THE TECHNIQUE OF PSYCHOTHERAPY

THE INITIAL INTERVIEW
MAKING A DIAGNOSIS

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The Initial Interview: Making a Diagnosis

Although diagnosis is, more or less, an arbitrary matter and should not prejudice the therapeutic approach or the goals, it is convenient to attempt classification as soon as possible.

All emotional problems spread themselves over a wide pathologic area and include a combination of intellectual, emotional, behavioral, and somatic symptoms. A disturbed character structure will be found in practically every patient, reflecting itself in difficulties in interpersonal and social relationships. One may discern, in most instances, at least mild manifestations of tension, anxiety, depression, and psychosomatic symptoms. If adaptation is being interfered with, there will appear psychological defenses singly or in combination, such as phobic, compulsive, conversion, and dissociative mechanisms. In some instances certain symptoms and defenses are so outstanding as to constitute definite syndromes. For example, the patient may complain of an inability to walk outdoors due to intense anxiety. Emphasis on this symptom tempts the therapist to diagnose the condition as a phobic disorder. Yet a search will probably reveal a concomitant personality problem, psychosomatic manifestations, depression, and symptoms characteristic of other syndromes.

What obscures diagnosis are a number of cultural determinants. Unlike organic pathology, psychological pathology is often a matter of values and standards. Whereas psychotic and severe psychoneurotic syndromes are sufficiently deviant from "normal" to be distinctive, the milder psychoneuroses and character disorders are afflictions that may pass unrecognized. Indeed, they are so common that they may not be considered in the category of disease, particularly when they are accepted in the culture or subculture in which the individual functions (Opler, 1957, 1963). Thus, within certain groups, alcoholic over-indulgence, compulsive-obsessive manifestations, and perverse sexual drives may not be considered unusual.

A diagnosis is frequently made on the basis of the most important complaint factor. This can be misleading. For example, a patient complaining of intractable insomnia may be classified as suffering from a habit disorder. Yet on examination there may be found underlying the insomnia a masked depression concealed by spurious conviviality. It is most advantageous to make a diagnosis on the basis of

the total picture, irrespective of the emphasis placed on symptoms by the patient.

RULING OUT ORGANIC SOURCES OF SYMPTOMS

It is important also, before making a psychologic diagnosis, to rule out the presence of a somatic disorder that may be inspiring emotional symptoms. In the event the patient has not had a recent physical examination, this should be recommended.

Most organic diseases are accompanied by various psychological symptoms, the latter sometimes severe enough to block the therapist from perceiving the existence or type of somatic problem. Some of these psychological manifestations result from tension aroused by a diminished sense of self-mastery because of the underlying disorder. Feelings of insecurity, helplessness, inability to function at an optimal level, fears of prolonged disability, dependency, or death will tax the coping capacities of the patient and mobilize varying degrees of anxiety. The symptom picture will depend on the individual's personality, strength of defenses, and characteristic mode of dealing with anxiety.

In addition, some emotional symptoms are inherent to certain physical illnesses. In view of the potential medicolegal problems involved in a missed diagnosis, and in service to the patient's best interests, it is important that the psychotherapist have sufficient knowledge of somatic symptoms so that any necessary referral for diagnostic studies can be made. Unfortunately, there are few pathognomanic signs so characteristic of each disease syndrome as to make possible an immediate diagnosis. The most that the therapist can do is to err on the side of caution and to secure consultative help at the least suspicion that a physical or neurological condition exists.

Epilepsy can be accompanied by alterations in emotional and behavioral expression that may be admixtures of psychologically determined personality problems and physiologically based disruptions in the pathways of the emotional centers of the brain. Periodic and inappropriate outbursts of rage, anxiety, and depression are common. Bizarre behavioral manifestations are also apt to occur and are characterized by compulsive sexual activities, inordinate food proclivities, and violence and aggression. These behavioral disorders may be anticipated and diagnosed if the patient has a history of epileptic seizures. They are not so easily diagnosed when there are no outright grand or petit mal attacks. The

only sign of organic disturbance are abnormal brain waves as recorded by electroencephalography over the temporal lobes. The test abnormalities are most pronounced when the behavioral disturbances are at a maximum. Another clinical type involves cases in which there are symptoms akin to an acute schizophrenic outbreak, with delusions, hallucinations, and disturbed cognitive functions. During symptom-free periods these manifestations are not apparent. The therapist should, consequently, be alerted to the possibility of epilepsy when the patient's history reveals fluctuating acute schizophrenic symptoms. If abnormal brain waves are discovered through electroencephalography, responsibility for therapy should be shared with a neurologist.

Brain tumors should be suspected if patients complain of headaches and display distinctive neurological signs. Such cases are relatively rare compared to the truly functional "tension" headaches, but when after long-term therapy a brain tumor is discovered, the consequences can be severe for the patient and present a potential legal problem for the therapist. The frequency of brain tumors in patients with neurotic symptoms is not known, but at autopsy in patients hospitalized for psychotic illness, the rate ranges from 1 to 2 percent. How many of these would have been operable if detected is difficult to say. Problems occur in diagnosis when brain tumors are "silent," that is, when they do not cause intracranial pressure and do not impinge on sensory and motor pathways, the effects of which may be undetectable during physical examination. Not even a neurologist, let alone a psychotherapist, can discover some early tumors. But the latter should be aware that brain tumors can mimic neurotic and psychotic syndromes, and, when it is impossible to explain confusing symptoms on the basis of dynamic formulations, a good physical and neurological examination—including electroencephalogram, skull x-ray, and diagnostic brain scan— should be obtained.

Head injuries may bring forth a host of neurotic and psychotic symptoms, including exhaustion, depression, memory impairment, confusional episodes, and vague psychosomatic symptoms. Psychological compensation for disability exaggerates and prolongs the physical symptomatology. The therapist obviously should have in the patient's records a report of a recent examination from a neurologist, and if neurological signs are discovered, work jointly with the neurologist. Other neurological conditions may be associated with neurotic or psychotic symptoms. In *multiple sclerosis,* for example, in a certain number of cases there are found emotional instability (such as silliness and giddiness) and various behavioral changes. The therapist is apt, if unaware of the patient's condition, to

credit these manifestations as well as the shifting physical signs to conversion hysteria.

General paresis, though rare because syphilis can be treated with penicillin when caught early, still occurs and may produce a variety of psychiatric syndromes, most commonly a manic type of euphoria with delusions of grandeur.

A number of endocrine conditions can be responsible for symptoms that the therapist may mistakenly credit to a functional neurotic etiology. *Pituitary disorders* may sometimes produce symptoms similar to depression and anorexia nervosa (Simmond's disease). *Thyroid disorders* are much more common, and the therapist should be alerted to *hyperthyroidism* when the patient is losing weight, sweating, and is tense, tremulous, and extremely irritable. Both overactivity and depression are possible, and in more severe cases a maniacal type of behavior with delusions may be seen. *Hypothyroidism* may be accompanied by mental apathy, sluggish speech, and dulled behavior as well as by dementia and even delirium. The physical signs of hypothyroidism—obesity, dry skin, myxedematous facies, puffiness of the hands and face, and alopecia of the scalp and eyebrows—should make the diagnosis of this condition possible. *Hypoparathyroidism,* associated with thyroid surgery can cause neuromuscular excitability, paresthesia, tonic contractions of the muscles, and impaired breathing. Neurotic symptoms such as anxiety, depression, and emotional instability are common. *Hypoglycemia* can be organic (as in tumors of the pancreas) and functional. Symptoms resemble those seen in anxiety states. Attacks often occur several hours after meals and include sweating, chilliness, trembling, headache, weakness, dizziness, apprehensiveness, restlessness, and emotional instability. Diagnosis is made by establishing, during an attack, a low glucose level (i.e., less than 40 mg/100 ml venous blood). A rapid relief of symptoms occurs with the administration of dextrose. In *hypoadrenocorticism* (Addison's disease) there is, as a consequence of atrophy or destruction of the adrenal cortex, increasing weakness, fatigue, anorexia, apathy, depression, intolerance to cold, negativism, dizziness, and syncope. If a patient displays such symptoms along with increased pigmentation over the exposed and nonexposed parts of the body, this condition should be considered and ruled out. *Hyperadrenalism* (Cushing's syndrome) is often accompanied by psychiatric symptoms (depression, delusions, hallucinations) and is due to hyperfunction of the adrenal cortex. A round "moon" face, truncal obesity, and slenderness of the distal extremities and fingers are the usual physical charcteristics in this disease. *Pheochromocytoma* (a chromaffin cell tumor of the adrenal medulla) is associated with increased release of catecholamine

hormones, norepinephrine and epinephrine. This produces persistent or paroxysmal hypertension along with symptoms that resemble an anxiety reaction: headache, nausea, sweating, pallor, and palpitation. Proper medical treatment for such endocrine disorders is generally followed by an abatement or loss of neurotic or psychotic-like manifestations.

Among common medical conditions seen are many nutritional deficiencies resulting from inadequate intake of nutrients—usually the product of poor diet, allergy, or gastrointestinal disease—resulting in vitamin, protein, or mineral deficiencies. For example, in *thiamine (vitamin B,)* deficiency, there is often a neurasthenialike syndrome that will clear up rapidly with the administration of thiamine. In severe thiamine deficiency, a condition of cerebral beriberi (Wernicke-Korsakoff syndrome) may occur in which mental confusion and aphonia are early symptoms. *Nicotinic acid (niacin) deficiency* may produce neurasthenic-like aberrations and even an organic psychosis, with confusion, disorientation, memory impairment, and confabulation in addition to the glossitis, stomatitis, and gastrointestinal symptoms characteristic of pellagra. *Vitamin C deficiency* over a long period may be accompanied by irritability, lassitude, weakness, and poorly defined muscular and arthritic pains. *Protein deficiency* may occur when the individual habitually (often as a result of a fad diet) fails to take in at least 30 grams of protein daily, Anorexia, lethargy, and weakness are common symptoms of this condition. *Hypervitaminosis,* caused by excessive intake of vitamins A and/or D may manifest itself in weakness, headaches, and tension. Vitamin B12 deficiency may produce pernicious anemia, sometimes manifested in psychotic-like symptoms such as fleeting paranoia, irritability, and depression.

In chronic alcoholics who have undergone *alcoholic withdrawal* we may observe tremor, sweating, weakness, and gastrointestinal symptoms. Severe withdrawal syndromes are characterized by delirium tremens with anxiety, confusion, insomnia, sweating, and depression. Hallucinations and convulsions may occur. Chronic excessive alcohol intake may result in *alcoholic hallucinosis,* with paranoidal delusions and hallucinations, or *Korsakoff's psychosis,* with lapses in recent memory, confabulation, euphoria, and lack of spontaneity.

A variety of rarer diseases may also be accompanied by neurotic or psychotic symptoms. In *hepatic porphyria* (acute intermittent porphyria), manifestations range from irritability, anxiety, confusion, and restlessness to delirium and hallucinations. The systemic form of *lupus erythematosis* may produce

psychotic symptoms, a complication shared also by *acute infectious endocarditis,* and *temporal arteritis* (an inflammation of the temporal arteries).

The fact that an individual has an organic disease does not mean that the person cannot benefit from psychotherapy in addition to medical treatment. Indeed, the disease may have so ruptured the individual's security mechanisms and adaptive capacities that he or she will require psychotherapy to avoid being plagued for months or years by a neurosis. If an organic cause of psychological symptoms is ruled out, the psychotherapist may proceed in the attempt at diagnosis.

A COMPREHENSIVE APPROACH TO DIAGNOSIS

If there is one great empty space in psychiatry it is in the area of nosology. Classifications are more or less inherited from late nineteenth-century pioneers, such as Kraepelin, who compartmentalized syndromes into neat, descriptive symptom clusters. Such systems have proven themselves to be surprisingly sterile in either providing an understanding of the disease process or supplying appropriate directions for therapeutic intervention. Even in so identifiable a syndrome as schizophrenia, symptomatic criteria for diagnosis are unsatisfactory, varying from doctor to doctor and hospital to hospital (Brill & Glass, 1965). D. A. Freedman (1958) appropriately deplores the lack of value of the term "schizophrenia" for purposes of understanding the etiology or approach to this illness. Moreover, emphasis on symptoms, as Kanfer and Saslow (1965) have pointed out, has resulted in efforts to change feelings, anxieties, and moods "rather than to investigate the environmental factors which produce and maintain these habitual response patterns." Questioned are the ultimate utility of current quantitative procedures for classification of psychiatric patients through objective symptom ratings programmed for computer applications (Overall & Hollister, 1964), although the validity of diagnoses by computer compares with that of interviewing clinicians.

Attempts to assort emotional problems by etiology are also unsatisfactory since the causes of disturbed behavior cannot be identified with any kind of assurance or precision (Zigler & Phillips, 1961). Collocation according to prognosis, furthermore, falls short of its mark since there are no reliable means of correlating measures of illness and responses to specific treatments (Fulkerson & Barry, 1961).

In criticisms of the medical model, suggestions have been made that it be abandoned or substantially supplemented (Scheflen, 1958; Szasz, 1960). A solution offered by Noyes and Kolb (1963) is that each diagnostic formulation be tripartite: (1) a genetic diagnosis of existing constitutional, physical, and historical-traumatic vectors; (2) a dynamic diagnosis that deals with the coping mechanisms and defenses of the individual; and (3) a clinical diagnosis that outlines the reaction syndrome, the probable course of the illness, and applicable treatment methods.

A learning-model avenue to diagnosis, presented by Kanfer and Saslow (1965), strives to assign preferred therapeutic procedures from an assessment of the patient's current behaviors and their controlling stimuli. This lends itself to pragmatic use since, as Ferster (1965) has stated, "a functional analysis of behavior has the advantage that it specifies the causes of behavior in the form of explicit environmental events which can be objectively identified and which are potentially manipulable." This way of viewing behavior—i.e., the continued evaluation of the patient's life pattern and factors that control it, with manipulation of discernible variables through such means as reinforcement and direct intervention—may, in the opinion of some therapists, lead to a more effective restoration of emotional health than efforts aimed at personally change through nonverbal therapeutic interactions (transference, self-actualization, and so on). Other proposals have been made to solidify the nosology used in psychiatry (Panzetta, 1974; Spitzer, 1975; Strauss, 1975), the current DSM-IIIR multi-axial approach being the most sophisticated.

It cannot be minimized that the present systems of nomenclature are still somewhat in a state of disarray and that proposed new groupings merely compound the confusion. Alternative proposals to scrap all systems of diagnosis have not been too helpful, although the arguments justifying this are many. Diagnostic labels do give incomplete data about etiology, prognosis, and response to therapy. They do not always help in the understanding or treatment of the presenting problem. In exceptional instances, diagnoses have been used as a means of social control to justify the apprehension, detention, and coercive involuntary treatment of patients. Diagnosis do not always designate the quantitative dimensions that differentiate average "normal" aberrations from disease. To classify all personality problems, educational distortions, and social malfunctioning as illnesses also leads to befuddlement. Moreover, it is difficult to establish in most patients a diagnosis to which even the most experienced psychotherapists would universally agree. A symptom picture may change drastically, sometimes from

day to day (as from an anxiety to a depressive reaction). Accordingly, the diagnosis revolves around a time axis, which is rarely kept in mind.

Computers, as has been mentioned, do process data that can be used for diagnosis and, on the whole, the results have been encouraging. How valuable computer programs (Smith, 1966; Sletten et al., 1971) will prove to be in solving current dilemmas about diagnosis is still problematic, but some of the computerized systems have been shown to provide diagnoses that are at least as accurate as those made by clinicians using the same protocols (Spitzer & Endicott, 1974). As the technology improves, a combination of clinician and computer diagnoses promises to provide the best results. (See Chapter 64.)

Although current systems of diagnosis are still deficient, we would be worse off without them. In a sizable number of cases, diagnosis provides facts that help assessment and offers leads toward treatment tactics. The words "feeblemindedness," "depression," "mania," "phobia," "obsession," "schizophrenia," and "psychopathic personality" bring to mind a generally valid, though perhaps incomplete, picture of the patient's behavior and suggest prognosis and suitable treatment interventions. Finally, some type of classification is insited on by insurance companies and other third-party fee dispensers. With the enactment by Congress of the Tax and Fiscal Responsibility Act (TFRA), the use of Diagnostic Related Groups (DRGs) has been mandated to determine the cost of hospital, and probably in the future psychological, medical care. From the standpoint of pragmatics the therapist must make a decision about what is being treated, and this, as may be seen from the foregoing, can be confusing: in every emotional problem all systems are implicated in major or minor degree—biochemical, neurophysiological, developmental-conditioning, intrapsychic, interpersonal, philosophical-spiritual. It may be difficult to select among these constituents the primary culprit. Here priorities in diagnosis are often determined by social and economic pressures. For example, to satisfy third-party insistence on a diagnostic label, therapists often are obliged to enter the term "anxiety disorder." This means very little in terms of identifying the real problem. But it does accomplish one thing: it gets the bill paid, which may not happen with a more descriptive and perhaps more accurate diagnosis not recognized by the reimbursement agencies.

A DYNAMIC INTERPRETATION OF DIAGNOSIS

Threats to adaptation, whether inspired by external stress or inner conflict, produce tension, anxiety, and physiological reactions associated with a disruption of homeostasis. This may result in a nascent *anxiety disorder* (anxiety state, anxiety neurosis) and/or *somatoform disorder* (anxiety equivalent, psychosomatic disorder, psycho-physiological disorder).

In general, four levels of defense are employed against anxiety: (1) conscious efforts at maintaining control, (2) characterological (personality) defenses, (3) repressive defenses, and (4) regressive defenses. The individual may stabilize at any of these levels with a disappearance of tension, anxiety, and physiologic reactions. Or the elaborated defenses may only partially control symptoms. Finally, the defenses themselves may involve the person in difficulties and may act as further foci of conflict, stirring up additional anxiety and necessitating other defenses. For instance, claustrophobia may interfere with the economic and social adjustment of the individual, and the ensuing anxiety may provoke characterological defenses, such as detachment, aggression, and dependency.

First-Line Defenses: Conscious Efforts at Maintaining Control through Manipulating the Environment

All persons employ defenses on the conscious level to lessen tension and to neutralize anxiety. Such defenses may be considered "normal." Among them are the following:

1. *Removing oneself from sources of stress:* A man irritated with work conditions may quit his job and find a less strenuous work situation.

2. *Escaping into bodily satisfactions:* Overeating, smoking, and excessive sexual indulgence may be employed as tension-relieving mechanisms.

3. *Extroversion:* Plunging into hobbies and recreational and social activities may divert the individual's attention from inner problems.

4. *Wish-fulfilling fantasies:* Indulging in daydreaming may act as a substitute gratification for unfulfilled impulses.

5. *Suppression:* Willfully keeping painful ideas or impulses from awareness.

6. *Rationalization:* Providing reality and social justifications for behavior motivated by inner needs.

7. *Use of philosophical credos:* Adoption of codes of behavior and ethics to reinforce one's conscience or to justify one's impulse indulgence.

8. *Exercising "self-control":* Forceful conscious inhibition of tension-producing impulses.

9. *Emotional outbursts and impulsive behavior:* Gaining release of tension through emotional catharsis and by acting-out.

10. *"Thinking things through":* Arriving at a rational solution of one's problems by carefully weighing alternative courses of action.

11. *Alcoholic indulgence:* Alcohol often serves as a means of reducing tension and of allowing emotional release; excessive alcoholic intake may occur.

12. *Use of drugs:* Minor tranquilizers (benzodiazepines) and sedatives (barbiturates) may be employed to alleviate anxiety and tension, while stimulants (amphetamines) help to promote energy in situations where the person feels listless and inert. Narcotics (marijuana, cocaine, and other opiates) and psychotomimetics (LSD) are abnormally employed. Excess drug indulgence leads to many complications.

Second-Line Defenses: Characterological Defenses

In the event that the first-line defenses allay anxiety, adjustment is possible. If anxiety is not relieved or if the device used to control anxiety creates more anxiety, second-line defenses may be exaggerated, which involve a disturbed manipulation of one's relationships with other people and with oneself.

1. *Strivings of an interpersonal nature*

    a. *Exaggerated dependency* (immaturity)

    b. *Submissive techniques* (passivity)

    c. *Expiatory techniques* (masochism, asceticism)

    d. *Dominating techniques*

    e. *Techniques of aggression* (sadism)

    f. *Techniques of withdrawal* (detachment)

2. *Strivings directed at the self-image*

a. *Narcissistic strivings* (grandiosity, perfectionism)

b. *Power impulses* (compulsive ambition)

The characterological defenses, if too exaggerated, inflexible, and maladaptive, may make for *personality disorders* that reflect themselves in educational, habit, work, marital, interpersonal, and social problems and in delinquency, criminality, sexual perversions, alcoholism, and drug addiction. The individual may manage to regain some stability and periodic freedom from anxiety but at the expense of disturbed personality manifestations. The person may still retain those first-line defenses that he or she finds helpful in subduing anxiety. The person may be stabilized temporarily while continuing to experience, from time to time, bouts of anxiety.

Third-Line Defenses: Repressive Defenses

If anxiety cannot be controlled with characterological defenses or if the defenses, and the conflicts they create, produce more anxiety, third-line defenses may come into play. These consist of mobilization of repressive defenses and other manipulations of the intrapsychic processes.

1. *General efforts directed at reinforcing repression*

a. *Reaction formations:* Characterologic drives to oppose and repudiate inner drives; for example, ingratiation and passivity to oppose hostile, murderous impulses.

b. *Accentuation of intellectual controls* (with compensations and sublimations).

2. *Inhibition of function*

a. *Blunted apperception, attention, concentration, and thinking*

b. *Disturbed consciousness* (episodes of fainting, increased sleep, stupor)

c. *Disturbed memory* (antegrade and retrograde amnesia)

d. *Emotional indifference or apathy* (emotional inhibitions)

e. *Sensory disorders* (hysterical hypoesthesia, anesthesia, amaurosis, ageusia, and so on)

f. *Motor paralysis* (hysterical paresis, aphonia)

g. *Visceral inhibitions* (e.g., impotence, frigidity): Inhibition of the various cognitive, affective, autonomic, and visceral functions reinforces repression of inner impulses to the point of keeping symbolic derivatives from awareness and preventing the expression of forbidden impulses. Behavioral syndromes that are characterized by repressive inhibition of function are *post-traumatic stress disorders* (traumatic or combat neuroses), *dissociative disorders,* and *conversion disorder*.

3. *Displacement and phobic avoidance:* The impulse here is displaced to an external object and then an attempt is made to repudiate the impulse by avoiding the object. The syndrome resulting from an extension of this mechanism is a *phobic disorder* (anxiety hysteria, phobic neurosis).

4. *Undoing and isolation:* The mechanism here consists of a kind of magical neutralization of the offending impulse or its obsessive derivates through compulsive acts and rituals. The resulting syndrome is an *obsessive-compulsive disorder*.

These efforts directed at reinforcing repression are usually interrupted by failing of repressive barriers with breakthrough and release of repressed impulses. This is usually in obsessional form, that, if accentuated, may produce an *obsessive-compulsive disorder* (obsessional state, obsessional neurosis, compulsion neurosis, psychasthenia). Intense revery and dreamlike states may also result. Among the other defenses are an autonomous expression of the repressed impulses by *dissociative disorders* (conversion disorder) in the form of somnambulism, fugues, dissociated (multiple) personality, and depersonalization. The repressed impulses may also gain expression by being converted into physical symptoms involving the sensory organs (e.g. anesthesia, blindness, deafness), motor organs (tics, tremors, posturing, spasms, convulsions, paresis, aphonia), and visceral organs (including globus hystericus and vomiting.) If sufficiently extensive, these may constitute a *conversion disorder* (conversion hysteria). An internalization of hostility and its concentration on the self may produce a *dysthymic disorder* (reactive depression, neurotic depression). A projection of hostility toward outer objects or individuals may assume the proportions of a *paranoidal reaction.* Finally, there may be an impulsive breakthrough of the repressed material, with "acting-out" in the form of an excited episode.

Characteristic, then, of the third-line defenses are manifestations of failing repression with release of repressed material and desperate pathological attempts at the reinforcing of repressive barriers. First-

and second-line defenses that are useful may be coordinately retained. Anxiety may be episodically present whenever defenses fail to preserve the equilibrium.

Fourth-Line Defenses: Regressive Defenses

Stabilization at the level of third-line defenses is possible, but if anxiety cannot be held in check, fourth-line defenses may eventuate.

1. *Return to helpless dependency:* Failing to adjust at an adult level, the individual may attempt to invoke the protective parenting ministered to him or her in childhood by assuming the attitudes and behavior of a child. This regressive appeal is associated with a renunciation of adult responsibility and the throwing of oneself at the mercy of a parental substitute.

2. *Repudiation of, and withdrawal from, reality:* Characteristic of withdrawal from reality are dereistic thinking; disorders of perception (illusions, hallucinations); disorders of mental content (ideas of reference, delusions); disorders of apperception and comprehension; disorders of the stream of mental activity (increased or diminished speech productivity, irrelevance, incoherence, scattering, verbigeration, neologisms); disturbances in affect (apathy, inappropriate affect, depression, excitement); and defects in memory, personal identification, orientation, retention, recall, thinking capacity, attention, insight, and judgment. The syndromes are in the form of psychotic (schizophreniform) episodes and *schizophrenic disorders,* the development of which probably requires a genetic predisposition.

3. *Internalization of hostility: Dysthymic disorder* may occur sometimes; when certain constitutional factors are present, *major affective disorders* and *bipolar disorders* may be precipitated. Suicide is common in these syndromes.

4. *Excited acting-out:* Hostile, sexual, and other repressed impulses may be expressed openly in the course of a psychotic reaction. Representative syndromes here are *manic disorder* and *paranoid disorder.*

The patient may manage to stabilize through fourth-line defenses at the expense of reality, while possibly still retaining some of the other three lines of defense.

Syndromes never occur in isolation; they are always contaminated with manifestations of other defensive levels. As stress is alleviated or exaggerated or as ego strengthening or weakening occurs, shifts

in lines of defense upward or downward may occur, and changes in symptoms and syndromes will develop.

STANDARD NOMENCLATURE

As has been mentioned before, for insurance and medicolegal purposes, standard diagnoses will often have to be made. The American Psychiatric Association published in 1980 a revised handbook the *Diagnostic and Statistical Manual of Mental Disorders DSM-III* (Spitzer & Williams, 1985) that in 1987 underwent some alteration (DSM-IIIR). The resulting revision, like DSM-III itself, has precipitated a great deal of debate and heated discussion (Tischler, 1985). The World Health Organization also has presented a system with which not everybody is in agreement. One of the aims of DSM-III was to transcend the strictures of diagnosis by developing a multiaxial approach that (1) considers the patient's living environment as a source of psychosocial stressors, (2) attempts to predict future adaptation by examining how well the patient functioned in the past, and (3) considers the impact on the emotional illness of physical, personality, and developmental problems. Recorded in axis I are the existing clinical syndromes, as well as conditions other than mental disorder that require attention and treatment; in axis II, personality and developmental disorders; in axis III, physical conditions and disorders relevant to the understanding and management of the psychological problem; in axis IV, the severity of the existing or, as in the case of post-traumatic stress disorders, past psychosocial stressors; in axis V, the highest level of adaptive functioning, rated from 1 (superior) to 7 (grossly impaired), in the past year. This biopsychosocial listing greatly expands the usefulness of the diagnostic system and may provide a basis for clinical research.

The standard nomenclature, it must be remembered, is merely a label used for convenience and tells us little about how the patient will respond to therapy. In addition to categorizing the patient in a special grouping, it is functionally useful to estimate (1) the degree of homeostatic imbalance as registered in tension and anxiety, (2) the mechanisms of defense that are employed to deal with anxiety and to gratify vital needs, (3) the personality distortions operative in terms of dependence-independence continuum, the level of self-esteem, and the kinds of interpersonal relationships the patient habitually establishes, and (4) the potential disintegrative tendencies. Important, too, is an identification, if possible, of stress factors (situations and people) outside of the patient as well as internal stimuli

(drives, defenses, and values) that precipitate and reinforce neurotic tendencies. This information will be useful in treatment planning and the setting of goals.

ILLUSTRATIVE CASE

The following case illustrates the process of making a diagnosis by studying the spontaneous verbalizations of the patient, as well as by asking pointed questions. It consists of a portion of an initial interview with a 34-year-old woman, married for 13 years, who has three children, ages 11,8, and 4.

Pt. I don't know where to begin. I'd rather you ask me a couple of questions.

Th. It's a little difficult for you to pull things together. So suppose I do ask you a few questions.

Pt. Yes, so I can pull things together for myself, I mean. Technically, I'm suffering from an anxiety, I suppose, that goes back a long way.

Th. How far back?

Pt. It's always been the *same* thing, this terrific feeling of insecurity, or the tenseness, or the fear of death and not being able to breathe, and not being able to swallow and having palpitations of the heart, ulcers of the stomach, or fears of brain tumor. It takes on different forms. I suppose, depending on the season of the year. *[The patient describes symptoms of collapse in adaptation that have existed for a long time. These are in the nature of tension, frank anxiety, and psycho-physiologic phenomena.]*

Th. Mm hmm.

Pt. I rarely ever suffer from any two diseases at the same time.

Th. In other words, there's a whole succession of things.

Pt. Yes, but not all the time. Sometimes I've gone for months without these symptoms, but it's gotten progressively worse as the years go by. *[From time to time her symptoms abate, probably as her defenses are mobilized and restore her to a kind of equilibrium.]*

Th. I see.

Pt. I had it pretty bad about 12 years ago. I learned to fight it off. But in recent years it's just been too much, and I can't fight it off any longer. I used to be able to get relief by going to plays or movies, or by an occasional drink, or by sedatives. I still try these things, but it helps a little only temporarily. *[These first lines of defense were insufficient to control her anxiety. She still uses them, nevertheless.]*

Th. Can you give me an idea of when this thing got so bad that you decided to get further help for it?

Pt. You mean recently? Within the last year it crept on me very suddenly—well, not so suddenly. I developed a pain

around my heart. It came to a climax one evening about a year and a half ago and I was positive at the moment that I was dying. Everything sort of blacked out. The feeling: "Oh, my God." *[This is an acute anxiety attack brought on perhaps by a crumbling of her defenses or the impact of stress too difficult for her to manage.]*

Th. This was brought on by the pain around the heart?

Pt. No, that's like an aftermath. Just that everything is blurry, and nothing is sharp. Everything closing in. I went to bed and called the doctor. He told me that I should rest up physically, because I was terribly run down. I do work hard, and usually I am able to pull myself together with a rest. But this time, in the middle of the rest, it got worse than ever before. I had a lot of worries and things. I was sure it was complete exhaustion and I knew what the doctor was going to say.

Th. What do you think caused this?

Pt. Well, my being overtired. I couldn't relax. I could hardly breathe. I was thoroughly exhausted. I've lost weight. I've gotten to a point where it's just too much for me to handle.

Th. I see.

Pt. It's either physical or it isn't. The doctor told me it wasn't. I know myself. I've read about this in books, and I believe in psychiatry. My husband, on the other hand, doesn't believe in it at all. He thinks I'm just about ready for an institution because of these attacks. I try not to have them when he is around. *[Conflict with her husband may somehow be involved in stirring up her difficulties.]*

Th. He doesn't understand this?

Pt. He gets furious. He stomps out, says he can't take it any more. I try to pull myself together. I'm scared of anger and any form of emotion at all. *[Her inability to deal with anger may be indicative of a personality disorder, other aspects of which will undoubtedly reveal themselves.]*

Th. Is there anything else that stirs you up?

Pt. The friction and tension in the house. The children are on the go all the time, and me not being able to stand friction or any kind of emotion at all.

Th. You're caught in the middle?

Pt. Yes, and the battles go on, and my husband can't stand it. It is horrible. Everybody gets on everybody else's nerves. I suppose I am responsible for some of it myself. But my husband won't understand. Personally, I think he's suffering from the same thing that I am, but he doesn't know it. He had a hell of a life himself. His mother is a nervous wreck, and his father is a tyrant. I think he needs to be built up, but unfortunately I'm so full of so many things myself that I can't do it. I suppose if I did do it, things would be better. He's popular outside; he's a lot of fun, jolly. People would be surprised to learn he had the problems he has. He's not mean, or anything like that; it's just that he won't take the time to be with me, understand me. I suppose he inherits that from his father. I don't dare tell him how I feel. I can't get reassurance from him. I have to get it from my mother. *[The patient is complaining here that her husband is not sufficiently kind and understanding and does not give her enough reassurance. She may be expressing frustrated dependency longings, either in response to a residual personality immaturity or because her adaptational collapse invokes characterologic defenses, among which increased dependency leanings are prominent. These second-level defenses are apparently not sufficiently adequate to*

neutralize anxiety.]

Th. From your mother?

Pt. Yes. You see my father died when I was little, and my mother had to pursue her career. She was a career woman. She always felt that money was security. She was after me constantly to get out and get a job and earn money. But I suppose I was more secure than the average person—my aunt was wealthy. But I was sickly and always needed doctors. I had pneumonia and eye trouble and stomach trouble even when I was 14 years old. She then started dragging me around to see people, including psychiatrists. She must have been disappointed that I didn't turn out to be the way she wanted me. She was a great fighter, an intellectual, and I'm not. *[Feelings of rejection, of not coming up to her mother's expectations, may be the background of her insecurity and devaluated self-esteem.]*

Th. She was disappointed in you?

Pt. Oh, definitely. I'm sure I don't come up to her standard. For many years we were estranged. She didn't approve of my marriage. I was the only child.

Th. You present the picture of being insecure as a child.

Pt. I'm sure I was. My mother always tried to push me into independency. I can see it now, in the light of looking back, that I didn't want to be independent.

Th. What about your husband when you first met him?

Pt. I was in love with him. But shortly after my marriage, my real trouble began. I was insecure before, but I got along. But after one year of marriage, things really got impossible. I had a terrible period with both our parents. My mother disapproved and so did his parents. He had an awful time at home. He never told his parents we married. I was upset and lost a lot of weight. Well, I suppose I should have seen at the time that he wasn't very strong and that he wanted someone to lean on. He was petrified of his father. He wouldn't set his foot in our house for years. *[One gets the impression that the patient resents her husband's weakness. As a dependent person herself, she would like a strong mate on whom she might lean. The fact that her husband did not provide this for her may have stirred up hostility and insecurity and, on the bedrock of her personality immaturity, created a collapse in adaptation.]*

Th. I see.

Pt. Well, anyways, things have gotten bad recently.

Th. Can you describe what trouble you have had recently?

Pt. I can't stay alone in the house for fear I'll jump out of the window. I can't take a bus; I have to take a taxi. I can't walk on the street for fear of falling on my face. Just fears of everything, especially of being alone or of walking on the street. *[These phobic symptoms are those of third-line defenses, representing a further breakdown in repression.]*

Th. This must really be very difficult for you.

Pt. It is, it is. I have this constant anxiety. Every minute of the day. I don't know whether I'll live or die. I can't breathe

deeply; I can't seem to get enough air. I'm afraid of everything. I can't go out. I don't want to drive a car. I don't want to be alone in the house. I can't go to a theater. I can't eat in a restaurant. Eating seems to have something to do with it. *[These are manifestations of anxiety representing a breakdown of defenses.]*

Th. It does?

Pt. Yes. I seem to be worse at meal times. If I'm eating in bed, it's all right. I noticed that I get tense as soon as I sit up at the table to eat. If I eat in bed, I'm all right, but I can't eat up. I don't like a restaurant for that reason. *[This may be a further defensive effort toward helpless dependency, perhaps a regressive need to be fed like a child.]*

Th. Are there any other symptoms?

Pt. Well, recently, thoughts come to me that frighten me. It started when first I was listening to the radio. First I listened to a murder program where a man murdered his wife, and then I was listening to the war situation. I don't know if that has anything to do with it or not. These thoughts seem to crowd in on me. If I pick up the papers and see that somebody got killed or that somebody died of a heart attack, I'm finished. I'm afraid to read the obituary. As long as they are over 65, that's all right, but anything under scares me. Two days ago I was driving with a friend, and she told me of a person she knows who had psychosomatic trouble with his heart and finally got heart trouble and died. This finished me. I couldn't think or anything. I went home to bed. *[These obsessional thoughts are indicative of a breakthrough of repressed conflicts, perhaps in relation to hostility.]*

Th. I see.

Pt. It's the funniest feeling; even though I tell myself it's all foolish, it doesn't help. Once it comes, there doesn't seem to be much I can do.

Th. Once it starts ...

Pt. I can't fight it; I can't reason or anything.

Th. Like you're over a bank of snow on skis.

Pt. Yes. I have to let it take its course. I know it will end. I fight it, but I'm a wreck. I've tried sherry, I've tried phenobarbital, nothing helps. I don't even have enough nerve to commit suicide.

Th. What about other symptoms?

Pt. Like what?

Th. What about physical symptoms?

Pt. Well, when I am upset, I notice my stomach is upset. It's upset most of the time. *[This may be a somatoform disorder associated with her anxiety, or it may be a somatic conversion symptom.*] Also from time to time I get a nervous twitch of my eyes, like blinking. I had it also when I was a child. *[This sounds like a conversion symptom.)*

Th. What about sexual problems?

Pt. Oh, that. My husband thinks I'm a mess. I'm very frustrated. I'm not...I'm... what's the word I want... I'm ... frustrated. I don't seek it. I'm always afraid, I'm always holding back. From the neck down I could see it might be a wonderful idea; but from here up something says, no. Once I get started it's all right, but I find it hard to get started.

Th. What do you think is involved?

Pt. Well I suppose it applies to all emotions. I don't cry, I don't get angry. I keep everything inside. A piece of music can make me emotional. I'm afraid I'll cry, so I don't do anything. I'm afraid. It scares me to death. *[Inhibition of emotions acts in the interest of maintaining repression.]*

Th. I see.

Pt. My mother had a violent temper, and I was scared of it. I'd rather do anything than have her lose her temper. I guess it's the same thing with my husband and his violent temper. *[The patient presents an aspect of the origin of her fear of hostility and its carryover into her present relationship with her husband.)*

Th. You're afraid of his temper?

Pt. I'm afraid of everybody. I'm one of the weakest people that ever lived. I can't stand up to anybody, which is another one of my mother's pet peeves about me.

Th. What do *you* think about that?

Pt. I think she's right, but I can't do anything about it. I feel guilty about it.

Th. Would you like to be able to emote and to express your feelings?

Pt. I suppose it would make me feel better. I'd like to be able to express myself. When my husband gets mad, I shrink up into a little ball. I can't be assertive with anybody. I feel hopeless.

Th. Hopeless as if you can't get over it?

Pt. That's what's worrying me because I can't go on like this much longer. *[One may suspect that her hopelessness may also be a defense against yielding her dependency need.)*

Th. Now what about dreams; do you dream a lot, or a little?

Pt. A little.

Th. Do you remember a recent dream?

Pt. Yes, I dreamed the Nazis came back and overran the country and it terrified me no end. There I was in a trap about to be annihilated.

Th. That's about how you feel literally.

Pt. Yes, it is.

In review, this is the case of a patient with a personality problem since childhood, consisting of dependency, insecurity, and devaluated self-esteem. She is still burdened by personality immaturities. Her present homeostatic imbalance is severe. Symptoms of collapse in adaptation are tension, anxiety, and psychosomatic symptoms. First-line defenses are extraverted activities, sedation, and mild indulgence of alcohol. Submissiveness and heightened dependency may be regarded as manifestations of second-line defenses. Third-line defenses are in the form of phobias and conversion symptoms. A waning of repressive barriers is indicated by a breakthrough of obsessions. Her defenses are apparently inadequate in mastering her anxiety. The disintegrative potential is low. Following the principles of conventional classification discussed, we may diagnose her as follows:

DIAGNOSIS:

Axis I: 300.01, Panic disorder

Axis II: 301.60, Dependent personality disorder

Axis III: None

Axis IV: Psychosocial stressors:marital conflict Severity: 5—severe

Axis V: Highest level of adaptivefunctioning past yearSeverity: fair—4

Recommendations:

Antidepressant medication may be prescribed for the panic attacks. In vivo desensitization may be employed for the agoraphobia. Couples therapy indispensable for the marital conflict. Individual dynamic psychotherapy for the dependent personality disorder.