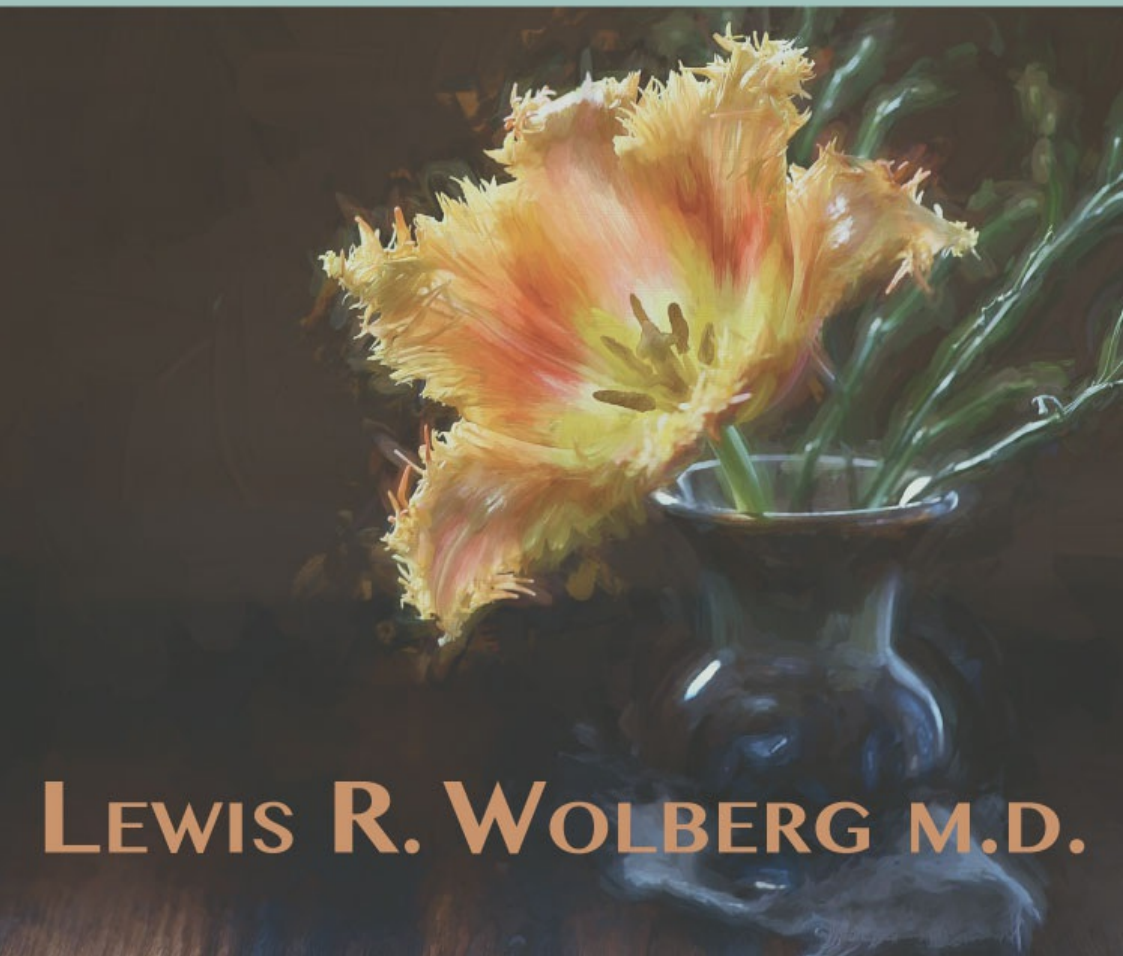
THE TECHNIQUE OF PSYCHOTHERAPY

SUPPORTIVE THERAPY



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From *The Technique of Psychotherapy* Lewis R. Wolberg

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Supportive Therapy

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

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

Since supportive therapy attempts the achievement of symptom relief or symptom removal, the question presents itself regarding the value of symptomatic cure. Among the most solecistic of legends is the notion that elimination of symptoms is shallow if not worthless. This notion stems from the steam engine model of psychodynamics that conceives of energy in a closed system, bound by symptomatic defenses, which when removed, releases new, more dreadful troubles. This is in spite of the fact that

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

In summary, symptom relief or removal is an essential goal in any useful psychotherapeutic program. It may occur "spontaneously" or be brought about by a variety of methods, such as by drugs, by conditioning techniques, by faith and prayer, and by insight. While one may not agree with Eysenck (1960a) that elimination of a symptom cures the neurosis, there is evidence that it contributes to a better adjustment and to the elimination of auxiliary symptoms clustered around the original complaints. Any therapy that leads to enlightenment and greater self-understanding *without* symptom relief may legitimately be regarded as a mediocre success if not a failure. But this does not mean that symptom control should constitute the sole objective of therapy. Undermining of the basis of the individual's symptoms, the resolution of past conditionings and current conflicts that nurture more symptoms

expands one's potentials for happiness and creativity. While such an objective may come about as a byproduct of symptomatic change, its studied achievement should be an important target.

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

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

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

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

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

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

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

Supportive therapy does not work in many cases where the problems with authority are so severe that the patient automatically goes into competition with the helping individual, depreciating, seeking to control, acting aggressive and hostile, detaching himself or herself, or becoming inordinately helpless. These reactions, appearing during therapy, may act as insurmountable resistances to the acceptance of even supportive help.

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

GUIDANCE

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

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

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

Under these circumstances any doubt regarding the strength or wisdom of the authority will arouse strong insecurity. Hostility and guilt feelings, if they develop at all, may be rigidly repressed for fear of counterhostility or disapproval. One may recognize in such irrational patterns the same attitudes that the child harbors toward an omnipotent parent. Actually, the emotional helplessness of the neurotic individual resembles, to a strong degree, the helplessness of the immature child. The neurotic person may project the original authority that was invested in parents, and may be seeking from the therapist

extravagant evidences of support and love. Characterologically dependent persons particularly demand demonstrations of infallibility. Should the therapist display human frailties or appear to lack invincible qualities, the faith of the person may be shattered, precipitating helplessness and anxiety. Mastery may then be sought by annexing oneself to another agency in whom magical and godlike features lacking in the previous host are anticipated. The life history of such dependent individuals shows a flitting from one therapist to another, from clinic to clinic, from shrine to cult, in a ceaseless search for a parental figure who can guide them to paths of health and accomplishment.

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

In spite of its disadvantages, guidance may be the only type of treatment to which some patients will respond. Desperately helpless in the grip of their neurosis, such individuals have neither the motivation nor the strength to work with a technique that requires self-direction. Resistance to self-assertiveness is so strong that a parental figure must prod them into performing their daily tasks.

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

Within its limited orbit, therefore, guidance has utility in therapy. One does not employ it under the

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

TENSION CONTROL

Tension activates many disturbing physiological and behavioral tendencies. More subdued than anxiety, of which it is undoubtedly a component, it often registers its effects subversively through the autonomic nervous system, influencing the functioning of various organs. It is one of the earliest signs of emotional disturbance, and once mobilized it may continue to torment the individual even after neurotic defenses have been established. Tolerance of the effects of tension varies. There are some persons whose repressive mechanisms work so well that they are unaware of how tense they are even though their physical health is affected by resultant physiological imbalances. There are others whose sensitivity to tension is so extreme that they are in a constant state of uneasiness and discomfort. Individuals with poor impulse control may release their tension in passionate outbursts even though this leads to violence, sexual acting-out, and sundry behavioral improprieties.

Because tension is so discomfiting, it is little wonder that escape from it constitutes a chief preoccupation of human beings, who will eagerly utilize assorted devices in pursuit of peace of mind. Some of the contingencies exploited have a destructive potential. Alcohol, for example, is often employed as a potent tranquilizer; its use is universal, a part of our social tradition. It narcotizes the brain and easily, while its effects last, subdues awareness of tension. Most people are capable of controlling the intake of drink, but for those who attempt to utilize it as a prime calmative resource, it poses serious hazards. In recent years other tranquilizing substances (such as Valium and Xanax) have entered the scene. Enthusiastically prescribed by physicians (by far, they constitute the most commonly sold drugstore medicaments), they are fervently utilized by patients, some of whom after several months may become addicted. Barbiturates and nonbarbiturate hypnotics continue to enjoy a risky popularity. This is

not to deprecate the value of tranquilizers, sedatives, and hypnotics as temporary expedients, but caution must be exercised in their use since they cannot be employed as a way of life.

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

It is to be expected that many practitioners, with and without proper qualifications, will offer unique schemes for tension release, including bodily massage, tapping, slapping, touching, intimate games, screaming exercises, spiritual discipline, and self-induced altered states of consciousness. Popular volumes flood the market and have varying virtues for individuals seeking self-help direction for tension control. The professional person may derive some good ideas from a few of these volumes (e.g., Krippner & Kline, 1972) that can be adapted to one's own technique and style of operation.

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

Unlearning of dysfunctional habits that escalate tension will require daily practice of a chosen method (Benson, H., et al, 1974). This may involve nothing more than E. Jacobson's simple progressive

relaxation of muscle groups (1938) from scalp to toes or vice versa. Such self-relaxation techniques can quiet major muscle groups and ultimately lead to substantial tension control. It is estimated that on the average approximately 2 months of daily practice are required for satisfactory results. As the subject experiences a sense of awareness about his or her bodily reactions, the subject may be able deliberately to reproduce at will an adequate state of relaxation without needing to go through all the prescribed exercises. Autogenic training (Schultz & Luthe, 1959) strives for a reorganization of subconscious thinking patterns through the use of a technique of "passive concentration," an unstructured relaxed form of cogitation and association. No formal muscle relaxation maneuvers are utilized, yet the technique promotes a sense of warmth and lightness over the entire body. Suggestions emphasize peacefulness and quietness and enjoin the subject to allow such feelings to develop without forcing them.

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

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

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

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

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

MILIEU THERAPY (ENVIRONMENTAL ADJUSTMENT, SOCIOTHERAPY)

A vast number of stimuli from the outside impinge on the individual daily. Some of these are clearly responsible for an existing acute emotional upset. Some are habitual aggravations that keep chronic troubles alive. In milieu therapy we attempt to define and eliminate provocative environmental irritants

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

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

No matter how benevolent a controlled environment may seem, the attitudes and reactions of administrative and clinical professionals will determine its therapeutic impact. Many programs have been wrecked by negative countertransferential reactions of the persons in charge. The treatment and rehabilitative facilities must also be vigorous and varied to fit in with the requirements of different

patients. Unless a program is flexible and possesses many alternative resources, it will not be suitable for all assigned individuals. Finally, some patients respond adversely to certain environments no matter how therapeutic they may seem. For example, detached and schizoid patients may not be able to tolerate the overload of stimuli characteristic of some programs (Van Putten, 1973).

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

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

Home treatment is a modality through which inaccessible patients may be reached before a crisis makes hospitalization inevitable (Becker & Goldberg, 1970; Goldberg, HL, 1973). It is especially applicable to disturbed individuals who are unable or unwilling to seek psychiatric help. For such people a team effort is best. That a visiting team sees the patient in the family and customary social setting facilitates diagnosis and treatment planning. In many cases, the visit promotes greater confidence and trust and elicits far less anxiety than would be the case in a strange setting like a hospital clinic. The interdisciplinary team with the different backgrounds of its constituent members can improve the quality of the total evaluation. The interaction of the entire family at the initial home visit permits a better

understanding of the dynamics that have led to the upset in the identified patient. Although home treatment may seem an expensive process, the cost to the community is probably less than maintaining the patient in an institution and providing aftercare. When several visits have been made, sufficient confidence may be inspired in the patient to be motivated to continue contacts with one or more members of the team in the central clinic. Family therapy and drug treatment are particularly suitable in home treatment: paranoidal patients have benefited from the use of long-acting injectible phenothiazines at intervals of 2 weeks (Goldberg, et al, 1970).

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

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

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

Hospitalization will occasionally be needed. When considering hospitalization for an acutely disturbed, depressed, or psychotic patient, it is important to recognize the disadvantages and advantages of removing the individual from the situation to which that individual will have to adjust on returning home. Most patients can be adequately cared for with partial hospitalization such as a well run day hospital. Research studies show that this resource is to be preferred in the majority of cases and yields better results than full hospitalization (Herz et al, 1971; Washburn et al, 1976). However, if the patient is too disturbed or uncooperative, or if suicide is likely, admission to an institution may be advisable for the protection of that person and others. What must be considered then is whether emotional stabilization is the preferred goal. Under these instances, a short-term crisis-oriented period of patient care of 1 to 3 months may suffice. However, where deeper structural personality changes are the objective for persons who have the capacity for such change but who resist altering their behavior, a longer period of hospitalization—1 year or more will be required. In the latter case, the referring therapist should ascertain that the staff of the hospital contains professionals trained in approaches that aim for deeper changes. Instead of hospitals, many rehabilitation units exist that may be ideally suited to some patients. It may be productive for a therapist to visit some of the rehabilitation facilities in the area to see what services they render. Some patients may be better suited for sheltered workshops than for other programs. Still others will need halfway houses that act as a bridge to community living. What is essential is the formulation of a plan both for immediate care and for therapy after the critical situation that necessitates referral has subsided. Guidelines are suggested in the book by Frances et al, 1984.

A *day hospital* may, in many cases, serve as a substitute for hospitalization (Budson, 1973). The cold impersonal institutional setting is replaced by a small intimate familylike atmosphere in which the individual may find a suitable identity. In a controlled study, investigators at the Washington Heights Community Service of the New York State Psychiatric Institute discovered that “on virtually every

measure used to evaluate outcome, there was clear evidence of the superiority of day treatment." Small community-based residential facilities in the form of *halfway houses* or neighborhood residences have also been increasing in great numbers for alcoholics, drug addicts, criminal offenders, maladjusted youths, and persons variously handicapped physically and psychiatrically. These facilities may serve as intermediate stations for the mentally ill patient after institutionalization, as a preliminary step to reentry into community life. They may also function as a form of continuous aftercare (Axel, 1959; Bierer, 1951, 1959, 1961; Boag, 1960; Cameron, DE, 1947; Cameron, DE, et al; 1958; Carmichael, DM, 1960, 1961; Cosin, 1955; Craft, 1958, 1959; Fisher, SH, 1958; Goshen, 1959; Harrington & Mayer-Gross, 1959; Harris, A, 1957; Jones, CH, 1961; Kramer, BM, 1960; Kris, EB, 1959; Odenheimer, 1965; Rafferty, 1961; Robertson & Pitt, 1965; Steinman & Hunt, 1961; Winick, 1960; Zwerling & Wilder, 1964). Obviously, emptying out mental hospitals and throwing sick patients onto the mercies of a community without adequate alternative rehabilitative facilities can be a disaster for both the patients and the community. What is essential is that the environment to which patients are assigned be organized as a "therapeutic community," which is more easily said than done.

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

In rehabilitative planning, the focus may be on the individual's physical work problems or social difficulties rather than on total functioning. The skills brought into play here often involve a multidisciplinary approach, including methods and techniques from medicine, surgery, psychology, pedagogy, mechanics, sociology, etc. (Greenblatt & Simon, 1959; Schwartz, CG, 1953; Bauman & Douthit, 1966; Eustace, 1966). Some of the beneficial emotional effects of rehabilitation come from the sense of mastery that is restored to the individual when the handicap is overcome for which help was sought.

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

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

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

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

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

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

EXTERNALIZATION OF INTERESTS

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

Occupational Therapy

Among the best organized activities, universally employed in mental institutions, is occupational therapy, which has proved itself a vital means of restoring the individual through the relationship with the occupational therapy worker, the symbolic meaning to the therapy worker of the tools used, and the end products of his or her manipulations, toward a more adequate integration (Am. Occup. Therap. Assn., 1972; Dunton, 1915, 1945; Fiddler, 1957; Haas, 1946; Linn, 1975; Linn et al, 1962; Meyer, 1922; Schaefer & Smith, 1958; Sub-comm. Occup. Therapy (no date on publication); Wittkower & La Tendresse, 1955). Occupational therapy is more than merely recreational and diversionary. It may be the sole means of entering into the inner world of the withdrawn and regressed patient. The occupational therapy worker has become an important and respected member of the psychiatric team (Conte, 1962).

As such, the therapy worker must be capable of providing adequate support and understanding for patients whose stability is at best tenuous and who are hostile, defeated, and uncooperative. At the same time the occupational therapy worker must be able to set limits and to apply adequate controls when necessary. The ability to detect, understand, and help the patients to work through conflicts as they manifest themselves in the patient's performances and relationships with fellow patients requires a high degree of training, perceptiveness, and stability. Facilitating these aims are an understanding of both rehabilitation and psychodynamic concepts.

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

Quality assurance is an objective of the American Occupational Therapy Association that has a membership of over 35,000 professionals. The Association as well as the Committee on Allied Health Education and Accreditation set standards for training and practice. Certification as an occupational therapist requires completion of standard training and full-time field work. Registration and licensure are necessary for practice in many states.

THE CREATIVE ARTS THERAPIES

Among the creative arts therapies, art therapy, music therapy, drama therapy, and dance movement therapy have been developing rapidly as adjuncts to the more traditional psychotherapeutic procedures, in addition to serving as supportive and educational methods in their own right. Recognizing the usefulness of these modalities especially with the chronically mentally ill and severely disturbed children and adolescents, legislation was formalized during the late 1970s in the Mental Health Systems Act that resulted in new federal job classifications in the creative arts therapies and thus vitalizing these fields of therapeutic activity. Originally designed for use in hospitals and institutions, these methods are

increasingly being utilized with individuals, their families, and other groups in outpatient clinics and even private practice. Standards of training, qualification, certification, registration, and licensure have been developed by emerging national organizations that are related to each area of the creative therapies, and research and writings have been increasing steadily in the last few years as a consequence of this ferment.

Art Therapy

Art therapy has become more formalized over the past decades and has developed from a casual technique used with children in clinics and with withdrawn patients in mental institutions to a sophisticated vehicle, which in the words of the American Art Therapy Association, is capable of "reconciling emotional conflicts and fostering self-awareness and personal growth." In this way it may serve as a bridge to help an individual "find a more compatible relationship between his inner and outer worlds." Understandably, art therapists trained in different theoretical schools will fashion their methods and interpretations around their special orientations whether these be behavioral, Gestalt, humanistic, psychoanalytic, etc. They will also devise uniquely personal ways of conducting the art session and of relating themselves to a co-therapist or team, if there be one, in an adjunctive collaborative, or supervisory way. Art therapy may be done individually, in groups, or with families. With schizophrenic patients, art therapy helps to bring them out of their regressive state and to establish a relationship with a helping individual. Kwiatkowska (1967) has developed a popular evaluation method for art therapy candidates that designates strengths, weaknesses, and family interactions. The diagnostic value of children's drawings in learning disabilities has been pointed out and detailed by Levick et al. (1979).

Music Therapy

There is an inherent quality in sound that tends to calm or disturb, contingent on its physiologic and psychological effects. Thus, sudden loud noises may arouse fear and apprehension; coordinated musical resonance may evoke pleasure; rhythmic cadence stimulates motor activity and relieves tensions; dissonant and shrill reverberations promote tension and may actually be experienced as painful. Sounds influence both cortical and subcortical areas, affecting the autonomic nervous system.

Harmonious and rhythmic tones can arouse emotional feelings, promoting happy, excited, and sad moods. For this reason, increasing interest has been shown in the use of music in medicine (Gaston, 1968; Licht, 1946; Mathews, 1906; Nordoff & Robbins, 1977; Ruud, 1980; Reese, 1954; Schullian & Schoen, 1948; Stein & Euper, 1974; Walters, L, 1954; Zimney & Weidenfeller, 1978). A *Journal of Music Therapy* exists with many interesting articles on the subject.

There is little doubt that music can stimulate, relax and sedate, depending upon past associations and present symbolic significances (Colbert, 1963). Accordingly, it has been employed in various ways in both psychotic and neurotic patients (Altshuler, 1944; Blaine, 1957; Blair et al, 1960; Folsom, 1963; Gutheil, 1954; Ishiy-ama, 1963; Jenkins, 1955; Joseph & Heimlich, 1959; Masserman, 1954; Muscatenc, 1961; Pierce et al, 1964; Reinkes, 1952; Rogers, 1963; Rose et al, 1959; Simon, B, et al, 1951; Soibelman, 1948; Winick & Holt, 1960b; Wortis, 1960). In some cases comprehensive programs have been organized around music appreciation assemblies, rhythm bands, singing groups, and concert and community singing clubs (Van de Wall, 1936; Soibelman, 1948; Gilliland, 1961, 1962), providing the means for both personal achievement and socialization. In hospitals, day hospitals, and other settings background music may help release tensions, allay fears, provide an escape from boredom, and encourage teamwork (JAMA, 1956).

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

correction of speech impairment, and (7) to facilitate transition from nonverbal to verbal codification systems. In this way, music becomes an adjunctive therapeutic agent, and the music therapist who is properly trained may be employed constructively as part of a team in a treatment program. The education and professionalism of music therapists is constantly being improved and monitored by the National Association of Music Therapy and the American Association of Music Therapy.

Drama Therapy

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

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

and restraint in free expression.

Role playing brings out both stable patterns of behavior and styles of interaction, as well as fleeting undercurrent inhibitions and impulsive outbursts that are both constructive and destructive in their consequences. What is especially interesting is the relationship of the actor to the role that is being played, as well as the interactions with the other actors in the play (McReynolds & DeVoge, 1977) (see also Psychodrama, Chapter 52).

Dance and Movement Therapy

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

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

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

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

Structural Integration

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

Poetry Therapy

A new ancillary technique, poetry therapy had its inception in Greenwich Village, New York, when

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

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

Social Therapy

The protected atmosphere of an institution, clinic, or agency encourages the organization of groups that can participate in a full spectrum of social activities (Bierer, 1943, 1958; Palmer, MB, 1958; Wechsler, H, 1960b). At the Postgraduate Center for Mental Health, in New York City, a program has been in operation for years that offers the individual who is or has been in psychotherapy expressive opportunities for emotional growth and development (Fleischl, 1962; Fleischl & Waxenberg, 1964; Waxenberg & Fleischl, 1965; Fleischl & Wolf, 1967). An environment is provided that is favorable for the overcoming of detachment, aggression, and social isolation. While patients may have gained insight through psychotherapy into their characterologic distortions, they may be unable to overcome these

defects in their usual environment that customarily imposes harsh penalties for even minor deviations. A therapeutic social club fosters real life experiences through interaction with other persons, directly or by means of such creative activities as arts, crafts, games, reading, dramatics, dancing, and music. Parties, visits to museums, and attendance at plays and outings provide further possibilities for rich experiences. The influence of group dynamics here cannot be discounted, many deviant patterns altering themselves in the relatively tolerant setting of the club. Group psychotherapy and vocational rehabilitation are often coordinately employed.

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

REASSURANCE

Reassurance is a partner in all psychotherapies, even where there is purposeful avoidance of pacifying consolations. The very presence of the therapist serves to conciliate the patient, apart from the auxiliary agencies of placebo and suggestion. This is especially the case in severely upset patients who, lacking the capacity to handle their anxiety through their own resources, seek comfort in the shadow of an idealized parental figure. Coming to therapy, therefore, in itself constitutes for the patient an inspiration that he or she is not hopeless.

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

thinking patterns.

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

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

PRESTIGE SUGGESTION

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

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

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

Generally, patients will tend to select from the content of what the therapist says or implies certain things they want to hear, to which they feel it important to respond. However, suggestion may be used deliberately by some therapists in the form of directives delivered with authoritative emphasis to

influence the patient in calculated ways. A positive and optimistic bearing on the part of the therapist helps reduce anxiety that the situation is hopeless and encourages motivation to address the tasks of therapy.

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

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

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

Abolishing the tic can influence the individual's general adjustment materially. A patient with a paralytic limb of psychological origin may be restored to economic usefulness, and that patient may benefit emotionally to a point of satisfactory social rehabilitation.

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

Among the techniques employed to reinforce prestige suggestion, *hypnosis* is paramount (Wolberg, LR, 1948). The peculiar powers vested in the hypnotist make the subject absorb suggestions with greater readiness than in waking life. But even with hypnosis as a reinforcing agent, the permanence of suggestions may be limited where symptoms serve important coping purposes or where strong conditionings have been organized, as in certain phobias. No symptom will be readily abandoned that neutralizes intense anxiety or possesses powerful pleasure values.

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

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

The relapse rate among disabled patients who have had their symptoms removed purely by suggestion is understandably substantial. Needless to say, the chances of helping a patient permanently are much greater where one does a reintegrative kind of therapy that treats the problem source. The

concomitant rebuilding of ego strength and inner security gives the person the best chance of remaining symptom-free, even in the face of a disturbing precipitant. In suggestive treatment, where no change has developed in the intrapsychic structure, there is always the possibility of a relapse. This, however, is not inevitable; the patient's life situation may get less complicated, or the patient may, as a result of therapy, develop more adaptive ways of dealing with conflict and of getting along with people. Here the loss of symptoms may be permanent.

Another objection that has been voiced to suggestive therapy, which is not entirely valid, is that it is apt to eliminate an important motivation for deeper treatment. It is said that the inconvenience and discomfort of symptoms incites the individual to want to inquire into their source. If made too comfortable by removing symptoms, incentive may be lost. Where the goal in therapy is to achieve reconstruction in the dynamic structure of the personality, suggestion or any other strongly supportive therapeutic method may thus act as a deterrent. This contingency is balanced by the paralyzing effect of strong symptoms on faith, hope, and trust. Modulating symptoms may actually be essential in keeping many patients in therapy since they will be prone to regard treatment as an unrewarding venture if they have no immediate proof regarding its efficacy toward reducing their suffering.

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

PRESSURE AND COERCION

Pressure and coercion are authoritative measures that are calculated to bring to bear on the patient rewards or punishments that will stimulate the patient toward fruitful actions. F. C. Thorne (1950) has indicated that coercive measures are useful in some dependent personalities who refuse to face life under any other circumstances than to be forced to comply. Injunctions may be of value for immature

individuals who tend to act out their problems, for persons who habitually shy away from reality, and for those who refuse to take resolute actions by themselves and manifest discouraging, indecisive wavering. In emergencies where the individual is endangering himself, or herself or others, and in uncontrolled emotionality where other methods fail, coercive devices may be mandatory.

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

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

PERSUASION

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

The persuasive technique is based upon the belief that the patients have within themselves the power to modify their pathologic emotional processes by force of sheer will or by the utilization of common sense. Appeals are made to the patients' reason and intelligence in order to convince them to abandon neurotic aims and symptoms and to help them gain self-respect. They are enlightened as to the false nature of their own concepts regarding their illness, as well as the maladaptive habits they have

formed. By presenting them with all the facts in their case, an attempt is made to show them that there is no reason for them to be ill. They are urged to ignore their symptoms by assuming a stoical attitude, by cultivating a new outlook aimed at facing their weaknesses, and by adopting an attitude of self-tolerance. In this way they are brought into harmony with their environment, and induced to think of the welfare of others.

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

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

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

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

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

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

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

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

problems would eventually be solved.

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

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

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

Dejerine (1913), using the methods of DuBois, also emphasized the "reeducation of the reason." but he stressed emotion rather than the weakened will as the basis for neurosis. He speculated that the emotions under certain conditions might overwhelm the intellect and cause illness. Dejerine believed that therapy must, therefore, aim for a liberation of the personality from the effects of harmful emotions.

The emphasis in therapy was to get the patient to talk about traumatic incidents in his or her life, especially fears and sorrows in the present. Unlike DuBois, Dejerine did not try to impose his philosophy; rather he worked toward developing an emotional relationship with the patient until a state of confidence developed. When this was obtained, Dejerine practiced persuasion to encourage the patient to correct the "bad habits." He contended that to cure nervous illness one had to fight the deceptive systems of "monism, fatalism, skepticism, and determinism." Reason could overcome obsession once emotions were given a proper outlet. It was necessary to keep salubrious ideas before the mind; to think thoughts of the noble, the just, and the beautiful; to learn to gain satisfactions by the fulfillment of duty, yet the brain had "always to be guided by the heart."

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

Psychocybernetics a term coined by Maxwell Maltz (1960), purports to change the self-image through a "teleological approach" designed after the "goal-oriented behavior of mechanical systems." The approach is essentially persuasion coupled with relaxation exercises. Change is best achieved by resourceful "experiencing." Results through diligent practice are said to be obtained in about 3 weeks. Basic to the philosophy of psychocybernetics is that there is a creative guidance system in all people that can be used as a "Success Mechanism" rather than a "Failure Mechanism." New habits of thinking, imagining, and remembering are essential and obtainable through the built-in "servomechanism" of the brain and nervous system. The reader is enjoined toward thinking about an attainable goal. Mistakes and errors are to be expected as in all mechanical systems and should encourage a change of one's course. Force through too much conscious effort is unnecessary—" 'Let it' work, rather than 'make it' work." One must employ one's *imagination* for 30 minutes daily, alone and undisturbed, relaxing, closing the eyes and picturing scenes of "acting and reacting appropriately, successfully, ideally." This practice usually

later translates itself into "acting differently without trying" in real test situations. Utilizing *relaxation exercises* also while visualizing a relaxed scene for at least 30 minutes daily, one may "dehypnotize himself' from the delusion that one is inferior or superior. There is no reason why one cannot utilize one's God-given power of reasoning to change negative beliefs and behavior, even those unconsciously determined. Errors that one makes in the present, and past mistakes, should be deliberately pushed out of the mind; successes are to be remembered and thought about. Causes of remorse *should* be examined and their absurdity emphasized. Foolish thoughts or feelings must be banished and rejected. Wrestling with false beliefs and substituting reason is vital to adjustment. Even during one's daily activities one will find time, though it be a few minutes lounging in a chair, to relax and remember briefly in detail the sensations of relaxation that one experienced during the 30-minute practice period. One may repeat to oneself, "I feel more and more relaxed." One may acquire the habit of happiness by thinking pleasant thoughts. Each morning, perhaps while tying one's shoes, one may give on-self suggestions to start the day with optimism, to act more cheerful and friendly, to anticipate success. It is essential to accept oneself as is, tolerate one's imperfections and shortcomings while striving for a goal of self-betterment. Maltz presents formulas of how to overcome failure, manage loneliness, overcome personality blemishes, and achieve peace of mind.

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

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

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

CONFESSION AND VENTILATION

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

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

Many of the patient's disturbing concerns have their origin in fantasies or misinterpretations of early childhood. Verbalization of faulty ideas gives the therapist an opportunity to correct misconceptions hitherto accepted without question. The patient may need clarification on phases of life relating to the physical functions or interpersonal relationships. Often one's preoccupations are

interpreted as unique to oneself. When assurance is gained that this is not so, that many impulses and needs are more or less universal, and that it is one's attitudes toward them that are faulty, a great deal of tension may lift.

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

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

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

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

Methods of desensitization during therapy will vary with the extent of repression. Conscious conflicts may be handled, as has been indicated, by open and unrestrained discussion. Less conscious material, however, will require techniques discussed under reeducative and reconstruction therapy. Hypnosis may be helpful as an adjunct in encouraging ventilation of feelings (Wolberg, LR, 1948).

Hypnotic drugs by intravenous injection have also been employed as a means of facilitating catharsis and desensitization. This method, termed narcoanalysis by Horsley (1943) and narcosynthesis by Grinker and Spiegel (1945), produces a hypnotic-like state that resembles, but is not similar to, hypnosis. Barbiturates, especially sodium amytal and sodium pentothal, are the most commonly used substances. With hypnotic drugs the patient may find relief in a relatively short time divulging material that would have required prolonged interviewing. Repressed conflicts and traumatic memories are released, generally producing temporary palliation. For this reason, narcosynthesis is particularly applicable to the acute neuroses of war, especially in dealing with functional amnesic states and conversion symptoms. The released material is worked through in a waking state in the hope of insuring more permanent results. Where this happens, the techniques employed are no longer supportive; rather, they embrace reeducative or reconstructive stratagems. Narcosynthesis is not so effective for conflicts that date back in time, even though considerable emotional catharsis may be achieved. What is required is a rather long-term working through of the accretions of defense that serve in the interests of repression.

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

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

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

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

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

SOMATIC THERAPIES

While they cannot be considered forms of psychotherapy, the somatic therapies are useful adjuncts. The studies of Sakel (1938) on insulin coma, of Meduna (1950) on convulsive therapy with cardiazol, of Cerletti and Bini (1938) on electroshock, and of Delay and Hart (1952), and Delay and Deniker (1960, 1961) on chlorpromazine introduced a new era into uses of the somatic treatments (Kalinowsky & Hoch,

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

PSYCHOACTIVE DRUGS

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

According to the current hypothesis, some forms of depression, namely, the endogenous depressions, are produced by a relative diminution of the neurotransmitters norepinephrine, and serotonin in the synapses. The antidepressant drugs are believed to enhance the synaptic actions of the neurotransmitters, the tricyclic drugs by inhibiting the reuptake process, the monoamine inhibitors by blocking the action of the enzyme monoamine oxidase thus increasing the concentration of the neurotransmitters. Some authorities believe that electroconvulsive therapy (ECT) similarly acts by enhancing the synaptic actions of norepinephrine. It is believed that some of the symptoms of schizophrenia are due to overactivity of dopamine transmission, and there is evidence that neuroleptics such as the phenothiazines and butyrophenones exert their antipsychotic effects by blocking dopamine receptors. The benzodiazepine antianxiety drugs are believed to act by facilitating the synaptic

inhibitory actions of the neurotransmitter GABA.

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

The fear expressed by some professionals, especially those practicing reconstructive therapy, that an anomalous guidance-supportive element is introduced into the relationship by administering medications has not proven itself to be a valid contraindication. On the contrary, there is growing evidence that the prescription of essential medicaments tends to enhance the working relationship, making the patient more cooperative in therapy. As with any other intervention, some patients may exhibit toward drugs psychological reactions in the form of neurotic defenses and disturbed personality responses. Such reactions may reveal important aspects of the personality that productively may be examined and analyzed as part of the psychotherapeutic operation. In reconstructive therapy this can provide grist for the analytic mill.

By their action on the brain, psychoactive drugs influence such provinces as perception, discrimination, conditioning, reasoning, learning, conflict, and motor behavior. Drug effects depend on their depressant or stimulant impact on neutral masses. Thus, the barbiturates depress the neocortex, reticular formation, limbic system, and hypothalamus while stimulating the thalamus. The substituted

alkenediols (meprobamate) depress the thalamus and limbic system. The Rauwolfia derivatives (reserpine) stimulate the reticular formation and limbic system, depress the sympathetic mechanisms of the hypothalamus (at the same time that they activate parasympathetic mechanisms), and deplete cerebral amines (serotonin, norepinephrine). The phenothiazines depress the reticular formation and sympathetic mechanisms of the hypothalamus, stimulate the thalamus and limbic system and have antiadrenergic properties. Table 9-1 illustrates some of the presumed effects of different drugs.

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

Table 9-1
Brain Functioning and Psychoactive Drugs

Brain Area	Function	Chemical Effect	Drug
Neocortex	Thinking; reasoning	Stimulation	Caffeine, Amphetamine (1), Methylphenidate (10)
		Depression	Barbiturates (3), Nonbarbiturate Hypnotics (11)
Thalamus	Integrating sensation; transmitting and modulating alerting impulses	Stimulation	Barbiturates (3), Phenothiazines (13)
		Depression	Meprobamate (9)
Reticular formation	Alerting; integrating emotional responses to stimuli	Stimulation	Rauwolfia derivatives (14) (small doses)
		Depression	Phenothiazines (13), Barbiturates (3), Rauwolfia derivatives (14) (large doses). Amitriptyline (2), Imipramine (7), Methylphenidate (10), Nonbarbiturate Hypnotics (11), Thioxanthenes (16), Butyrophenones (17)
Limbic System	Regulating emotions	Stimulation	Phenothiazines (13), Rauwolfia derivatives (14), Thioxanthenes (16), Butyrophenones (17)
		Depression	Meprobamate (9), Barbiturates (3), Chlordiazepoxide (4), Diazepam (5), Oxazepam (12), Tybamate (15), Hydroxyzine (6)
Hypothalamus	Controlling autonomic and	Stimulation	*MAO inhibitors (hydrazines)(8). Amphetamine (1)

	endocrine functions	Depression	Phenothiazines (13), Rauwolfia derivatives (14), Barbiturates (3), Thioxanthenes (16), Butyrophenones (17)
Synapses	Transmitting nerve impulses	Stimulation	Rauwolfia derivatives (14), Acetylcholine
		Depression	Epinephrine, Amphetamine (1), Mescaline, LSD, Imipramine (7), Amitriptyline (2), Gamma Aminobutyric Acid
Interneuronal circuits	Coordinating neuronal masses	Depression	Meprobamate (9)
Neurohormonal depots (serotonin, norepinephrine. etc.)	Regulating brain metabolism	Stimulation	MAO inhibitors (8), Imipramine (7)
		Depression	Phenothiazines (13), Rauwolfia derivatives (14) Benzoquinolizenes, Thioxanthenes (16), Butyrophenones (17)

* Electroconvulsive Therapy is said to stimulate the posterior hypothalamus (Gellhorn et al. 1963).

(1) Amphetamine (Benzedrine. Dexedrine, etc.); (2) Amitriptyline (Elavil); (3) Barbiturates (Phenobarbital. Pentothal. Seconal, etc.); (4) Chlordiazepoxide (Librium); (5) Diazepam (Valium); (6) Hydroxyzine (Vistaril); (7) Imipramine (Tofranil), Desipramine (Norpramin, Pertofrane); (8) MAO inhibitors (Nardil, Marplan), Niacin, etc.; (9) Meprobamate (Equinal. Miltown); (10) Methylphenidate (Ritalin); (II) Nonbarbiturate Hypnotics (Doriden. Noludar, etc.); (12) Oxazepam (Serax); (13) Phenothiazines (Thorazine. Stelazine. Mellaril, Trilafon, Permitil. etc.); (14) Rauwolfia derivatives (Reserpine etc.); (15) Tybamate (Solacen); (16) Thioxanthenes (Taractan. Navane); (17) Butyrophenones (Haldol).

From Wolberg LR: Psychotherapy and the Behavioral Sciences. Orlando, FL, Grune & Stratton, 1966.

The neuroleptics have a calming effect in tension and anxiety as well as a controlling (antipsychotic) influence in schizophrenic and orgnic psychosis, producing what has been referred to as a "chemical lobotomy." The neuroleptics (phenothiazines, Rauwolfia derivatives, thioxanthenes, tricyclic antipsychotics, butyrophenones; dihydroindolones) suppress conditioned avoidance behavior and reduce aggressive activities in animals. Anxiolytics (meprobamate, diazepam, chlordiazepoxide, etc.) have an effect on mild to moderate anxiety. Antidepressants (tricyclics, MAO inhibitors) reduce psychomotor retardation, whereas psychostimulants (amphetamines, methylphenidate, oxazolidine,theionized caffeine) increase alertness and enhance physical and mental activity. Psychotomimetics (mescaline, psilocybin, [lysergic acid diethylamine] LSD) act as toxins to nerve tissue, inducing "model psychoses." Table 9-2 outlines the therapeutic uses of the more popular drugs.

Table 9-2
Symptomatic Uses of Psychoactive Drugs

Desired Drug Effect	Drug
Enhancing cortical activity	Amphetamine (Benzedrine, Dexedrine, Dexamyl), Methylphenidate (Ritalin),

(facilitating alertness and thinking)	Caffeine
Diminishing excessive cortical activity (producing calming and sedation)	Barbiturates (Phenobarbital), Nonbarbiturate hypnotics (Doriden), Bromides (Triple Bromides)
Controlling anxiety and tension	Diazepoxides (Valium, Librium)
Elevating mood (overcoming depression)	Amphetamine (Benzedrine, Dexedrine, Dexamyl), Methylphenidate (Ritalin), Mono-aminooxidase inhibitors (Nardil, Parnate, Marplan), Amitriptyline (Elavil), Imipramine (Tofranil), Desipramine (Pertofrane, Norpramin)
Eliminating apathy (especially in borderline or schizophrenic states)	Phenothiazines with a piperidine or piperazine ring on side chain (Mellaril, Stelazine, Trilafon)
Inhibiting excitement, confusion, tension, and anxiety (especially in schizophrenic and manic states)	Phenothiazines (Thorazine, Mellaril), Thioxanthenes (Taractan, Navane), Butyrophenones (Haldol)
Restoring mental integration (controlling hallucinations and delusions)	Phenothiazines (Thorazine, Mellaril, Stelazine, Permitil, Trilafon, etc.). Rauwolfia derivatives (Reserpine), Butyrophenones (Haldol)
Producing "model psychoses" (for abreactions and hypermnesia)	LSD, Mescaline, Psilocybin

From Wolberg LR: Psychotherapy and the Behavioral Sciences. Orlando, FL. Grune & Stratton. 1966.

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

Psychostimulants that are clinically useful include the sympathomimetic amines. Amphetamine and its derivatives (Benzedrine, Dexedrine, and Desoxyn) are employed to combat fatiguability and lack of interest and drive (Myerson, 1936). In doses of from 5 to 10 milligrams twice daily, amphetamine is used to relieve mild depression to produce a sense of well-being and vitality in patients who complain of lack of energy and a sense of exhaustion. It is used also temporarily in certain cases of alcoholism and drug addiction. In children its effect is extraordinary in that hyperactivity and excitability are reduced in aggressive and disturbed youngsters (Bradley, 1950) and those suffering from attention deficit disorders. This reaction is also observed in excited schizophrenics, helping to reduce the need for sedatives and hypnotics (Bis-choff, 1951). Great caution must be exercised in prescribing amphetamine drugs since more than temporary use may result in addiction and where large doses are employed, a paranoid psychosis may be produced (Connell, 1958; Leake, 1958). These drugs have been placed on the list of compounds whose prescription is controlled by the federal government.

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

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

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

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

Antipsychotic drugs (neuroleptics) are noted for their influence on psychotic states. Most prominent of these are the phenothiazines, which have not only effected a revolution in the management of the disturbed mentally ill in institutions but have permitted a return of previously hopeless patients to the community. Because of serious side effects and sequelae, supervision is necessary. Among the neuroleptics, thiothixene (Navane), haloperidol (Haldol), and molindone (Moban) have been enjoying increasing popularity. Chlorpromazine (Thorazine) still continues to be used, with thioridazine (Mellaril) an adequate substitute. Greater antipsychotic potency is possessed by

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

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

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

Experimental studies with *psychodysleptics* (psychotomimetic, hallucinogenic, or psychedelic

drugs) particularly mescaline, LSD, and psilocybin are indicative of the contemporary efforts that are being made to correlate neurophysiologic, biochemical, and psychological processes that have both heuristic and practical value. Psychodysleptic drugs effect the individual in a number of ways. First, they encourage a psychotic-like experience with panic, grandiosity, paranoid delusions, impairment of reasoning and depression being most common. Second, they introduce a unique, often lucid, mode of seeing problems from a unique perspective. Third, there is a change and intensification in sensory perception. Fourth, an upsurge of unconscious or preconscious ideation occurs with reliving of past incidents or symbolic portrayal of conflicts. Fifth, distortion of ego boundaries is accompanied by peak cosmic transcendental or mystical experiences. According to Pahnke et al., (1970) who worked with the drug at the Maryland Psychiatric Research Center, the effects of LSD "can be an enhancer of skilled psychotherapy when integrated with an intensive psychotherapeutic program of sufficient duration (30 to 50 hours)." This conclusion was generally endorsed by a sizable number of investigators who believed that the administration of the psychotomimetic drugs, usually LSD, was justified as an adjunct in psychotherapy since ego defenses become weakened and the patient is better able to reveal himself or herself (Savage et al, 1969; Kurland et al, 1971; McCabe et al, 1972; Savage & McCabe, 1973; Grinspoon & Bakalar, 1985). The effects, however, cannot be predicted being dependent on the method of administration, the state of patient immediately prior to treatment, the surroundings, and the attitude and activity of the therapist. There is little agreement regarding the conditions that may be benefitted. Some observers believe anxious, upset, obsessional, and hysterical patients are most responsive (Sandison et al, 1954; Cutner, 1959). Other therapists exclude such patients (Cohen, S, 1960). Some are of the opinion that psychopathic personalities and alcoholics are helped most. Others restrict the use of LSD to detached, inhibited, and uncooperative patients. There is little question that channels are opened to forgotten or repressed memories and that the abreactive effect may be great. How therapeutic this will be is another matter. In patients who find it difficult to make contact with their inner feelings, and who have gained little from prolonged psychotherapy, hallucinogens may prove to be a means toward greater reexamination of the self. Its specific effect cannot be dissociated from the placebo influence, emotional catharsis, suggestion, and other auxiliary healing forces. The coordinate use of psychotherapy is mandatory and the manner of its employment will have a determining effect on the results (Crocket et al, 1963).

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

Miscellaneous Drugs

Tonics and vitamins are indicated in instances of dietary deficiency. Where there is evidence of specific glandular impairment, appropriate hormones may be employed (Hoagland, 1957; Paredes et al, 1961). The most commonly utilized products are thyroid and estrogenic and androgenic hormones. During physiologic upsets in the involutional period, natural estrins (Premarin), and stilbestrol and other synthetic estrogenic hormones, have been found useful. Androgens, such as testosterone (Oreton), are prescribed in males who show a deficiency in this hormonal substance, manifested in waning libido, muscular weakness, and atony.

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

disorders, pyromania, and schizoaffective disorders, but its value here is not as yet as fully established as with the bipolar disorders.

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

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

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

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

Miscellaneous somatic therapies. As might be expected a host of somatic therapies have been introduced that have not proven themselves to be of lasting value. Among these are implantation of brain pacemakers, detoxification procedures as with hemodialysis, desensitization with histamine, administration of acroagonine suspensions and acetylcholine, cerebral oxidation procedures, cerebral pneumotherapy, use of a hyperbaric chamber, and acupuncture. Where a pateint has faith in any of the above or other procedures, and the therapist applies them with conviction and enthusiasm at least temporary improvement may be expected purely through the placebo and relationship dimension.

CONVULSIVE THERAPY

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

An anesthetic agent (Pentothal, Surital, Brevital), atropine, and a muscle relaxant (succinylcholine chloride—Anectine) administered prior to the electrical stimulus, reduce discomfort and eliminate skeletal complications. To minimize the memory loss, unilateral ECT rather than bilateral ECT may be employed, though in the opinion of some, a somewhat attenuated antidepressive effect results (Abrams, 1972; Abrams & Taylor, 1976). This is disputed by other unilateral ECT advocates who claim equal antidepressant effects provided the induced seizure is adequate. *Indokolon* (hexafluorodiethyl ether) administered by inhalation is an alternative method of inducing convulsions (Krantz et al, 1957; Esquibel et al, 1958; Karliner, 1966). It is employed by some therapists when regular ECT treatments are unacceptable or have failed. Since it is not manufactured in the United States it may be difficult to obtain.

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

ELECTRONARCOSIS AND ELECTROSLEEP

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

Utilization of weak electrical currents have been employed to produce behavioral and subjective relaxation without concurrent changes in heart rate, blood pressure, and respiratory rate (Rosenthal, SH, 1971). Improvement in anxiety, depression, and sleep disturbance has been claimed (Rosenthal, SH, 1972). The best results have been obtained with chronic anxiety and tension states. However, Frankel, BL, et al. (1973) reported an ineffectiveness of electrosleep in chronic insomnia. Treatments are usually given from 3 to 5 times weekly, each session lasting i hour, treatment current ranging from 0.5 to 1.5 milliamps. In this age of electronics we may expect that the mysterious equipment trappings have great placebo value for some patients. The relaxation induced, which may proceed to a hypnotic state, increases the suggestive dimension. A rapid positive relationship with the therapist is also established. Whether there are specific therapeutic effects beyond these intercurrent influences is difficult to say.

INSULIN COMA

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

PSYCHOSURGERY

Psychosurgery is only rarely done today being restricted to long-term, disabling, severe psychiatric illness after all medicinal, somatic, and psychosocial procedures have failed after being tried for at least one year (Freeman & Watts, 1942). The most frequent condition for such a radical intervention is endogenous depression that has not responded to antidepressant drug treatments as well as ECT.

Sometimes psychosurgery is done to eliminate long-term unmanageable pain not helped by any other method. A much less frequent indication has been intractable obsessive-compulsive neurosis and, even more rarely, schizophrenia with affective symptomatology.

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

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

INSPIRATIONAL GROUP THERAPY

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

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

Inspirational group therapy is also employed as part of a psychotherapy program by some therapists who claim beneficial effects for it, including the mastery of symptoms, the institution of self-discipline, the tolerance of anxiety and tension, and the repression of antisocial impulses and drives (Pratt, 1934; Rhoades, 1935; Harris, HI, 1939; Wender, 1940; Blackman, 1942). The patient feels an acceptance in the group that could not be experienced elsewhere. The patient finds that he or she can be self-expressive and that admitting to certain strivings does not make one "bad" or worthless in the eyes of others. The patient may eventually discover that status can be gained within the group. Emphasis is upon day-to-day victories, self-control, finding new social outlets, and strengthening will power.

Herschelman and Freundlich (1972) have described an inspirational group experience in working with a large group of patients utilizing multiple therapists. Group therapy meetings were held at the Philadelphia Naval Hospital inpatient psychiatric service attended by the entire patient population of 35 to 45 patients and staff (5 psychiatrists, 2 or 3 psychiatric residents, 2 hospital corpsmen, and 1 psychiatric nurse). Meetings were of one hour's duration on a weekly basis. Most of the patients were poorly motivated for formal psychotherapy, and the staff at first was resistant, passive, and

non-participant. As the latter gradually resolved their anxiety, they became more enthusiastic and participant. Staff-patient conference techniques were utilized such as those proposed by Berne (1968) in the spontaneous meetings held immediately after large group sessions. The results exceeded expectations and point to the advantage of utilizing multiple therapists rather than single therapists with large groups.

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

The self-help movement has been gaining momentum over the years, many taking the form of "therapeutic clubs" of members suffering from various habit, behavior, and psychiatric disorders. Curiously, some of the most stubborn problems that resist the ministrations of professional personnel appear to be benefitted by group experiences without the presence of a therapist, in which the patients relate to each other and share their past experiences, present difficulties, and progress with peers suffering from similar ordeals and backgrounds. Perhaps the oldest group of a self-help type is Recovery, Inc., consisting of former mental patients. Founded in 1937 by Abraham Low, Recovery, Inc., has rendered service to many thousands of patients. At present there are hundreds of such groups in the United States. They are generally headed by nonprofessionals drawn from the membership. At their meetings a panel discussion format is employed with the leader selected from the group and trained along lines of Low's book *Mental Health Through Will-Training* (1952). Hanus J. Grosz (Psychiatric News, 7, [14], 1972, 1973; and 8, [12], 1973) has studied and reported positively on the results of Recovery, Inc., as a resource that is available to many patients who otherwise would have no other form of help available to them.

Many other self-help groups have flourished because they provide a helping resource that for considerable numbers of individuals eclipses that provided by trained professionals. Why this is so is still shadowy, but such factors undoubtedly operate as fear of and subtle antagonism against authority as vested in traditional psychiatry and psychology, the presence in the group of individuals with whom the person can identify, the opportunity for modeling by group leaders who have overcome destructive

habits the person seeks to relinquish, opportunities for constructive group interaction and postgroup companionship, the force of peer pressure to maintain improvement, and other bounties of group dynamics. Economic factors also play a part especially for those on meager incomes since attendance is usually free or at a low cost.

To a large extent the success of these movements is related to the leaders who run them. Intelligent, empathic yet firm direction is essential in running a group of this kind due to the inherent personality problems of members who seek help, particularly those who have difficulty with authority and with interpersonal relationships in general, borderline cases, severe obsessive-compulsives, paranoidal individuals, and psychotics. Many have tried outpatient resources and private therapists without success. They require special reassurance and the installation of hope. Members are usually most responsive to a warm, non-authoritarian yet structured environment, led by leaders who have experienced and conquered the devastation the members themselves have gone through. The leader must consequently be relatively free from emotional illness and capable of dealing with transference and personal countertransference. This will usually require training and some personal therapy that some leaders refuse to accept. Self-help groups that run into problems generally are victims of poor or destructive leadership. In leaderless self-help groups, the most aggressive individuals with needs for control usually take charge, which may cause difficulties unless the other members are strong enough to prevent the leader from becoming too dictatorial.

Alcoholics Anonymous (see Chapter 60) particularly has inspired many self-help groups. These include Narcotics Anonymous (NA) for persons seeking to overcome narcotic addition, as well as Nar-Anon for their families; Pills Anonymous (PA) for those habituated to various sedatives, tranquilizers, hypnotics, and stimulants, and Pil-Anon for their families; and Overeaters Anonymous. All of these organizations allege themselves to be nonprofit societies with no initiation fees or dues and are self-supporting through their own contributions, with no affiliations with any sect, denomination, politics, organization, or institution. In all of these habit controlling groups 12 steps toward recovery are presented. The individual is enjoined (1) to admit and accept one's inability to manage one's life single-handedly, (2) to recognize that only a Power, an ultimate authority greater than oneself, can restore one to health (this Power can be God, a force in the Universe, the group in itself, or nature), (3) to decide unequivocally to turn one's life and will over to this Power; (4) to make a searching and fearless moral

inventory of oneself; (5) to admit the exact nature of one's wrong to oneself, to God (or the Power) in order to remedy one's defects of character, (7) to ask this Power to remove one's short-comings, (8) to list the people one has harmed and be willing to make amends to them all, (9) to see that such amends are made if possible except where some injury may result, (10) to continue to take a personal inventory and when wrong to admit it, (11) to improve, through meditation and prayer, one's contact with this Power as one understands it, praying for knowledge of God's (or the Power's) will and the ability to carry out what is necessary, and (12) after having a spiritual awakening, to carry this message to others in need and to practice these principles in all of one's affairs.

We may see in the 12 steps the devotional help and protection one expects of religion or other guidance resources, as well as the need to alter one's values and meaning systems such as occurs in cognitive therapy. Not insignificant also in these groups are the benefits of emotional catharsis and group dynamics. The principles and practices of groups organized for addictions and habit disorders have also been extended to general emotional problems in a self-help group calling itself Emotions Anonymous (P.O. Box 4245, St. Paul, Minnesota 55104). Other self-help groups following to some extent the format of Alcoholics Anonymous are Gambler's Anonymous and Weight Watchers. Excellent pamphlets, articles, booklets, audio tapes, films, and video cassettes dealing with self-help groups are sold by Hazelden Educational Materials (Box 176, Center City, Minnesota 55012). Branches of self-help groups, where they exist, are listed in local telephone directories.

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