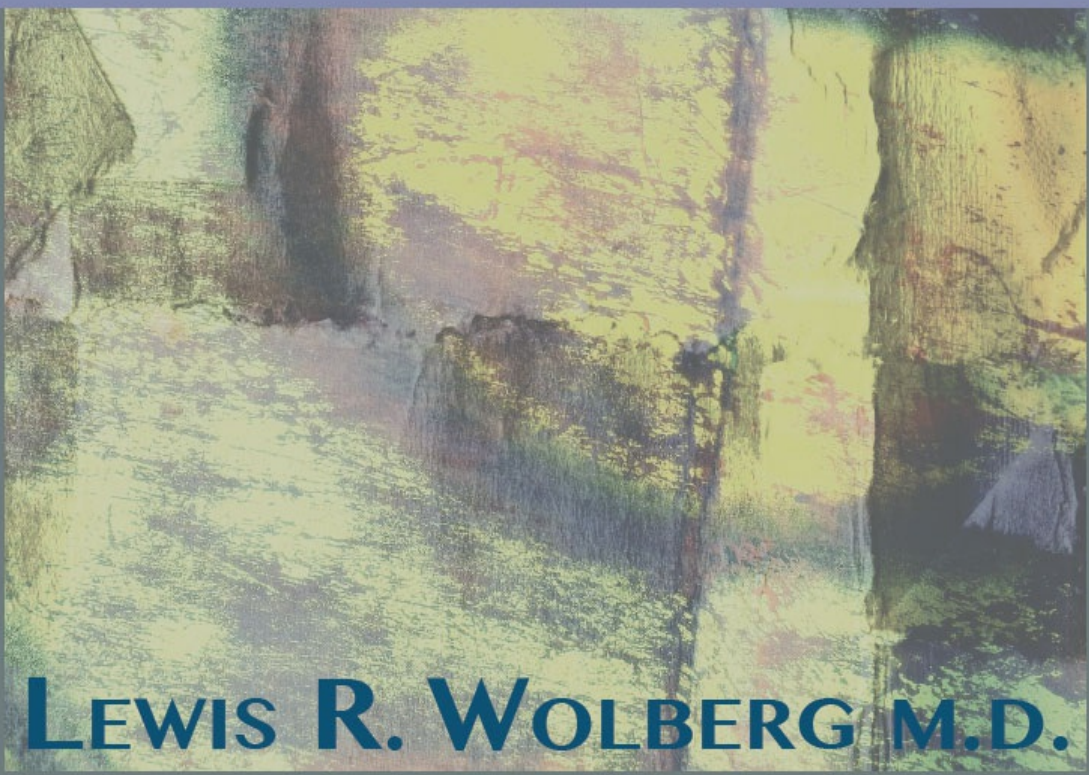
THE TECHNIQUE OF PSYCHOTHERAPY

ADJUNCTIVE AIDS IN PSYCHOTHERAPY



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Adjunctive Aids in Psychotherapy

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Adjunctive Aids in Psychotherapy

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.

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.

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

See Table 56-3

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 anticholingeric 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 ($mE_q l$) but during maintenance can be as low as 0.6 or 0.4 $mE_q l$ 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 (Tegretal) 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.

ANTIDEPRESSANT DRUGS

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 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 treat-merits 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].*
>
> *[On being brought back to the waking state, the patient exclaimed]* This is one of the most remarkable experiences I ever had. This peculiar feeling. I felt the chair was much narrower than it is and that you were getting closer. I felt a good feeling, a secure feeling, like I sometimes felt when I went to see my analyst. But then something happened. I see myself in a restaurant with my parents, a child. I am that child. I am downstairs eating lobster. I felt as if I was going to throw up, and I didn't want to throw up at the table. I kept it in and went into a panic. I thought of my father. I hated him. He rejected me. He was extremely critical. He never praised me for anything. Something in him that wouldn't permit him to compliment me. When I was 3 or 4 years old, mother used to push food into me and I used to vomit it. When I was 10, I had polio and I was afraid to be alone. I was afraid to let Mother go out. I was afraid that something would happen to her. If an accident occurred, what would happen to me? I was afraid to stay alone. I had great anxiety until she came home. Before I was 13 I wasn't allowed to go myself. My mother was a terrific worry-wart about my physical condition and about where I was at nighttime.

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.

ART THERAPY

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.

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When Things Go Wrong, What Can You Do?(n.d.) NMHA. 300

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Stuart RB &Jacobson B: Second Marriage. New York, Norton, 1985

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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

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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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