patient.

      ii. Appraising what might have gone on in a previous therapy.

      iii. Being alert to grievance collecting.

   d. Speaking in terms natural to the patient; using technical language only when necessary.

   e. Ability to use values judiciously especially when therapist's value judgments differ from those of the patient.

   f. Ability to learn by mistakes.

2. Ways of relating to supervisor.

   a. Ability to communicate therapy sessions and problems meaningfully to the supervisor.

   b. Relative freedom from defensiveness in relation to what is going on in therapy with a patient.

   c. Respect for and honesty toward the supervisor.

   d. Use of supervisory sessions in order to learn.

   e. Tolerance for new point of view other than one's own.

   f. Ability to discuss one's own evaluation in a mature way.

3. Ways of relating to the administration.

   a. Reliable in relation to requirements (e.g.paperwork)

   b. Reliable in relation to class attendance.

   c. Reliable in making arrangements for supervision.

   d. Reliable in relation to patient load.

   e. Honesty in relation to administration.

   f. Reasonable consideration for clerical personnel.

4. Ways of relating to colleagues.

a. Respect for colleagues in different disciplines.

b. Ability to cooperate with colleagues on related cases (husband and wife, child and parent).

c. Mature attitudes in classroom and professional meetings, toward presenting of case material by colleagues.

Direction of Growth and Promise

1. Continuing ability to learn from patients

   a. Continuing improvement in recognition of similarities and dissimilarities in various patients.

   b. Awareness that one does not know everything about the psychodynamics of one's patients (accepts the fact that one does not know all the answers).

2. Recognition of areas in which one is competent as well as those in which one needs to learn more.

3. Ability to develop own individual style without needlessly imitating an idealized supervisor.

4. Progressive diminution of countertransference reactions.

5. Continuing interest in scientific problems of personality (diagnosis, prognosis, and psychodynamics) and psychotherapeutic techniques.

6. Estimate by supervisor(s) as to how the therapist with function when on his or her own and in a new status.

   a. Will the therapist continue in supervision or consult when there is a need?

   b. Will the therapist feel free to exchange problems with colleagues?

7. After certification will the therapist work in the community, such as teach, do research, work in some organization or clinical setting, or participate in professional activities?

Supervisor-Supervisee Relationship

1. Ease with which supervisor can work with supervisee (Add any statement you wish to make about your evaluation).

Table 67-1

A Multilevel, Multisystem, Method for the Study of Problems of Organizations and the Individual Functioning in these Organizations as They Attempt the Solution of Problems: A Mental Health Consultation Technique—Directives to the Consultant

Part 1. Definition of Problem

Succinctly formulate the chief problem for which the study is undertaken based on the subjective estimation of the problem by members from three levels of the organization, (administrative, supervisory, and line staff). The statement must include what the problem means to the organization and to the individuals functioning in the setting. Important administrative, supervisory, and staff members should be interviewed.

Part 2. Detection, Identification, and Description of the Problem

    A. Study of the individuals in the organization who have the particular problem or who are affected by it.

        1. Study formal records.

        2. Study anecdotal records.

        3. Study questionnaires that have been answered by the individuals requesting the study.

        4. Direct interviews with three or four individuals affected by this problem.

        5. Study the work records of individuals affected by this problem in relation to skill, absenteeism, illness.

    B. Study peer groups in three levels of the organization, (administrative, supervisory, and staff personnel) members of which are affected by the problem.

        1. Hold a series of four group discussions with peers from each

organizational level and answer these questions:

(a) How does each individual react in the group?

(b) Can the members communicate?

(c) Do subgroups form as the discussion proceeds?

(d) Are some members disruptive?

(e) Are any of these group members emotionally disturbed?

(f) Does this disturbance cause trouble in the group?

(g) Does the emotional difficulty affect work roles?

C. Study of the organization in relation to this particular problem.

1. What is the function of this organization?

2. Study the institutional records for the purpose of determining how the problem affects the operation of the organization.

3. What disposition has been made of the problem up to the present?

4. How seriously does the problem affect the organization?

5. Has the problem affected individuals in a destructive way?

6. What institutions or organizations or agencies in the community is this organization responsible to with respect to this problem?

7. Is this trend or problem a unique one that exists only in this organization? Or does it exist in all organizations? Or only in some? Specify.

8. What efforts have been made to reverse this trend? And what techniques have been used? By whom? Where?

9. Typical day in the organization with respect to this problem.

10. Group discussion with at least four or more individuals on the supervisory level with respect to the information collected to date.

11. Is there any discrepancy between the ideas of the supervisors and those of the staff with respect to the problem?

12. Are there subgroups within the organization that are competing or are antagonistic to one another?

13. Is the consultative process threatening to individuals within the organization, and do they build up resistance to it? Illustrate.

Part 3. Analysis of Data

A. What are the motivations of the individuals who requested the consultation?

B. Where are the main pressures in the organization?

C. What groups of individuals need additional skills?

D. Can the supervisory staff give the members of the group the appropriate training for the skills, or do they themselves need further education?

E. Can you determine the point at which information is acceptable and at which it can be integrated by the supervisors and by the staff?

F. Are other resources than skills of the consultant needed to assist in the retraining of the staff?

G. Is there conflict between workers and supervisors? Between supervisors and administrators?

H. Are there intra-agency clashes between departments? Among people due to lack of role boundary? Due to personality problems?

I. What are the main problems as you see them according to the analysis of the data? List.

J. Will the changes in role by training or retraining cause dislocation of a temporary nature in the organization?

Part 4. Planning and Decision Making

A. What plan do you suggest?

B. How will you explain this plan to the administration? To the supervisors? To others who may have to be informed?

    1. Illustrate the types of communication that you will use with the above categories in the social organization.

C. Where do you anticipate that resistance will occur and for what reasons?

    1. Can anything be done to counteract this?

D. What is the nature of your relationship with the members of the organization with whom you will have to work? Explain.

E. Steps in working out the plan.

    1. List the steps you will take to carry out the plan.

    2. How will this reverse the trend or help the problems that you have found?

        (a) Document this plan and the rationale for the steps you are taking with theoretical concepts from the literature.

        i) What are the specific techniques you will employ?

        ii) What do you anticipate as a result of the carrying out of this plan?

Table 67-2
Mental Health Consultation Guide for Multisystem Consultation Method

Within an Organization Tensions are Expressed on	Expressions of Problems Found upon Entry into an Organization	Psychological, Social, and Health Factors Contributing to Organizational Difficulties
Individual Level: by Executives Supervisors Staff	Lack of clarity in goals Inability to achieve objectives Lack of skills (inadequate training) Rigidity; confused hierarchy Inability to change practices Apathy, boredom, and lack of interest in work Procrastination, lack of initiative Sense of hopelessness Inability to undertake responsibility Self-excusing	Characterologic, neurotic, and psychotic difficulties Frequent illnesses Alcoholism Delinquency and crime Drug addiction Chronic disease Absenteeism Other
Internal Relationships Level by individuals who belong to subgroups involved with agency philosophy, policy making, and establishing rules and regulations. Management in relation to owners, stockholders, and boards of trustees Intramanagement relationships Administrative actions Staff-management relationships Staff interaction Staff-client relationships	Inadequate administration Cluttered and inoperative channels of communication: divisive techniques; unclear administrative channels; lack of coordination of activities Confusion in giving and taking orders Interdisciplinary and departmental conflicts (prestige, control, status, and authority problems) Unqualified staff Conflicts between policy makers and those who carry out policy Lack of participation in group process Fear of democratic process and need for authoritarian system Inadequate system of rewards and recognition for personal achievement Inadequate personnel practices, training programs, and counseling Vague and conflicting aims Inadequate programming for goal achievement Inadequate board of trustees, owners, or corporate personnel	Projection of difficulties onto others Hostility, aggression, or compulsive competitiveness Acting-out of sadomasochistic fantasies Withdrawal Obsessive doubting, indecisiveness Resistance to change Recurrent frustrations in work effort Conflicting interpersonal relations Unconscious sabotaging Paranoid feelings (griping, complaining, undermining) Laissez-faire attitudes
External Relationships Level by individuals who are working with Organized Professional Groups Labor Religious organizations Civic organizations Political groups Business groups Press Government	Difficulties in obtaining cooperation of community leaders Inadequate interagency cooperation on programs Failure in communication with groups Failure in obtaining acceptance from professional groups Difficulty in obtaining acceptance of community	Failure of staff and/or organization to satisfy standards acceptable to the community Failure of staff to meet standards of professionals in the community Inadequate service

groups
Inability to reduce conflicts with
groups in the community
Poor image of performance and
role of organization
Inadequate techniques to deal
with community criticism and
pressures

Failure to meet
community needs

Consequences to Organization	Consultation Activity Aimed at Problem Resolution; Consultant Assists Staff toward	Recommendations and Plans
Inadequate service Loss of work due to high rate of lateness and absenteeism	Presenting of problems through case method Discussing staff studies and staff understanding of problems presented by individuals Collecting of information on staff attitudes based on opinions expressed Observing of interaction of staff members (in framework of group dynamics) Making inferences as to problems presented and their analysis and evaluation	Programming for individual counseling, psychotherapy, and/ or referral sources Clarification of roles Clarification of duties Clarification of supervisory practices
Organizational goals not achieved due to inappropriate planning and programming Inadequate supervision and controls; unclear responses and practices Inability of staff to meet requirements of job High turnover of qualified people Duplication, errors, minimization of benefit from skills of expert staff Difficulty in rendering service Failure on collaboration efforts Low morale	Discussing of organizational chart to obtain clarification of lines of authority and channels through which decisions are made and implemented Identifying needs and problems of staff and making inferences as to kinds of and intensity of problems in the organization; establishing the expertness of staff and agency resources to cope with the problems Exchange of ideas Handling feedback from communication	Changes in staff orientation and role Education for new roles through training Adaptation of mental health information and techniques to the needs of the organization and its goals and practices
Low prestige Confused public image Lack of community	Interpreting goals and purposes to community Organizing services useful to the district in which the organization exists Public relations	Joint programs with agencies Community education Consultation services Work in professional

| acceptance Difficulty in raising funds or obtaining credit Difficulty in obtaining adequate staff | Fund raising (for non-profit organizations) Changes in board membership Programming in relation to other organizations | societies Explicit public relations programs that are educational as well as informative Reporting of work done |

1 *ego strength* is somewhat ambiguous, but in the sense it is employed here it connotes the positive personality assets that will enable the individual to overcome anxieties, to yield secondary gains of illness, and to acquire new, more adequate defenses.

2 The existence of a portion of mental activity at the periphery of awareness or permanently blockaded from awareness was known to scientists and philosophers before Freud. Freud's contribution was to demonstrate the dynamic operation of the unconscious in the daily life of the individual and its role in psychological illness. He devised ways of examining and exploring unconscious ideation, and he formulated a theory organized around the workings of this hidden portion of mental activity. Though some of his hypotheses have been altered and new terms for the unconscious have been elaborated (such as Rado's "nonreporting brain activity"), Freud's basic contentions about the unconscious and his methods of decoding it continue to be accepted as a most fundamental contribution.

3 Freud (1934) regarded the original libidinal charge or "cathexis" of the ego, as "primary narcissism." Part of the libidinal cathexis of the ego was later yielded to outside objects. This enabled the individual to participate in relationships with others. The original libidinal cathexis of the ego persisted and was related to the object cathexis, like the body of an amoeba is related to the pseudopods that it puts out. And like pseudopods that could be withdrawn into the body of the ego, so object libido might, in times of stress, be withdrawn with return of narcissism ("secondary narcissism"). Infantile conflicts and patterns were also revivified in this process. Sexual perversions constituted the positive expression of pregenital libidinal fixations, while neurotic symptoms were a negative or converted expression (Freud, 1938a).

4 For example, an investigation of the results of 241 private patients treated over a 15-year span revealed that psychoanalysis of whatever duration and intensity had only supportive value for seriously sick patients (Heilbrunn, 1963).

5 There are, of course, many agencies that are not typical in this sense but are "primary" casework agencies in the sense that caseworkers administer the agency and carry the main treatment load. Psychiatrists, psychologists, and other professionals are used as consultants in such agencies. They are also more purely treatment agencies in the sense that need for their services is defined primarily by emotional breakdown. Many child guidance clinics and family service agencies fall into this category. The typical caseworker does not work at such an agency, however. The practice of a caseworker in such a setting is akin to that of a psychotherapist.

6 Some parts of this section have been adapted from Wolberg LR, Kildahl JP: The Dynamics of Personality. Orlando, FL, Grune & Stratton, 1970.

7 This case history is from Wolberg LR: The Handbook of Short-term Psychotherapy. New York, Thieme-Stratton, Inc., 1980. Reprinted with permission.

8 A good bibliography on stress research may be found in McGrath JE (ed): Social and Psychological Factors in Stress. New York: Holt, Rinehart and Winston, 1970; and McGrath, JE: Settings, measures and Themes: An integrative review of some research on social-psychological factors in stress. In Monat A, Lazarus RS (eds): Stress and Coping. New York: Columbia University Press, 1977, pp. 67-76.

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