Psychotherapy of Ambulatory Patients with Severe Anxiety

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Psychiatrists who treat ambulatory patients with severe anxiety reactions must have immediate, intermediate and long-range goals. Different therapeutic procedures may be more or less effective with regard to the attainment of one or another of these aims. Depending on the therapist's personality and earlier training, a broad spectrum of treatment modalities may be brought into play. Some psychiatrists who are purely organicists in their orientation will automatically administer tranquilizing drugs or electroshock therapy, and these treatment procedures will be the sum and substance of their planned therapy.

Other psychiatrists and psychologists will only employ purely psychotherapeutic techniques in the management of severely anxious patients whether the prime nosologic problem is psychoneurosis, schizophrenia, or sociopathy. These polarized therapeutic conceptualizations of the treatment of patients manifesting severe anxiety are anachronistic at our current level of psychiatric development (1). In my experience, psychoanalytically oriented psychotherapy, combined with properly chosen and administered tranquilizing drugs, is the optimum therapeutic technique for the effective management of the vast majority of patients in whom severe or even massive anxiety is a prominent clinical feature.

I will present a step-by-step description of the technical intricacies involved in the use of tranquilizers in combination with psychoanalytically oriented psychotherapy. It is a digest of more than 20 years of experimentation and experience with this treatment procedure in the management of many hundreds

of severely anxious patients who had a broad spectrum of psychiatric illnesses (2, 3).

The combined tranquilizer-psychotherapy procedure is a complicated method from a theoretic basis, because it involves the compounding of biodynamic, psychodynamic, and sociodynamic elements into a single unified treatment approach. At present, few psychiatrists use combined therapy in a planned, intended fashion. Dynamically oriented psychotherapy has not been purposefully combined with psychopharmacologic therapy, owing mainly to the lack of broad training that is necessary if one is to employ this technique. Psychiatrists, in order to utilize this combined procedure effectively, must have extensive experience with the organic therapies and with dynamically oriented psychotherapy, particularly brief analytically oriented psychotherapy. Unfortunately, most psychiatrists adhere either to the organic treatments or to the psychotherapies and use combined therapy only unintentionally.

Combined Therapy in a Patient with Marked Anxiety

The combined process can be introduced at any of three phases of the therapeutic procedure, namely, at the inception of therapy, during the course of treatment, or as maintenance therapy.

At the Inception of Treatment

Combined therapy logically should be instituted at the beginning of the therapeutic procedure in patients who are too overtly anxious to be amenable to psychotherapy alone or on an ambulatory basis. It is especially effective if the motor component of anxiety is extremely marked. At this phase of treatment, the therapist is primarily interested in short-term goals related to the amelioration or blunting of the initial level of anxiety and the symptoms and signs that are the secondary defenses against this anxiety.

Prior to the advent of the tranquilizers, when psychotherapeutic techniques

were employed alone, weeks or months were often spent in ameliorating the level of anxiety to the point at which the patient had sufficient ego strength to cooperate effectively in a dynamically oriented psychotherapeutic relationship. In a great many instances, the early administration of tranquilizing drugs greatly shortens the period of anxiety decompression and thereby enables the patient to cooperate effectively and meaningfully more quickly. Since the advent of the combined technique, many patients who formerly would have required hospitalization can be managed on an ambulatory basis. The proper use of the combined technique prevents the necessity for hospitalizing many severely anxious schizophrenic patients and some patients with agitated depressions, who otherwise would have been exposed to the psychic trauma and economic drain that are often associated with institutionalization.

Combined therapy is particularly effective among those severely anxious patients who are commonly diagnosed as having schizophrenia, pseudoneurotic type (2). I would go further and state that, from my point of view, the combined therapy technique is the treatment of choice for most pseudo-neurotic schizophrenics who overtly manifest a marked degree of anxiety. I have also found that many severely decompensated schizophrenic patients, whose illnesses were previously considered incompatible with ambulatory psychotherapy, often become suitable candidates for analytically oriented therapy when it is combined with tranquilizing drugs, particularly those of the phenothiazine group.

Combined therapy is a necessity in the management of many very anxious patients who have organic mental reactions. Prior to the advent of the tranquilizing drugs, outpatient electroshock therapy or hospitalization was mandatory for a very large group of these individuals. At the present time, a high percentage of those anxious patients with organic mental illnesses, particularly those that fluctuate in appearance and intensity, can be managed very effectively by a combination of tranquilizing drugs and supportive psychotherapy.

Though combined therapy has its most dramatic effects in the outpatient treatment of anxious psychotic patients, it is also indicated at the very inception of treatment with some extremely anxious psychoneurotic patients. Weeks and even months of painful anxiety that severely limits the benefits of all psychotherapeutic efforts may be greatly shortened if combined therapy is diligently employed.

The combined therapy approach is also indicated at the inception of treatment with very anxious, acting-out adolescents and some hyperactive children, where the acting-out or hyperactivity is a secondary defense mechanism against a marked increase in the degree of anxiety.

During the Course of Treatment

The tranquilizing drugs also may serve a purpose when introduced during the course of analytically oriented psychotherapy or even during the course of intensive, reconstructive, psychoanalytic psychotherapy. They should be considered when the level of anxiety escalates sharply or persistently secondary to an increase in environmental stress or psychotherapeutic events. The judicious introduction of the tranquilizers may often literally save psychotherapy. This is particularly so in the ambulatory management of anxious schizophrenic patients.

The insights unveiled during the course of dynamically oriented psychotherapy may precipitate a marked or even massive elevation in the intensity of anxiety in some neurotic patients, and most particularly in a large group of schizophrenic patients, no matter how diligent and careful the therapist may be. This marked increase in anxiety may be attended by the appearance of a strong negative transference and a decrease in effective free association. The tranquilizing drugs, when properly utilized, by rapidly reducing the level of anxiety not only may ameliorate the secondary signs and symptoms associated with the increased level of anxiety, but also may ameliorate the destructive

effects of a strong negative transference and permit more significant free association.

As Maintenance Therapy

Many patients require intermittent psychiatric treatment throughout their lives. This is particularly true with schizophrenic patients. To a lesser degree it pertains also to a segment of the population of neurotic patients who have been chronically ill and to some with recurrent depressions.

An experienced therapist learns to recognize and appreciate which patients require scheduled visits and which patients may be permitted to use their judgment as to when they should seek help. As I have noted before, it is imperative that patients be taught to recognize the earliest evidences of mounting anxiety and the threshold beyond which they should return for further treatment.

The nature of maintenance therapy will differ depending on the patient, the therapist, and the environment. Some patients are unable to function successfully vocationally, socially, or sexually without maintenance drug therapy even in the face of routine, everyday responsibilities. Usually the required dose of a tranquilizer for maintenance purposes is far less than the amount needed to ameliorate the original anxiety. Indeed, a less potent tranquilizer than that originally required, one that may also have less severe side effects, may be sufficient during the maintenance period.

There are literally tens of thousands of patients who are on a continuous program of tranquilizing drugs. Very often, when they evidence psychic decompensation, the problem may be met by a simple increase in the dose of the prescribed drug. On occasions it may be necessary to change the drug with a different biochemical agent being substituted. The psychotherapeutic techniques utilized in combination with the drugs will differ depending on the intensity and

rate of increase in the level of anxiety and the patient's immediate response to the tranquilizers (4, 5). If the level of anxiety is readily controllable, an analytically oriented psychotherapeutic approach, in which reeducation is continued, is feasible. If the level of anxiety is very pronounced, a return to a supportive psychotherapeutic approach will be necessary.

Certainly not all patients require maintenance drug therapy but instead can be managed with various types of psychotherapeutic techniques alone, the visits being scheduled periodically or as required by evidences of psychic decompensation. Usually, maintenance psychotherapy merely reinforces previously learned processes. Less frequently, the widely spaced maintenance visits may further the learning process by bringing to light insights that advance psychic maturation.

If the presenting level of anxiety is severe or if the rate of increase is pronounced, the therapeutic process will become more supportive until the overt manifestations of anxiety are significantly reduced. Very commonly it is advisable to supplement the psychotherapeutic regime by the addition of a tranquilizer, depending once again on the degree of manifest anxiety and the rate of acceleration in the degree of anxiety. If the level of anxiety is not marked, small amounts of the original drug or even a less potent tranquilizer usually are sufficient to block or ameliorate the presenting symptoms and signs. In any case, when employing am drug, one must use the appropriate preparation in sufficient amounts.

Selecting the Proper Tranquilizer

My rules for the selection of a particular type of preparation are very simple. Wherever there is clear-cut evidence of marked or extreme, overt anxiety, usually accompanied by one or more secondary symptoms or signs, I select a neuroleptic, usually a phenothiazine preparation. If the patient has a history of an inadequate response or a sensitivity to drugs of the phenothiazine

group, then one of the butyrophenones or thioxanthenes may be chosen. In patients in whom anxiety is obviously very pronounced I find that chlorpromazine, the first of the phenothiazines to be introduced, is still the most reliable and effective preparation. The initial soporific side effect commonly associated with chlorpromazine may be beneficial.

Where the level of anxiety is moderate, and the patient has not responded to psychotherapeutic procedures alone, drugs such as Librium (chlordiazepoxide) or Valium (diazepam) may be utilized.

If neurotic patients are extremely anxious, the so-called minor tranquilizers are of relatively little benefit and the major tranquilizers usually must be employed (1). Conversely, there are ambulatory schizophrenic patients, seen in private or clinic practice, who will respond to chlordiazepoxide or diazepam if the degree of manifest anxiety is not severe.

Analytically Oriented Psychotherapy in Combination with Tranquilizers

Initial Phase

This combined technique is optimally suited to patients whose illnesses are characterized by marked or extreme overt anxiety, together with various secondary symptoms and signs. Indeed, it is the preferred technique for such patients. The primary purpose during the initial phase of treatment is to ameliorate the severe pathologic level of anxiety, this decrease being accompanied by a blunting or removal of the secondary clinical manifestations.

When this is accomplished, the therapist should not be deluded that he has caused a grand metamorphosis that will stand the ravages of time and stress. All that has been accomplished is the lessening of the patient's psychic pain, as evidenced by marked anxiety, and of those symptoms that are secondary defense mechanisms against this anxiety.

The initial process of the combined therapeutic procedure usually lasts from one to three weeks. It is rare for this phase to be of longer duration. The psychotherapeutic aspect is strongly supportive and is conducted in a face-to-face setting. Under no circumstances should the patient be placed on a couch at this point, for it is imperative that the therapist be sharply aware of all clinical changes, whether the information is transmitted to him by visual, auditory, or tactile means.

The recording of the anamnesis is an intimate part of the technique of anxiety reduction. The therapist should take great pains to reassure the patient as to a positive outcome. During the initial interview, the therapist must obtain a detailed qualitative and quantitative analysis of the anxiety that is present, together with a sharp awareness of the sequence of appearance of the secondary defense mechanisms. He must also evaluate as clearly as possible the sources of stress, both chronic and acute. In addition to being aware of the initial value or level of anxiety, the therapist must know prior to the institution of therapy whether the level of anxiety is increasing, has already plateaued, or is decreasing. The therapist may require a number of visits before he can accurately ascertain the direction and rate of change in the quantitative degree of anxiety. The therapist should be aware also as to whether the anxiety and secondary symptom formation are in a psychotic or neurotic framework. (Though this determination cannot be made in some instances during the initial interview, a tentative evaluation is a great aid.)

The patients should be seen two to three times during the first week of combined therapy. This permits the therapist to adjust the dosage of medication, obtain further history, and continue the supportive psychotherapy begun during the initial interview.

In very anxious patients the tranquilizers are prescribed at the time of the initial interview. The psychiatrist should have a thorough knowledge of the drug that he is employing, both from a therapeutic standpoint, and with regard to

possible side effects. He must be confident in his handling of the medication. It is also imperative that he be experienced in the technique of brief analytically oriented psychotherapy. He should understand the capacities, as well as the limitations, of both the organic and psychotherapeutic aspects of the procedure. The therapist should also understand the benefits and limitations of hospitalization, for with many of these patients, should their ailments worsen instead of improving, emergency hospitalization may be necessary. Finally, the therapist should be cognizant of the benefits of ambulatory electroshock therapy, for some of the psychotic patients who continue to regress or show no significant improvement may be excellent candidates for electroshock therapy as far as the amelioration of the initial levels of anxiety and secondary symptoms and signs is concerned.

Before the therapist prescribes a drug, its nature and purpose, especially its potential positive benefits, should be described to the patient in general terms. The mechanism by means of which the combined technique operates can best be described to the patient in terms of anxiety reduction, with symptomatic relief being secondary to this amelioration. Many patients come expecting medication. Indeed, many may request one particular "magic pill." Environment may exert a negative effect on the patient. Some patients come with great antipathy to drug therapy or psychotherapy or to a particular type of drug therapy or a particular type of psychotherapy. This is especially true if they have had any prior treatment. Such a situation may complicate the initial therapeutic situation to varying degrees.

The most common potential side effects that many occur secondary to a particular drug should be presented simply and honestly. The descriptions must take into account the patient's preconceived conceptualizations, correct or incorrect. Every therapist should be prepared for possible difficulties arising in anxious patients who have hypochondriacal manifestations as part of their secondary defense mechanisms, should side effects occur. Finally, one should be aware of difficulties that may arise among severely anxious schizophrenic

patients, particularly among those in whom there are evidences that a decrease in the level of consciousness may be followed by difficulties in reality contact. Some very anxious patients who have organic mental deficits also are prone to pose problems should the tranquilizers have a potent soporific side effect. Finally, patients with a very pronounced obsessive-compulsive matrix may pose a problem in the very initial phase of therapy as a manifestation of their fear of losing control secondary to the use of any drug.

One of the primary aims during the initial phase of treatment is to foster a very strong, positive transference reaction (2). The accomplishment of this aim is rendered relatively easy if the therapist's and patient's initial goals are in harmony and the prime basis for concomitancy at this point is an expectation of rapid amelioration of the presenting symptoms and signs. If the initial aims are divergent, therapy will be star-crossed from the very beginning. Unfortunately, a negative transference reaction is likely to occur if the therapist states, in effect, that "the main purpose of treatment is reeducation and this will take a long, long time.'' The severely anxious patient's prime desire at this point is symptomatic relief, and he should be approached overtly with the general idea that, "I will relieve you of your pain."

By the use of this combined tranquilizer-psychotherapeutic approach, a working relationship between doctor and patient that would have taken months to establish with psychotherapy alone may be accomplished in a matter of weeks. Many patients react to the rapid relief of painful anxiety with unquestioning gratitude and a desire, indeed an eagerness, to relate to the psychiatrist. This is quickly established and enhances the strong positive transference. It occurs at times as part of the magical expectancy, with the therapist being viewed as an all-powerful father who is infallible in the patient's judgment.

I cannot stress too forcefully that the initial phase of the combined technique produces rapid clinical changes that are ever-changing and that have a momentum far greater than that seen when psychotherapy is used alone. This

puts greater demands on the therapist. Indeed, some therapists are poorly equipped psychologically to effectively handle this type of procedure.

During every visit, by direct questioning and careful observation, the degree of the patient's anxiety, the nature and status of the secondary symptoms, the vocational, social, and sexual behavior, and the dream material are reviewed in detail. Close contact is made, where possible, with the patient's family and friends. I appreciate the fact that relatives and friends may be poor informants, but the nature of the information to be gathered is simple and can be readily correlated with the data obtained from questioning and observing the patient.

In view of the rapid change in the patient's clinical status, the therapist may be prone to overestimate the patient's capacities for vocational and social adaptation. However, I must emphasize that at this point the improvement is primarily symptomatic in nature, with the patient having little or no understanding of the nature or origins of his problems. It is safer to be conservative in the estimation of a patient's ego capacities At this point in treatment, overoptimism could result in anxiety to the point of panic if the patient is exposed prematurely to excessive vocational or social stress.

The rate of change that occurs as a result of the combined technique can be controlled. This pacemaker can take several forms. First, the dosage of the tranquilizer can be varied. A rapid buildup is often necessary during the first week with changes being made daily or every few days until the intensity of anxiety is very definitely ameliorated. After the level of anxiety is decreased, the total daily dosage of medication may be lessened. The total daily dosage has to be titrated against the degree of overt anxiety.

From a psychotherapeutic standpoint, the level of anxiety can be affected by the relative control or encouragement of the process of patient catharsis. In some patients, a free outpouring of affect-laden material may be an effective tool leading to anxiety decompression. However, at times it can cause a negative

feedback reaction and actually increase the level of anxiety, leading to a new pananxiety state. In such instances the therapist may aid anxiety amelioration by limiting the nature and rate of catharsis. Systematic autorelaxation exercises, vigorous physical outlets, and occupational diversions are good temporary channels that may serve as braking mechanisms. It should be understood that this process is very fluid and depends entirely upon the rate and direction of the patient's clinical change. The rate of clinical change can also be affected by controlling the patient's activities relevant to work, socialization, and sexual relationships.

It can be affected to a lesser degree by interpretations. At this phase of treatment, interpretations should be made sparingly. The therapist must be careful not to precipitate insights that the patient is emotionally incapable of handling. Interpretations, when they are given, should deal with the here and now. When they involve situations from the patient's past they should be pertinently related to the patient's current behavior or life situation. Poorly timed and poorly conceived interpretations may precipitate a massive panic reaction.

The reporting of dreams is encouraged even in the initial phase of therapy. As the level of anxiety is rapidly decreased, there is a greater awareness of dream material. The therapist should be cautious and not overwhelmed by this seeming deluge of dream recall. Once again, at this point he should refrain from making profound interpretations that the patient may not be able to tolerate. *At this phase of treatment dreams should be viewed primarily as a source of psychodynamic information and secondarily as a means of anxiety decompression*. Interpretations, when deemed pertinent, should be related to the current scene and should be gauged according to the patient's capacities to tolerate an awareness of the latent content.

Dangers Associated with the Initial Phase

Many complications can occur during the initial phase of treatment. Most can be anticipated and avoided. Others can readily be corrected.

Excessive Tranquilizing. At times the dosage of the tranquilizers may be increased too rapidly or, as the overt level of anxiety is decreased, the drug level may be kept at levels more appropriate for the period when the overt level of anxiety was much greater. It is imperative that the dose of medication be optimally titrated according to the intensity of manifest anxiety. This titration should proceed gradually, never precipitously.

One must be particularly cautious in the reduction of drug dosage in schizophrenic patients, for at times an excessively rapid decrease in medication may precipitate a panic episode. On the other hand, overtranquilizing may cause a paradoxic, massive pananxiety state in schizophrenic patients if the soporific side effects of the drug lead to difficulties in reality control. On occasions this may be relieved by the addition of small amounts of amphetamine.

Excessive tranquilizing also may produce a degree of placidity and passivity that will block further effective treatment. The overly rapid amelioration of anxiety may lead some patients to minimize the severity of their illnesses. Indeed, in some, one can observe the unfolding of a complete scheme of denial or illness. Some will run from treatment. Others may remain purely to receive the medications. It was interesting that these patients are afraid, in many instances, to have other physicians take over the administration of drugs. This is an example of what I have called *drug transference*, in which the therapist becomes merely the purveyor of a "magic elixir" (6).

Insufficient Dosage of Tranquilizer. The danger of an insufficient dosage is self-evident. If the therapist utilizes the information that can be accumulated from an awareness of the basic mechanisms of anxiety reduction (4), he should have little difficulty in administering the amount of drug necessary for the amelioration of a certain quantum of anxiety. I repeat that the therapist must

know his drug, its benefits and its limitations.

Side Effects of Medication. All drugs that have any potency may have adverse side effects. Fortunately, most that occur as a result of the administration of tranquilizers are mild and transient. The patients should be forewarned to minimize the anxiety that is associated with the appearance of side effects.

As side effects appear the therapist should interpret them clearly to the patient so that they are not falsely conceived by tire patient as being an integral part of his illness. This is particularly important in patients who have hypochondriacal defense mechanisms. It is also important in patients who have an obsessive-compulsive personality matrix, for they may conceive that side effects are a further indication of their lack of control. Paranoid schizophrenics may interpret side effects as evidence of the therapist's malevolence toward them.

Excessive Positive Transference. In some instances the patients develop a degree of dependency that renders them affectively almost inert. In general, this is not a problem during the initial phase of treatment; it usually becomes a major concern during the second, or psychoanalytically oriented phase of treatment. Quite often this difficulty may be associated with overmedication and can be corrected by a reduction in the daily dose of tranquilizer.

Drug Transference. As mentioned earlier, drug transference pertains to situations in which patients will remain in therapy with a given psychiatrist because they associate him with the administration of a successful drug and are afraid that the same drug will not be so effective if administered by a different physician (6). In these instances, the therapist becomes merely the purveyor of a pill. At times drug transference may be confused by the therapist as representing a true, strong, positive transference. When such misinterpretations are marked, owing to the therapist's own emotional needs, effective treatment is bound to collapse. With the use of drugs, as with all types of treatment, accurate

observations, undiluted by exaggeration due to immodesty and neurotic wishful thinking, are necessary for optimum benefits.

Premature or Excessive Environmental Commitments. The rapid amelioration of the initial level of anxiety and secondary symptoms and signs is interpreted by most patients as a sign of a "return to health." When this occurs, almost all patients, if left to their own design, immediately will attempt to resume full vocational and social activities. Indeed, many will strive to make up for lost time. They will try to compensate for that period of time in which their psychic difficulties limited effective activity.

I cannot emphasize too urgently that, following the initial symptomatic improvement secondary to drug therapy, premature resumption of routine responsibilities may lead to a massive psychic collapse. It is one of the main tasks of the psychotherapist, at this phase of treatment, to guide the patient's vocational and social performance with a firm hand until the patient demonstrates firm evidence of increased ego capacities. The failure on the part of psychiatrists to follow these suggestions is one of the commonest causes of failure in drug treatment.

Family Interference. The rapid amelioration of the presenting symptoms and signs is considered to be synonymous with a cure in the minds of most relatives and friends of patients, and they often become a negative influence with regard to the patient's remaining in therapy.

To a degree this can be forestalled by predicting for the patient and family at the first visit that symptoms and signs will probably disappear very quickly but that any cessation of treatment at that point would be fraught with danger. This admonition may now be repeated, if unintentionally malevolent advice from the family threatens to interfere with further treatment. Both the family and the patient should be warned in no uncertain terms of the dangers of premature termination of treatment.

Psychoanalytically Oriented Phase

There is no sharp demarcation between the initial and secondary, or psychoanalytically oriented, phase of treatment. Rather, the change takes place gradually, with the psychotherapeutic process becoming less and less supportive. The change usually begins from one to three weeks after the onset of treatment, after there has been definite evidence of a marked decrease in the quantitative degree of anxiety and a significant amelioration of secondary symptoms and signs. In some instances the secondary symptoms and signs may be completely gone. In other patients, one or even two of the symptoms may be present but only intermittently and without their pretherapeutic level of affect.

Aberrations such as delusions, illusions, and hallucinations should be ameliorated completely before the analytically oriented phase of the treatment begins.

The primary aims of the psychoanalytically oriented phase of treatment are 1) reinforcement of anxiety decompression begun in the initial phase of treatment and 2) reeducation with the aim of increasing the patient's psychosocial maturation.

As treatment progresses, the first goal becomes less and less important as the second goal becomes increasingly realized. I would like to reaffirm that at the onset of this second phase of treatment the patient has little or no insight as to the sources or psychodynamics of his difficulties. Improvement, thus far, has resulted from the tranquilizer, the supportive psychotherapy, and various placebo effects.

This is a dangerous point for a therapist to become overwhelmingly enthusiastic and undercautious, particularly if he becomes enamored with his own magical powers. Poor judgment, in this regard, may lead to a precipitous collapse of all that has been attained. At this point, die patient still has relatively fragile ego capacities.

The psychotherapeutic support that characterized the initial phase of therapy can be gradually relaxed when there is adequate indication of increasing ego strength. This is measured to a great extent by the degree of overt anxiety and the patient's vocational, social, and sexual adaptation. Therapy remains ego supportive in nature but to a gradually lessening extent. Free association is encouraged but in a guided fashion.

The clinging positive transference relationship is given active attention. As noted before, if it continues in an undiluted form, therapy will become paralyzed. The positive transference is actively interpreted and dissipated, for its existence is a constant threat to the effective continuation of the psychoanalytically oriented phase of treatment. Its presence is a residue of magical expectations and is antithetical to any psychotherapy that has emotional maturation as a goal.

As mentioned before, in the presence of a very strong positive transference reaction there is often a marked inhibition of any negative or hostile responses. I do not mean that repressed hostility is completely inhibited. To the contrary, marked anxiety has a hostility-inhibiting effect in many patients, and during the initial phase of therapy, as the level of anxiety is rapidly reduced, anger directed toward persons other than the therapist may come forth.

The decompression of anxiety during the initial phase of treatment is often followed by a free flow of repressed hostility, but this hostility is rarely directed toward the therapist in the form of a strong negative transference reaction. This situation poses a therapeutic problem in a number of instances if it persists in the psychoanalytically oriented phase of treatment. Manifestations of negative transference, when kept within reasonable bounds, afford an excellent means for the controlled discharge of hostility and at that same time serve as a valuable medium by means of which the patient obtains significant insights.

As the excessively positive transference is reduced in intensity, the therapist usually can expect the appearance of a negative reaction. However, it

will usually not be so intense as it might have been if a tranquilizer had not been used in the initial phase of treatment. This poses an active task for the psychotherapist to guide the release of hostility in such a manner as to benefit the patient, while at the same time avoiding an indiscriminate and inappropriate outburst of rage against family and friends. I have noted only a few instances, in my studies, in which the released hostility could not be managed by diligent guidance even with schizophrenic patients.

Communication Zone

The term *communication zone* refers to a quantitative degree of anxiety in which the patient appears to communicate most freely (6). In some patients the range appears rather broad, whereas in other patients, it is relatively narrow. Psychotherapists, beginning with the classical psychoanalysts, correctly warned that, if the patient's level of anxiety is depressed to too great a degree, the patient will not communicate efficiently. Relatively few psychotherapists have drawn attention to the fact that when patients are extremely anxious there is also relatively little effective communication.

Though the pattern is highly individualized, in many instances I find that there is a certain threshold of anxiety below which the patient will communicate with greater freedom. The rate of change in the quantitative degree of anxiety also appears to affect communication. The level of communication is greatly enhanced as an excessive level of anxiety is decreased and is less evident as anxiety establishes a plateau effect. Similarly, as the quantitative degree of anxiety is increased in patients who present a flat affect, a zone of anxiety will appear characterized by relatively free communication that may disappear if an excessively high level of anxiety is attained. I repeat, once again, that this is a highly individualized process that requires greater study.

With regard to interpretations made by the psychotherapist during the combined therapy technique, the same general rules pertain as in any other brief

psychoanalytically oriented procedure. It should be remembered, once again, that the process of change is much more rapid here than in the usual psychotherapeutic process. The therapist must be very cautious lest he permit the development of a free-floating pananxiety state secondary to interpretations that the patient is unable to accept at a particular state of emotional maturation. As in dream interpretation, the interpretation of other material should focus on the here and now, with past events and associations being related as much as possible to current processes. At all times, evidence of increasing anxiety should be probed.

Vocational and social adaptation, with pride and pleasure in relationship to past and present relationships, is stressed, with primary emphasis on current processes. The necessity to function within one's current psychic capacities is prominently emphasized throughout this analytically oriented phase of treatment. The patient is conditioned, so to speak, to an awareness of the earliest evidences of increased anxiety secondary to any type of environmental stress. As the patient attains a more mature level of awareness, he learns to anticipate situations more positively. Usually, at this point, the amount of anxiety precipitated by a particular situation is relatively slight. The final attainment of maturity with regard to a particular situation is attained when the patient is automatically able to manage a situation without significant anxiety.

If the tranquilizing drugs are introduced during the psychoanalytically oriented phase of treatment for the first time, or if they are reintroduced after having been discontinued, the degree of the positive transference that occurs is not so profound as noted when drugs are introduced in the initial stage of the combined therapy program. Similarly, in such instances it is rare for a strong drug transference to occur. The patients in this situation usually maintain a realistic attitude toward the medications, and they merely credit the therapist with good judgment for having employed the tranquilizers.

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