THE TECHNIQUE OF PSYCHOTHERAPY

PSYCHOTHERAPY IN SPECIAL CONDITIONS

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Psychotherapy in Special Conditions

The principles of psychotherapy that have been outlined and the technical procedures that have been delineated apply to all emotional problems and conditions irrespective of clinical diagnosis. It may be possible, with the proper working relationship and the adroit use of appropriate techniques, to approach the goal of some personality reconstruction in any syndrome. Experience, however, has shown that certain conditions make extensive therapeutic objectives difficult to achieve. Experience also indicates that they seem to respond favorably to specific techniques or combinations of methods. In this chapter we shall consider the problems and technical modifications encountered in the treatment of neurotic, psychophysiological, personality, and psychotic disorders.

ANXIETY DISORDERS (ANXIETY NEUROSIS, PHOBIC NEUROSIS, ANXIETY STATES)

Some anxiety is a universal human experience considered by existentialists as basic to the nature of existence. It is common to all physical and emotional ailments in which the problems are conceived of as a threat. Anxiety usually generates a host of defenses marshaled to neutralize its effects. Some defenses, however, contribute to greater maladaptation than the anxiety experience itself, for example, recourse to avoidance behavior, inhibitions of function, or overindulgence in drugs and alcohol; When anxiety becomes excessive, it is regarded as a pathological syndrome to which several labels are applied, such as panic disorder, agoraphobia, generalized anxiety disorder, social phobia, simple phobia, obsessive-compulsive disorder, and posttraumatic stress disorder. Except for the anxiety, the specific features of these syndromes are fashioned by the unique personality and cognitive styles of the patient, by family dynamics, and by variable features in the environment. Although anxiety as a symptom is

found in many disorders such as depression, schizophrenia, and organic brain disease, the panic, phobic, obsessive-compulsive, and generalized anxiety disorders constitute a distinctive and discrete assembly of entities (Lesser & Rubin, 1986) that are probably biologically based and affect only approximately 8 percent of the population.

Panic Disorder Without Agoraphobia (DSM-III-R Code 300.01) Panic Disorder With Agoraphobia (DSM-III-R Code 300.21)

The identifying feature of this disorder is that intensive anxiety and catastrophic feelings of impending doom are apt to erupt unexpectedly or in relation to situations that realistically should not be threatening. Faintness, trembling, dizziness, heart palpitations, sweating, depersonalization, chest pain, and paresthesias overwhelm the individual and cause him or her to seek safety at home or in a doctor's office. If the condition repeats itself under the same conditions, phobic defenses may be organized, leading to anticipation of the attacks and further discomfort. The patient may resort to alcohol and barbiturates. Panic disorder must be differentiated from symptoms of certain physical conditions such as hypoglycemia, hyperthyroidism, and pheachromocytoma and from panicky attacks in patients with depression, schizophrenia, somatization disorder, and organic brain disorder. There is some evidence that early separation anxiety is a precursor to the condition and that a genetic predisposition may exist.

In treating the condition it should be kept in mind that appeals to reason have little effect and that insight will be deluged and rendered worthless by the flood of anxiety that overwhelms the individual. The best therapeutic focus is on the biochemical and conditioning links in the behavioral chain. When panic attacks have diminished or disappeared, cognitive therapy may be valuable, and if unconscious conflictual elements are suspected, psychoanalytically oriented psychotherapy may be attempted.

Drug therapy with antidepressants (see Table 56-1) gives us a choice of three classes of medication: tricyclics, MAO inhibitors, and a benzodiazepine antidepressant, alprazolam. Each has its advantages and disadvantages. Tricyclics, such as imipramine (Tofranil), are the most common medications used,

but they may require as long as 8 weeks before a substantial response occurs. Moreover, anticholinergic side effects, such as dry mouth, blurred vision, and rapid heart beat, may upset some patients. Tofranil is started with 10 to 25 mg daily to reduce the patient's fear of side effects. Gradually, over a 2-to-4-week period, the dose is raised to 100 to 200 mg/day. If in 8 to 12 weeks the response is poor, the dose may be increased to 300 mg. Should tachycardia and heart palpitations frighten the patient, a beta blocker such as propranolol (Inderal) may be tried. A MAO inhibitor such as phenelzine (Nardil) requires restrictions of diet and avoidance of certain medicaments that some patients find inconvenient. The beginning dose is 15 mg/day, increased by 15 mg every 3 to 4 days until 60 mg are taken daily. The medication should be given in the morning and at noon to avoid possible insomnia. If after 8 to 12 weeks the effect is not impressive, the dose may be raised to 75 to 100 mg. If a side effect of muscle twitching occurs, 150 to 300 mg of vitamin B6 should be given. One should never go from a regime of tricyclic therapy (which was not effective) to MAO inhibitors without stopping medication for 2 weeks. Alprazolam (Xanax) works within 1 to 2 weeks but may produce some drowsiness, and, taken over a long period, it can be addictive. It is started with 0.25 or 0.5 mg two or three times daily, increased every 3 days by one pill to 4 mg/day. A combination of Xanax 1-3 mg/day and propanolol (Inderal) 40-160 mg/day has resulted in an almost total relief of both panic attacks and anticipatory anxiety (Sheki & Patterson, 1984). Patients, especially those on tricyclics and MAO inhibitors, should be informed that medications require weeks to take effect. The results will depend on consistency in taking the medications.

Some patients absolutely refuse to take these medications. For these patients, relaxation therapy, systematic desensitization and then in vivo desensitization should be employed. In any case the latter therapies are almost indispensable even when drug therapy has controlled the panic. Moreover, if other links in the behavior chain are pathologically implicated, therapies bracketed to these links may productively be employed (see table 57-1). Thus group, couple, and family therapy are valuable if serious interpersonal problems exist; milieu therapy to resolve environmental difficulties; cognitive

therapy for rectification of faulty attitudes, self-statements, and belief systems; and dynamically oriented, psychotherapy for personality difficulties of long standing that act as sources of continuing anxiety. In most cases psychotherapy will be needed, with a focus on interpersonal problems, such as marital conflict.

Generalized Anxiety Disorder (DSM-III-R Code 300.02)

Symptoms of a generalized anxiety reaction include restlessness, jitteriness, sighing, fidgetiness, sweating, heart pounding, sensations of tingling in the extremities, gastrointestinal symptoms, urinary frequency, a lump in the throat, flushing, great apprehensiveness, anticipation of catastrophes, fear of losing control, death fears, edginess, irritability, fatigue, and insomnia. The anticipatory expectations relate to unrealistic events or those in which possibilities are not sufficient to justify the patient's massive emotional response. In this way the anticipated happenings may be distinguished from a fear reaction that is stimulated by realistic threatening circumstances. Fears of death, disease, violence, sexual perversions, and so on are often at the basis of undifferentiated excessive anxiety, which may readily be activated by minimal unfortunate or threatening outside events, for instance, sickness in the family, the discovery on physical examination of a minor organic ailment, or an unfortunate environmental happening. The rapid heartbeat, rise in blood pressure, chest pains, and distress in breathing may convince the victim that he or she is suffering from cardiac illness, initiating persistent visits to practitioners and specialists who may diagnose the condition as "psychosomatic," the functional nature of which the patient usually fails to believe.

Most patients with generalized anxiety are so upset by their symptoms that relief from suffering constitutes their only motivation. Because they feel helpless and frightened, they are apt to demand an authoritative, directive relationship in which they are protected and through which they seek to obtain immediate symptomatic relief. To abide by these demands, the therapist may decide to employ emergency measures, which prove temporarily successful in abating anxiety. Some measures will help

bring the individual to a point where the anxiety is reduced and spontaneous reparative forces come into play (see Supportive Therapy, Chapter 9). Such supportive treatment may be all that is needed to eliminate suffering, especially if the basic ego structure is reasonably sound and has broken down under the impact of severe external stress. Palliative measures may alleviate anxiety in these cases even if the problems are internally inspired. Should supportive tactics prove to be successful, most patients will lose their incentive for further help and be content to function in their symptom-free state, even though it may be impermanent. If treatment is unsuccessful, they may lose confidence in the therapist and go elsewhere in search of relief.

It is important, therefore, to persuade the patient to accept more than supportive therapy. This may prove to be a greater task than the therapist has bargained for. Because repression is a chief defense against sources of anxiety, the patient may be unwilling to challenge habitual coping mechanisms, even though they are inadequate in dealing with the difficulty.

Treatment of pathological anxiety reactions must be adapted to their intensity, the needs and motivations of the patient, and the readiness to accept help. We now have a battery of medications that are successful in dealing with anxiety on a symptomatic level. It is always best to see if one can abate anxiety through psychosocial measures before resorting to medications, because, unless the sources of the anxiety are handled with the object of modifying or removing them, the patient will be tempted to use pills as a way of life. This is particularly important when employing the benzodiazepine drugs, which, though relatively safe and less addictive than barbiturates, are still subject to abuse. Alternatively, we may focus on vulnerable links in the behavioral chain (see Table 57-1) and use interventions that have proven helpful in dealing with these links. For example, we may in interviewing a woman with anxiety recognize that many of the patient's problems are organized around ambivalence toward a spouse. To subdue the patient with drugs, acting as if the marital situation can be bypassed, will not help the patient come to grips with the source of her trouble. Marital therapy would not preclude

our dealing with any other pathogenic links in the behavior chain with suitable coordinate interventions. If she was so demoralized by anxiety that she could not use psychosocial treatments effectively, we could add anxiolytics to our therapeutic interventions.

Among the most suitable anxiolytics for achieving symptomatic stabilization in from 1 to 6 weeks are alprazolam (Xanax), 0.75 to 4.0 mg/day, diazepam (Valium), 4.0-40 mg/day, lorazepam (Ativan), 2-6 mg/day, oxazepam (Serax), 30-180 mg/day, and clorazepate (Tranxene), 15-60 mg/day. Elderly patients require a reduced dose. The actual dose is titrated to the patient's response, starting with the smallest dose and working up. We can expect some relief in from 1 to 2 weeks, with optimal effect after 6 weeks.

A new anxiolytic that undoubtedly will receive extensive testing is buspirone (Bu-Spar). This medication has been found to be as effective as the above drugs and to produce less drowsiness and sedation (Cohn & Wilcox, 1986).

Phobic Disorders (Phobic Neurosis, Anxiety Hysteria)

As a defense designed to control anxiety, the phobic reaction constitutes one of the most common syndromes that the psychotherapist must handle in everyday practice. When we consider the structure of a phobia, we must recognize that a maze of primary and auxiliary phenomena embrace this defense. First, the phobia, apart from the simple conditioned fear reaction, is generally a facade that conceals an underlying, earlier causative factor. Second, it is a manifestation that protects the individual from constant and intense anxiety. Third, a phobia gradually changes in its dimensions by generalizing to stimuli that are more and more remote from the initiating phobic excitant. Fourth, as the phobia spreads and circumscribes the individual's activities, the person feels increasingly undermined, self-confidence is progressively shattered, self-image is more and more devalued, and the individual may become

depressed and even phobophobic. Loss of mastery revives regressive defenses and needs, including childish dependency promptings, which, if gratified, further contribute to feelings of helplessness.

Agoraphobia (DSM-III-R Code 300.22)

The most common and paralyzing phobia is agoraphobia, which usually manifests as a fear of being alone or of being adrift and helpless in public places such as shopping centers, transportation vehicles, tunnels, bridges, and elevators. In many cases the phobic reaction follows one or more experiences of severe panic while away from home. Safety is sought within the confines of one's home, and the individual becomes housebound, venturing out only in the company of a spouse, parent, or other member of the family. There is both great dependency on and hostility toward the protective agent whose own neurotic needs to control may be gratified by the patient's helplessness. In this way a mutual neurosis is nurtured and kept alive amid hypocritical protests on both sides. Therapy for agoraphobia is directed principally at the panic against which the agoraphobia is the defense. In vivo desensitization and other adjuncts, such as the antidepressants described above for panic disorders, are also indicated. If the marital or family relationship is symbiotic, marital and family therapy are indispensable. Experience teaches that unless the family member most intimately involved with the patient is also in therapy, he or she will experience disrupted homeostasis and try to undermine the patient's treatment.

Social Phobia (DSM-III Code 300.23)

Here the individual is fearful of exposing himself or herself to the scrutiny, judgment, and possible condemnation of others. Such people justify avoiding situations where their "nervousness," shyness, weakness, inferiority, or ineptitude will be detected. In the extreme form, patients apply judgmental criteria to themselves and develop a fear of manifesting any failings even when they are alone. A common fear of such individuals is of shaking, spilling food, belching, or showing other peculiarities in behavior while eating with one or more people. Stage fright is a frequent form of social phobia found in countless numbers of people, including experienced performers. Erythrophobia, or fear of blushing, and insistence that people can detect expressions on one's face that will be misinterpreted as a sign of

"craziness," nymphomania, or homosexual interest are peculiarly resistant to reasoning even when colored movies display the patient in close-ups with normal facial expressions under varied circumstances. The patient may seem to be close to a paranoidal condition here but lack other symptoms that would justify this diagnosis. Secondary depression sometimes accompanies social phobia, stimulated by the patient's conviction of helplessness in being able to do anything about his or her reaction.

Therapy for social phobia is organized around behavior therapy, particularly desensitization, with repeated exposure to the phobic situation. Too early attempts at in vivo desensitization or flooding are not recommended since the patient may panic and thus reinforce the phobia. Assertiveness training, relaxation therapy, hypnosis, and systematic desensitization using imagery can prepare the individual for exposure to the phobic stimulus that he or she dreads. Cognitive therapy may help deal with attitudinal distortions. Group therapy and psychodrama can also be of great value in giving the individual opportunities for performance desensitization and reality testing. The benzodiazepines (e.g., Valium, Atavan) may sometimes be employed as a preliminary form of treatment. They subdue anxiety, but there is always the danger that they will become a primary shield and lead to habituation. Of value for stage fright is 40 mg of propranolol (Inderal) taken shortly before performance. It helps control the shaking, rapid heart beat, and palpitations but does not dull the mind or interfere with muscular coordination, frequent consequences of tranquilization with anxiolytics. Psychoanalytic therapy has not proven to be of much help in the usual run of social phobias, in part because most patients with social phobias are not motivated to receive such intensive help and are unable to tolerate the anxiety inherent in altering ego-syntonic personality distortions. Analysis of pre-Oedipal stresses, in a more supportive object-relations format, is sometimes successful with motivated patients who have not responded to other therapies.

Simple Phobias (DSM-III-R Code 30029)

Phobias of insects, dogs, mice, bats, snakes, lightning, heights, swimming, closed spaces, air travel, and the like may be conditioned-avoidance responses that are patterned after parental phobias or that followed upon anxiety-provoking experiences with the objects or situations in question (near drowning, air crash, etc.). They may yield to behavior therapy with imagery, desensitization, relaxation exercises, and gradual exposure, first to pictures of the phobic objects and situations, then to imitation objects (toys, insects, mice, etc.), and finally to in vivo desensitization and implosive therapy, perhaps at first in the presence of the therapist. A claustrophobic patient, for example, may lock oneself in a closet in the therapist's office for gradually increasing periods. Group behavior therapy with participants suffering from the same or similar phobias can accelerate treatment, especially during the phase of in vivo desensitization.

Sometimes, however, simple phobias turn out to be not so simple. In such cases anxiety over one's unconscious dangerous drives have been displaced onto external objects and situations that have become disguised symbols of the repudiated inner drives (Oedipal strivings, perverse sexual cravings, hostility, etc.). For example, a person may avoid knives and other potentially lethal objects as a defense against repressed anger. Because of its apparent protective quality, the phobia may become fixed, the patient manifesting the greatest obstinacy in facing it. The treatment of choice is dynamic psychotherapy, which in the most stubborn cases will necessitate setting up and resolving a transference neurosis using the technique of classical analysis. In some cases hypnoanalysis may expedite therapy, but this requires a subject capable of entering a somnambulistic trance (Wolberg, 1964a).

Obsessive-Compulsive Disorder (DSM-III-R Code 300.30)

In obsessive-compulsive disorders ideas, usually with obscene, violent, necrophobic, or thanatophobic content, flood the mind and liberate aversive feelings of guilt, shame, and anxiety. The phenomenon sometimes takes the form of an inner voice that commands the person to do antisocial acts. Attempts to neutralize these ego-alien thoughts may in some cases provoke certain compulsive

movements or rituals, which, seemingly absurd to an observer and even to the patients themselves, temporarily relieve the painful feelings. Attempts to control or resist obsessive ideas and the compulsions they inspire generally are in vain and may even activate the obsessions. Compulsive acts that oppose rational conduct may be executed in secret. Obsessives usually chastise themselves for their weakness and betrayal of common sense. Fears of losing control, of becoming psychotic, and figuratively or literally of being possessed by demons complicate the picture and add to the victim's misery (Nemiah, 1985).

The etiology of the disorder is still obscure. There are indications that a biochemical factor of some kind exists in this illness perhaps related to serotonin imbalances. Hypothesized also is an affiliation with depression, since many patients exhibit biological markers of an affective disorder. Some authorities postulate that there are anatomical abnormalities in the cingulate gyrus and hippocampus. Though psychological mechanisms in obsessive-compulsive disorders offer themselves luxuriously to psychoanalytic inquiry, psychoanalysis and psychoanalytic therapy have failed to bring about hoped-for results in alleviating obsessive and compulsive symptoms.

Clinically, several types of obsessive patients are commonly seen (Insel, 1983). The largest number are those who fear contamination and who then indulge in washing or scrubbing rituals. Such "washers" may, to their dismay, spend a good deal of their time in the bathroom. A second large group are the "checkers," who have to check repeatedly that they have completed an act because they fear that dereliction may bring harm to themselves or others. A third group are the "stallers," who may take forever to execute a simple task; for example, the completion of normal activities such as dressing or eating may take hours. A fourth group are the "worriers," who are preoccupied with Cassandra-like fears of evil acts and catastrophes that are about to happen; usually patients do not perform rituals to neutralize them. Although each patient exhibits the unique traits of his or her personality structure, obsessive persons demonstrate remarkably similar behaviors in every country the world over.

Many therapies have been unsuccessfully employed to bring relief to these suffering and handicapped individuals. Of all treatments, behavior therapy has scored the greatest successes in controlling obsessive and compulsive symptoms (Rachman et al, 1973; Rachman, 1976; Wilson TG, 1976; Marks et al, 1975; Marks, 1981; Foa et al, 1985). The most effective method (scoring up to 80 percent benefit) is in vivo desensitization with practice sessions of (1) deliberate prolonged exposure (45 minutes to 2 hours) to thoughts, fantasies, and situations that inspire disturbing symptoms; and (2) coordinate blocking of compulsive responses (hand washing, checking, ritualistic behavior) that have temporarily served to neutralize anxiety in the past. In implementing this approach, which consists of 10 to 20 sessions, graded exposure to increasingly intense stimuli from 45 minutes to 2 hours and the absolute blocking of responses for long periods (sometimes for days) requires a motivated patient willing to endure the anxiety and suffering that such restrictions entail.

Obviously the patient will protest vociferously and express dread of being exposed to dangers. It will require tact, understanding, and great persuasion, utilizing the working relationship skillfully, to convince a patient to try this intervention.

The treatment protocol evolved by Stekete and Foa (1985) for exposure and response prevention details the sequence of treatment and contains useful appendices and a case study that illustrates the application of specific procedures. Approximately 3 to 6 hours are spent in gathering information and in treatment planning. The patient is then given a full explanation as to what to expect. The scenes to be used in imagery (flooding), the situations to be met in in vivo desensitization, and the responses and rituals to be prevented are delineated. A decision is made as to whether the patient's home or a hospital is to be used, and the aides (family members, friends, nurses) to assist the patient in the assignments are chosen. Since massed sessions produce better results, a minimum of 3 sessions weekly are given. The total number of sessions are between 15 and 20. At each session the first few minutes are spent in discussing what has happened since the last visit. Next, the patient is exposed to the target thoughts and

fantasies and is enjoined to try to fantasize that he or she is actually in the imagined situation. Every 10 minutes, levels of anxiety are monitored. This exercise, which lasts from 1 to 2 hours, is at first highly anxiety provoking, but eventually the anxiety lessens. In advance of the sessions, a series of five graded upsetting scenes are prepared to be presented in low to high order, and each is used until the anxiety diminishes greatly or is gone. After this exposure, the patient is confronted by the therapist with the situations he or she fears most (touching dirt, being prevented from checking a gas stove, etc.) and the therapist models normal behavior (e.g., touching dirt and refraining from washing). Projected slides, pictures, movies, or video recordings may be used to convey the feared situations (funerals, homosexuality, etc.) if the actual situation cannot be confronted. In the case of "washers," no washing of hands is allowed (sometimes for as long as several days), and only a brief shower is permitted every fifth day. In the last few sessions, the patient is instructed as to normal modes of behavior. Thus "washers" are enjoined to wash their hands only before meals, after bathroom use, and after handling especially dirty objects. Following the intense treatment period, a self-exposure maintenance program (practiced at least weekly) is prescribed as a preventive measure. When necessary, interpersonal skills training, assertiveness training, marital therapy, and family therapy may be prescribed. A follow-up self-help group may be valuable. Only when absolutely essential should hospitalization be prescribed since many provocative situations are likely to be absent in a hospital setting.

As accessory therapy, relaxation exercises may periodically be employed for tension relief (Jacobson, 1974; Benson, 1974). Another technique that some patients find useful is "thought stoppage" (Wolpe, 1958). Here thoughts to be controlled are identified and deliberately practiced at the same time as one shouts "Stop" and perhaps coordinately bangs one's hand against one's thigh. Or one may wear a rubber band around the wrist and flick it to deliver a painful stimulus. Attention should then be diverted elsewhere. Systematic desensitization (Wolpe, 1958) may also occasionally be effective if tension is high. The patient may be enjoined to engage in regular practice sessions of fantasies, such as being

exposed to extremes (often to a most ridiculous degree) of his or her symptoms and perhaps their consequences. The logotherapeutic technique of paradoxical intension (q.v.) is a form of this type of therapy. At home the patient may be requested to engage in such varied tension-relieving exercises as keeping a diary record of accomplishments (such as response resistance or blockage) and his or her reactions.

Because depression has been so frequently observed in obsessive patients, a variety of drugs have been tried, including clonidine, loxapine, and the tricyclic antidepressants. The latter class of drugs has proven especially beneficial both for their antidepressant and anti-obsessional effects (Mavissakalian et al, 1985). Clomipramine (Anafranil) in particular has proven to be valuable and in many cases has enabled an intractable patient to become cooperative. This medication appears to have a specific anti-obsessional effect that is distinct from its antidepressive property (Singh & Sexena, 1977). I have found clomipramine almost indispensable in working with some obsessive-compulsive patients since by muting symptoms motivation is greatly improved. The initial dose of clomipramine (which is available in Canada, Mexico, and Europe and may soon be released in the United States) is 25 mg three times daily, increased to 150 mg/day as required (maximum dose 200 mg and 300 mg for hospitalized patients). Adolescent and elderly patients should be given 20-30 mg daily, increased by 10 mg daily, if necessary, depending on response and tolerance. A history of glaucoma, liver damage, or blood dyscrasias or pregnancy contraindicates treatment. Use of a MAO inhibitor drug following the use of clomipramine necessitates a delay of 14 days, the same as for any other antidepressant drug. Anticholinergic effects as with other antidepressants, are to be expected. In some cases a combination of clomipramine and clonopin reinforces the beneficial effect. Physical examinations and blood tests should be done periodically. The combination of clomipramine and in vivo desensitization is at this date the best treatment for the symptomatic relief of obsessive-compulsive illness.

Any therapist who believes that the relief of obsessions and compulsions in the obsessive patient is all that is necessary is, however, in for an unpleasant surprise. Although dealing with the biological and conditioning links in the behavioral chain is important, this will not resolve all the problems encountered by the patient any more than relieving painful and distracting hemorrhoids will cure a coordinate sinus condition. Additional implicated links in the behavioral chain (see Table 57-1) require attention since the troubles they cause will sometimes cry out for help. In certain patients, symptom alleviation enhances the chances for a reasonable adjustment, including the usual evasions and compromises essential in our society. Other patients may find their liberated energies merely intensify their interpersonal, environmental, and intrapsychic problems. Here interventions related to these areas of trouble are indicated. Counseling, interpersonal therapy, group therapy, marital therapy, family therapy, and milieu therapy are indicated for dealing with difficulties in special areas. Cognitive and dynamic approaches enable the individual to give a more authentic meaning to his or her symptoms than the misinterpretations usually assigned to them (such as that he or she is destined to psychosis, sexual perversion, cancer, murderous acting-out, etc.). Recognition that fantasies and impulses are manifestations that possess a symbolic significance and that they do not have to be taken literally can be reassuring to many patients, even if it is not completely curative.

The great problem is not only how to deal with the unexpected outbursts of nascent anxiety, which become particularly pronounced when obsessional ideas periodically break loose, but, more significant, how to manage the hostile, disturbing character structure that is a component of the disorder in many patients.

Obsessive-compulsive neurosis does not respond to insight therapy as well as do other neurotic syndromes. It can be done, of course, but the therapist must be extremely skilled in handling the transference and must have much fortitude to tolerate the vicissitudes that will come up in the course of treatment. Years of futile probing into the unconscious and careful unravelment of the sources and

meanings of rituals may accomplish little. The obsessional personality is an expert in "one-upmanship." He or she engages in a verbal tug-of-war, must get in the last word, undermines psychotherapy as a process, and derogates the ability of the therapist to provide help. Yet obsessional patients bitterly complain that they are not being helped. What is important in therapy is to deal with the immediate transactions between therapist and patient and to prevent the patient from entering into gambits through which he or she can conspire to wrest control from the therapist. The therapy for compulsive-obsessive personality disorders must, therefore, take into account the patient's dependence, profoundly hostile impulses toward people, need for detachment, tendency to "isolate" intellect from feeling, and the magical frame of reference in which the patient's ideas operate. Salzman (1966) points out that the obsessive-compulsive defense of persistent doubting, negativism, unwillingness to commit oneself, and striving for perfection, omnipotence, and omniscience are attempts to control the universe and to guarantee one's safety, security, and survival. This defense acts as a block to constructive learning. Free association and concern with past memories are used as a screen behind which the obsessional person conceals his or her coping maneuvers. According to Salzman (1983), what is essential in working with obsessional patients is to be continually aware of their obstructive personality characteristics; their defensiveness, which causes them to reject the therapist's observations; their need for control; their striving for perfection; and their doubt, ambivalence, and tendency to obfuscate issues. This calls for great activity on the part of the therapist, a focus on the present, a need to deal with the patient's grandiosity, continual reexamination of issues so as to facilitate working-through, and "risk-taking" by the therapist.

Most therapists find working with the patient on an analytic level a most difficult and frustrating experience. Classical analysis is usually ineffective and therapy can become interminable as the patient and therapist become locked into a sadomasochistic relationship, very much like a bad marriage, that can go on for years. This does not mean that one has to cast a dynamic approach to the winds. I have

found it helpful with many obsessive cases to work dynamically with derivative rather than nuclear conflicts, showing the patients, how the characterological distortions of dependency, hostility, low feelings of independence, devalued self-esteem, and tendencies toward detachment operate in producing disruptions in their relationships with people and their attitudes toward themselves. Patients must be shown how their personality characteristics inevitably create the stress and generate the anxiety that initiate many of their disruptive defenses. Although a patient may seemingly accept such explanations and interpretations, they will at first have little effect on his or her behavior. The therapist will have to demonstrate the workings of the patient's dynamics in his or her everyday life over and over again until a tiny chink occurs in the patient's defensive armor. Most penetrating will be the elucidation of how the patient's personality problems display themselves in the transference with the therapist. A tremendous amount of dogged perseverance will be necessary which can tax the tolerance of the most empathic therapist. Countertransference must be watched assiduously and used as constructively as the therapist can manage given the undisciplined, resistive, and helter-skelter behavior of the patient. Therapists who have the stamina and forbearance to work with their patients beyond the profits of symptom relief toward alteration of the character structure will have to resign themselves to the battle conditions of tempestuous long-term therapy, which, while unnerving in the beginning, may very well prove worthwhile in the end. Some helpful leads may be found in the section in this chapter on the therapy of personality disorders. The articles by Barnett (1972), E. K. Schwartz (1972), Salzman (1966, 1983), and Suess (1972) contain interesting pointers.

The prognosis for obsessive-compulsive neuroses will depend upon the severity of the condition and the residual ego strength. It will also depend upon the length of time the patient has been ill. In some cases obsessive-compulsive patterns appear to be of relatively recent duration, the compulsive difficulty having developed as a result of external pressures and problems to which the patient could not adjust. The prognosis for these patients is much more favorable than it is for patients who have been ill since

puberty. Some psychiatrists recommend that patients who do not respond to medications, behavior therapy, and psychotherapy and whose anxiety and suffering become unendurable ultimately submit to leucotomy, which, in some cases, will control symptoms when everything else fails. Tippin and Haun (1982) report that more than 69 of 110 obsessive patients who had modified leucotomy operations were symptom-free or improved and needed no further treatment. Understandably, this radical form of therapy will be resisted and should not be used except under extraordinary circumstances.

Posttraumatic Stress Disorder (DSM-III-R Code 309.89)

Under unusually harsh and catastrophic conditions of stress, therapists may confront reactions of great physiological and cognitive severity, beyond what we encounter in the face of such adversities as bereavement, marital conflict, chronic illness, and other calamities (see Chapter 59). These conditions include such natural disasters as earthquakes, floods, hurricanes, famine, transportation and industrial accidents, rape, assault, torture, and bombings. For the most part, posttraumatic stress disorders are mainly consequent to the disasters of war. Especially prominent is combat fatigue among soldiers of the participating armies. The most common reaction is an anxiety state characterized by tension, emotional instability, somatic symptoms, insomnia, and nightmarish battle dreams. Less common are conversion, depressive, and psychophysiological reactions. Acute temporary psychotic-like episodes may also occur.

Knowledge of the dynamics of war neurosis made certain preventive measures possible in World War II. Soldiers who had had training that had made them feel they could defend themselves under all circumstances, who had been shown that they had adequate weapons of attack, who had confidence in their leaders, and who had obtained sufficient indoctrination and morale building were best prepared to resist a breakdown. An important element in prevention was group identification. Cooperation with others was essential, and the individual had to be made to feel that he was part of a team and that he had enough of an idea of the battle situation and the planned strategy so that he would not be caught by surprise.

The incidence of war neuroses is proportionate to shattered morale and to feelings of isolation from fellow soldiers. An organized body of men fighting for a cause that they consider just can best overcome war stress and hardship.

Adequate information regarding the significance of the conflict, assignment to units with congenial companions, fair discipline, commanding officers who merit respect, periodic relief from duty in the combat zone, and confidence in the assigned weapons all contribute to better morale and greater stress tolerance. Teaching soldiers that fear is normal and that one can function with it may be reassuring. A history of previous emotional disorders, an unstable family situation, and poor socioeconomic conditions in civilian life are usually though not always bad prognostic signs. Some solders maladjusted in civilian life relish the conditions and even dangers of army life. Upon termination of army service, having adjusted adequately up to this time, a certain number of such individuals are unable to adjust to civilian life. A phenomenon that was noted among officers and enlisted personnel in Korea and Vietnam was separation anxiety, which developed when the end of their service was near and the solder had to leave his companions. This occurred even among soldiers in combat units. The group identification which held the individuals together was reluctantly given up.

In spite of preventive attempts, stress reactions of varying degrees of intensity may occur, particularly in response to precarious conditions of combat. A more vulnerable soldier may manifest panicky reactions during which thinking gets disorganized, non-productive somatic symptoms become pronounced, and behavior tends to become maladaptive, exposing the individual to even more danger. In combat situations during fierce shelling, for example, the soldier may flee safety areas and run wildly away, exposing himself to shrapnel and gunfire. Overwhelming stress may produce a temporary shock-like reaction followed by what seems to be recovery.

Even the most stable combatants are apt to exhibit a good deal of muscle tension, faintness, giddiness, tachycardia, palpitations, shaking, and tremors during an engagement. The bravest soldier

will experience fear, which prevents him from throwing caution to the winds. In many cases gross stress reactions are brought on by killings, fatigue, loss of sleep, hunger, and cold over a prolonged period. Homesickness, uncertainty about the future, physical discomfort, and sexual deprivation may be as traumatic as actual engagement in combat. Reactions will usually follow responses to past situations of acute stress. One of the most important factors in subduing these reactions is good leadership, including thoughtful directing of activities toward maintaining morale.

Experience in treating gross stress reactions in the last war indicated that removing soldiers from forward areas to hospitals in the rear tended to aggravate the difficulty. Good results were obtained when treatment was organized around the expectation of returning to duty. It has been observed that an aversive attitude toward "nervousness" and "weakness" by frontline troops acts as a deterrent to neurotic combat reactions. Expectations that a soldier who "breaks down" will be moved away from the battle zone, released from the army, and perhaps compensated for his disability encourage neurotic symptoms. Group identification tends to reassure the individual and bolster morale. The need to be accepted by the group is one of the most important safeguards against "breaking down." A soldier removed from his unit and sent to a hospital is a candidate for psychological disability, which will stir up guilt feelings and devalued self-esteem. The security of the hospital setting paradoxically prevents him from making a rapid recovery. During the last war, rest outside of a hospital, good food, and the opportunity to verbalize fears and other feelings to a reassuring person proved most successful. Tranquilization, narcosyntheses, and hypnosis in serious cases were employed with rapid success in susceptible subjects. Combat exhaustion, if treated early, did not necessarily result in neurosis. A moderate anxiety state cleared up in 24 hours with rest, reassurance, and some tranquilization if needed. It was assumed that the soldier would go back to the front. Where there was reluctance to return to battle duty, appeals to patriotism, courage, and "not letting one's buddies down" often built up the person's courage and

determination. Encouragement to verbalize fear and disgust was vital, since the soldier in this way released tension and discovered that others shared his anxieties.

The value of respecting the soldier's "gripes" in building morale has long been recognized. The role of the leader is important, too, and an intrepid commanding officer has always been of great service. It is amazing how often a change in attitude in a soldier can prevent neurotic collapse. Under constructive leadership, a soldier has the best chance of pulling himself together and of dealing with his need to protect himself from danger while discharging his duties honorably to preserve acceptance from his peers.

In many cases an incubation period ensues during which what Kolb (1982) has termed "secondary reflective cognitive consequences of the catastrophic experiences" surface in the form of survival guilt, shame, and heightened sensitivity to stimuli directly or remotely resembling the initial stressful assault. Mardi Horowitz (1976), in pointing out this reaction, has emphasized the importance of existential threat as a basic cognitive factor in posttraumatic states.

The posttraumatic reaction may occur within 6 months of the trauma (the acute subtype) or after 6 months and even after several years (the chronic or delayed sub-type). Often it develops after the individual has become stabilized and has resumed habitual functioning. Reactions here draw upon latent personality strengths and on the degree of repression that has sealed off appropriate emotional reactions to the offensive stressor. After the individual has apparently digested the implications of what has happened, he may respond with depression, bouts of anxiety, restlessness, aggression, guilt feelings, obsessions, insomnia, nightmares, fugue states, and amnesia, which may continue indefinitely. In the majority of cases, however, an adaptation is made, even though certain symptoms continue, and, after a period of adjustment, these symptoms may become fixed. In some instances detachment, aggression, startle reactions to noise, muscle tension, tremors, depression, insomnia, battle nightmares, psychosomatic complaints, and bouts of anxiety may be very difficult to handle. In serious cases,

outbursts of violence, detachment, and paranoia may interfere with a constructive social adjustment. Guilt feelings about one's behavior in the army, particularly related to the killings and personal feelings of cowardice, may sponsor a good deal of recrimination and self-punishment.

Therapy for posttraumatic stress disorders may require some time, especially if alcohol or drugs have been employed to quiet the symptoms. Even when these are brought under control, a good deal of working-through of the guilt feelings may be required. Hendon et al. (1983) have evolved a useful questionnaire as a first step, along with an excellent outline for a five-session evaluation of the problem. Most important, a provision should be made for continuing therapy after the initial sessions have opened the door to suppressed feelings. Working through such feelings is important. Otherwise the patient will be left in a more vulnerable state than before. Once a treatment is started, exploration of the meaning of the combat experiences and the devices the veteran uses in covering up his guilt and pain are in order.

Treatment of stress reactions in civilian life (hurricanes, floods, explosions, mass bombings, etc.) should be started as soon as possible, since delay permits the neurosis to become more highly organized and allows the secondary gain element to take hold. First aid helps victims of disasters to return to proper functioning in a short time. Preventive measures are of incalculable value if a disaster is anticipated and potential victims are apprised of dangers as well as suitable protective and ameliorative actions that may be taken. Practice drills under simulated disaster conditions, faithfully repeated, help to establish appropriate patterns if and when emergencies occur.

Responses of people to both unexpected and expected dangers will vary depending on the specific meaning of the danger situation to them and their residual stabilities and habitual coping mechanisms in the face of stress. They will also respond uniquely to any warning signals. Among the gravest dangers to the group are the wildly uncontrolled panic reactions of a few unstable individuals, which can have a contagious influence on the rest of the group. If the leader knows in advance which members are apt to

manifest unrestrained fear, he or she may select them in advance and assign them definite tasks so as to divert their energies.

Even with drills, exercises, and warning signals, the impact of a disaster is bound to provoke immediate reactions of anxiety and confusion. These, however, should soon be replaced by adaptive responses encouraged during the practice sessions. As soon as the violent impact of the disaster has subsided, organized activities will take place. Working together and helping the more physically and emotionally disabled has a profoundly reassuring effect. People who are unable to compose themselves may need special treatment. For example, a person who shows blind panic will require firm restraining by two or three people to avoid spreading panic throughout the group. Drug therapy may be necessary as described in the section on dealing with panic reactions in emergencies (see Chapter 58).

In treating disaster victims whose neurotic or psychotic responses do not subside with the termination of the emergency, the first principle is to permit them to verbalize feelings; the second, to accept their reactions, no matter how unreasonable they may seem. Supportive therapy coupled with sedation or tranquilization will usually suffice to restore the person to his or her previous state. Imagery plays an important part in working through these disorders (Horowitz MJ, 1970, 1976; Brett 1985) and may serve as a productive therapeutic vehicle, especially in hypnosis.

If a patient has a continuing stress reaction that threatens to become chronic, narcotherapy (q.v.) and hypnotherapy (q.v.) are often effective for purposes of symptom removal. In instances where anxiety is extreme, one may utilize an “uncovering” type of technique. Here hypnosis and narcotherapy are also of help. The recovery of amnesias, and the reliving of the traumatic scene in action or verbalization, may have an ameliorative or curative effect.

While hypnotherapy and narcotherapy accomplish approximately the same results, the emotions accompanying hypnotherapy are often much more vivid, and the cathartic effect consequently greater,

than with narcotherapy. There are other advantages to hypnosis. The induction is usually brought about easily without the complication of injections and without post-therapeutic somnolence. Additionally, hypnotic suggestions are capable of demonstrating to the patient more readily his or her ability to gain mastery of functions. On the other hand, narcotherapy is easier to employ and does not call for any special skills.

If it is essential to remove an amnesia, the patient is encouraged under hypnosis or narcosis to talk about the events immediately preceding the traumatic episode and to lead into the episode slowly, reliving the scene as if it were happening again. Frequently the patient will approach the scene and then block, or he or she may actually awaken. Repeated trance inductions often break through this resistance. Also, it will be noted that the abreactive effect will increase as the patient describes the episode repeatedly. Apparently the powerful emotions that are bound down are subject to greater repression than the actual memories of the event.

Hadfield's (1920) original technique is still useful. The patient is hypnotized and instructed that when the therapist's fingers are placed on the patient's forehead, the patient will picture the experiences that caused the present breakdown. This usually produces a vivid recollection of the traumatic event with emotions of fear, rage, despair, and helplessness. The patient often spontaneously relives the traumatic scene with a tremendous cathartic effect. If the patient hesitates, the therapist must encourage a detailed description of the scenes dominating the patient's mind. This is the first step in therapy and must be repeated for a number of sessions until the restored memory is complete. The second step is the utilization of hypnosis to readjust the patient to the traumatic experience. The experience must be worked through, over and over again, until the patient accepts it during hypnosis and remembers it upon awakening. Persuasive suggestions are also given, directed at increasing assurance and self-confidence. After this the emotional relationship to the therapist is analyzed at a conscious level to prevent continuance of the dependency tie.

Horsley (1943) has mentioned that when the ordinary injunctions to recall a traumatic scene fail, several reinforcing methods can be tried. The first has to do with commanding the patient to remember, insisting that he or she will not leave the room until memory is completely restored for the traumatic events. The second method is that of soothing, coaxing, and encouraging a total recall ("You are about to remember the troubled scenes that will remind you of your experiences.") If this is unsuccessful, the patient is told that although the memory has not yet come through, it will upon awakening reveal itself in any way the patient sees fit. Instruction to recall more details in a dream the same or the next night is given.

Various hypnoanalytic procedures, such as dramatization, regression and revivification, play therapy, automatic writing, and mirror gazing, may be utilized to recover an obstinate amnesia (Wolberg, 1964a). The reaction of patients to the recall of repressed experiences varies. Some patients act out the traumatic scene, getting out of bed, charging about the room, ducking to avoid the attacking objects and people. Other patients live through the traumatic episode without getting out of bed. Some individuals collapse with anxiety; they should be reassured and encouraged to go on. If the patient voices hostility, he or she should be given an opportunity to express grievances and dislikes. Clarification of feelings of injustice may afford considerable relief.

It must be remembered that the object in therapy is to dissipate feelings of helplessness and of being menaced by a world that the patient no longer trusts. The sense of mastery and the ability to readjust oneself to life must be restored. The best reactions to hypnosis are obtained when it is executed as close in time to the trauma as possible. This may prevent organization of the condition into a chronic psychoneurosis. Follow-up therapy is essential, with integration on a waking level of the material brought up during the trance. If the anxieties relating to the disaster have precipitated hysterical, phobic, compulsive, and other reactions characteristic of the ways that the patient has dealt with anxiety in everyday life, long-term insight therapy will usually be required.

In chronic stress reactions, treatment is difficult because of the high degree of organization that has taken place and because of the strong secondary gain element involving monetary compensation and dependency. The recovery of amnesias should always be attempted, but even where successful, this may not at all influence the outcome. An incentive must be created in the patient to function free of symptoms, even at the expense of forfeiting disability compensations, which in comparison to emotional health may be shown to be diminutive indeed. (See also Chapter 59; Crisis Intervention, Chapter 57; and pertinent parts of Chapter 58 on emergencies.)

DISSOCIATIVE DISORDER (HYSTERICAL NEUROSIS, DISSOCIATIVE TYPE)

Dissociative disorders manifest themselves in disturbances of consciousness, memory, and identity. In *multiple personality disorder (DSMIII-R Code 300.14)* a dramatic interruption of the habitual personality is periodically produced by the intrusion of a seemingly foreign personality or personalities that inspire variant behaviors often at odds with the usual patterns of the individual. In *psychogenic fugue (DSM-III Code 300.13)* the person wanders off away from home with the assumption of a new identity and amnesia for the previous identity. In *psychogenic amnesia (DSM-III Code 300.12)* disturbances in recall are characteristic. These blank spots may occur without identifiable cause or may follow an accident or catastrophic incident. In *depersonalization disorder (or depersonalization neurosis DSM-III-Code 300.60)* the reality sense is impaired with feelings of detachment from oneself.

The basic defense employed in dissociation reactions is repression. Therapeutic techniques are best organized to resolve the repression and deal with inner conflicts. Transference analysis, especially the working through of a transference neurosis, is ideally suited to therapy of this disorder, but may not be possible for practical reasons and because of patient resistance. When transference analysis cannot be used, a less intensive psychoanalytically oriented psychotherapy may be employed. From the viewpoint of mere handling and removal of symptoms, hypnosis is classically of value. Although hysterical

symptoms can often be eliminated in relatively few hypnotic sessions, the dramatic, infantile, and self-dramatizing personality constellation associated with this reaction will require prolonged psychotherapy, preferably along reconstructive lines. Unfortunately, even though insight therapy is accepted by the patient, a great many impediments will become manifest during the course of treatment in the form of intellectual inhibitions and other devices to reinforce repression.

Whereas insight therapy is the best treatment for this condition, circumstances of obstinate resistance, faulty motivation, and profound secondary gain may prevent any other than a supportive approach.

Symptom removal by authoritative suggestion, with or without hypnosis, is occasionally indicated, particularly where the symptom produces great personal discomfort and interferes with the individual's social and economic adjustment. Some symptoms serve a minimal defensive purpose in binding anxiety. The inconvenience to the patient of such symptoms is an important incentive toward their abandonment. If the symptom constitutes a plea for help, love, and reassurance on the basis of helplessness, the therapist, by ordering cessation of symptoms, virtually assures the patient of support and love without the need to utilize symptoms for this purpose. Should the patient sense that his or her demands are not being fulfilled, a return of symptoms or histrionic acting out may be expected.

Although some symptoms vanish with a strong authoritarian suggestive approach, one must not overestimate the permanency of the apparent cure since the original motivations that sponsored the symptom are not altered in the least and a relapse is always possible. Consequently, whenever the therapist can do so, the patient should be prepared for future therapy by explaining the purposeful nature of the symptom and its source in unconscious conflict.

Since hysteria often represents a reaction to unpleasant circumstances that stimulate inner conflicts, a guidance approach is sometimes utilized in appropriate cases to adjust the patient to environmental

demands from which he or she cannot escape and to help the patient modify existing remediable situational difficulties. It may be possible to get a hysterical individual to make compromises with the environment so that he or she will not be inclined to overreact to current stresses. Here, too, an attempt must be made to acquaint the person with the fact that the symptoms, though inspired by external difficulties, are actually internally sponsored. Once the patient accepts this fact, therapy along insight lines may be possible.

The treatment of hysteria through hypnotic symptom removal and by guidance therapy are least successful if the symptom serves the purpose of providing intense substitutive gratification for sexual and hostile impulses.

Difficulty will also be encountered if the symptom tends to reinforce the repression of a traumatic memory or conflict, as in amnesia. The extent of amnesia varies. It may involve a single painful experience in the past, or it may include a fairly wide segment of life. It may actually spread to a point where the person loses his or her identity and forgets the past completely. Amnesia serves the defensive purpose of shielding the individual from anxiety. The intractability of an amnesia, consequently, is related to the amount of anxiety bound down and to the ego resources that are available for coping with the liberated anxiety. The fear of being overcome by anxiety may be so great that an impenetrable block to recall will exist despite all efforts to reintegrate the person to past memories. Indeed, the fear of uncovering a memory may be so strong that the person will resist trance induction.

When resistance to hypnosis is encountered, a light barbiturate narcosis, either oral or intravenous (see the section on Narcotherapy), may remove the block. A trance, once induced, is deepened, and a posthypnotic suggestion is given the patient that he or she will henceforth be responsive to hypnosis without narcosis.

It must again be emphasized that, although certain hysterical symptoms may be treated rapidly through short-term supportive treatment, the basic personality problems associated with the hysterical disorder require a considerable period of reconstructive therapy.

SOMATOFORM DISORDERS

A number of psychophysiological autonomic and visceral disorders are included in this category, namely, somatization disorder, somatoform pain disorder, hypochondriasis (or hypochondriacal neurosis), body dysmorphic disorder, and conversion disorder (hysterical neurosis, conversion type). In *somatization disorder (DSM-III-R Code 300.81),* the patient presents a variety of somatic complaints resulting in frequent consultations with physicians. Despite batteries of negative tests, and medical reassurance that no organic basis exists for the symptoms, the patient is never fully convinced that this is so. Such "psychosomatic" or "psychophysiological" manifestations are complicated by a depressive and anxiety overlay, which adds to the suffering of the individual. An exaggerated form of this symptomatology is found in *hypochondriasis (or hypochondriacal neurosis) DSM III-R Code 300.70*. Here the symptoms, though intense, are still not of a delusional nature, and some appeal to reason is possible. A special condition in this category is preoccupation with presumed defects in the appearance of one's face and body in the absence of any real anomaly (*body dysmorphic disorder [dysmorphobia*]) that may drive the victim to a succession of plastic surgeons for correction that never comes about. Where pain for over six months constitutes the complaint factor and persists in the absence of organic pathology, we may be dealing with a *somatoform pain disorder (DSM-III-R Code 307.80)*. This must be differentiated from a conv*ersion disorder (or hysterical neurosis, conversion type (DSM-III-R Code 300.11)*, which usually takes the form of a neurologic disease (paralysis, aphonia, visual disorder, anesthesia, astasia-abasia, and hysterical contractions) or of such morbidities as persistent vomiting, false pregnancy (pseudocyesis) and other peculiar symptoms that are basically symbolic manifestations of inner conflict. In many conversion syndromes a casual attitude (la belle indifference) accompanies the

outwardly alarming symptoms. Somatoform disorders are often rooted in disturbances in the personality organization; some are engendered by defects in the earliest contacts of the infant with the mother. The personality structure of the patient, consequently, contains dependent, hostile, and masochistic elements that tend to obstruct a good working relationship. Because the ego is more or less fragile, anxiety, mobilized by the transference and by interpretation, may be intolerable. Insight therapy may, therefore, have to be delayed in favor of discreet supportive techniques during which the patient is permitted to relate dependently to the therapist.

The negative elements of the relationship with the therapist must constantly be resolved, and the therapist must be alert to hostile manifestations, which the patient will perhaps try to conceal. Once a good working relationship is established, exploration of inner strivings, needs, and conflicts with cautious interpretations may be attempted. Most patients with somatoform disorders find it difficult or impossible to think abstractly, however, and revelations of conflict seem to do little good. They cannot seem to describe their affects and to relate their fantasies, and they fail to respond to free association and interpretation (Nemiah, 1971). Exaggeration of the patient's physical symptoms is a common sign of resistance. When symptoms increase in intensity, the patient may be tempted to leave therapy. Treatment is generally a long-term proposition, since the deep personality problem associated with the symptoms resolves itself slowly. Essentially, therapy may follow the design for the management of personality disorders (q.v.).

A constant danger during insight therapy is the unleashing of excessive quantities of anxiety, usually the result of too speedy symptom removal or too rapid dissipation of defenses. Often the somatic disturbance represents the most acceptable avenue available to the patient for the discharge of anxiety and hostility. Because the ego has been unable to handle these emotions on a conscious level, the mechanism of repression is invoked. When coping devices are threatened without a coordinate strengthening of the ego and the person becomes prematurely aware of unacceptable conflicts and

strivings, there is definite danger of precipitating a crisis. The patient may release such intense anxiety that he or she will employ symptomatic contingencies to bind this emotion. The patient may, for instance, develop depressive or compulsive symptoms or display detachment and other characterological defenses. Anxiety may, nevertheless, get out of hand and shatter the ego in fragile personalities even to the point of precipitating a psychosis. In hysterical conversion disorders symptoms may astonishingly be temporarily dissipated by strong authoritative commands as during hypnosis. Little impact is registered on the underlying personality distortions.

It may be impossible to do more for the patient than to give supportive therapy. For instance, persuasion and guidance may enable the patient to organize his or her life around the defects and liabilities, to avoid situations that arouse conflict and hostility, and to attain, at least in part, a sublimation of basic needs. The object here is to bolster the ego to a point where it can handle damaging emotions more rationally as well as to improve interpersonal relationships so that hostility and other disturbing emotions are not constantly being generated. In some instances such therapies help to liberate the individual from the vicious cycle of neurosis, facilitating externalization of interests, increasing self-confidence, and indicating ways of discharging emotions. Minor tranquilizers, such as Librium and Valium, may be administered periodically if symptoms are especially harsh. Considerable relief from symptoms may be obtained through relaxation exercises, meditation, hypnosis, and biofeedback (see Chapter 56). Behavior therapy works better than dynamic psychotherapy.

The therapeutic relationship is kept at as positive a level as possible, an attempt being made to show the patient that the symptoms are not fortuitous, but that a causal relation exists between symptoms and difficulties in dealing with life. The circumstances under which symptoms become exaggerated are investigated with the objective of determining areas of failure in interpersonal functioning. Once a pattern is discerned, its significance and origin are explored. Finally, the patient is encouraged to put

into action the retrained attitudes toward life and people. In some cases sufficient ego strength may be developed to make psychoanalytically oriented psychotherapy possible.

Where the patient is coordinately under the care of an internist, cooperation between the therapist and internist will improve the results.

PERSONALITY DISORDERS

Personality problems plague every human being. They are an inevitable consequence of cultural and family aberrations that cannot help but influence child-rearing practices. The great majority of people manage to live with and around disturbing personality problems and to make a reasonable adjustment to everyday pressures and responsibilities. When problems become intolerably distressful, however, maladjustment may ensue.

Personality disorders encompass a heterogeneous group of traits, tendencies, and patterns of behavior that impair social and occupational functioning. Some of these disorders have a long history dating back to childhood. In the DSM-IIIR classification a number of syndromes fit this description: (1) Disruptive Behavior Disorders (conduct disorder, attention-deficit hyperactivity, oppositional-defiant disorder), (2) Anxiety Disorders of Childhood (separation anxiety disorders, avoidant disorders of childhood or adolescence, overanxious disorder), (3) Eating Disorders (Anorexia nervosa, bulimia nervosa, pica, rumination disorder of infancy), (4) Gender Identity Disorders (gender identity disorder of childhood, transsexualism, (5) Tic Disorders, (6) Disorders of Elimination, (7) Other Speech Disorders, (8) Other Disorders (reactive attachment disorder, stereotyping/habit disorder, elective mutism, identity disorder). Some of these disorders may in history-taking be identified as early manifestations of the pathology for which the patient now seeks help. In many, perhaps most cases, we have problems in tracing the histories of personality disorders because the individual usually forgets, conceals, distorts, or rationalizes early difficulties.

Urgent, inflexible, “ego-syntonic,” and resistive to change, personality disorders interfere drastically with adjustment. There may be some awareness of the nature of the problem but it cannot seem to be controlled.

When a patient presents for therapy, the complaint is generally a disturbing symptom or a stressful event that has upset the habitual equilibrium. Most patients do not see the connection between their personality operations and their symptoms at the beginning of therapy. A too early emphasis on such a connection will tend to be confusing. It is important to consider that personality is the machinery through which the individual regulates his or her relationships with life and people. Individuals regard their traits as integral a part of themselves as their skin, and a premature effort to peel away traits that are disruptive will be staunchly resisted. Why this is so is not difficult to understand. During development, the individual evolves defenses to cope with stresses brought about by hurtful or depriving circumstances. Such defenses endure as a way of life far beyond their period of usefulness. They become welded into the intrapsychic structure, and the original events that initiated them are repressed and more or less relegated to unconscious oblivion. In adult life, they nevertheless continue to operate insidiously, independent of reality. Individuals may even attempt to create conditions that will justify their reactions, as if they seek to master a challenge and to complete the unfinished business of their past.

Treatment with the goal of some reconstructive change is a long-term proposition. It cannot be completed in 6 or 20 or even 40 sessions. It requires detailed work during which the patient is brought to an awareness of the nature of his or her problem and its investment in past history. Once some insight is achieved, the working-through process slowly takes place, aided by homework away from the therapist’s office in the crucible of life experience itself. Permanent change may require several years of dedicated treatment. A sequence of operations usually takes place: (1) the disorder is clearly identified; (2) the consequences of the patient’s behavior are delineated; (3) motivation to alter offensive patterns

are developed; (4) exploration of the origins and purpose of the disorder may be required; (5) modes of rectification of attitudes and a reconditioning of behavior are designed; and (6) termination of treatment is carefully structured.

In the treatment of a personality disorder, we may accordingly execute the following *baseline interventions*:

1. *The patient is brought to an awareness of the traits he or she pursues that create problems.* Detection of these traits will not be difficult from the case history as revealed by the patient, from reports of informants if these are available, and particularly from the patient's attitudes and behavior toward therapy and the therapist. Some patients are at least partially aware of their maladaptive patterns; some appear to be oblivious to their nature and the effect on themselves and others. One cannot jump in immediately and vigorously confront the patient with his or her self-defeating attitudes and corrosive conduct unless a good working relationship has been established. The patient will either not listen or will assume he or she is being unfairly attacked and misunderstood. But as soon as the therapist feels that a reasonably sound therapeutic relationship exists, confrontation blended with empathic understanding may be necessary and invaluable. If repression acts like an interfering block of concrete, analysis of dreams, transference, and acting-out may be helpful in expediting awareness. Interpretations must be carefully titrated to the patient's ego strength and level of anxiety.

   Interpreting character drives in a way that will be therapeutic is an art because reactions to interpretations of anger, offensiveness, denial, disbelief, or detachment can have a negative effect on the therapeutic alliance.

One way of softening the negative impact of interpretations is to couch them in universal terms. In this way, one hopes to avoid a disintegration of the therapeutic relationship. For example, the following statements were offered patients:

> (Strong dependency traits in a man) "Many people come through a difficult childhood with scars that burden them. Because of an unfulfilled early life, they try to make up for satisfactions they failed to get by looking for and getting dependent on a better, more idealized parent figure. Could it be that you are reaching for a more fulfilling relationship, which you believe your wife is not supplying?"

(Masochistic tendency) “There is really nothing so unusual in the way you are reacting. People who are angry at what has happened to them often are very guilty and may seek to punish themselves for even feeling angry.” (Detachment) “It is only natural that when a person feels hurt there is a need to escape from one’s feelings. Sometimes not feeling emotions or physically getting away from people is an effective defensive maneuver. But there are penalties one pays for detachment.”

(Perfectionism) “Doing things perfectionistically is one way people have of protecting themselves. The only trouble is that nobody can ever be perfect, and if perfection is a goal one always has to suffer.”

By avoiding confronting the patient directly with a character defect, one may obliquely be able to penetrate defenses. Once the patient acknowledges a problem openly, confrontation can then be more direct and personal. The therapist should watch the patient’s reactions to interpretations to see whether the patient is strong enough to tolerate and make use of them. Initial reactions should not be taken at face value. As long as there is evidence that confirm the assumptions of the therapist, interpretations should carefully be woven into questions, continuously presenting these to the patient in the hope that the patient will eventually make the proper connections.

In the case of a man with untoward aggression, his acting-out patterns were vivid enough so that it required little from me to get him to realize that his behavior was problematic, although he attempted to justify and rationalize it. Interpretations fell on deaf ears, even though explanations were deliberately modulated. It was obvious that he defended against using them in the early phases of treatment.

2. *The aversive consequences of the patient’s patterns are reviewed in detail*. These are abundant and usually well-known to the patient, although he or she will ascribe them to being misunderstood or discriminated against. A wealth of excuses, resentments, and recriminations will drown the patient’s judgment. The therapist will soon realize that no matter how severe the punishment is that follows untoward behavior, the patient is completely unable to control it. Indeed it may become evident, as happened in my patient, that he or she masochistically seems to welcome punishment.

3. *Detailed determination of the function of the disturbed patterns must be elaborated*. Here dynamic thinking is indispensable since the purpose behind the manifest symptomatology is

often not explicable in terms of everyday logic. In our patient under discussion it became apparent through exploration of his dreams, associations, and behavior toward me that he was trying to mask underlying passivity, low feelings of independence, and a non-masculine image he believed he was displaying to the world. Blustering verbal attacks and an appearance of belligerence served the purpose of presenting a macho front. He had guilt feelings about homosexual fantasies but apparently never acted them out. Interest in women was high, and he enjoyed heterosexuality. He was, however, unable to establish an enduring relationship with any one woman. Discussions about his irrational fantasies created motivation to inquire further into their nature.

4. *In some cases it is important to explore the origins of the personality disorder in past formative relationships*. Memories of early determining experiences are usually blurred and their connection with present-day behavior obscure. As therapy proceeds, some memories and connections become clearer. The transference may reveal significant feelings toward early caretaking agencies that are being projected toward present-day authorities. The most dramatic revelations will occur when an actual transference neurosis precipitates. A few motivated patients may be susceptible to the classical analytic technique, which will most reliably produce a transference neurosis. Countertransference, if studied assiduously, may also yield data about some of the patient's projected unconscious processes. One occasionally finds that the patient's behavior is molded by identification with a parental figure and that the patient is acting-out the hidden designs of these figures with the therapist, or outside persons (projective identification). In many cases a modified analytic approach, dealing with derivatives of nuclear conflicts, is all that is possible. Presentation of a schema such as outlined in Chapter 44 may enable the patient to reconstruct past experiences and to assign to his or her personality patterns a more significant meaning. This will help establish better controls.

   Our patient became aware of his continuing dependency, his futile search for an idealized maternal figure, his delayed separation-individuation, his resentment of women as symbols of the controlling and castrating mother, his feelings of low independence and masculinity, and his compensatory strivings for more effective affirmation of his masculinity through power drives, aggression, and fantasies of penis acquisition via homosexual fantasies. These insights fascinated him but still were not sufficient to cure his personality disorder. It did provide him with motivation to want to halt some expressions of self-defeating aggression.

5. *The acquisition of more constructive modes of reacting to provocative stimuli may be expedited through the employment of cognitive and behavioral techniques*. Here the patient may keep a diary of successes and failures in controlling his or her symptoms under various circumstances. Cognitive therapy helps rectify faulty self statements. Assertiveness training, group therapy, and psychodramatic role playing may aid in the reconditioning process if the patient is unable to achieve greater control through simple homework practice. These adjunctive measures were all employed with our patient because of his continuing resistance. Many patients will not need all of these measures.

6. *As soon as the patient manifests some control over his or her patterns and substitutes more productive behavioral alternatives, termination of therapy is in order, with injunctions given to continue homework practice*. A 5-year follow-up of our patient revealed continuing assertiveness without need for aggression, as well as gratifying signs of personality maturity.

7. *Severe chronic personality disorders do not lend themselves to a "quick fix."* Reinforcements in the environment keep their patterns alive, and resistances to change interfere with progress. Some cases of personality disorders, antisocial personality disorder, and very severe borderline personality disorder, for example, may require treatment in an institution staffed by personnel sufficiently well trained to deal with encrusted characterological patterns that will not yield to anything other than reconditioning in a therapeutic milieu.

The above outline of therapy for personality disorder is a barren description of treatment that of necessity extends over a long period and that requires innovative management. While treatment focuses ideally on intrapsychic and interpersonal links in the behavioral chain, difficulties related to other links may claim priority and need to be treated with special techniques, as well as the baseline interventions described above (see Table 57-1). Diagnosis of personality disorder is usually made on the basis of the most obnoxious or maladaptive traits that are being exhibited. Blatant and unpalatable, these may mask other less disagreeable but equally important personality distortions. Not uncommonly, two or more diagnostically distinct personality disorders may appear in the same person. The classification of character types into diagnostic entities is convenient but faulty to the extent that traits shift and vary with prevailing needs and existing stresses imposed on the individual. Accordingly, at irregular times,

different impulses and demands may appear that will inspire a complex array of defenses and reaction formations and suggest many different classifications. Nevertheless, distinctive diagnostic categories are listed in the DSM classification system.

Paranoid Personality Disorder (DSM-III-R Code 301.00)

Individuals with this disorder, which rarely produces sufficient discomfort to bring an individual to therapy for the personality problem alone, exhibit an unwarranted sensitivity to actions in the environment that they believe are designed to annoy, humiliate, or take advantage of them. Such suspicions are impervious to reason. Most persons with this disorder come to treatment for symptoms such as depression, anxiety, phobias, and other manifest disturbances. Only when the therapist gains their confidence will they reveal some of their peculiar ideas. When attempts are made to bring logic into the picture to prove the ideas incredulous, the relationship may begin to disintegrate. Indeed, these patients may consider the therapist allied to their enemies. It is difficult to convince them that they are trying to preserve themselves by building an impenetrable wall between themselves and others and that secrecy, guardedness, jealously, lack of humor, and involvement with fantasies of being humiliated and downgraded are symptoms of a disorder.

The best way to manage therapy with the paranoidal individual is to listen respectfully to his or her qualms and not argue about them. When the patient expresses concern about being threatened and humiliated by others, the therapist might say: “Anyone who is going through what you are is bound to be upset.” One deals with the patient’s emotional turmoil and does not try to ridicule or belittle his or her twisted cognitions.

Because of the vulnerability of the relationship with the therapist, the patient is apt to regard criticism as a blow to his or her self-esteem, initiating depression, rage, or anxiety. Criticism is interpreted as evidence that the therapist does not approve of him or her. The patient is apt to

intellectualize the entire therapeutic process, using knowledge either as resistance or as a means of fortifying against change. Despite all logic, the patient strives to wedge therapy into the framework of his or her distorted attitudes toward life. Feelings of rejection and distrust are exhibited, and at the slightest challenge from the therapist, defenses crumble, leaving the patient in a state of anger and despair. The patient may then show a psychic rigidity that refuses to yield to reason or entreaty.

Some therapists attempt to gain the goodwill of paranoidal patients through a form of strategic therapy in which they act as if the patient's ideas are factual and even become a partner in the patient's bizarre schemes. This may work at first to solidify the relationship since the patient may accept the therapist as an exceptional friend who does not ridicule his or her ideas and judgments. Unless the therapist is an excellent actor, the acutely sensitive patient will detect a fraudulent note in the play-acting maneuvers.

Some patients achieve relief from severe symptoms such as depression with antidepressants, and eventually are able to accept the therapist as a sincere friend who wants to help rather than harm. They may then begin to express some doubts about their suspicions. At this point, one may institute cognitive therapy carefully designed so as not to convey the impression that the patient is peculiar or psychotic.

Dependent Personality Disorder (DSM-III Code 301.60)

The character trait of extreme dependency sponsors relegation of responsibilities to other persons and avoidance of decision making. The individual allows a spouse or parent to arrange the most simple matters and has little incentive to promote action on his or her own. The dependence is actually one manifestation of a widespread deficit in separation-individuation, the product of faulty early development. Inability to transcend the dependency stage of development results in severe damage to the self system, including evolvement of compensations and reaction formations such as those described

in Chapter 44. An inability to manage the ordinary stresses of life may result in adaptive breakdowns, with ensuing anxiety, depression, phobias, and other neurotic difficulties.

Treatment poses special problems. Dependent persons often show up for treatment not because they feel a need for change but rather because parents, marital partners, or friends insist that something be done for them. Visits to the therapist in such cases are a mere formality. Such patients expect that no change will occur and will be resistant to any effort to get them to participate in the treatment process. The limit of their cooperativeness is to expose themselves to the therapist during the allotted hour.

Dependent patients seek to establish themselves with the therapist in ways that resemble the infant's imposition on the parents. They do not seem to be interested in developing resources within themselves. Rather, they desire to maneuver the therapist into a position where constant favors will be forthcoming. They will abide by any rules of therapy in order to obtain this objective, even to the apparent absorption of insight. It is most disconcerting, therefore, to learn that assimilated insights are extremely superficial and that the patients are less interested in knowing what is wrong than in perpetuating the child-parent relationship. They actually seem incapable of reasoning logically, and there is an almost psychotic quality to the persistence of their demands for support and direction. Sometimes the residual hostility is expressed in aggressiveness, which is usually masked by passive maneuvers such as procrastination, obstinacy, recalcitrance, and stubbornness, hence the term "passive-aggressive character disorder."

Interpretations of the patient's dependency are usually regarded as chastisement. He or she will assume that any attempt to put responsibility on his or her shoulders is a form of ill will expressed by the therapist. The patient will demonstrate reactions of disappointment, rage, anxiety, and depression and will repeat these reactions in spite of lip service to the effect that he or she wants to get well.

In treating a dependency reaction, it is essential to recognize that hostility is inevitable in the course of therapy. The demands of dependent people are so insatiable that it is impossible to live up to their

expectations. Only when such people begin to experience themselves as people with constructive assertiveness and independence are they able to function with any degree of well-being. This goal, unfortunately, may in some instances never be achieved.

Supportive therapy that propitiates the patient's dependency needs is of extremely temporary effect. It is advisable, where possible, to promote a therapeutic approach in which the individual learns to accept responsibility for his or her own development in the hope that the patient will utilize this opportunity to grow.

There are some individuals, however, whose self-structure has been so crushed that they will resist any attempt to make the therapeutic situation a participating one. Here the treatment program may have to be directed at a limited therapeutic goal. The therapist will then have to become resigned to educating the patient to function with his or her dependency strivings with as little detriment as possible.

Behavior therapy is sometimes very helpful. Conditionings are organized so that the patient is rewarded for making his or her own decisions. It is to be expected that the patient will resent this vigorously, accusing the therapist of refusing to accept responsibility. The therapist may then explain that pandering to the patient's demands for support and making decisions for him or her only tends to infantilize the patient. It would make the patient more dependent and more unable to develop to a point where he or she could fulfill himself or herself productively and creatively. The therapist does not wish to shirk responsibility but withholds directiveness out of respect for the patient's right to develop. Although patients may still resent the therapist's intent, they may finally understand that unless they begin to make their own decisions, they will never get to a point where they are strong within themselves. Behavioral assertive training may prove helpful.

Some patients who seemingly are fixated on a dependent level may, with repeated reinforcements and assertiveness training, finally begin to accept themselves as having the right to make their own

choices and to develop their own values. Unflagging persistence, however, is the keynote. In therapy the patient will exploit every opportunity to force the therapist to assume a directive role. Nevertheless, when the patient sees that the therapist has his or her welfare at heart, he or she may be able to develop more independence and assertiveness. The shift in therapy from a directive to a non-directive role calls for considerable skill, and it must be tempered to the patient's incentives and ego strength. Unless such a shift is made at some time, psychotherapy will probably be interminable, and the patient will continue on a dependent level requiring the ever presence of the therapist or some other giving person as a condition to security.

Should it become apparent that one cannot work along participating lines and that the patient's only objective is to become dependent on the therapist, visits may be cut down to 15- to 20-minute sessions once weekly or bimonthly, and/or the patient may be referred to a supportive social or reeducative group with periodic fulltime sessions when required.

Obsessive-Compulsive Personality Disorder (Compulsive Personality) DSM-III-R Code 301.40

Compulsive personalities are obsessed with orderliness, preoccupied with trivia, irritatingly perfectionistic, immovably obstinate, over conscientious, and addicted to work and what they consider demanding daily responsibilities. They have little time for leisure and enjoyment, and their relationships with people are often organized around manipulations for their own ends. Lack of confidence in themselves forces many of these individuals to engage "experts," whose advice they rarely follow, to instruct them in "what to do." Maintenance of control becomes a preoccupation, and every thought and action is measured carefully so they will not be caught off guard. Occasionally, particularly in emergencies and under the impact of great stress, controls may shatter and behavior becomes impulsive and disorganized. It becomes apparent then that forced control at all times is a means of preventing the possibility of being destroyed by unpredictable disasters. Because of the fears of making mistakes, some

compulsives ruminate about alternative solutions and find it difficult to arrive at decisions. They then ask for advice, which they question and doubt, and make a nuisance of themselves pillorying people with questions. Feelings of warmth and tenderness are subordinated to cold intellectualizations and formal stiffness in manners. The more adjusted compulsive persons are cautious, conscientious, conservative, and conforming solid citizens, and for this reason are often put in positions where punctilious work is demanded. Too frequently, the joy of living is sacrificed to a sense of responsibility. Certain cultures encourage and reward some compulsive traits that are considered desirable, not abnormal.

Though obsessive compulsive personality disorder seems related to obsessive-compulsive disorder, relatively few persons with compulsive personalities succumb to an actual neurosis. They come to therapy because their controlling defenses have failed to function, resulting in underlying fears of shattering. Symptoms of anxiety and depression constitute the complaint factor. Environmental stresses such as severe financial problems, physical illness, forced retirement, and marital difficulties may have taxed coping capacities.

If the individual has adequately adapted to the compulsive personality most of his or her life and if it has not been responsible for a serious physical ailment (such as cardiac disease in the compulsive Type A personality), the objective in treatment is restitution of the old personality controls. Resolution of identifiable environmental stress (via counseling, environmental manipulation, etc.) and medicinal management of symptoms related to the implicated biological links (anxiolytics, antidepressants, etc.) are instituted when indicated. Relaxation therapy is often of great value, and many of these patients are good subjects for hypnosis and biofeedback. Marital therapy may be employed. Cognitive therapy to change attitudes, as toward forced retirement, may be tried, but the patient’s stubborn clinging to established belief systems may be difficult to overcome.

Because many of these patients are intellectually keen, some alteration of stubborn personality traits may be possible through persistent application of the "baseline interventions" described at the beginning of this chapter. Supplying the patient with a chart delineating how personality drives operate may prove helpful since this permits the patient to put his or her patterns into an ordered arrangement that can be studied as assigned homework.

Passive-Aggressive Personality Disorder (DSM-III-R Code 301.84)

Persons who display extraordinary resistance to demands being made on them in their education, work, and social relationships may be suffering from a passive-aggressive personality disorder. This diagnosis is, along with "atypical, mixed, or other personality disorder," a kind of wastebasket into which varied reaction patterns are dumped. One often gets the impression that many passive-aggressive individuals utilize their resistance as a form of aggression. They refuse to allow themselves to be "pushed around." In their way, their "forgetting," inefficiency, procrastination, and oppositional tendencies serve the purpose of supporting a spurious independence.

At the core of these traits is a severe developmental disturbance characterized by incomplete separation-individuation. The high level of dependence may be concealed or masked by projecting it onto a religious deity who is worshipped for hoped-for rewards in the present (e.g., winning at Lotto) or in the future (e.g., reserving an established seat in heaven). Where it is expressed toward a human target (i.e., parent, spouse, lover, authority, etc.), the individual will usually downgrade the strength, wisdom, and designs of his or her chosen host as failing to achieve the virtues of an idealized parental figure. Patients will project toward this person great though controlled hostility for failing them in their need and additionally will blame them for taking away their independence. Hostility may assume the form of aggression, scapegoating, or sadism toward others; or it may be fed back internally with self-punitive and other masochistic maneuvers. Low independence may produce self-criticism and a devaluated self-image, which may sponsor fantasies of being inferior, physically damaged, or sexually inadequate.

Compensations take the form of perfectionism, overambitiousness, grandiosity, and compulsive drives to prove one's strength and power. Resorting to alcohol and drugs to overcome anxiety and depression may complicate the picture.

Therapy of patients with a passive-aggressive personality disorder is difficult because of the strong ego-syntonic nature of the associated traits and the ambivalent transference that is bound to emerge. One may deal with such symptoms as anxiety and depression on a short-term basis, but the basic personality structure will continue to stir up problems for the person. Implementation of the "baseline interventions" (page 1167) is desirable, recognizing that a dynamic long-term approach is essential to make any impression on the individual.

During the course of treatment the patient will seemingly modify attitudes toward the therapist, but in this alteration the therapist must search for areas of resistance. For instance, a submissive, ingratiating attitude, which is often a cover for a fear of abandonment, may, upon interpretation, be replaced by an apparently sincere attempt to search for and to analyze inner problems. The therapist may, if the patient is observed closely, detect in this new attitude a fraudulent attempt to gain security by complying with what the patient feels is expected of him or her. While the patient appears to be analyzing his or her problem, the real motive is to gain security by adjusting to what he or she considers are the demands of the therapist. In this way the process of therapy itself becomes a means of indulging the neurosis.

In analyzing resistances, their sources in infantile attitudes and conditionings usually become apparent. Eventually it is essential to bring the patient to a realization of how the machinery with which he or she reacts to the world now is rooted in early conceptions and misconceptions about life. The interpretation of passive-aggressive character strivings does not suffice to change their nature, for they are the only way the patient knows of adjusting.

A breakdown of character strivings often brings out in sharp focus the repressed needs and impulses from which the strivings issue. When the patient becomes cognizant of what produces insatiable destructive interpersonal attitudes, he or she has the best chance of taking active steps toward their modification.

In certain cases, particularly if there are time limitations, the only thing that can be accomplished is to compromise with the existing disorder in as painless a manner as possible. Environmental manipulation may be necessary to take pressures off the patient. The patient may be shown how to adjust to the reality situation. For instance, if a woman has a strong striving for perfectionism that drives her incessantly into positions that she cannot handle with her intellectual and physical equipment, she may be shown how she can confine herself to a project that she can master proficiently. Whereas the scope of her operations may be limited, she can indulge her perfectionistic strivings in a circumscribed way, gaining some measure of gratification in this. If she is inordinately dependent on strong people, it may be pointed out that she can maintain a certain freedom of action in spite of the fact that she has to lean on authority. If she has an insatiable need to dominate, avenues for its toned-down exercise may be suggested. This approach, of course, merely panders to the patient's neurosis, but it may be the only practical approach for the time being; in many cases it will make the patient's life immeasurably more tolerable.

Whenever possible, patients should be brought to an awareness of the nature, genesis, and dynamic significance of their passive-aggressive character trends. They should be encouraged to observe how mercilessly they operate in everyday life and to scrutinize why they cannot change their attitudes toward people. Desirable as this may be, a shift in therapeutic orientation toward insight may stir up a hornet's nest in the relationship with the therapist.

Though character trends in the passive-aggressive person are constantly shifting, they are usually interrelated and the fusion makes for a picture that is unique for each individual. Behavior is not the

static product of a group of isolated trends; rather, it is a complex integrate of a number of drives. The product of this intermingling differs from any of the component strivings. That is, if the person is compulsively modest, is fired by perfectionism, is quiet at some times and arrogant and aggressive at others, some of these traits will tend to neutralize and some to reinforce each other. Nevertheless, for treatment purposes, we should consider them part of a conglomerate and not deal with them as isolated and distinctive entities.

Power Patterns

While not listed as a separate personality disorder in DSM-III-R, compensatory power impulses predominate in some individuals. Here all that seems to matter in life is forcefulness and strength. The feelings and rights of other people are disregarded. There is a blind admiration for everything invincible. The person is contemptuous of softness and tenderness, and self-esteem is seemingly dependent on the ability to be dominant. As in dependency, the dynamic force behind the power impulse is a profound sense of helplessness and an inability to cope with life with the available resources. A motive behind the power drive is to coerce people to yield to one's will, which provides bounties of various sorts.

The treatment of power drives is oriented toward building up frustration tolerance and increasing the capacity to withstand tension without resorting to aggression. A reeducative or behavioral approach may be effective in helping these patients develop inner restraints capable of controlling their impulses. It is essential to be firmer in working with this type of pattern than with either dependency or detached reactions. These patients must be constantly reminded that there are limits beyond which they cannot go and that they must face responsibility for their actions. The dynamic significance of their power drive must be constantly pointed out, particularly its use as a means of shoring up the patient's devalued self-image. Patients should be encouraged to make efforts toward the expansion of their personal resources so as to minimize the need for power ploys.

A man may display unprovoked aggression whenever he tries to assert himself or when he feels deprived. Figuratively, he uses an elephant gun to kill a sparrow. He rationalizes his behavior to the effect that people pay no attention unless one forces them to do so. Behind this attitude is a feeling of helplessness and a fear of being rejected or attacked when one expresses one's rights. Consolidated is the conviction that one must display an image of strength and invulnerability to prevent exploitation. When people back away from his violence, this proves to the patient that they are unwilling to pay attention to his reasonable demands. He then becomes all the more angry, demanding, and forceful. The end result of his obnoxious conduct is that he is rejected and cannot hold a job even though he is intelligent and highly qualified. Depression forces him to seek psychiatric help. In therapy we can deal rapidly with the complaint factor of depression by prescribing an antidepressant medication, which in a few weeks may dissolve his malaise. If this is all he wants from therapy, the patient will then terminate treatment secure in the belief that he is cured and that he can now set off to find a new job. Undoubtedly the pattern will repeat itself because his illness has not been dented, let alone resolved. To go beyond mere symptom relief to correction of personality deficits will entail an extensive carefully planned stretch of psychotherapy.

If dependency and power drives are fused, the individual may be shown how he functions in a dual manner, seeking security from stronger people by shows of helplessness or wresting security from them by force and aggression. The chief resistance the therapist will encounter is transference, which may not be resolvable until the patient connects his reactions to historical developmental data.

Schizoid Personality Disorder (DSM-III-R 301.20)

The schizoid personality disorder is organized around the defense of detachment. The individual is often referred to as a "loner" or "isolate" with whom it is difficult to establish a relationship. There is a consuming flatness of mood with an inability to resonate through the spectrum of normal feelings from happiness to sorrow to anger. People who seek to establish contacts with schizoid personalities complain

that they are withdrawn, isolated, and "standoffish" ("I'd like to shake him into reacting and feeling"). Daydreaming and living in fantasy are common. The schizoid personality disorder must be differentiated from the schizotypal personality disorder, which is closer to schizophrenia and in which there are distortions in thinking (ideas of reference and influence, depersonalization, peculiar fantasies, and paranoidal notions), odd manner of speaking, and episodes of eccentric behavior.

Such isolated and detached individuals, who shy away from establishing close interpersonal relationships and yet maintain a good hold on reality, rarely come to therapy for the disorder itself. If, however, the need for a relationship of some kind becomes pressing or, more likely, the individual is caught in a relationship from which there is no escape, anxiety may occur and motivate the victim to seek professional help. The disorder, with its features of coldness, aloofness, and absence of concern with and indifference to the feelings of others, is a protective screen and consequently resists therapeutic alteration.

Detachment may be the means elaborated by the individual to protect himself or herself from intense dependency strivings. A close relationship poses dangers of being overwhelmed, for in it the patient may envisage a complete giving up of his or her independence. Detachment may also be a technique of avoiding injury or destruction that the patient believes will occur when he or she comes close to a person. Finally, it may be a method by which the patient protects himself or herself from fears of attacking and destroying others.

In treating a detached patient, one must anticipate that there will be difficulty for a long time in establishing a close relationship, since this tends to mobilize fears of injury and inspires the building of a protective wall. Much active work will be required in detecting and dissolving resistances to change. The detached patient often has a tendency to intellectualize the entire therapeutic process. The patient will particularly shy away from expressing feelings because he or she will conceive of them as dangerous.

Great hostility is bound to arise, which may be disconcerting principally because it is usually unexpressed or liberated in explosive outbursts. The therapist must realize that hostility is a defense against interpersonal closeness. It is extremely important that the therapist be as tolerant toward the patient's provocations as possible. The patient will probably attempt to goad the therapist into expressions of counteraggression to justify attitudes toward people as untrustworthy and withdrawal from the world because it is potentially menacing.

Sometimes the patient may be encouraged to participate in social activities, competitive games, and sports. Commanding, restrictive directions should, however, be avoided. With encouragement, detached people may begin to relate to others. In groups they drift cautiously from the periphery to the center as they realize that they will not be injured in a close interpersonal relationship. Group therapy may sometimes be most rewarding in certain detached, schizoid individuals, as long as no pressure is put on them to participate. Social groups with a wide range of activities may be prescribed.

A common reaction in the therapy of schizoid personalities is anxiety, which is manifested by disturbing nightmarish dreams or by actual anxiety attacks. The reaction will usually be found when the patient experiences for the first time real closeness or love toward the therapist. The emotions terrorize the patient and cause him or her to fear injury of an indefinable nature. It is essential to deal with this reaction when it occurs by giving the patient as much reassurance and interpretation as is necessary. Detached patients whose defenses have crumbled may go into a clinging dependent attitude when they realize the full weight of their helplessness. Supportive therapy may have to be given here, in an effort to provide the patient with an experience in which he or she receives help without being domineered or smothered with cloying affection. Should anxiety become too disturbing, anxiolytic medications may temporarily be prescribed.

Schizotypal Personality Disorder (DSM-III-R Code 301.22)

The schizotypal personality disorder is closer to schizophrenia than the schizoid personality disorder. Emotional instability, peculiarities of ideation, involvement with superstition and magical thinking, and perhaps bizarre preoccupations as with clairvoyance and "out-of-body" experiences convey a feeling of strangeness and a psychotic-like tinge, although a definite psychosis is not present. Ideas of reference, fragmentary illusions, and odd mannerisms may be present. The patient often seeks therapy because of depression, anxiety, and depersonalization that have come on spontaneously or as a result of a stressful experience. Insight into cognitive dysfunctions is lacking, and motivation is confined to achieving freedom from disturbing symptoms. It is futile to reason with or to argue these patients out of their peculiarities of thinking and oddities of behavior. Therapy should be confined to dealing supportively with symptoms while establishing a friendly helping relationship. Anxiolytic, antidepressant, and carefully administered neuroleptic treatment in small doses may be indicated.

Narcissistic Personality Disorder (DSM-III-R Code 301.81)

In recent years an interest in the dynamics and therapy of narcissistic subjects has been revived. Scrutiny of the earliest phases of ego development have led to a number of hypotheses on how the disorder evolves and its influence on treatment (Kohut, 1971). Attempts have been made, with variable results, to differentiate narcissistic reactions from borderline cases and schizophrenia, which are distinctive ailments even though a strong bond exists among these entities. Problems in all three have occurred in the primary stages of separation and individuation. Object relationships, as a result, become distorted and shallow and are oriented around how they can enhance the individual's status and interests. Fusion and dependency are basic themes; love objects are imbued with both terrifying and grandiose qualities. In therapy the transference reaction, which is essentially narcissistic, encourages regressive episodes with fear of the loss of the love object, paranoidal symptoms, and a fear of mutilation. The regression is never as deep in narcissistic personalities as in borderline or schizophrenic patients.

Therapists experience much difficulty in treating the character disorder of excessive narcissism. Persons with this problem seem to have such a need for personal admiration that they conceive of therapy as a means of making themselves more worthy of praise.

Unlike the mature person who gains security from cooperative endeavors in attitudes of altruism and sympathy, narcissistic individuals concentrate most of their interest on themselves. Self-love may actually become structured into grandiose strivings, omnipotent impulses, and megalomania. Although the image of the individual appears to be bloated, analysis readily reveals how helpless and impoverished he or she actually feels. There is danger here of precipitating depression or excitement by presenting insights prematurely. The shock-absorbing capacity of the ego must always be weighed, and interpretations must be given in proportion to the available ego strength. In markedly immature individuals little development may be expected other than a somewhat better environmental adaptation through guidance techniques.

Many of these patients often band together in Bohemian groups, posturing and posing, displaying a haughty defiance of convention, garbing themselves in outlandish dress, arranging their hair out of keeping with the accepted style as a way of expressing their exaggerated exhibitionistic, omnipotent, sadistic, and masochistic impulses. Language for them serves to release tension and not as a genuine means of communication. As long as they impulsively discharge their tension and anxiety in acting-out, they will not be too uncomfortable. “They are hunting eternally for satisfactory and secure models through which they may save themselves by a narcissistic identification. On the surface it appears later as a scattered, superficial pseudo competitiveness” (Greenacre, 1952). There is little motivation for therapy, which is usually sought not by the person but by a concerned parent or friend who is shocked or frightened by the patient’s behavior. Under these circumstances psychotherapy proceeds under a great handicap, the patient generally breaking appointments or manifesting such resistance that the therapist’s tolerance is put under the severest test. The only incentive that the patient has for treatment is to please

the parent or referral agency, usually to avoid the catastrophe of having his or her allowance cut off. If the person is unable to release tension because of the absence of or removal from environmental resources, anxiety may then come to the surface. Symptomatic discomfort will then act as a motive for help.

Classical psychoanalysis is disappointing in its results with narcissistic patients, but if a semblance of a relationship can be maintained, a modified analytic approach, perhaps drawing inspiration from object relations theory or self-psychology (see Chapter 11) may be useful. Some guidelines for therapy are found in the section on borderline personality disorder that follows.

Borderline Personality Disorder (DSM-III-R Code 301.83)

From the numbers of papers and books published and the frequency of seminars given, borderline patients have replaced white rats as the prime research subjects in the psychological field. Research has yielded some interesting hypotheses about the origins and the dynamics of borderline personality disorder, but it has not definitively established reliable ways of managing the difficult and fragile groups of patients embraced by this diagnostic category. Characteristic is a fluctuating assembly of symptoms that markedly cause subjective distress and impair social and occupational functioning. These include lack of impulse control leading to patterns of unstable and impulsive behavior that seemingly make no sense and involve the patient in difficulties with authority and peers. There are shifts in mood ranging from feelings of emptiness and boredom to temper outbursts and violent bouts of anger that are inappropriate and occasionally lead to quarreling, fighting, suicidal attempts, and other destructive activities. There may be confusion about one's identity in relation to self-image and gender. Fluid, unexpected changes in attitudes, moral precepts, values, and belief make it difficult to reason with and securely adapt to the person. Sometimes, especially when under great stress, transient, quickly recoverable, psychotic episodes occur. Characterologically, the individual manifests dependency, immaturity, detachment, and a wide variety of shifting traits.

Unlike the mature personality whose coping mechanisms are reality-oriented, the borderline patient retains and employs the archaic defenses that were evolved during infancy and childhood in relationship to parental agencies. Prominent among these are projection, displacement, withdrawal, autism, dissociative processes (splitting of the ego), denial, and hysterical and obsessive-compulsive maneuvers. These combine with a fragmentary delusional system that is repressed but used as a coping device whenever the patient is under extraordinary stress. The existence of this system may be exposed during narcosynthesis or with the administration of small quantities of the psychotomimetic drugs.

Borderline patients are sometimes falsely classified as schizophrenics. Gunderson et al. (1975) have shown that there is little justification for this, since borderline patients do not exhibit distinguishing schizophrenic symptoms and differ in the quality of the thought disorder. Kernberg (1974) has described the personality organization of the borderline as one in which there is ego weakness with primitive mechanisms of defense, such as splitting, denial, omnipotence, devaluation, and early projective tendencies; a shift toward primary process thinking that may come through only in projective testing; and pathological internalized object relations. Kohut (1971) has expounded on the early traumatic disturbances in the relationship with the archaic idealized self-object and the damage to the maturing personality that continues because of this trauma. Fixation to aspects of archaic objects fashions the regression that occurs during analytic therapy.

The psychotherapy of borderline personality disorder is a long and difficult procedure, largely because of the fragile character of the patient-therapist relationship (Eisenstein VW, 1951; Bychowski, 1950). Borderline patients often seek help on an emergency basis when a crisis occurs or when symptoms such as anxiety and depression become intolerable. Some recognize that their interaction with people is disturbed and that they are unable to make a satisfactory social and occupational adjustment. At the start of therapy the therapist may be regarded as a curative deity who will rapidly dissolve the patient’s troubles. This idea rapidly vanishes when immediate cure is not forthcoming. Disturbing

transference reactions then interfere with the patient's ability to cooperate with treatment routines. There seems to be a deficit in the quality of the "observing ego," that part of the self that can judge one's pathological maneuvers. This interferes with establishing a trustful and realistic therapeutic alliance and encourages disturbing transference. How to deal with these reactions is a matter of controversy. Therapists such as Kernberg (1975) believe that the best method is to attempt reconstructive personality change by encouraging regression, by allowing the transference to build up, and then to interpret it. Others like Zetzel (1971) and H. Friedman (1975) have a dimmer view about the possibilities of reconstructive change in borderline patients and are firm in their belief that all that can be done is to keep transference under control and improve adaptation. Still others try pragmatically to move from one to the other paradigm as required. There are advocates and dissenters who support or ridicule each of these three viewpoints.

Disagreements about the most suitable approach probably occur because borderline disorders are constituted by a wide variety of patients who genetically, constitutionally, developmentally, and experientially are different. Moreover, patients are exposed to therapists whose training, skills, philosophies, and personalities may or may not provide a good match. No hard and fast rules about preferential treatment choice can therefore be made for all cases, but a flexible approach may be rewarding (Katz S, 1982).

Most therapists are dubious about curing patients with borderline pathology. They therefore adopt the course of supporting the defensive structure by avoiding unconscious conflict, minimizing concentration on the past, and providing symptom relief in the medium of a benevolent relationship with as much setting of limits as situations warrant. They will then adopt interventions that deal expediently with remediable pathology related to pathological links in the behavioral chain, for example, psychopharmacology for severe anxiety and depression, relaxation exercises for tension, desensitization techniques for phobias, behavioral therapy for impulsivity and self-destructiveness, environmental

manipulation for situational disturbances, and cognitive therapy for distortions in thinking. They will veer from counseling, reassurance, confrontation, education, and concern with dynamics within the limits of their training and as required by the immediate needs of their patients. Therapy is usually conducted on a once- or twice-a-week basis. Modifications in method include the following:

1. Establishing a warm supportive relationship is of paramount importance.
2. Time restrictions in the session must be elastic.
3. A long testing period is to be expected. It may often be very difficult for the patient to make a relationship with the therapist.
4. Environmental manipulation may be inescapable.
5. Working with the patient's family to reduce pressure on the patient is frequently indicated.
6. The interview focus is on reality, the patient's relapse into daydreaming or delusion being interpreted as a reaction to fear or guilt.
7. Avoiding the probing of psychotic-like material is advisable.
8. Active reassurance and advice giving may be necessary.
9. Directive encouragement is given to the patient to participate in occupational therapy, hobbies, and recreations.
10. Neurotic defenses are supported and strengthened.
11. Challenging or disagreeing with the patient's distorted ideas is delayed until a good relationship exists.
12. The patient may at the start of therapy be told what to expect during therapy, especially that at times he or she may be upset with the therapist for not doing more for him or her. The patient may want to quit therapy. If the patient does quit, he or she is welcome to return (Katz, 1982).
13. Therapy may last a long time, perhaps the rest of the patient's life.

The importance of keeping the relationship with the therapist as non-distorted and productive as possible with a minimum of acting-out is paramount. When necessary, there is a search for maladaptive defenses and, when there is evidence of interference with transference, (1) elaboration of how they influence the patient's relations with others, (2) confrontation and interpretation of defenses that sponsor a negative transference, (3) the setting of limits in the therapeutic situation, and (4) the employment of modalities such as hospitals, and foster homes when needed. Combined individual and group psychotherapy for the borderline patient has special advantages and a specific function. It is at present used widely for borderlines in private offices, clinics, and institutions where insight into the necessity for treatment and an ability to relate to a therapeutic situation remain at least partially intact.

While the one-to-one relationship of individual therapy satisfies dependency needs, the borderline patient also feels threatened by it. Many of these patients profit in a group therapeutic setting where they feel less dependent and the therapist appears less powerful. In the security of the group the members relate to each other and to the "democratic" authority figure of the therapist with more freedom and less anxiety than in any other situation. The group atmosphere facilitates expression of one's feelings. It makes interaction and with it socialization desirable and rewarding. The all-or-none conflict that leads to emotional inhibition and withdrawal out of fear of one's own destructive impulses is worked through under the protective leadership of the therapist and by testing the reality of anticipated dire consequences following expression of one's emotions. In the social situation of the therapy group, with its graded anxiety-releasing potential and the opportunity for reality testing, the borderline patient may find his or her first constructive experience in human relationships and may grasp a glimpse of understanding into the positive sides of socialization.

In working with dynamic vectors, care must be taken to prevent the patient's anxiety from getting too extreme. It is better to deal with the secondary elaborations of nuclear conflicts (derivative conflicts) as reflected in personality interactions (see Chapter 44) than with the nuclear conflicts directly. This may

be especially useful if the patient displays evidence of obstructive transference and resistance and has enough of an "observing ego" to handle interpretations. Some of the techniques of A. Wolberg described later in this section may be helpful here. Management of countertransference is a most vital part of therapy because in trying to understand one's untoward feelings and reactions the therapist can obtain important clues regarding basic conflicts that are being extruded through projective identification.

The prescription of psychotropic drugs may be indicated if the patient urgently requires calming or depression is bogging him or her down. Here one must recognize that the reports by patients of benefit may not coordinate with that of outside observers. Drugs may be poorly tolerated in borderlines, and even minor side effects may tempt the patient to discontinue medications. Haldol (Soloff et al, 1986) and Navane (Serban & Siegal, 1984) in moderate doses may be useful for anxiety and emotional instability as well as for psychotic-like symptoms. MAO inhibitors, such as Nardil, have been recommended for depressions associated with experiences of rejection (Klein DF, 1977). Benzodiazepines (Xanax, Valium, Ativan) may occasionally be useful for strong anxiety, recognizing the potential for abuse and that they may stimulate destructive actions. Tegretol in some cases has lowered tendencies toward impulsivity. Lithium has also been used when emotional instability was extreme (Rifkin et al, 1972).

Psychological testing for borderline patients has its advantages. Frieswyk (1982) believes that testing is especially valuable when manifestations of borderline pathology are subtle. We may detect "potential for acting-out, depressive mood swings, suicide, psychotic decompensation, as well as circumstances most likely to evoke untold reactions." We are helped to estimate the patient's capacities for a therapeutic alliance and "potential responses to different treatment modalities."

Short-term hospitalization may be required during critical phases of adjustment, particularly when the patient encounters rejection in a close relationship, is fired from a job, is involved in an accident, or during family crises. When serious regression has been stirred up by negative transference, an explosive reaction or suicidal gesture may require control in a protective setting. A halfway house sometimes is all

that is required. The therapist must guard, however, against the patient's desire to use hospitalization as a repetitive escape device.

Reconstructive Psychotherapy

Borderline patients have traditionally been considered unsuitable candidates for psychoanalysis, but in recent years, inspired by the work of such analysts as Kernberg (1975), Gunderson et al., (1975), Masterson (1976), Kohut (1971), Rinsley (1980), and others, and under the influence of object relations theory, certain modifications in psychoanalysis have been introduced geared toward the hitherto considered impossible goal of reconstructive change. Unfortunately, the writings of some of the innovators have been vertiginous and difficult to understand. Moreover, there are fundamental disagreements regarding the best way to implement psychoanalytic psychotherapy.

Although true classical psychoanalysis is generally contraindicated, some analysts agree with Kernberg that regression should be promoted in order to activate pathological object and self representations and their projection onto the analyst in the transference. Consequently, the therapist is enjoined to be technically neutral and non-interfering. Primitive transference, which rapidly precipitates, should immediately be interpreted in here-and-now terms. Suggestive and manipulative techniques are best avoided, but the patient's condition may necessitate some structuring of daily routines. The therapist is empathic but must be as non-interfering as possible, activities should be confined to clarification and interpretation and external arrangements left to others. Genetic reconstructions cannot be made early in treatment because self and object representations are too fuzzy and undifferentiated and projective identification and splitting are too imminent. Later in therapy when there is a better differentiation and part-object relations have given way to more mature (whole-object) relations, genetic reconstructions may be effective. This form of treatment is long-term, with session frequency no less than three times weekly. Because primitive transferences may activate psychotic processes, hospitalization may be necessary to protect the patient and others. If the patient's defenses are

sufficiently strong to prevent acting-out, therapy may proceed outside of a hospital, perhaps with day-hospital arrangements, and if living with a disturbed family is intolerable, in a foster home. This modified analytic approach, known also as "expressive psychotherapy," may not be possible if the patient's secondary gains through exploitation of the illness are too powerful and milieu distortions are so strong as to necessitate constant environmental manipulation. Social isolation may also be too prominent, ego weakness too intense, and antisocial tendencies too dangerous. In addition, there may be too little motivation, too low economic wherewithal, too poor psychological mindedness, and too limited capacity for introspection to recommend this kind of treatment. Finally, the therapist may have too little training and sophistication in the use of the requisite techniques and too little confidence in their effectiveness to give the method a fair trial.

A large group of analysts question the value of expressive psychotherapy with its promotion of regression as the principal technique and think that it may pose dangers for the patient. They believe that the therapist must be more active and maintain an openly empathic front and provide a reassuring "holding," limit-setting, structured environment irrespective of the intensity of disturbance of the patient. This group, following the leads of "self-psychology," has evolved an elaborate concept of the "self-object" and of personality development that encourages a conception of the borderline patient as less of a laboratory of pathological strivings that require activation and interpretation in an atmosphere of technical neutrality and more of a creation of faulty conditioning and inadequate development with deficits that must be repaired in a nurturant relationship. The patient is helped to tolerate his or her transference reactions and then to replace destructive and angry feelings that emerge in the transference. Only very much later is interpretation utilized.

A modified analytic approach that has proven effective with some borderline patients is illustrated by the work of Arlene Wolberg (1952, 1959, 1960). She recommends that reconstructive treatment must be slowly and carefully organized because of the ever-present projective frame of reference and the

danger of throwing the patient into anxiety that will force the patient to use his or her delusional system as a defense, thus pushing the patient over the border into an active psychosis. Freud's account of his management of the patient described in his paper "An Infantile Neurosis" contains tactics that may be used with borderline patients: "The patient...remained…unassailably entrenched behind an attitude of obliging apathy. He listened, understood, and remained unapproachable. His shrinking from an independent existence was so great as to outweigh all the vexations of his illness. Only one way was to be found of overcoming it. I was obliged to wait until his attachment to myself had become strong enough to counterbalance this shrinking, and then played off this one factor against the other" (*Collected Papers, Vol. III*, pp. 477-478). In view of the degree of sadomasochism in the borderline patient, the treatment process must take into account the severe anxiety to which such patients are constantly subjected, the peculiar composition of the ego, which tends to be organized around oppositional tendencies (sadism), stubborn negativism, the need of the patient to fail in certain situations, the passivity, the projective framework, the psychotic-like transference, and the characteristic failure of the various defensive structures. Special techniques are needed.

The first phase of treatment must involve what A. Wolberg (1960, 1973) has called "projective techniques." These are methods of coping with the sadomasochism of the patient, the acting-out tendencies, the denial and dissociative mechanisms, the autism (fantasy life), and the negativism so that the therapist does not become embroiled with the patient in a sadomasochistic relationship. Three projective techniques are recommended: (1) "the use of the other," (2) "attitude therapy," and (3) "ego construction," i.e., reinforcement of the patient's constructive ego trends.

In the "use of the other" the therapist takes advantage of the tendency of borderline patients to deny their own feelings and ideas and to project them onto others. When they speak of "others," therefore, they are actually talking about themselves in a masked way to avoid anxiety. Should the therapist do what is ordinarily done with neurotic patients, i.e., interpret the projection and confront the patient with

the defense, borderline patients will be unable to organize themselves and to utilize the interpretation constructively. Instead they will become more resistive and deny the validity of the interpretation, incorporating the interpretation into their sadomasochistic operations by beating themselves with it and advancing it as another reason to hate themselves or, on the other hand, by becoming paranoid against the therapist and using the interpretations as a rationalization for the distrust. The relationship with the therapist is bound to disintegrate under these circumstances; a transference neurosis may precipitate out abruptly; psychotic manifestations may emerge. For these reasons the therapist must preserve the projective defenses of the patient and always (at least during the early stages of treatment) talk about the motives and maneuvers of the "others," allowing the patient to make personal connections or to deny them as he or she wishes. Such a method will help cement a positive relationship with the patient. Dreams are handled in the same way, never pointing an accusing finger at the patient. Fantasies that have motivated the acting-out are analyzed in a manner similar to dreams: the therapist does not challenge or confront the patient. One merely explores. One does not justify or reassure the patient, even though one acts empathic.

The "others" in the interpersonal encounters are analyzed by conjecturing as to •why they feel and act as they do and what their motives could possibly be. The therapist does not charge the patient with the fact that he or she is like the "others." Eventually when the working relationship consolidates, the patient will acknowledge this. When the first statements are made by the patient that "this is like me," the therapist simply agrees and does not pursue it further. Each time that the patient says "this is like me," the therapist agrees that is might be true. Should the patient repeatedly bring up the consociation, the therapist may suggest that this is a pattern worth exploring. The therapist may query, "How does the pattern operate? It is not too obvious in the sessions. This could be worth exploring."

"Attitude therapy" is a projective device used to point up the patient's patterns of operation within any given interpersonal relationship. Inevitably he or she will bring up details of a personal encounter

that are highly prejudiced and contain a paranoidal flavor. Accurate accounts will be resisted since this will reveal the patient's acting-out proclivities that mobilize his or her guilt. The therapist must not be put off by the patient's maneuvers; the therapist keeps asking for details, but not to the point where the patient becomes overly defensive. In such a case the therapist discontinues questioning, indicating that it is causing too much anxiety in the patient. When other incidents are reported, however, questioning is begun again.

Eventually the patient's true attitudes and feelings, which contain fragments of the fantasies motivating the acting-out, will be revealed. The therapist may then say, "Incidents like this can be very upsetting." As the patient brings up accounts of further encounters, definite patterns will emerge. Eventually the therapist will be able to help the patient consolidate his or her thoughts, attitudes, feelings, and behavior in these situations. The interpretations are in the form of broad statements that in a roundabout way, through focusing, indicate a connection between thoughts, feelings, fantasies, anxieties, and patterns of acting-out behavior. Questions are posed in such a manner that the patient makes the associations. If the therapist offers the patient an interpretation before he or she is ready for it, i.e., before the patient has mentioned the possibility several times, then the therapist may become involved in the patient's obsessive mechanisms. The patient will weave the therapist into the warp and woof of his or her fantasy life and chew on the information instead of using it to work out the problem.

In the technique of "positive ego construction" the therapist is the projective object, taking positive trends in the patient's ego and reflecting them back to the patient as if they were the therapist's own. This is because borderline patients cannot accept good things about themselves or utilize their own constructive thinking without excessive anxiety. Such patients are guilty about their positive trends since they have been taught by their parents to disbelieve them; they have been encouraged to fail in certain ways in order to play the roles consigned to them. Success constitutes a greater threat than failure in specific areas. To reduce their guilt but not to analyze it is one of the purposes of this technique. For

instance, if a patient brings in the tale of having applied for a job and having bungled the interview by purposefully saying that he could not qualify because of lack of skills, and if he then reflects back on what happened with the remark, "I should have told him that I know enough about this work to be able to learn the special details rapidly, which is the truth," the therapist may respond in a qualified positive way: "It is definitely my opinion that you know enough about this work to able to learn the special details rapidly." Thus the phrases the patient has uttered are repeated as the therapist's own ideas. The phrases may also be reorganized and the same thing said in different words. For example, the patient states: "Probably I feel I don't deserve the job." The therapist does not reply with the conventional, "Why not?" Instead the comment may be, "I've thought of this too. Many people I've worked with feel guilt when a good opportunity presents itself. They shouldn't have to feel this way, but they do."

Role playing may also be employed to rehearse with the therapist what the patient *might* have said, the patient and therapist interchanging roles of patient and employer. After a certain number of incidents have been "role played," a patient may wonder why he or she acts this way. The therapist then replies, "This is an important thing for us to figure out." The therapist does not give the patient the answers when questioned, "Why?" Rather the therapist indicates that the two must seek answers together; this is a cooperative effort between two people who have come to an agreement on certain points.

After the patient is able to accept responsibility for his or her own actions without developing intense anxiety or manifesting the usual defenses, the treatment may take on a form similar to that of working with a neurotic patient. Should the patient become excessively anxious, projective techniques, as outlined above, should be used.

Avoidant Personality Disorder (DSM-III-R Code 301.82)

The determining feature of avoidant personality disorder is possession of a markedly devaluated self-esteem. This produces a defensive reaction of avoidance of any stimulus that points to this defect.

Avoidant individuals safeguard against criticism, rejection, humiliation, failure, and social derogation by withdrawal tendencies and refusal to take chances or to expose themselves to any activities that threaten to bring out their inferiority and personal shortcomings. Ungratified needs for love, acceptance, and recognition sponsor frustration, anger, self-debasement, and other masochistic tendencies. Unlike the schizoid personality, who displays some of the same tendencies, the avoidant personality has not given up desires for success and good social relations, and in fact retains an unquenchable thirst for these bounties.

During psychotherapy, the thrust should be toward encouraging exposure to challenges and to activities that promise self-enhancing rewards. In addition to the baseline interventions, the following are recommended:

1. Behavioral assertiveness training to enable the patient to accept challenges and to put his or her best foot forward;
2. In vivo desensitization in situations that are usually avoided;
3. Group therapy and psychodrama to provide a platform for the practice of assertive behavior; and
4. Cognitive therapy to correct false attitudes and inhibiting self-statements.

Histrionic Personality Disorder (DSM-III-R Code 301.50)

The need for histrionic and dramatic displays characterize the histrionic personality disorder. A strong narcissistic tinge colors attitudes and interpersonal relationships. The individual, while evincing a superficial though exaggerated show of affection for and concern with others, is actually self-centered, seeking to impress the immediate audience with his or her charm and talents. Emotional instability with periods of screaming, crying, and explosive carrying-on break out when wishes are not granted or actions are disapproved. The irritability, egocentricity, demandingness, and irresponsibility of such persons result in rejection, which is apt to stimulate retaliatory rage and paranoidal-like recriminations. Such behavior is usually forgiven because of the individual's skilled show of remorse and clever

seductiveness, only to be repeated at the next frustrating episode. Dependency patterns are common. The histrionics typically fasten onto hosts whose lives they make a continuing episode of crises. Suicidal threats and abortive attempts at destroying themselves are prominent chapters in the book of theatrical displays.

Therapy is usually sought when a spouse or lover seriously threatens to abandon the person unless the latter begins therapy or analysis. With astonishing rapidity, the therapist becomes the object of the patient's displays, seductiveness, and acting-out, since transference is easily mobilized in these patients. Treatment is usually unsuccessful because motivation to change is shallow and insincere. As long as the patient has another human subject to fasten onto, the referring agency is temporarily relieved of the burden. If a therapeutic relationship can be established and the therapist does not allow countertransference to distort a professional stance, some of these patients may be helped with long-term dynamic psychotherapy.

Antisocial Personality Disorder (DSM-III-R Code 301.70)

Allied to narcissistic character disorders is an antisocial personality manifested by poor frustration tolerance, egocentricity, impulsivity, aggressiveness, antisocial acting-out, an inability to profit from experience, undeveloped capacities for cooperative interpersonal relationships, poorly integrated sexual responses, and urgent pleasure pursuits with an inability to postpone gratification. Many such patients lied, fought, stole, and were truants during childhood and resorted to severe substance abuse during adolescence. Vagrancy, sexual promiscuity, and criminality are hallmarks of the disorder in adults. Because of the indelible warping in ego formation, goals in therapy, as with the narcissistic personality, are geared toward symptomatic relief rather than character change. Modification of destructive and antisocial behavior is, of course, desirable but usually visionary. Recognition of acting-out, the circumstances and needs that initiate it, and the way that the patient draws other people into his or her maneuvers are not too difficult. Doing something to prevent this behavior is another matter.

Most authorities agree that the management of an antisocial personality is most difficult. All approaches have yielded meager results. In many cases the only thing that can be accomplished is manipulation of the environment to eliminate as many temptations as possible that stimulate the patient into expressing his or her vicarious impulses.

If an antisocial individual can establish a relationship to a person, the latter may be able, as a kind but firm authority, to supervise and somehow restrain the patient's actions. Hypnosis may reinforce this authoritative relationship but the patient will usually continue to test the powers of the therapist who acts as a repressive moral force and as a pillar of support. The patient may get to the point where he or she will turn to the therapist for guidance when temptation threatens. Suggestions are couched in terms so as to convince the patient that he or she is actually wiser and happier for resisting certain activities that, as he or she knows from past experience, are bound to have disastrous results. On the basis of a guidance relationship, the patient may be instructed in the wisdom of postponing immediate gratifications for those that in the long run will prove more lasting and wholesome. The patient is taught the prudence of tolerating frustration and the need to feel a sense of responsibility and consideration for the rights of others. Not that these lessons will be immediately accepted or acted on, but constant repetition sometimes helps the patient to realize that it is to his or her best interest, ultimately, to observe social amenities and to exercise more self-control.

Experience demonstrates that it is possible to modify to some extent the immature explosive reactions of the patient by an extensive training program, particularly in cooperative group work where the individual participates as a member toward a common objective. Adequate group identifications are lacking in these people, and the realization that ego satisfactions can accrue from group experiences may create a chink in the defensive armor. In cases where the individual comes into conflict with the law and incarceration is necessary, a program organized around building up whatever assets the individual possesses, particularly in a therapeutic community, may, in some instances, bring success. In young

patients vocational schools that teach a trade may contribute to self-esteem and provide a means of diverting energies into a profitable channel. Should group therapy be deemed necessary, the constituent members ideally should be antisocial personalities with problems similar to those of the patient. The group leader should ideally be an antisocial personality who has recovered and gained respectability. Even if therapy seems successful, intervals of acting-out are to be expected.

PSYCHOACTIVE SUBSTANCE-INDUCED DISORDERS

Alcoholism (Alcohol Abuse) [DSM-III-R Code 305.00]; Alcohol Dependence [DSM-III-R Code 303.90]

People with alcohol dependence rarely come to psychotherapy because they want to quit drinking of their own accord. They are usually pushed into it because of aversive circumstances that their drunkenness has created. A wife threatens her husband with divorce unless he stops his irresponsible tippling. An employer gives an old employee a last chance to get off the bottle by personally arranging a consultation with a therapist. A drunken driver is about to lose his license and his lawyer insists that it is a good strategy to be in treatment. A judge suspends sentence on a person who has committed a crime while drunk on the condition that he do something about his alcoholic habit. A physician has frightened the drinker or his family with the announcement that alcoholic liver disease will result in incurable cirrhosis. In many cases the principal reason alcoholics seek help is for symptoms of anxiety, depression, blackouts, and insomnia or for stressful environmental conditions with which they cannot cope even under the influence of alcohol or other abusive substances. Alcoholics will often fail to mention their proclivity to drink until the therapist asks how much they drink. Alcoholics will usually minimize the amount they consume and derogate the idea that they cannot hold their liquor. They do this not because they want to deceive the therapist, but because *they are unable to stop their habit* and want to ensure its continuity without paying the penalty with which they are now confronted. The therapist will then realize that the complaint factor may be a secondary complication and that the basic problem is

that the patient is poisoning himself and ruining his life with drink. The therapist will recognize also that unless the alcoholic stops drinking completely psychotherapy will have little effect. If the individual is only psychologically and not physiologically dependent on alcohol, it may be possible with psychotherapeutic help to wean the person from drink. If the pattern has progressed to the point where there is a physical need for alcohol, the problem may be an insuperable one unless motivation is created to achieve complete abstinence. Without this motivation, therapeutic efforts will be useless.

Because motivating drinkers to give up alcohol and other abused substances is so difficult, alcoholism has become, world over, one of the most serious and prevalent problems that threatens society today. The more than 10 million alcoholics in the United States affect the lives of 40 million family members. The economic loss to the nation amounts to $120 billion annually. Alcoholism accounts for a great many illnesses with fatal consequences. It is the fourth leading cause of death. Liver disease, gastritis, an increased risk of acquiring certain cancers, toxic interactions with other drugs, nutritional deficiencies, birth defects, hypertension, sluggishness of the cardiac musculature, interference with hypothalamic and pituitary hormones, and various other calamities shadow the existence of the indiscrete drinker. In addition, there are the ever-too-abundant psychological ravages that interfere with adaptive functioning which affect work, marriage, family, and social relationships, create accident proneness, and otherwise disrupt one's personal life. These problems are too well known to require elaboration here. In sum, alcoholism is the most commonly abused and most dangerous drug habit today.

The fact that alcoholism has traditionally been regarded as a moral failing rather than a disease with genetic associations has led families to regard it as a stigma and a disgrace. In recent years, however, this attitude has changed. The courageous revelation by First Lady Betty Ford of her struggle with alcoholism has helped enormously to give people a more authentic outlook at this crippling and potentially fatal malady. Recognition that alcoholism can be treated has led to the introduction of a

number of regimes that try to approach the illness from a scientific perspective. Acceptance of modern treatments give the alcoholic patient almost a 75 percent chance of returning to productive life. The fact that one-half to three-quarters of all referrals to recently created employee assistance programs are for alcohol misuse has stimulated industry and unions to develop services for alcoholically impaired employees. Many deterrents exist, however, (JAMA, 1983). First, there is the matter of confidentiality and the patient's right to privacy. Revealing the nature of the difficulty can threaten advancement if not termination of one's job. Second, follow-up studies on treated alcoholics are thwarted by federal confidentiality regulations. Third, there is difficulty in coordinating the accumulated information so that it can be distributed effectively and utilized in medical curricula and by specialists. Fourth, reliable cost-effective methods of assessing new treatment programs must still be developed.

Aggressive programs, such as one at General Motors Corporation, have proven not only that such programs have economic advantages for a company, but also that they enable the company to retain valued employees and thus minimize staff turnover. Three- to 4-week care in institutions practicing a variety of interventions have proven so popular that freestanding inpatient and residential facilities for alcoholism and substance abuse have multiplied. Medically supervised programs and "Care-Units" now exist that provide hospital-based medical care, as well as educational and psychological counseling for patients and their families. On some units offering multimodal programs some staff members are themselves recovered alcoholics who, because they have gone through similar experiences and "speak the language" of alcoholics, can often provide better role models than professionals.

A common treatment format includes at the start medical detoxification in a hospital. When the patient is able to do so, he or she attends daily group and individual psychotherapy and counseling sessions as well as recreation therapy. Weekly family seminars with patients and their families are held to discuss mutual problems and to explore changes that are essential in the future. Films are shown, literature distributed, and workshops are held to enrich education about the nature and consequences of

alcoholism. An aftercare program acts as a bridge to the community to prepare the individual for the habitual stresses he or she will face without alcohol. These treatment units are located in different parts of the country, and information about them may be obtained from local social service agencies.

Getting off alcohol, it is now recognized, is not the end-all of therapy. It is the beginning. What one must do in addition is maintain sobriety and ideally deal with the sources of the drinking problem. Here we come back to the problem of motivation. It is hard enough to get an alcoholic to want to try to stop drinking and enter a unit that will enable him or her to get off alcohol; it is even more difficult to get the alcoholic to do something about the conditions that have created the drinking problem.

Creating Motivation for Abstinence

As mentioned previously, the first step in therapy is to create a sincere desire to remove from one's life the toxic substances that one uses to subdue anxiety. Initial resistance to the idea of accepting help is common and confounding. It is especially a problem in elderly alcoholics, whose denial mechanisms are abetted by their need to flaunt independence. Motivating an individual to accept that he or she needs to give up alcohol to feel better requires a good deal of patience and skill.

The following points and caveats may be of help:

1. When the average alcoholic applies for therapy, he or she usually expresses or suggests a secret hope of learning to drink normally and to "hold my liquor like anyone else." This may be possible in anxiety drinkers following abatement of their neurosis; it is not possible in the case of real alcoholics.

2. Although some persons believe that alcoholics can be cured by weaning them gradually from the bottle and that they may learn to engage in social drinking without exceeding their capacity, experience has shown that success is possible only where alcohol is completely and absolutely eliminated from an individual's regime. The object in therapy is complete elimination of all alcoholic beverages, including wine and beer.

3. The treatment of alcoholism not only embraces the removal of the desire for alcohol; it also involves restoration of the patient to some adaptational equilibrium. Without such restoration, the person will become pathologically depressed, and tension will drive him or her to drink no matter what pressures are exerted.

4. In the anxiety drinker any attempt to force or shame the person into sobriety will interfere with the therapeutic relationship. A useful rule is not to make the diagnosis of alcoholism for the patient but to give the patient information so that he or she makes the diagnosis or at least genuinely asks for help. It is fruitless to design a treatment program for an alcoholic unless he or she is ready to accept the need for help.

5. Never accuse the patient of being an alcoholic, this will stimulate defiance and denial. The patient will accept any other diagnosis except alcoholism. One may tell the patient that some people are chemically unable to tolerate alcohol and that it acts like a poison to their bodies. Many patients will accept that they are "allergic" to alcohol more easily than that they are psychologically unable to control their drinking.

6. Emphasize that it is difficult to break the habit without professional help because the body has become chemically dependent on alcohol and requires medical and psychological interventions to control the effects of withdrawal.

7. Never pressure a patient into giving up alcohol. Explain its effects on the body and tell the patient to be the judge of whether he or she wants to try to give it up.

8. If the patient asks what the signs of alcoholic dependency are, one may simply say: "If you can't get through the day without a drink, you may want to do something about it. This indicates that the body is asking for help."

9. Warn the patient that he or she may need some support to stop drinking. The best support is an AA (Alcoholics Anonymous) or similar group. If the patient claims he or she is not an alcoholic and does not see the reason to go to an AA group, tell him or her that people with a wide assortment of problems other than drinking are helped by such groups. Deal with the patient's resistance.

10. You may not be able to do very much with an alcoholic without AA or a similar group as a helping adjunct.

11. Avoid psychoanalytic probing or any other insight therapy until the patient is off alcohol; such treatment will do no good. The triad of confrontation, empathy, and proffered hope is the best technique for breaking down denial mechanisms and other resistances (Whitfield, 1980).

12. A patient may be able to start and continue in psychotherapy without becoming an inpatient in a hospital or treatment unit if he or she has sufficient motivation to join a supportive group such as AA and is able to detoxify himself or herself.

Detoxification

A large number of patients who have no serious physical illness can be detoxified at home or preferably at a local detoxification center, usually without drugs (Whitfield, 1980). A pleasant atmosphere is important. The patient being ambulatory, introductory group sessions are initiated, and distracting group activities are arranged. Drug-free detoxification, if it can be done, has advantages; it is shorter, less expensive, can be executed by non-medical personnel, avoids dependence on drugs, and helps the patient remember the unpleasant withdrawal experience, which acts as an aversive stimulus in the face of temptation. Any medications that are needed except anxiolytics and energizers should be continued. If the patient is uncomfortable, however, benzodiazepines such as Librium or Ativan may be prescribed during the first few days and then discontinued. A strong multivitamin, 50-100 mg of thiamine, and 1 mg of folate should be given daily. If withdrawal seizures have occurred in the past, 300 mg of phenytoin (Dilantin) should be given daily for 5 days. Where an anxiolytic is deemed necessary for more than a few days BuSpar may be used since this medication produces tranquilization with no apparent abuse liability and no withdrawal syndrome reported at the end of therapy.

Conditioned reflex therapy is not as popular as it was in past years. It requires hospitalization in a special unit when it is used. A popular model is to administer an emetic paired with alcohol. Apomorphine is given for purposes of conditioning if there is no disease of the kidney or liver and the patient has not recently been on Antabuse. The patient then receives several glasses of warm water flavored with his or her favorite alcoholic beverages. Several spasms of vomiting may occur.

Suggestions are made that the patient will be able to control his or her drinking by disliking all alcoholic beverages; in this way a person's health is restored. This treatment is repeated on successive or alternate days. Salt should be added to the diet to compensate for the salt lost in vomiting. The conditioning method is expensive, and statistics on its usefulness are still unclear.

Some behavior therapists attempt detoxification by training the patient in behaviors that are incompatible with excessive drinking (Miller, 1977). The patient is taught substitutive behaviors in situations that operate as cues for drinking. Thus assertive training (Alberti & Emmons, 1973) may be instituted to enable the individual to express personal rights and feelings without his or her customary recourse to alcohol. Relaxation training and systematic desensitization teaches the patient to master anxiety-provoking situations that lead to drinking. Because troubled marriages are sometimes at the basis of an alcoholic's drinking, couples may be instructed in the use of mutual positive reinforcing behavior with contingency contracting (Stuart, 1969). A variety of other operant approaches have also been employed (Cohen et al, 1972; Azrin, 1976). "Covert sensitization" utilizes imagery to pair a desire for alcohol with nausea (Elkins, 1980). Hypnosis has also been employed (Katz RC, 1980).

If a patient continues to drink or whatever approach is tried proves only partially effective, he or she should be counseled, best in the presence of the spouse, to take a vacation and go to a treatment unit for help. There are many such units, some good, some not so good. The Yellow Pages of the telephone directory lists them under "Alcohol Information and Treatment," but finding units in this way will require investigating their qualifications. They should be hospital based, state certified, and approved by the Joint Commission for the Accreditation of Hospitals (JCAH). There are more than 100 "care units" around the country. They should have a rounded-out program from detoxification to aftercare. The reason concentrated therapy in a closed unit is necessary is that the alcoholic, despite his or her show of independence, is very dependent and needs people around all the time, as well as activities to divert his or her mind. Boredom easily sends the patient to drink. The alcoholic cannot fill the day with sufficient

activities at home or at work. Stresses associated with everyday routines may be too anxiety provoking. A complete change of scene in a well-run unit is needed to get these patients off to a fresh start.

In heavy drinkers, detoxification will precipitate abstinence reactions in 12 to 24 hours. Shaking and agitation may frighten these patients, delirium tremens may kill them unless they get proper treatment. Librium, 50-100 mg intravenously, repeated as necessary in 2 to 4 hours, or Ativan intramuscularly, 0.05 mg/kg up to 4 mg, may be required. Emergency reactions will need special interventions (see Chapter 58, "Handling Emergencies in Psychotherapy"). It usually requires 3 to 5 days to detoxify an alcoholic, and up to 3 weeks if other addictive substances have been taken, which is very common. Coincident with and subsequent to detoxification, a multimodal program of counseling, education, group work, and recreational therapy is implemented. Family counseling and therapy are employed as needed. The patient is prepared to continue in an Alcoholics Anonymous or similar group in the area in which he or she lives, and the spouse and family are referred to Al-Anon (Anthony, 1977). The telephone number for Al-Anon is listed in the telephone directory or may be obtained from Alcoholics Anonymous, also listed in the directory.

A considerable number of alcoholics take abuse substances in addition to alcohol. Among the most popular of these drugs are sedative-hypnotics such as barbiturates (Nembutal, Seconal), non-barbiturate hypnotics. (Noludar, Placidyl), opiates (heroin, illicit methadone), and stimulants (dexedrine, cocaine). After being detoxified from alcohol, the alcoholic may experience symptoms of withdrawal from the other abused substances, which may also require therapy. In some cases the primary problem was the abuse of substances other than alcohol, and alcohol was taken to reinforce the effects of or to deaden withdrawal symptoms from the drugs. Because of the ease and relatively low cost of alcohol, the drinking continued, resulting in alcoholism.

Not uncommon are manifestations of such syndromes as major or bipolar depression, panic disorder, agoraphobia, impulse control disorder, and psychogenic pain, which appear after detoxification has

rendered the patient alcohol free. In many cases the primary problem was the syndrome, whose symptoms the individual has tried to control with alcohol. In such cases corrective interventions will be needed.

Once the patient is free from the mind-befogging effects of alcohol, he or she more easily becomes aware of how drinking has interfered with his or her life and happiness. The patient may still have symptoms of anxiety and depression; stress situations will still exist at home and at work; or a personality problem may continue to interfere with proper adaptation. The patient will continue to need care and psychotherapy for these problems. During the period of hospitalization the therapist will have telephoned the patient once or twice or, better still, if possible, would have visited. In this way, continuity of treatment is maintained.

Post-abstinence Therapy

When the patient returns for psychotherapy, he or she may be able to accept the diagnosis of alcoholism. The patient is told that alcoholism is a treatable disease like diabetes for which one cannot be blamed. However, it must be watched and taken care of the rest of one's life. While the patient is better now, care must be taken not to slip back into old habits. This is best prevented by going regularly to an AA group and by continuing in psychotherapy. A common question is "Can I ever resume normal drinking?" The answer is a categorical no. Alcoholism like diabetes is a lifelong disease and resuming drinking (even one drink) will activate it again." The patient is told that the recovery rate is high if a person follows a good treatment plan. Doing this is the patient's own responsibility. Nobody else can do it for the patient.

If the patient, in spite of this talk, cannot seem to avoid tippling, he or she should be put on Antabuse (disulfiram) after discussing the urgent need for this helping agent. The average daily dose of the drug is 250 mg (with a range of 125 mg to 500 mg), although sometimes more is needed. The patient must be

completely off alcohol when it is started. The patient should be instructed that the drug is harmless unless he or she drinks, and that "going off the wagon" will make him or her violently and even dangerously sick. Antabuse will protect the patient from temptation, so taking it daily is important. Ayerst Laboratories puts out a patient education booklet entitled "Now that You're on Antabuse." After one or two years of abstinence, the patient, in conference with the therapist, spouse, or close family member and AA group leader, may experiment with going off Antabuse, provided the patient is able to cope with life and with crises adequately, is relating well with people, and most important, continues in the AA group. Antabuse is most helpful in older motivated individuals who need to control psychological stressors that invite drinking. Contraindicated for Antabuse use are illnesses such as diabetes, cardiac disease, and cirrhosis of the liver. Antabuse is not suitable for schizophrenics and patients with schizoaffective reactions and markedly unstable impulse disorders. It is best to arrange for a relative or a trusted person at work to supervise the regular and uninterrupted taking of Antabuse to maintain a constant level of the drug in the bloodstream. With too small doses of Antabuse, the patient may be able to override its effect with alcohol resumption.

Psychotherapy

The psychotherapeutic treatment of an alcoholic is vital, since true alcoholics never get over the threat of relapsing into drinking. During the period when they are well, they become non-drinking alcoholics. For many, attendance at AA is necessary all their lives. Older members eventually become leaders and helpers, ministering to the more vulnerable alcoholics. In this way, by identification, non-drinking alcoholics help themselves. Immediately after detoxification, individual therapy is needed in addition to the supportive AA group experience. The danger of relapse during the first 6 weeks after stopping drinking is real and the patient should be seen as frequently as possible during this period. Vulnerable patients who need supervision may be taken care of in a halfway house.

Designing a treatment program for the non-drinking alcoholic is dependent on what pathogenic links in the patient's behavioral chain require treatment. Basic to any treatment program is, to repeat what has been said before, continuing membership in AA or a similar group. Some alcoholics terminate the group program and are able to remain abstinent. For most, however, a good group is indispensable indefinitely as an anchor to sobriety. Psychotherapy for patients who do not have severe marital, family, or environmental problems can be short term, but group membership should continue without interruption.

Many alcoholics suffer from an underlying depression, which should not be too difficult to diagnose. A major depression may require antidepressant therapy with tricyclics or other drugs. A bipolar depression may need Lithium therapy. A neurotic depression is best helped by cognitive, interpersonal, or other form of verbal therapy. Some borderline cases may need carefully controlled neuroleptic therapy. Panic disorders and agoraphobia should be treated with behavioral approaches and antidepressants; and sedative-hypnotics assiduously avoided. Anxiety and tension are ubiquitous complaints, and the individual may importunately petition for some medications to relieve it. This request should not be treated lightly, but the patient must be reminded that the benzodiazepine drugs may be as harmfully addictive for him or her as alcohol. It is therefore best to use other tension-relieving approaches, such as relaxing exercises (a relaxing tape may be made), biofeedback, hypnosis and meditation, as well as physical exercise. Joining a YMCA or YWCA or other athletic club, running (if it is physically permissible), and swimming are often helpful. Where an anxiolytic is absolutely necessary, buspirone (BuSpar) may be employed.

Searching out and finding existing causes of stress and anxiety in the patient's work, marital, or family situation will necessitate appropriate interventions. In examining the work situation, a battery of vocational lists may disclose that the patient's interests and aptitudes are in a direction other than the existing work. The patient may then be guided to develop along the lines indicated by the tests. Marital difficulties are best approached with marital therapy and family problems with family therapy.

Environmental stress will require counseling and environmental manipulation. Consultations with a social agency for recommendations of suitable resources can save a great deal of time. Any existing remediable elements in the patient's environment that may be creating conflict for the patient should be straightened out with the aid of a social worker if necessary. In spite of expressed optimism, the patient is unable to handle frustration, and any objective source of difficulty may suffice to promote tension that will produce a craving for drink. An inquiry into the patient's daily routine and habits may be expedient. Often one finds a gross defect in the person's diet. Alcoholic overindulgence has been coincident with a depletion in dietary intake and with vitamin deficiency. Bad food habits may persist. Prescribing a well-balanced diet with sufficient calories and with supplementary vitamin B is important. The patient should also be encouraged to appease his or her hunger whenever he or she feels a need for food. Hitherto the patient has propitiated hunger pains by drinking alcohol. He or she may be surprised to observe that eating three square meals a day can remove much of the craving for liquor.

The numerous difficulties a patient has experienced through increasing inability to control drinking, the general condemnation of society, and the disdain of family all contribute toward a depreciation of self-esteem. It is difficult to rebuild self-esteem by reassurance, but an effort must be made to underscore repeatedly that the patient has many residual assets that can be expanded. Because alcoholics become negligent about their appearance, it is essential to rebuild interest in their personal care. Appearing neat and well groomed usually has a bolstering effect upon the person. Alcoholic women may be directed toward taking care of their complexions and hair by going to a beauty parlor. Whatever interest the patient shows in hobbies or external recreations should be encouraged. Patients must be reminded that they are not hopeless cases and that they have many good qualities that they have neglected. Their guilt may be continuously appeased by showing them that their alcoholic craving is part of an illness and that it will be possible to substitute something much more constructive for it.

Teaching the alcoholic to handle frustration will require considerable effort. The patient must be brought around to a realization that everyone has frustrated feelings and that an important job in life is to exercise control. Because of what has happened, the patient is apt to misinterpret any disappointment as a sign of personal failure. It is mandatory that the patient build up a tolerance of frustration, even though willful effort must be extended in this direction. Behavioral therapy may enable the patient to adjust better to many frustrating situations.

Since frustration is usually accompanied by gastric distress, it may stimulate a desire for drink. The patient, therefore, may be advised to carry, at all times, a piece of chocolate or candy. Whenever he or she feels frustrated or under any circumstances a craving for drink develops, he or she can partake of this nourishment. Hot coffee, cocoa, and milkshakes are also good for the same purpose. As the patient gains more self-respect, greater and greater amounts of frustration may be tolerated.

Many misconceptions and faulty self-statements plague the alcoholic, and clarification, persuasion, as well as cognitive therapy are usually in order. In many cases the basic difficulty is a personality disorder. There is no one predisposing personality problem. The character trait of dependency is often prominent, although the patient may try to conceal it. Dependency makes for a host of difficulties that have been outlined previously. Treating a personality disorder usually necessitates using a modified psychoanalytic approach, which is a long-term procedure (see Personality Disorders). If the patient is motivated and it is done properly, however, the reconstructive effects can be most gratifying.

Other Abused Substances

A miscellaneous group of psychoactive substances other than alcohol are used in all societies for mildly stimulating, tension-relieving, or recreational purposes. Among these are caffeine and tobacco. Only if the incorporation of such substances is beyond the individual's tolerance level, or if they impair social or occupational functioning, or produce abnormal physical and psychological changes, or if

habituation upsets the individual or those around the individual, may help be sought from a psychotherapist. When the individual is unable to control the intake of a substance, he or she is suffering from what is commonly called a *substance abuse disorder*. If there is physiological dependence on the drug, it is regarded as a *substance dependence disorder*.

Although noxious substances such as alcohol and tobacco, which are consumed legally by average citizens, can have a pathological impact, minor abuse of these substances is generally disregarded. Serious addictions that lead to lives of crime and other social evils are of much greater concern to society. Prominent disorders encountered other than alcohol abuse and alcohol dependence are cocaine abuse, opioid abuse and opioid dependence, barbiturate and other sedative-hypnotic dependence, amphetamine and other sympathomimetic drug abuse and dependence, hallucinogen abuse (such as with cannabis, phencyclidine, and psychedelic drugs), and tobacco dependence.

The chief objective of this growing stable of substances is to reduce tension, anxiety, and depression and to stimulate feelings of tranquility and euphoria. The search for these rewards has brought forth a host of substances, some of which for years have languished unnoticed in chemical laboratories. Periodically, "revolutionary" drugs appear on the streets which are said to produce heaven on earth. Peace of mind, the ability to love unambivalently, the painless acquisition of deep insights, and other astonishing bounties have never before been promised as they are today. Such a drug was MDMA, dubbed "Ecstasy" by its habitués, who claimed results in minutes never before obtained with other substances. Word travels fast among aspirants looking for lasting euphoria, and before long Ecstasy became the promising gate to a new life. But like other miracle drugs, disillusionment rode on the wings of reality: changes were short-lived, and episodes of disinhibition and psychosis destroyed the fantasy of harmlessness. Like other hallucinogens, its abuses led to its scientific discreditment and prohibition. Since then, other substances have taken its place. The latest "miracle drug" is "crack," a reincarnation of time-honored cocaine.

Cocaine Abuse (DSM-III-R Code 305.60) and Cocaine Dependence (DSM-III-R Code 304.20)

"The psychic effect of cocaine of .05 to . 1 gram consists of exhilaration and lasting euphoria, which does not differ in any way from the normal euphoria of a healthy person.…One senses an increase of self-control and feels more vigorous and more capable of work.…One is simply normal and soon finds it difficult to believe that one is under the influence of any drug at all."

These words of Sigmund Freud describe what the founder of psychoanalysis observed during his own dalliance with the champagne of illicit substances, which now has become a public health and safety menace. Cocaine is rapidly becoming the major drug problem in this country because of its intense euphoric impact, ready availability on the street, and ease of administration. Snuffing (snorting) small amounts rapidly produces heightened alertness, feelings of well-being, and self-confidence, which last only a short time. Intravenous injections, ("freebasing") and smoking the concentrated refined drug ("crack") have a strikingly exaggerated effect, but the aftermath of this "high" are uncomfortable physical symptoms. Headache, palpitations, stereotyped movements, confusion, incoherence, rambling, nausea, vomiting, perspiration, chills, tachycardia, skin paresthesias ("insects crawling"), anxiety, trembling, and depression enjoin the addict to dose again. Overactivity, impaired judgment, and other behavioral abnormalities may occur. Recovery within 24 hours is usual unless the individual gets a "fix," initiating a new cycle of exhilaration followed by more unpleasant symptoms. Cocaine addiction is associated with weight loss, insomnia, irritability, and paranoid ideas. It may lead to violent activities and crime. With continued use of large amounts of the drug, psychotic attacks may eventuate, resembling amphetamine psychosis. Serious physical ailments also intervene, especially when the addict habitually combines cocaine with opiates ("speedballs"). Cardiac abnormalities, brain seizure, and pulmonary dysfunction may be followed by respiratory arrest and even death. The cocaine abuser may try to calm anxiety with Valium, but continued physical suffering soon motivates the addict to search for funds to buy relief, often resulting in thievery. The power of the drug is described by Grinspoon and

Bakalar (1985): “Cocaine, along with some amphetamines, is the drug most eagerly self-administered by experimental animals under restraint; they will kill themselves with voluntary injections.” Human beings seem to be no less hedonistic, and cocaine addiction is spreading at an alarming rate. At a national information and treatment referral service, for example, more than 1000 telephone calls (the number is 8OO-COCAINE) are received daily and more than $50 billion for the purchase of cocaine are spent annually by abusers of the drug.

Management of acute symptoms of abstinence is urgent to prevent the individual from dosing again with cocaine. Anxiety and restlessness may yield to 10 to 20 mg of Valium or Librium, repeated as necessary. This, of course, is a temporary measure and as soon as some control is established, more permanent therapeutic measures, including residential care, counseling, and psychotherapy, should be initiated. If an overdose of cocaine has been taken, forced oxygen inhalation and muscle relaxants are given, and for convulsions, sodium pentothal (25-50 mg) is injected intravenously. In the event anxiety and tachycardia are especially strong, 1 mg of Inderal (propanolol) is sometimes injected intravenously every minute for up to 10 times. There is some evidence that bromocriptine (Parlodel), a dopamine agonist, may represent a new adjunctive treatment for cocaine abuse.

Opioid Abuse (DSM-III-R Code 305.50) and Opioid Dependence (DSM-III-R Code 304.00)

An occupational hazard for physicians, and pharmacists because of their easy accessibility, a component of pleasure seeking among psychopaths and sociopaths, a means of proving their masculinity among adolescents belonging to gangs, an unfortunate consequence of their prolonged use for pain or anxiety, opiates (particularly heroin) constitute a growing menace to the population. Harsh penalties for the possession and sale of these drugs make their cost so high that the average addict must steal and engage in other criminal activities to secure a constant supply. The addict consequently becomes a social

menace. Because he or she neglects his or her physical health, the addict suffers from disease and premature aging. Suicide is common as an escape from pain when drugs are not available.

Among the numerous narcotic opioid drugs in use today are heroin, morphine, hydromorphone (Dilaudid), oxycodone (Percodan), nalbuphine (Neubain), meperidine (Demerol), alphaprodine (Nisentil), anileridine (Leritine), methadone (Dolophine), propoxyphene (Darvon), pentazocine (Talwin), propiran (Dirame), levorphanol (Levo-Dromovan) and butorphanol (Stadol). The most frequent abusers of these drugs are teenagers, who are introduced to addiction by their peers.

The action of these drugs mimics the effect of built-in pain relievers released by the brain (endorphins and enkaphalins). Both the artificial and natural analgesics can be neutralized by certain substances such as naloxone, naltrexone, nalorphine, and cyclazocine, which block the effects of the addictive drug.

Generally, narcotic drug addition is not a simple matter of physical dependence. It is a manifestation of a long-standing personality problem that has many forms, addiction being one of the symptoms. It is not only a consequence of social and economic deprivation, although many users of drugs come from areas of poverty and destitution; it also occurs among the wealthier classes. Juvenile drug users are (1) seriously disturbed youngsters with a delinquent orientation to life who, because of a lack of cohesiveness, supervision, and discipline in their homes, drift toward renegade gangs to supply them with a sense of belonging and, through antisocial actions, to bolster up a stunted sense of identity; (2) adolescents in schools, whose peers induce them to experiment or who are depressed, bored, defiant, or simply seeking excitement. Drugs provide them with an answer to the tensions and anxieties of growing up. The pleasure rewards of drug intake followed by the violent discomfort of abstinence make drugs the central interest in the life of the addict. It requires a good deal of money to satisfy the drug need. This sum is generally obtained through crimes against property and by “pushing” drugs, selling them at profit to other addicts.

The treatment of the drug addict with any of our present methods is frustratingly unsuccessful, principally because the addict traditionally lacks the motivation for cure; the presence of narcissistic, immature, schizoid-like personality patterns that stir up incessant inner conflict and interfere with an adaptation to reality; and the existence of a home environment that imposes burdens for which the addict can find no solution. The following guidelines, nonetheless, may be useful:

1. The treatment of addiction to narcotic drugs is best achieved in a specialized institution where withdrawal symptoms can be handled and there is close supervision to prevent the addict from obtaining drugs. If the financial condition forbids hospitalization in a private institution, it is advisable to ask the patient to apply for voluntary admission or commitment to a U.S. Public Health Service hospital at Lexington, Kentucky, or Forth Worth, Texas (Council on Pharmacy and Chemistry, 1952).

2. Withdrawal or detoxification, which takes 4 to 12 days, is best accomplished with methadone, which may be administered orally (Dole and Nyswander, (1965). According to Fraser and Crider (1953) and H.A. Raskin (1964), 1 mg of methadone is equivalent to 2 mg heroin, 4 mg morphine, 1 mg Dilaudid, 20 to 30 mg Demerol, and 25 mg codeine. The dosage of methadone must be titrated to the tolerance of the patient. Too concentrated a dosage may produce respiratory depression, circulatory depression, shock, and cardiac arrest. Generally, detoxification treatment is administered daily under close supervision, does not exceed 21 days, and may not be repeated earlier than 4 weeks following the preceding course. A single oral dose of 15 to 20 mg of methadone will usually control withdrawal symptoms. This may have to be repeated if symptoms are not suppressed. A usual stabilizing dose is 40 mg per day in single or divided doses. After 2 or 3 days the dosage is decreased at a daily or 2-day interval. Hospitalized patients generally are reduced by 10 to 20 percent each day; ambulatory patients require a slower reduction. In cases of great physical debilitation, a high caloric diet, vitamins, hydrotherapy, massage, and glucose infusions are helpful. It is important to prevent all visitors and other persons not concerned with treatment from seeing the patient who is hospitalized since drugs may be smuggled in as a result of pitiful pleas to relieve his or her suffering. Patients who have been taking low doses of an opioid and who have a good relationship with the therapist may be given Clonidine, 0.1 to 0.3 mg, three or four times daily for detoxification purposes instead of methadone. Patients must be watched for excessive lowering of blood pressure and for excessive

sedation. The relapse rate is high once a patient leaves the hospital. Theoretically, a drug antagonist such as naloxone, cyclazocine, and naltraxone should prevent resumption of the habit. Practically, patients can be induced to start, but they rarely continue on the drug antagonist, and in one study 94 percent gave up the medication within 9 months. Librium, Thorazine, Trilafon, or Sodium Amytal may be taken to alleviate distress. Hypnotherapy has served to make some patients more comfortable. A prolonged period of hospitalization is best. Follow-up studies have shown that a high percentage of addicts released before 4 months become readdicted within 6 months.

3. While many drug addicts do well in a sheltered, drug-free environment, a return to the pressures and conflicts of their everyday world rekindles tensions, escape from which will be sought in drugs. An aftercare program is mandatory. Some authorities advocate legislation to force the addict to obtain aftercare services.

4. Aftercare is best administered in a day-night hospital or halfway house where the addict may spend a good part of his or her time, be exposed to the forces of group dynamics, and obtain a full range of social, rehabilitative, vocational, recreational, and psychotherapeutic services geared to his or her needs. The aftercare of drug-free addicts poses many hazards and disappointments principally because of their immature, hypersensitive personalities, their low level of frustration, and their inability to find adequate ways of dealing with their needs and tensions. A return to drugs is easily initiated by one disturbing experience.

5. An aftercare rehabilitation and guidance center is not enough. Rather, *constant care and supervision* are required, with daily interactions with some person (social worker, minister, rehabilitation worker, or psychotherapist). An adequate drug-control program must be so organized as to meet the individual patient's changing needs. Medical, psychiatric, social, educational, and rehabilitative services are part of this program; and unless these are closely coordinated, treatment can become both chaotic and ineffective. Methadone maintenance programs by themselves are inadequate without the additional services of counseling, vocational training, and psychotherapy.

Psychotherapy of the opioid addict is usually unsuccessful unless all the measures outlined above supplement the treatment program. In a 12-year follow-up study of addicts who had achieved abstinence, it was found that recovery is possible among delinquent addicts provided there is

compulsory supervision and a discovery by the addict of gratifying alternatives to drugs (Vaillant, 1966). Since a considerable number of the patients are borderline or schizophrenic, they must be handled with methods attuned to sicker patients.

Addicts sometimes consult psychiatrists asking that they be given an opiate for renal or gall bladder colic or some other emergent condition that requires temporary narcotic administration. Signs of the addiction include the presence of needle marks on the arms, legs, hands, abdomen, and thighs or physical signs of withdrawal.

Other marks of opioid intoxication are constricted pupils, euphoria, dysphoria, apathy, motor retardation, slurred speech, drowsiness, and memory and attention impairment. Withdrawal symptoms (sweating, diarrhea, tachycardia, insomnia, eye watering, running nose, and yawning) may rapidly be brought on in an addict by injecting naloxone (Narcan) as an antidote to morphine, heroin, and similar narcotics. The presence of an opiate may also be detected from chemical analysis of the urine.

Because it is impractical to treat addiction unless the drug intake is completely brought under control, the therapist should insist on hospitalization as a preliminary step in the treatment program. During aftercare, a small number of addicts will have sufficient ego strength to respond to reeducation, behavior therapy, or psychotherapy. But, it must be emphasized, psychotherapy unreinforced by a prolonged, perhaps perpetual program of rehabilitation is, as a rule, unsuccessful. An important deterrent in treating a drug addict by psychological means is countertransferential resentment and strong sympathy with the addict, which interfere with the therapist's capacity to show both tolerance and firmness when necessary. The addict's acting-out tendencies and low level of frustration will upset the equilibrium of the most stable therapist.

Some authorities, disappointed with the results of all treatment methods, advocate supplying addicts legally with drugs to keep them in balance, in this way eliminating the illegal supply outlets. Other

authorities argue against dispensing drugs, saying that the factor of increasing tolerance enjoins the addict to expand the dose required to secure the desired effect. Having obtained the limit prescribed from the physician or clinic, the addict will return to the illegal market and continue to be exploited by drug peddlers, resorting to crime for funds as usual.

For this reason, methadone maintenance therapy has become the most common approach for chronic opioid dependence. Patients come to a methadone maintenance clinic (which is controlled by federal regulations) for their daily (up to 40 mg) methadone and after 3 months are given a supply (100 mg) to take home. Progress is monitored by interviews and urine testing. During the first few months of methadone maintenance some side effects may occur, such as sexual dysfunction, sweating, and constipation. Eventually, tolerance of methadone develops and patients feel more comfortable. We are dealing with a difficult population, however, and violent outbursts may be expected, especially among unstable personalities around such issues as take-home supplies of methadone. Some patients continue to seek opioids in addition to methadone (Maddun & Bowden, 1972; Newman, 1976), and some use alcohol and sedative-hypnotics. But many are helped toward a more productive life; criminality lessens, employability increases, and general adaptation is better (Cushman, 1972; Sharoff, 1966). Even some patients who have complicated psychotic and personality problems are helped with adequate counseling and psychotherapy to stabilize with methadone. A few who are not too ill emotionally may achieve complete abstinence from drugs provided environmental stress can be controlled. The preferred objective, of course, is to render the individual completely free of all abused substances as well as methadone. This may be possible in some cases. In other cases abstinence is obtained by administering an opioid antagonist which the addict continues to take much as some alcoholics rely on Antabuse to help keep them dry.

Among the newer treatments for heroin control in addition to methadone is methadyl acetate, a synthetic congener of methadone. Methadyl acetate appears to be equal to methadone in its rehabilitative

efficacy, but its duration of action is from 48 to 72 hours, so it can be dispensed three times weekly instead of daily. It may be useful for a certain subgroup of the addict population (Senay et al, 1977).

There are some incurable addicts who are "well-adjusted and leading useful, productive and otherwise exemplary lives which would probably be upset by removing their drugs. They are contented with their present states, do not desire treatment and would resist change. The wisdom of disturbing them is to be questioned, for the result socially and economically might be destructive and bad" (NY Academy of Medicine, 1963). This applies also to elderly addicts with healed lesions of various sorts.

Some addicts seem highly motivated to rehabilitate themselves but require a drug other than methadone and a narcotic antagonist to sustain them in resisting narcotics. Neuroleptics are helpful in certain situations, particularly if psychotic symptoms threaten. Roskin (1966) believes that the schizophrenic addict uses narcotics as a tranquilizer in the throes of severe schizophrenic decompensation. The schizophrenic addict, in his opinion, has a better prognosis than the pure acting-out addict. "If a drug addict seeks help on his own volition, it may be suspected that he is a schizophrenic." Neuroleptic drugs, therefore, and the supportive relationship with the therapist are helpful replacements for narcotics in the adjustment of the schizophrenic addict. Patients with primary and bipolar depression will require antidepressants.

As mentioned before, clonidine has been used as a detoxifying agent (Mark et al, 1980; Chamey et al, 1981) to wean addicts completely off opioid substances and methadone. This is followed by administration of a substance like naltrexone (Resnick et al, 1974). Naltrexone (Traxan) is a non-addicting narcotic antagonist that has fewer side effects than the older cyclazocine (Martin WR et al, 1965; Jaffe and Brill, 1966) and naloxone (Narcan) (Zaks et al, 1971). Blocking the euphoric effects of opioids, naltrexone acts somewhat in the same way with narcotic addicts as Antabuse does with alcoholics (i.e., by reducing motivation for drugs). The patient must be narcotic free when it is started. After detoxification and the slow reduction of methadone to where it is completely withdrawn and when

7 to 10 days of freedom from all opioids and methadone has been verified (sustained by urine tests), naltraxone (50 mg) is administered daily. Charney et al. (1982) have described use of a combination of naltraxone and clonidine as a "safe, effective, and extremely rapid method for treating the methadone withdrawal syndrome."

Motivated addicts also have been helped in groups by relating themselves to other addicts who have broken the habit. The most successful experiment is that of Synanon under whose care the addict deliberately places him- or herself (Casriel, 1962; Gould, 1965; Walder, 1965). Part of the Synanon idea includes an intensive leaderless form of group therapy—usually three times weekly—during which each member is expected to reveal his or her feelings truthfully, and to lay bare fears and hates. "At Synanon we snatch off all the covers of our dirty little secrets. Then we stand there naked for everybody to see" (*Life Magazine*, 1962). Groups with a leader also exist, ideally consisting of three male and three female addicts and one ex-addict ("Synanist"). The Synanist acts as moderator who utilizes insight into himself or herself for interpretations. The Synanist also employs such tactics as ridicule, cross-examination, and hostile attack to stir up involvement and activity. Another device, used with a new addict is the "haircut," in which four of five significant members of the Synanon family structure "take one apart," criticizing actions and performances to date. While the "haircut" may be a verbally brutal experience, it is usually quite effective. "When the word gets around that 'haircuts' are being given, people seem to get in line.…Many of the people who have experienced these 'haircuts' reported a change in attitude or a shift in direction almost immediately." Lectures are given daily by one of the more experienced members. The members support each other and come to each other's aid when temptation threatens to disrupt drug abstinence. Each member is also expected to perform household tasks according to ability, which gives the addict a sense of participation. Additionally, "a concerted effort is made by the significant figures of the family structure to implant spiritual concepts and values that will result in self-reliance. Members are urged to read from the classics and from the great teachers of

mankind—Jesus, Lao Tse, Buddha. These efforts have been successful to a rather surprising degree. The concept of an open mind is part of a program to help the addict find himself or herself without the use of drugs" (Dederich, 1958). As soon as the addict is adjusted to the new environment, he or she is encouraged to get a job on the outside, to contribute some salary to the group, and to continue living at the Synanon house. Dropout rates, however, are high.

The Synanon idea, which essentially depends for its force on group dynamics, is being adopted in some correctional institutions. The lack of communication between the inmates of an institution and the authorities who run it has always posed a problem. To circumvent this, the people chosen to work with offenders are themselves ex-offenders who have modified their own deviant behavior. Offenders, alcoholics, and drug addicts seem to respond to a leader who, like themselves, has gone through criminal, alcoholic, or drug addiction experiences, who talks their language, and who, in having achieved resocialization, becomes a model with whom new identifications may be made. Such a leader usually approaches his or her work with an evangelical-like zeal to point out new directions in life from which he or she cannot be outmaneuvered by specious arguments. Another technique that has come into recent use with drug addicts is the "marathon group" of continuous group interaction for 2 or more days with short periods of rest.

Residential treatment centers like Synanon have been developing in different parts of the country. An example is Day-top. Therapeutic communities, such as Odyssey House and Phoenix House (DeLeon et al, 1972; Densen-Gerber, 1973), have provided a refuge for some addicts and beneficial effects are usually maintained for as long as a patient is an active member.

Coincident psychiatric problems found among drug abusers are, in order of frequency, affective disorders, especially major depression; alcoholism; personality disorders, principally antisocial personality; and anxiety disorders. Schizophrenia sometimes may be seen, but paranoidal conditions are more common. Therapy, such as Doxepin for depression, Antabuse for alcoholism, and neuroleptics for

schizophrenia, should be instituted if necessary. About one-quarter of opioid addicts take other substances, such as barbiturates, benzodiazepines, cocaine, cannabis, amphetamines, and alcohol. This accents the need to work with many variables that influence continuance of the drug habit. Therapists looking for an ideal model of therapy should consider detoxification with methadone as a preliminary step toward complete abstinence, the use of an antagonist such as naltrexone as safeguard against resumption of the drug habit, and treatment in therapeutic communities of drug-free day-care centers, with the use of behavioral, cognitive, and, in a few cases, modified analytic therapy according to the needs and aptitudes of the patient (see Summary).

The following readings on narcotic addiction are recommended: Dole and Nyswander (1965, 1966), A.M. Freedman (1966), A.M. Freedman and Sharoff (1965), Mueller (1964), Nyswander (1956), Ray (1961), Sabath (1964), Seevers (1968), Senay (1983), Stimson and Oppenheimer (1982), U.S. Department of Health, Education, and Welfare (nd), Verebey (1982), and Wikler (1980).

Sedative, Hypnotic, or Anxiolytic Dependence (DSM-III-R Code 304.10) and Abuse (DSM-III-R Code 305.40)

Dependence on *barbiturates* was once as serious an addiction problem as dependence on narcotics is now. Barbiturates in overdose are lethal and constitute one of the chief means of suicide. They are especially dangerous when taken with alcohol. Sometimes suicide is unintentional if an individual, because of sluggish thinking or chronic intoxication, forgets he or she took pills and swallows additional ones.

In 1962, a survey by the Food and Drug Administration revealed that more than a million pounds of barbituric acid derivatives were available in the United States (Committee on Alcoholism & Addiction, 1965). This 1-year inventory is enough to supply two dozen 1.5-gm doses to every man, woman, and child in the country. The survey led to the conclusion that “any patient whose psychological dependence on a barbiturate drug has reached a degree sufficient to constitute drug abuse has some form of

underlying psychopathology." He or she is "directly comparable to the opiate-dependent person." There are no specific syndromes involved; practically all diagnostic categories are represented. Since federal restrictions have been placed on the sale of barbiturates, benzodiazepines have largely taken their place.

Short-acting barbiturates (Pentothal, Seconal, Amytal) are particularly addicting "They are as truly addicting as heroin or morphine and give the individual and his physician an even greater problem" (U.S. Department of Health, Education, & Welfare, nd). Like alcohol, they are intoxicating, produce confusion, lack of coordination, and emotional instability. Sudden or complete withdrawal of barbiturates from an addicted person usually results in convulsions and sometimes in a temporary psychosis like delirium tremens. Death may follow.

A sizable class of barbiturate addicts are middle-aged and older people who have been given barbiturates for insomnia and have consumed pills for years. This leads to hazy thinking, poor judgment, memory loss, emotional instability, and diminished motor skills.

The most common barbiturates sold illegitimately are secobarbital (Seconal), known on the street as "reds," pentobarbital (Nembutal), dubbed "yellows" or "nembies," and amobarbital secobarbital (Tuinol), called "double-trouble" or "tooies." Sometimes inveterate addicts, especially alcoholics and amphetamine users ("speed freaks"), inject barbiturates ("downers") intravenously ("pill popping") and use them interchangeably with heroin and amphetamines ("uppers"). Behavior is affected markedly and may include episodes of violent disruptive outbursts.

Any person who has taken an overdose intentionally or unintentionally should be rushed to a hospital for immediate treatment. While waiting for the ambulance, vomiting should be induced and the airways kept clear to prevent strangling. The person should be prevented from slipping into unconsciousness. Withdrawal from the drug is essential, but complete immediate withdrawal is dangerous. The patient must be put back on barbiturates to counteract abstinence symptoms and then

phased into withdrawal. No more than 0.1 gm should be withdrawn daily, and physiological signs should be monitored throughout withdrawal (Ewig, 1966). The daily intake is reduced over a 1- to 3-week period. Librium or Valium may be given temporarily to control agitation, tremor, and insomnia. Supportive restoration of electrolyte balance, vitamins, and intravenous fluids are in order (see Chapter 58 on Emergencies). Hospital admission and proper nursing care are mandatory. Physical dependence on minor tranquilizers (Miltown, Librium, Valium) will also be followed by abstinence symptoms, convulsions, and occasionally even death if withdrawal is abrupt, and emergency measures as for barbiturate overdose should be employed. Continuing aftercare, as with narcotic addiction, will be necessary. Caution in prescribing tranquilizers and sedative drugs with dependence-producing properties is essential in "dependence-prone" persons (Bakewell and Wikler, 1966).

Methaqualone (Quaalude) has had some use in recent years as an agent to counteract insomnia, but it has been abused, especially by young people who take one or two pills, sometimes with wine, to produce relaxation and euphoria. It has a reputation for being an aphrodisiac. Depersonalization and various physical symptoms are common adverse effects. Convulsions, delirium, and death may occur with overdose. Other non-barbiturates that may be overused are glutethimide (Doriden), ethinamate (Valmid), ethchlorvynol (Placidyl), and methprylon (Noludar). Emergency treatment for overdose is similar to that for barbiturate intoxication. While benzodiazepines (Valium, Librium, Xanax, etc.) are much safer than sedative-hypnotics, addiction can occur when they are taken over an extended period. After a month or so, even therapeutic doses may produce a tolerance. Since withdrawal symptoms are apt to occur, a gradual slow reduction of the medication is necessary. If large doses of benzodiazepines have been taken and withdrawal was abrupt, convulsions are possible and Dilantin (hydantoin) is indicated.

Amphetamine or Similarly Acting Sympathomimetic Abuse (DSM-III-R Code 304.40) and Dependence (DSM-III-R Code 305.70)

Addiction to *amphetamine* and similar-acting sympathomimetic stimulants has been growing in this country. It is used by students to prod them into greater alertness, by pleasure seekers in search of "kicks," and by those who habitually try to suppress their appetites to control overweight. Such addiction results in serious physical effects, the disorganization of the personality, and can even precipitate outright paranoid psychoses (Lemere, 1966) that resemble paranoid schizophrenia. Other symptoms are impaired judgment, aggressive behavior, and lack of coordination. Tolerance to the drug causes the abuser to increase the dosage for a euphoric effect, sometimes to 20 times the original dose. The intake of large amounts of amphetamine may cause a delirium. Attempts at withdrawal produce a letdown or "crash," with depression, physical symptoms, and aggressive behavior that usually send the addict out for a "fix." Amphetamines have been implicated in increasing numbers of automobile accidents and crimes of violence (Medical Society of the County of New York, 1966). Treatment of the individual who takes only 2 or 3 tablets a day requires quick withdrawal and administration of ammonium chloride to bring the pH to the acid side. Though withdrawal is not as urgent in these cases as in persons who take large amounts, there is always the danger that the intake will be increased. Mandatory withdrawal for persons who consume large quantities of amphetamine substances should be carried out in a hospital. The drug is removed abruptly, and the withdrawal effects are treated with intramuscular neuroleptics such as Haldol and, if necessary, barbiturates at night. These are especially indicated if amphetamine-barbiturate mixtures have been used (Connell, 1966). Depression may need to be treated with antidepressant medication such as tricyclics. Aftercare is as important as it is for narcotic addiction, and psychotherapy may be an essential part of the rehabilitative program.

Cannabis Abuse (DSM-III-R Code 305.20) and Cannabis Dependence (DSM-III-R Code 304.30)

Marijuana (cannabis) continues to be a popular substance, especially among students in school and young people in middle- and upper-income groups. The drug is neither as innocuous as is claimed by its friends nor as destructive as contended by its foes. It is a hallucinogen with varying potentials for toxicity depending on the host and the conditions under which it is taken. Generally, marijuana ("joints," "dope," "pot") is smoked experimentally on only random occasions and the hallucinogenic ingredient is in too low a dose to create any real difficulties. Some authorities say that harmful physical and psychological effects of prolonged marijuana use have not been consistently demonstrated and are minimal compared with the ravages of alcohol intake. Emotionally disturbed persons will, however, continue to indulge in concentrated efforts to experience euphoria by using the most potent substances such as hashish and purified THC, which can cause greater mischief, including depersonalization, paranoidal ideas, anxiety, depression, tachycardia, and apathy. The abuse potential of marijuana is high. There is, nevertheless, no evidence that the use of marijuana is associated with crimes in the United States (Medical Society of the County of New York, 1966). Nor is there evidence that the drug is a narcotic or that it is truly addicting. Yet, in its usual form, it *is* a mild hallucinogen and may, in some susceptible persons, promote panic and aggressive behavior. Moreover, the impaired judgment under the influence of the drug interferes with skilled activities such as driving. Some people with severely disturbed personality problems may proceed from marijuana intake to a heroin habit, although the exact correlation between marijuana and subsequent heroin addiction has not been established. Pressure to legalize marijuana understandably has brought forth heated debate and controversy. Arguments pro and con related to the harmlessness of marijuana do not suffer from a dearth of misinformation. Research has had little effect on bias and the polarization of opinions.

Phencyclidine (PCP) or Similarly Acting Arycyclohexylamine Abuse (DSM-III-R Code 305.90) and Dependence (DSM-III-R Code 304.50)

Phencyclidine (PCP, "angel dust," "crystal," "Peace Pill") and similar substances such as ketamine (Ketalar) and TCP may be taken orally and intravenously, as well as by smoking and inhalation (Cohen, 1977). Effects are rapid and consist of euphoria, grandiosity, hallucinations of color and sound, and slowing of the time sense. Agitation, vomiting, anxiety, nystagmus, elevated blood pressure, ataxia, muscular twitchings or rigidity, anesthesia, paranoidal ideas, and other symptoms may follow. Delirium can occur with large doses (20 mg or more). Hospitalization and administration of antipsychotics such as haloperidol (Haldol) may be helpful as an emergency measure.

Indulgence of other hallucinogens has been increasingly reported. The use of dimethyltryptamine, psilocybin, bufotenine, peyote, mescaline, charas, morning glory seeds, and nutmeg sometimes produces variant problems, and glue sniffing among youngsters of school age can become disturbing (Jacobziner, 1963). LSD, which was popular in the past, was obtained from amateur chemists or from organized criminal groups. Usually 100 to 600 micrograms were ingested by individuals on a sugar cube for the purpose of "taking a trip," which was embarked on once or twice a week. Large doses (more than 700 micrograms) were ingested to produce more intense psychotic experiences. Psychotic episodes persisted for days or weeks and, in schizoid personalities, for months or even years, requiring hospitalization. The use of these hallucinogens has diminished in favor of such drugs as cocaine.

Nicotine Dependence (DSM-III-R Code 305.10)

According to the World Health Organization approximately one million persons die of cigarette-related diseases each year the world over and approximately one-third this number (350,000) in the United States alone. This is not because of misuse or abuse of cigarettes since "no safe use for this product exists; every cigarette smoked is intrinsically harmful to health.…even when used normally and as intended" (JAMA, 1986). The National Institute on Drug Abuse has warned that nicotine in tobacco

is “a powerful addictive drug.…six to eight times more addictive than alcohol.” In the United States, medical care and cost productivity associated with cigarette smoking total approximately $65 billion per year.

Promotional advertising linking cigarettes to a healthy and athletic life style nevertheless continue in force. To a large extent, adolescents and children fail to comprehend the dangers of the habit, which they continue as adults. Billions of dollars of profit pour into the coffers of the cigarette companies annually. In the meantime the ravages of cigarette smoking promote heart disease, emphysema, cancer of the lung, cancer of the upper respiratory tract, as well as other debilitating and fatal diseases. These are amply detailed in medical journals, although most of the cigarette-smoking public overlook or minimize medical warnings. But some request help.

Cure of the smoking habit is a difficult task, especially if smoking serves the purpose of alleviating tension. Educational campaigns, psychotherapy, and pharmacological aids have all yielded limited success (Ford & Ederer, 1965). Mark Twain’s comment, “It’s easy to quit smoking; I’ve done it hundreds of times,” is tragically the experience of most inveterate smokers who try to force themselves to give up tobacco. Group therapy with smokers, anesthetic lozenges, astringent mouth washes, anticholinergic drugs, vitamins, tranquilizers, stimulants, sensory deprivation, systematic desensitization, aversive conditioning, stimulus control, and lobeline as a nicotine replacement may produce temporary withdrawal from tobacco, but the relapse rate is high—75 to 80 percent. The entire process of smoking becomes for the inveterate user of tobacco an adjustment mechanism serving to satisfy specific needs: appeasing and reducing tension, providing a facade of nonchalance and poise, controlling anger, overcoming embarrassment in upsetting interpersonal situations, providing mouth and oral gratifications, acting as a substitute for overeating. Giving up smoking leaves a hollow in the life of the tobacco addict, mobilizes tension, and deprives the addict of a powerful adaptational tool.

In many cases smokers will openly or indirectly reveal that they are convinced that they will be unable to stop. In one case I was consulted by a professional man with Berger's disease, an illness in which smoking is dangerous. When he was admitted to a hospital for the beginning of gangrene of a toe, he had strapped cigarettes across his back to conceal them from the nurses and attendants, knowing that they would remove any cigarettes on his doctor's orders!

The "I can't" resistance ("I don't have what it takes," "My life is too unsettled now," "I'm not strong enough," etc.) is a means of reducing anxiety stemming from the conflicting desires of wanting to smoke and wanting to maintain one's defensive gratifying prop (Clark R, 1974). The defeatist belief is a way of denying this conflict. In applying for help, there is a forlorn hope that someone other than the patient can control his or her smoking. The resistance if unresolved will defeat any applied therapeutic efforts. The fact that smoking continues in spite of treatment convinces the individual that he or she is hopeless and provides an excuse for continued smoking. The idea that the smoker has exposed himself or herself to therapy appeases the guilt. "I know it's bad for me, but I don't care, it doesn't matter, I'm not going to think about it." In working with any smoker, therefore, this resistance should be tackled at first. The therapist should verbalize the nature of the resistance and explain its purpose. Smokers should be encouraged to stop pretending that they are doing all they can to overcome the habit. At the same time the therapist should express confidence that they *can* quit smoking if they want to and work toward kindling the patients' faith in themselves.

It is important in treating individuals who want to give up smoking to keep in mind that immediate abstinence is possible with many techniques. As with any other addiction, resumption of the habit will usually follow within the first year unless the needs that led to smoking originally are adequately fulfilled.

The first step in smoking control is to ask the patient why he or she feels he or she should give up tobacco at this time. The patient will probably have been warned by a physician to stop the habit

because it is a health risk. Such warning usually has fallen on deaf ears. The habit is compelling and insidious. The patient may be told that he or she, like many others, can succeed by recognizing the *positive* value of abstinence. Some therapists give the patient a typewritten form that says something along the following lines:

Overcoming the tobacco habit may be achieved with a minimal amount of suffering if you follow these principles:

1. First, prepare a written or typewritten list of the *benefits* you will gain in giving up tobacco, such as that your health will improve, and that you will feel more vigorous, look better, lose the offensive tobacco odor, save money, and respect yourself more for abandoning a self-destructive habit.

2. Choose a time to quit when you are under the least stress or tension. *Then quit completely*. Shred or destroy every cigarette or cigar in your possession. Give away your lighter and ashtrays.

3. Discomfort during the next few days is to be expected but will disappear within 2 weeks. Such discomfort may be minimized by (a) reading the list you have prepared once in the morning when you get up and at bedtime and more often if you desire; (b) practicing relaxing exercises at least twice daily (meditation, self-relaxation, self-hypnosis, listening to a relaxing audiotape); (c) oral substitutes like Nicorette gum or smoke-free cigarettes (Favor) *if you need it* to stop physical reactions. Keep sugarless candies, carrot sticks, and menthol-filled plastic fake cigarettes on hand to take to work or use at social functions; (d) tell your friends that you are quitting smoking for health reasons and ask them, please, if they can, not to smoke in your presence for the next few weeks; (e) during the first 24 hours of abstinence expect to feel some muscle cramps, fatigue, headaches, or nausea as nicotine disappears from your body. Expect periodic cravings for a cigarette. Push your mind away from the thought and busy yourself with some activity; take a long walk, write letters, or do other activities; (f) spend as much time as you can in smokeless surroundings such as libraries and theaters; (g) cultivate a hobby (golf, swimming, tennis, bridge).

4. Your eating habits may need to be changed because in giving up tobacco you are apt to crave sweets and more food. Drink 6 to 8 glasses of water daily; keep water, some fruit juice, or a diet

soda near you while watching television and sip it to appease your appetite. Avoid spicy foods, and minimize the intake of alcohol and coffee, which can stimulate a desire for tobacco and increase your appetite. Do not despair if you gain a few pounds; you will lose weight after the craving for cigarettes disappears.

5. In about 2 weeks you will have conquered a good deal of the tobacco desire, but the rest of your life fight off the impulse to take even one puff. When nicotine has completely left your body, the joy and vigor you will feel will more than compensate for the loss of this dangerous habit.

In many cases, these simple suggestions may suffice. If they do not, more extensive measures may be needed. Among the chief methods for getting the smoker off tobacco are behavior modification, hypnosis, and group approaches.

Behavior modification methods are fashioned after the techniques used to overcome overweight and obesity. An investigation is launched into the history of the smoking habit, how many cigarettes are consumed daily and under what circumstances, when the frequency increases, what puffing on a cigarette does for the individual, what efforts have been made to stop in the past, and why the individual wants to give up smoking now. Behavior modification techniques are then devised to replace reaching for a cigarette with other activities, thus providing a non-smoking routine for the patient (Bernstein & McAlister, 1976). Holding a sizable sum of money in escrow that is forfeited with the taking of even one puff of a cigarette within 6 months may be effective beyond any other technique.

Therapists acquainted with the hypnotic technique will find hypnosis a useful adjunct. Many ways of employing hypnosis have been described, with varying claims of success (Crasilneck & Hall, 1968; von Dedenroth, 1968; Spiegel H, 1970; Watkins H, 1976). In my own experience I have found that hypnosis can help eliminate sources of tension, especially after the smoking habit has been broken. The initial visits should, if possible, be frequent. Suggestions are made in the trance to the effect that the patient will develop a *desire* to stop smoking and that he or she will grow so strong that neither temptation nor tension, no matter how intense, will deviate him or her from the resolve to give up tobacco. This

achievement will be rewarded by a feeling of wellbeing and strength that will be greater with each day of continued abstinence. It is strongly suggested that the patient will, in relinquishing smoking, be able to control his or her appetite so as not to overeat. Dictated recordings, made by the therapist, which the patient plays at home twice daily (see section on Induction of Hypnosis) often help to reinforce suggestions and to reduce tension. They are especially useful if the patient cannot come for frequent reinforcing sessions. Self-hypnosis, facilitated by the recording, will also prove to be of value.

Should the patient inquire about other oral gratifications, such as gum chewing or allowing a hard piece of candy to dissolve in the mouth, "permission" for this may be given if it is not overindulged. Some patients who have a need to defy authority will, rather than return to smoking, engage in these harmless oral activities beyond what they believe is permitted. In this way the tobacco habit may become more readily extinguished. The gum chewing and candy indulgence are gradually given up on their own. Because nicotine addiction drives smokers back into the habit, nicotine in a flavored chewing gum (Nicorette) is sometimes prescribed to ease the physical craving for nicotine. The gum may be helpful during the first few weeks of quitting smoking (Russell et al, 1982). Other common methods that may be used to get individuals off cigarettes (Schwartz I, 1977) are rapid concentrated smoking inhalation and group approaches (supportive and behavioral). The latter prove especially valuable when behavior modification and self-control methods are combined. Powell and Arnold (1982) have described a multiple-treatment design for coronary-prone men that achieved a 50 percent smoking cessation rate at the end of one year, which is about double the usual reported rate of abstinence. Their "Stop Smoking Program" consisted of four consecutive 1 ½-hour sessions, Monday through Thursday, composed of highly structured activities along the following lines:

1. Stimulus control (altering the antecedents leading to smoking);
2. Relaxation training (deep breathing with pleasant imagery);
3. Thought stopping to eliminate thoughts about reaching for a cigarette;

4. Eating management (avoiding food and eating situations that stimulate a desire to smoke);
5. Substituting props (such as sugar-free candy);
6. Rehearsal of suitable non-smoking behaviors;
7. "Cognitive coping" to associate positive thoughts with quitting smoking.

In addition, mild aversive stimulation (pairing smoking with pain stimulation to reduce the appeal of tobacco) was employed in some cases. Three once-weekly meetings were held after the formal 4-day program. A manual containing persuasive "pep" talks was supplied, and a counselor telephoned the patient to inquire about progress and to encourage maintenance of abstinence. At the start of therapy, return of part of the patient's fee is promised (contingency contracting) if abstinence is maintained after three to six months, thus providing further motivation to stop the habit.

Smoking cessation programs have been prepared by the American Cancer Society (1971) and by Dananer and Lichtenstein (1978). An innovative behavior modification program, "Quit-by-Mail," using a home computer has been devised by Schneider (1984). Participants mail out weekly correspondence detailing their progress and problems, and their questions are addressed in pointed computerized responses. It has shown some promise.

Regardless of the methods employed to produce abstinence, many patients need continuing help to deal with the stress and other factors that promote a craving for cigarettes. The nature of such help will have to be designed for specific problems: environmental factors through environmental manipulation, marital difficulties through marital therapy, family problems through family therapy, faulty attitudes through cognitive therapy, and so on. The continued use of self-relaxation techniques, indulgence in interesting diversions and absorbing hobbies, and graded regular physical exercise are valuable. Should excess tension develop as a result of unusual stress, a minor tranquilizer (Valium, Librium) prescribed for only a short period may be required to ease a patient through the crisis. Patients' feelings of well-being in ridding themselves of the tobacco habit, their enhanced physical stamina as a result of

eliminating nicotine from their bodies, and the approval they sense from their therapist and friends for their "courage" will, one hopes, suffice in maintaining abstinence. If smoking persists, more extensive therapy will be needed.

A "non-smoking kit" of pamphlets written for children, adolescents, and parents may be obtained at a small cost from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C., 20402.

Summary of Treatment Approaches in Substance Abuse

The treatment of substance abuse is a difficult task as attested to by the worldwide pessimism about the prognosis for this disorder. Dropouts from therapy are more the rule than the exception, and non-compliance with therapeutic routines tax the patience of the most empathic therapist. The therapist has to be more active in approaching substance abusers than is customary, especially at the start of treatment. In an attempt to deal with resistance, the therapist should call when the patient misses a session. Continued non-compliance with routines that have been set up and failure to execute homework assignments may require more aggressive tactics (Marlatt & Gordon, 1985). The maintenance of discipline, so important in acquiring essential non-drinking and non-drug-taking skills, requires that therapists refuse to be lied to or manipulated, since these merely reinforce the patient's self-destructive patterns. The patient does not, however, have the substitutive skills to deal with stress at the beginning of therapy, so the therapist will have to tolerate an occasional relapse at the start. Such relapse provides an opportunity to review what has produced it. The manner of its management by the therapist can be important in consolidating the therapeutic relationship.

Treatment outcomes in substance abuse are dependent on the severity of the psychopathology (McLellan et al, 1983; Woody et al, 1984; Woody et al, 1986). Supportive therapy and drug counseling may suffice for patients who are not too psychiatrically disturbed. Those with a moderate degree of

pathology may be helped, often substantially, by additional psychotherapy. But severely psychiatrically handicapped individuals will show a poor outcome whatever the intervention.

A growing problem in the treatment of substance abuse is that more and more people are increasingly using combinations of substances for purposes of recreation, relaxation, control of disturbing psychological and physical symptoms, and the ever-constant search for euphoria ("pharmacodynamic elation"). A recent estimate placed the figure of polydrug use at 84 percent of all substance abusers. The choice of alcohol, tranquilizers, sleeping pills, marijuana, cocaine, amphetamines, opioids, and other substances makes for mixtures whose effects are unpredictable and that pose many health hazards. Detoxification programs will have to deal with the fact that polydrug use can lead to dangerous withdrawal reactions. For this reason, detoxification, which is basic to the start of any organized treatment program, should be done in a hospital or residential center that has adequate facilities. The incidence of withdrawal and abstinence reactions makes mandatory the use of staff members in these units who are experienced in emergency treatments, and the management of problems specific to the substances that are being abused.

Temporary administration of substitute narcotics such as methadone in the opioid addiction, and small doses of barbiturates in barbiturate abuse, can prevent convulsions and other dangerous physical reactions. Thereafter, phased slow withdrawal, while monitoring physiological responses, is mandatory. The use of oxygen, neuroleptics, and, if they exist, specific drug antagonists (e.g., naltraxone in opioid addiction) can also be better controlled in an institutional setting. Most important, abused substances must not be made secretly accessible in institutional surroundings.

Once the patient is detoxified, the next step is to keep him or her off alcohol and drugs. Here, psychosocial treatments are instituted. The largest handicap in using such therapies is lack of cooperation. Most addicts or alcoholics are brought to a psychotherapist by frantic parents, spouses, or friends. The patients, despite verbal declarations, are not fully committed to staying off drugs, or, if they

have “hit bottom” and suffered the after affects of a “binge,” their commitment soon vanishes when they recover. If the therapist can establish a relationship with the patient, confrontation may be possible and some motivation stimulated. Despite considerable skepticism, it has been shown that *properly* conducted treatment for alcohol and drug abuse can be effective along a wide range of parameters, including, in overcoming the habit, finding employment, reducing criminal behavior, and enhancing psychological functioning (McLellan et al, 1982).

In formulating a proper treatment plan, the therapist should be aware of a number of essential factors:

1. The patient’s enthusiasm for therapy, however, sincere, may be short-lived, giving way sooner or later to what seem to be self-destructive impulses. Extreme physical dependence is inescapable with habitual use of opiates, barbiturates, and alcohol. There is some physical dependence and considerable psychological dependence with the long-term use of amphetamines. Psychological dependence is present with marijuana, tobacco, and hallucinogens, but only moderate physical dependence unless dosage has been high. Great tolerance is soon established with opiates, amphetamines, and hallucinogens; somewhat lesser tolerance with the barbiturates, alcohol, and tobacco.

2. The addict is convinced that drug indulgence, better than anything else, enables him or her to overcome despair, dissatisfaction, depression, and anxiety.

3. Drug abstinence achieved outside of an addict’s habitual environment may not last long after the addict returns to his or her customary surroundings.

4. Since single addictions are rare, removal of one substance does not lessen the craving for others. Indeed, it may provoke the addict to try new experiments with other potentially exciting or calming materials.

5. Detoxification and “cure” of the desire for drugs has little effect on underlying pathological personality problems, only one manifestation of which is the thrust toward drug intake. Other manifestations will require psychosocial interventions. These may yield meager results, and

prolonged care (1-2 years) in a therapeutic community like Synanon and Phoenix House may be needed to achieve a social adjustment.

6. A support group (Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous) of some kind will be necessary, sometimes for the remainder of the individual's life, as a source of reassurance, education, and companionship and as a "port in the storm" when troubles at home or at work brew or the inevitable cravings for a "fix" or drink return. The best support groups are patterned around the precepts of groups that have proven valuable, such as Alcoholics Anonymous or Synanon, and are composed of peers with similar substance abuse problems. Preferably, some of the leaders have suffered from and conquered similar problems. A professional person should be available for supervision and consultation. Periodic urine and serum drug screens should be employed if possible to detect early defection from abstinence. The choice of a proper group cannot be overemphasized because bad leadership and the presence of too disturbed or offensive members can negate the positive benefits of group participation. In large cities, resources for finding good groups are usually ample. In smaller communities, groups in neighboring towns may need to be explored. The therapist may enlist the assistance of social agencies for this purpose. Other community reinforcement resources—social, athletic, and so on—may be available to provide leisure-time positive reinforcements. Caution is needed in their selection, however, since social (or heavier-than-social) drinking may be the norm in some of these groups. One cannot protect the patient from the presence of alcohol. It is everywhere, being consumed freely in and out of homes. The patient must be able to resist any goading and encouragement to "have a short one." Most patients learn to cope with this pressure by restricting themselves to plain soda and lime or soft drinks.

7. Marital therapy and family therapy are usually conjunctively needed for marital and family problems, and stress factors in the environment will call for counseling and environmental manipulation.

8. Nondrug management of tension and stress are important because the use of any anxiolytics or hypnotic-sedatives after the first week following detoxification is contraindicated. Here, relaxing exercises, self-hypnosis, and meditation may be taught individually and in groups. Cognitive therapy should be employed to rectify faulty philosophies and attitudes. Proper physical exercise daily and instructions regarding diet to overcome and prevent nutritional deficiencies are necessary. Education in self-care may be needed if there is a pattern of habitual neglect.

9. Depression is one of the most common symptoms of substance abuse, and if it is intense may require antidepressants, such as amitriptyline (Elavil) or sinequan (Doxepin). Psychotic ideation and behavior may necessitate antipsychotic drugs such as haloperidol (Haldol), trifluoperazine (Stelazine), or thiothixene (Navane). Some alcoholics need Antabuse, and some opioid addicts off methadone do well with naltrexone (Trexan) to offset impulsive drug use.

10. Once abstinence is sustained by faithful attendance at a support group, and environmental stresses have been mediated through counseling, the therapist should consider whether individual psychotherapy would be valuable. Depth therapy, focused on unconscious conflict and the acquisition of insight into early conditionings, has failed notoriously with this class of patients. Some analysts believe that this is because substance abusers possess an arrested personality and are so handicapped by infantile omnipotence that they cannot make a proper transference to the therapist. Any transferences that do develop are bound to reflect distortions that developed in the original family that are now ego-syntonically indelible. Their revival will prove antitherapeutic. Treatment programs that have proven successful have taken into account the patient's disturbed character structure but have dealt with it in ways other than through insight. They have approached the need on the part of the patient to engage masochistically in unrewarding behaviors by reconditioning responses through a social learning paradigm. The model of treatment described below (12 to 15) can be adapted to both alcohol and substance abuse (McGrady 1983, 1985; Miller WR et al, 1980; Miller PM, 1982).

11. Preaching the evils of drug and alcohol intake, and its effects on oneself or one's family, does not work. What the patient must achieve is the conviction that he or she can be happier over a longer period without the abused substances than with them. One hopes that through positive reinforcements the patient will acquire this conviction during the early stages of abstinence. Every satisfactory experience of social and vocational adjustment should be rewarded by praise or other reinforcer to encourage a better life style. Designed programs will vary because of differences in personal needs and environmental opportunities, as well as specific responses to reinforcers. What is universally important is a job, occupation, or diversion to engross the individual a good part of the day; boredom is a leading source of stress. If the patient is unemployed, involvement in a hobby (music, art work, occupational therapy, etc.) or organized work-adjustment or volunteer program may have to precede finding paid work. Some substance abusers, especially adolescents, turn with vigor to religion or esoteric philosophies (Zen, Yoga, etc.), which supply them with a meaning for existence that they have sought through spurious

chemically induced "insights." This should not be discouraged unless it is overdone and counterproductive.

12. The actual treatment process starts with identification of the stimuli that initiate alcohol or drug intake. This necessitates consideration of all the disturbing factors in the patient's personal, marital, family, and social life. Elements that further reinforce or that punish the drinking or drug response in the present situation are examined. This intensive study of external and internal stimuli that inspire the taking of drugs or alcohol is done with the object of determining ways of modifying or eliminating these stimuli or of finding better modes of dealing with them, cognitively, emotionally, and behaviorally. The treatment interventions that will be used will depend on the resources available, the readiness of the patient to accept them, and the skill of the therapist in implementing them.

13. Vital to the success of any program is motivation to stop the bad habit of resorting to the abused substance. If the patient does not have adequate coping skills, the best resolve will go down the drain as soon as he or she experiences strong anxieties or stress. Further, depression may have been masked by alcohol or drug intake. Insidious also are the ubiquitous desires for pleasure, and need to escape from responsibilities in living and from the pressures of inner conflicts. Because the patient minimizes the bad consequences of his or her habit and exaggerates his or her ability to control it, efforts toward abstinence may be minimal. The therapist may work on the patient's false assumptions through cognitive therapy, by providing reasons why the patient will be better off dealing with pressures and problems in more suitable ways. Some therapists hand the patient a list of the negative consequences of drinking that the patient has previously identified and ask the patient to read the list several times a day as homework. Training in self-relaxation techniques and a relaxing ego-building audiocassette tape may be valuable. Some patients will require assertiveness training over a period of many months.

14. The therapist must keep searching for stimuli that provoke the patient. Dealing with such mischief mongers directly is an important part of treatment. A prime source of stress here is a family member or spouse who nags, attacks, criticizes, and acts-out his or her problems through the medium of the patient. Counseling of the spouse on an individual or group basis may be important. Marital therapy or family therapy may be indicated, and self-help organizations such as Al-Anon should be sought out. Family members who have been battered by the patient's

substance abuse may discover in these group settings better ways of dealing with the patient's difficulties.

Help in the acquisition of new stress-resolving skills and strategies is an important part of the therapy program. The patient is enjoined to search for "triggers" that initiate drinking or drug taking (e.g., an invitation to have a drink, fatigue, stressful events, receiving bad news, perceiving good news, engaging in "happy hour," etc.) and to explore non-alcoholic and non-drug responses to these triggers. The effects of a drink or other substances are then discussed in depth: talking too much, acting foolishly or brashly, guilt, self-disgust, feeling bad physically, a hangover, and so on. Instead of stopping the desire for drugs or drink, these aversive consequences may be shown to act as stressful triggers that initiate more substance abuse. So a chain reaction ties the patient into his or her destructive habit. One strategy to break the chain is to teach the patient to think *immediately* of the negative consequences the moment an impulse, invitation, or other trigger brings up the desire for a drug or drink. Some therapists ask the patient to prepare and carry around a card for each day of the week and to write down the cues that stimulate a desire for indulgence as well as what the patient did about it. Honesty in recording is stressed, and if a slip occurs the exact amount of drug or drink that was taken must be written down.

Alternative ways of dealing with triggers are encouraged. Insofar as doing something about the environments that tempt the habit, two ways of management are possible. The first consists of reducing environmental temptation, such as avoiding parties where conviviality demands imbibing alcohol, marijuana, or cocaine for good cheer. The second way is deliberate exposure, necessitating in vivo desensitization practice in some situations. Actually, alcohol and recreational drug taking are so much a part of the subculture that one cannot avoid exposure. Patients are constantly confronted with temptation, and it is best to deal with such challenges while in therapy.

Even with all the skills, the therapist will need dedication and concern to deal with substance abusers. Some patients will fail to achieve complete abstinence. Recourse to alcohol and drugs may constitute a preferred way of life. There seems to be little one can do with these patients to stimulate the motivation essential for sobriety or drug abstinence. In these cases, the therapist can perhaps act as a good friend and counselor who is available when the patient needs help with a crisis, to arrange for detoxification if necessary, and to get the patient back to work and

acceptable functioning. The therapist need not consider himself or herself a failure in such cases but instead recognize that for some patients neither God nor man can do more than the patient wills.

15. It may be possible with a certain number of patients who have been off abused substances for a while to approach underlying personality conflicts, being aware that such probings may produce untoward transference reactions that will serve as stress stimuli. There are, however, a few patients who have the curiosity and the residual ego strength needed to reach for reconstructive goals.

16. The following self-help groups may be contacted:

    Narcotics Anonymous World Service Office, Inc. P.O. Box 622 Sun Valley, CA 91352

    World Service Office, Inc. 16155 Wyandotte St. Van Nuys's CA 91406-3423

    Nar-Anon Family Group Headquarters, Inc. P.O. Box 2562 Palos Verdes Peninsula, CA

    Families Anonymous P.O. Box 344 Torrance, CA 90501 Telephone: 213-775-3211

    Pills Anonymous P.O. Box 473 Ansonia Station New York, NY 10023

SEXUAL DISORDERS[1]

A complex aggregate of physiological, psychological, and environmental factors enter into the sexual reaction. The capacity or incapacity for responsiveness to sexual needs and the distorted or perverted forms of their expression are largely products of past conditionings. Interfering emotions may relate to defects in early training and education (e.g., prohibition of masturbation), to transferential projections (e.g., incestuous feelings toward parental figures), to carryovers of later childhood experiences (e.g., fearsome and humiliating seductions), and to unsatisfactory adult human relationships (e.g., a hostile or non-responsive partner). Resulting anger and fear are anathema to proper sexual

1 See also the section on sexual therapy in Chapter 56.

functioning. These affects are not always clearly perceived by the individual suffering from sexual difficulties. Indeed, their existence may be completely denied, and even if the early initiating circumstances are remembered, the emotions relating to them may be shielded under a coat of non-feelingness. This anesthesia influences sexual behavior, distorting the perception of sexual stimuli or altering the manifestations of the sexual drive. Joining this conspiracy are defects in the self-image prompted by disturbances in personality development and by prolonged exposure to humiliating happenings.

The most common phenomena influencing sexual behavior are premature ejaculation and impotence in the male and non-orgasmic response, frigidity, dyspareunia, vaginismus, and conflicts about infertility in the female (Practitioners Conference, 1957; Kleegman, 1959; Geijerstam, 1960; Hastings DW, 1960; Mann EC, 1960; Nichols, 1961). The degree of failure of response may range from total disinterest in sex and inability to derive any sensation from autoerotic stimulation, to prurience under special circumstances (e.g., singular dreams, fantasies, and fetishes), to orgasmic response to certain acts (e.g., rape, "bondage," humiliation, pain, or sadistic acting-out), to selective reaction to the embraces of a specific love object, to excited behavior with a variety of sexual objects, to constant preoccupation with sexuality (e.g., nymphomania and satyriasis). People are "turned on" by a host of stimuli that are unique to their personalities and early conditioning experiences. Objects and circumstances accompanying the first sexual arousal may be indelibly imprinted and may motivate actual or symbolic revival for sexual feeling thereafter. Later sexual expression may host consequences dependent on the significance of guilt-ridden experiences (e.g., relaxation and exhilaration or self-punitive mechanisms, like anxiety, migraine, and gastrointestinal symptoms). It is understandable that with the complex array of operative contingencies, a vast assortment of patterns will be displayed by different people and at different times prior to, during, and after the sexual act. The degree of orgasmic reaction will also vary individually, from mild release to violent, ecstatic excitement and even unconsciousness.

Sexual Dysfunctions (DSM-III-R Codes for Hypoactive Sexual Desire, 302.71; Sexual Aversion Disorder, 302.79; Female Sexual Arousal Disorder, 302.72; Male Erectile Disorder, 302.72; Inhibited Female Orgasm, 302.73; Inhibited Male Orgasm, 302.74; Premature Ejaculation, 302.75; Dyspareunia, 302.76; Vaginismus, 306.51)

A diagnostic assessment of any sexual problem is vital to determine what kind of treatment is necessary. It is important to determine which of four phases of sexual response is implicated. Is the disorder one of inhibited desire or inability to maintain excitement and genital tumescence, to control or achieve orgasm, or to achieve post-orgasmic relaxation and well-being? (Kaplan & Moodie, 1984; Lief 1981). Distinguishing these phases of sexual response is important because different mechanisms and neural pathways are operative in each and different therapeutic interventions may be called for. For example, inhibited sexual desire may be the product of guilt about and repression of sexuality produced by overmoralistic promptings in childhood with consequent fantasies or needs for self-punishment, indulgence in rape or bondage fantasies, and sexual masochism as a condition for the release of sexual feeling. Conquest of these developmentally sexual inhibitions may inspire the individual to imagine or act-out violently and sometimes sadistically (sexual sadism) and to use antisocial behavior as a way of subduing or symbolically destroying the conscience or projected guilt representations. Guilt feelings and masochistic self-punishment usually follow these releases but rarely eliminate them. Treatment when sought will require psychotherapy, preferably dynamically oriented, and behavioral approaches later should sexual functioning continue to fail. Inhibited sexual desire may also be associated with the release triggers that open the gates to sexual feeling, such as fetishism, transvestism, zoophilia, pedophilia, exhibitionism, and voyeurism, which must be approached psychotherapeutically, although prognosis for recovery in these ailments is guarded. Sexual desire can be deadened by ailments such as depression, as well as by antihypertensive, antidepressant, tranquilizing and other medications. These interferences require specific correction. Finally, one's relationship with a marital partner may be pathological (e.g., incestuous) or so seeped in ongoing hostility as to deaden all thoughts of sex. Here marital therapy and dynamic psychotherapy may be essential. Appropriate treatment for all these

conditions requires accurate diagnosis. In the case of inhibited sexual excitement with frigidity and impotence, once organic (endocrinopathics, diabetes, arteriosclerosis, etc.) and medical factors (antihypertensive and beta-adrenergic drugs, alcohol, tranquilizers, etc.) have been ruled out, behavioral sex therapy may be effective in itself, especially if the onset of the dysfunction has been recent or the causes minor. If personality difficulties exist or anxieties and phobias are strong, however, coordinate psychotherapy may be necessary. The same may be said for inhibited female and male orgasm, premature ejaculation, dyspareunia, and functional vaginismus. If post-orgasmic relaxation and well-being are a concern, such treatment as cognitive therapy to alter meaning systems and dynamic psychotherapy to explore conflicts may be useful (Wasserman et al, 1980). If an antidepressant is found necessary for depression, bupropion (Wellbutron) has been found less associated with sexual dysfunction than other antidepressants.

Unfortunately, there has been a tendency on the part of some professionals to project their own experiences into their opinions of what constitutes "normal" sexuality instead of dealing with it as a broad spectrum of behavioral repertoires that cannot rigidly be circumscribed in terms of "healthy" and "pathological." Thus, there are writers who insist that oral contacts are abnormal, that manual genital stimulation is immature, and that orgasm derived in any other way than through penetration of the penis in the vagina is aberrant if not perverse. These injunctions reinforce any prevailing misconceptions that a patient may be harboring and add to guilt feelings.

Brief sex therapy (see pages 1036-1046) may be eminently successful in modifying or curing some milder sexual disturbances. In an inspired setting, away from everyday problems and pressures, a couple has the best opportunity for loosening up their inhibitions, relaxing their defenses, and under the prompting of new permissive authorities acquiring better habits of sexual response. Interpersonal hostilities are quietly subdued under these circumstances, and new and more constructive communicative patterns are set up. After therapy is terminated, the real test occurs. Can the improved

functioning be sustained in the couple's habitual setting? There is always a possibility that reinstitution of customary pressures and responsibilities may restore tensions and break down the new communication patterns. It would, therefore, seem vital to continue to see the couple after the instruction period is over to help resolve developing problems.

The key to successful sexual therapy is the therapist. One's personality, one's casualness, one's flexibility, one's empathy, one's understanding, one's sense of humor, and one's capacity to communicate all influence the techniques. In many couples the strong defenses and resistances to the directives of the therapeutic authority are apt to create frustration and anger in the therapist. The therapist has to know how to deal with the patient's reactions in an easy-going way without taking offense. The therapist actually needs the skills of a good communicator. It is not possible to adopt a passive analytic stance with this type of treatment.

The short period of therapy can provide a biopsy of the prevailing pathology between the two people. If the pathology is not too severe, if healthy defenses are present, if reasonable flexibility of adaptation prevails, new sexual habits may be maintained. On the other hand, if the sexual difficulty is a reflection of a personality problem, there may still be some improvement sexually but the personality difficulties will have to be dealt with by more intensive methods.

For example, an impotent single man comes to therapy harboring deep hostile feelings toward women, stemming from a high level of dependency that one may historically trace to his being overprotected by a dominant mother figure—by no means an uncommon condition in problems of impotency. The immediate precipitating factor for the impotency in our present patient, let us imagine, was sexual association with a dominant, demanding woman who somehow undermined his confidence in himself. Let us also hypothesize that, through behavior therapy and in relationship with a cooperative and non-dominant woman, the patient is restored to potency. Lacking recognition of his inner drives and needs, however, he may soon lose interest in what he would consider "uninteresting weak females" and

seek out domineering women with whom he could act out his dependency and hostility. Without speculating too much, we would probably witness in a new relationship with a controlling woman a revival of his symptom. A thorough understanding of the problem, however, may help him not only to try to desensitize himself to domineering women, but also to manage more assertively their specific domineering traits. By seeing that he was projecting attitudes toward his mother into his contemporary relationships, he might better be able to deal with "strong" women. The evolvement of firmer controls may enable him to relate even to manipulating women without fear. Or, realizing his choice of women as a weakness he must overcome, he may decide to restrict his sexual contacts to more passive types, while handling his impulse to goad them into domineering roles.

A complicating factor in many patients is that the sexual function in the human being is often employed as a vehicle for the expression of varied strivings, interpersonal attitudes, and needs. Thus, sexual behavior may embrace, among other things, impulses to hurt or to be hurt, to humiliate or to be humiliated, and to display or to mutilate oneself.

When impotence results from vascular surgical procedures, an implant or a recently developed surgical procedure may be effective (Zorgniotti, 1987).

Paraphilias (DSM-III-R Codes for Exhibitionism, 302.40; Pedophilia, 302.20; Sexual Masochism, 302.83; Sexual Sadism, 302.84; Transvestism Fetishism, 302.81; Voyeurism, 302.82)

Among the more serious and less prevalent sexual disorders are those that relate to gender identity and the paraphilias. An assorted group of problems are embraced under the term *transsexualism*. Here there is conflict about one's anatomic sex and a desire to exchange it for genitals of the opposite sex. Assumption of a role consonant with the desired sex identity are compelling, and occasionally submission to surgery to amputate the undesired sex organs is yielded to. The cross-dressing here is distinguished from transvestism in that in the latter there is no desire to rid oneself of one's genitals. The

cross-dressing appears to act as a stimulus for sexual excitement, which in most cases is expressed heterosexually. *A gender disorder of childhood* is characterized by a repudiation of one's sexual identity and a frantic need to act like a member of the opposite sex. The little boy plays with dolls and desires to dress like a girl; the little girl engages in male activities and may deny not having a penis. In the paraphilias there is a compulsive need to utilize imagery or to engage in unusual acts in order to stimulate sexual desire, such as specific items of clothing (fetishism) or animals (zoophilia); to be humiliated, bound, and beaten (sexual masochism); to inflict pain or humiliation on the sexual object (sexual sadism); to exhibit one's genitals to strangers (exhibitionism); to spy upon and observe people in situations of undress or intercourse (voyeurism); and to engage in sex (usually mingled with aggression) with a child (pedophilia). Neurotic and personality disorders often coexist with these sexual distortions.

These conditions are among the most difficult of all syndromes to treat. Because of the intense pleasure values inherent in the exercise of the perversions and the fact that they fulfill deep needs other than sexual, the patient is usually reluctant to give them up. Although there may be a desire to overcome certain disagreeable symptoms, such as anxiety or tension, the motivation to abandon the coveted sexual expression may be lacking. Because of the lack of incentive, resistance often becomes so intense as to interfere with the therapeutic process.

There is, nevertheless, a growing conviction that sexual deviations are pathological conditions that sometimes may be helped by psychotherapy. The specific approach to perversions will vary with the theoretical orientation of the therapist (Bieber I, 1962; Bychowski, 1961; Deutsch H, 1965; Fried, 1962, Lorand, 1956; Marmor, 1965; Nurnberg, 1955; Ovesey, 1954, 1955a & b; Ovesey et al, 1963; Saul & Beck, 1961; Stark, 1963).

Some authorities speculate that a genetic defect complicated by conditionings in childhood makes certain preliminary fantasies or acts mandatory for sexual feeling and performance in adult life. The origin of many of these conditionings are forgotten, repudiated, and repressed, although the individual is

mercilessly bound to special stimuli (fetishistic, masochistic, sadistic, etc.) to release his or her sexuality. In many instances the sexual disturbance reflects improper identity. If normal masculine identification is lacking (an overly possessive controlling mother, intimidation by an overwhelming father, passive indulgence by a weak father) tendencies toward effeminacy may develop in a male. Lack of a feminine and motherly mother who can act as a feminine model may divert a girl from female identification. Under these circumstances, the sexual direction may be altered.

Whether all forms of homosexuality should be classified as abnormal is a moot point about which there are differences in opinion among professionals. Under pressure of some groups, the trustees of the American Psychiatric Association (amidst considerable controversy) officially ruled that the term "homosexuality" be replaced in the Statistical Manual of Mental Disorders by the phrase "ego-syntonic homosexuality" to avoid the stigma of being classified as a disorder. Ego-dystonic homosexuality was a diagnosis applied only to those homosexuals who were in conflict with their sexuality. In justification of this move, we do find many homosexuals who are happy and adjusted, and some studies reveal that symptoms and behavioral disorders among this group are no more frequent than among heterosexuals.

Under these circumstances, it is argued, homosexuality might for some individuals be regarded as a manifestation of a preferred normal life style rather than as a distortion of sexuality. On the other hand, there are those who continue to accent the point that analysis of even so-called well-adjusted homosexuals indicates without question that they have a developmental block in the evolution of the sexual drive. In appraising the pathological nature of homosexuality, we do have to consider the fact that many homosexuals suffer from the abuse and discrimination heaped on them by society, without which they would probably be able to make a better adjustment.

Homosexuals who apply for therapy are in a special category when they are ostensibly disturbed and upset about their sexual behavior. They may seek therapy for their symptoms, but they may not be motivated to change their sexual orientation. A therapist's forceful attempts to induce change under

these circumstances will usually fail. If there are strong conflicts about homosexuality and a sustained and powerful desire for heterosexuality, dynamic psychotherapy or psychoanalysis may succeed in a certain number of cases (Bieber I, 1962) in changing their sexual orientation. Adolescents disturbed about homosexuality may well benefit from some brief counseling along the lines suggested by Gadpaille (1973), which may help lessen their identity problems.

Sometimes homosexual preoccupations in a conflicted individual become so uncontrollably compulsive as to cause the person to act out impulses in a destructive and dangerous manner. Masochistic and sadistic drives are usually operative here. The problem is that the person can easily jeopardize one's safety by becoming involved with psychopathic individuals or by getting into trouble with the law. Such a person may seek from psychotherapy not so much stoppage of homosexual activity as the opportunity to direct one's behavior into less dangerous channels.

Traditional psychotherapy, unfortunately, has had little to offer such applicants; neither insight nor appeals to common sense influence the driving determination to involve themselves in exciting trouble. A form of therapy still in the experimental state is aversive behavioral treatment. Some behavior therapists recommend that if patients are insistent on being forced to stop their behavior, and if sufficiently motivated, they may be able to endure exposure to a series of slides that are sexually stimulating to them but are rewarded with a painful electric shock through electrodes attached to the fingertips (Feldman & MacCulloch, 1965). In a technique evolved by McConaghy (1972) the male patient selects 10 slides each of a nude adolescent and of young men and women to which he feels some sexual response. At each session three male slides are shown for 10 seconds. A 2-second shock is delivered during the last second of exposure, with the level of shock as unpleasant as the patient can stand. Following this, a slide of a woman is turned on for 20 seconds without accompanying shock. Variable intervals between 3 to 5 minutes pass between showing the three sets of male and female slides. Sessions are given three or more times the first week and are gradually reduced in frequency over

the following few months. In female patients the shocks would be delivered with the slides of women, and no shocks would be delivered with the male slides. Again, unless the incentive to control one's homosexual activities is high, this treatment is doomed to failure.

The treatment of sexual perversions, such as sadism, masochism, voyeurism, and exhibitionism, must be organized around removing blocks to personality development in order to correct the immature strivings that are being expressed through the sexual perversion. Fears of adult genitality and of relating intimately and lovingly to persons of the opposite sex must be resolved before adequate sexual functioning is possible. The only rational approach is, therefore, reconstructive in nature. Lack of motivation may, however, inhibit the patient from entering into reconstructive treatment. Additionally, ego weakness and disintegrative tendencies are often present in sexual perversions and act as further blocks to deep therapy. For these reasons the therapeutic objective may have to be confined to the mere control of the perversion and to its possible sublimation. Behavior modification has been utilized here. The therapist may have to function as a supportive, guiding authority who helps the patient to lead a more restrained life.

In treating perversions, the therapist must be prepared for a long struggle. Resistances are, as has been mentioned, usually intense, and the patient will repeatedly relapse into the sexual deviation. The patient should not be blamed, reproved, or made to feel guilty for this. Rather, he or she must be helped to see the purposes served by the perversion and to appreciate why the need to express it becomes more overwhelming at some times than at others. While the ultimate outlook is not as favorable as in some other problems, there is no reason why patients who become motivated for, and who can tolerate reconstructive therapy, cannot achieve satisfactory results.

SPEECH DISORDERS

(Developmental Articulation Disorder (DSM-III-R Code 315.39), Expressive Language Disorder (DSM-III-R Code, 315.31); Receptive Language Disorder (DSM-III-R Code 315.31); Cluttering, 307.00; Stuttering, 307.00)

Functional speech problems, which are sometimes arbitrarily called "stuttering" or "stammering," are the consequence of the lack of coordination of various parts of speech wherein the speech rhythm becomes inhibited or interrupted. Associated are vasomotor disturbances, spasm, and incoordination of muscle groups involving other parts of the body. The speech difficulty is initiated and exaggerated by certain social situations, so that the individual is capable of articulating better under some circumstances than others. This is confirmed by the fact that the person is usually able to sing and to talk without difficulty to himself or herself and to animals. Some authorities insist that since there is no actual pathology of the speech apparatus, it may be a grave misnomer to label stuttering a speech disorder. Rather it might be conceived of as a manifestation of total adaptive dysfunction.

Martin F. Schwartz (1974) of Temple University has presented evidence that stuttering is produced by an inappropriate vigorous tightening of the larynx (contraction of the posterior cricoarytenoid) triggered off by subglottal air pressures required for speech. Psychological stress reduces the action of the usual supramedullary inhibiting controls of the involved muscle. To correct this, the patient must place the larynx in an open and relaxed position, which helps keep the air pressure in the voice box low. One-way mirrors and videotape equipment are used to coach the patient. The therapy is still in the experimental stage but a "reasonable expectation of perhaps a 90 percent success rate with stutterers given the proper therapeutic implementation" may be expected within 2 or 3 months (Pellegrino, 1974). Should the therapy prove itself to be this successful, it will undoubtedly replace the traditional treatment methods.

The counseling of parents of a stuttering child is important in the total treatment plan. Generally, parents react with dismay, frustration, and guilt feelings in relation to their child, many assuming that

they are responsible for the problem. At the onset of counseling the parents should be told that we are still unsure of what produces a stuttering child and that worry about complicity in it is not as important as doing something about it. There are, however, things they can do that may help the problem. Constant emphasis on mistakes and subjecting the child to drilling helps aggravate the non-fluency by making the child more self-conscious and aware of his or her failings. The stuttering child requires a great deal of demonstrated love and affection, and the parents must be enjoined to go out of their way to give these. It is essential also that they encourage the child to express feelings openly no matter how badly the child enunciates these and that they control themselves if the child bumbles along in front of friends and relatives. This does not mean that proper discipline should not be imposed, even punitive measures for outrageous behavior, since discipline is an important learning tool for healthy growth. There is in some families a tendency to infantalize and to overprotect a stuttering child. This must be avoided, and the child should be expected to manage whatever responsibilities one of his or her age must assume. The role of the father is important in providing proper guidance and companionship. Since tension in the home contributes to the child's disturbance, it may be necessary to institute marital therapy or family therapy before appreciable improvement can be expected.

Therapy with a child therapist, particularly one experienced in speech difficulties, may have to be prescribed for the manifestly disturbed child or one who has been undermined by the speech problem. These children are exposed to ridicule, teasing, and social ostracism by their classmates. They shy away from talking and presentations in class, resulting in an undermining of self-esteem.

The usual treatment of adult stuttering proceeds on two different levels: correction of the improper speech habit and the handling of the deeper emotional problem that originally initiated and now sustains the difficulty. A guidance approach and social skills training are used toward achieving the first objective (Brady, 1984).

The second goal is obtained through a persuasive, reeducative and, where possible, reconstructive approach. Therapy involves correcting patent difficulties in the environment that stir up the person's insecurity, and dealing with disturbing inner conflicts. Since the character disturbance in stutterers is usually extensive, therapy is bound to be difficult, prolonged, and, in many cases, unsuccessful insofar as alteration of the underlying personality disorder is concerned. The most that can be done for many stutterers is symptomatic relief in the form of speech correction.

Speech training may do as much harm as good. It is valuable only as a means of building up confidence in the individual's powers to articulate. Unfortunately, it may psychologically have the opposite effect since it overemphasizes will power and control and concentrates the stutterer's attention on the mechanics of speech rather than on what is being said. Instead of becoming less conscious about the speech difficulty, the person becomes more involved with it, thus intensifying the problem. This is not to say that proper exercises in diaphragmatic breathing, phonetics, and articulation are of no value in certain patients. Sometimes, with these methods, a symptomatic recovery may take place in mild cases. In severe cases, however, they are relatively ineffectual, and, especially if the person makes a voluntary effort to stop stuttering, the severity of the speech problem may increase. Rhythmics and eukinetics are sometimes helpful. Training methods, when used, should be employed by a therapist experienced in speech techniques.

In supportive approaches with stuttering adults certain evasions and defenses are sometimes taught to tide the stutterer over situations in which he or she must talk. Drawling, speaking in a rhythmic manner or in a sing-song tone, utilizing distracting sounds like "ah" or a sigh prior to articulation, employing a gesture or engaging in some motor act like pacing or rubbing a watch chain, purposeful pauses, and a variety of other tricks are used. These are entirely palliative and must be considered escapes rather than therapeutic devices.

A persuasive approach is sometimes helpful. The first step in therapy consists of convincing the patient that because of disappointing experiences, he or she has come to overemphasize the speech function. To the stutterer it constitutes an insignia of aggrandizement and defamation. Self-esteem has become linked with the performance of speech. Because of this the stutterer concentrates attention on the manner of talking more than the content of what is being said. While the speech problem is understandably disturbing, it is probably not regarded with the same emphasis by others. People suffering from stuttering overcome it more easily when they stop running away from acknowledging it. The best tactic is to face the situation and even admit it. As soon as this is done the person will be more at ease and the speech will improve.

A talk such as the following may be indicated:

> *Th.* There is nothing disgraceful about stuttering. Avoiding social situations because of fear of ridicule merely serves to exaggerate the sense of defeat. It is necessary to regard stuttering in the same light as any other physical problem. If you stop being ashamed of it, and do not concern yourself with embarrassing others, people will notice your speech less and less. As you become more unconcerned about how you talk, you will concentrate on what you say. Keep concentrating on what you say, and pay no attention to how it sounds. Fear and embarrassment exaggerate your speech difficulty, so make yourself act calm and you will feel calm, and your speech will improve.

The next stage of therapy draws on some reeducative techniques and consists of demonstrating to the patient how he or she becomes upset and loses the sense of calmness in some situations. There will be no lack of material since the patient will bring to the therapist's attention many instances in which his or her stuttering becomes exaggerated. Examining the patient's emotional reactions to these situations as well as his or her fantasies give the therapist clues as to the dynamic elements involved in the patient's speech disorder. These may be pointed out to the patient in terms that conform with his or her existing capacities for understanding. The aim is to show the patient that the speech difficulty appears when he or she loses the capacity to remain relaxed and when, for any reason whatsoever, emotional instability develops.

In some cases it will be advisable to refer the patient to a good speech therapist. The therapeutic approach that appears most successful comes from the work of Van Riper (1971), and Wendell Johnson (1946). This aims at the elimination of anxieties about stuttering, which is considered a learned reaction to conscious fears of speech or fluency failure. Patients are enjoined to adopt an "objective attitude" by facing the fact squarely and, instead of avoiding displaying their stuttering, talking about the speech handicap to others, deliberately meeting all fearful and difficult speaking situations, and articulating in the best way they can, utilizing, if necessary, the evasions, defenses, and tricks that are so often employed by stutterers. Exposure to various speaking challenges while maintaining as objective an attitude as possible is also advised.

Specifically, patients are taught to open up, in as casual and objective and even humorous a way as possible, the speech problem with others, even if the listeners do not know that they have a speech problem. Clearing the atmosphere in this way will put both the listeners and themselves at ease. They are asked to observe how others falter and make mistakes in speaking and by this to realize that normal fluency is imperfect and quite variable. They are requested to observe how certain listeners react to what they say and to check their observation with those of others present. In this way they will discover that they project their personal fears and prejudices onto other people. Most important they are requested to give up running away from fearsome words that cause stuttering and to utter them deliberately, particularly in situations in which they have stumbled over them while remaining emotionally detached and not caring how the listener reacts. Role playing may be used here to prepare the patients for such stints. They are requested to discuss their experiences with the therapist at the next session. The patient is reminded to try to cultivate a calm, unemotional tone of voice. They may practice this with a friend or with members of the family. One-half hour each day is devoted to reading aloud from a book, jotting down those words that are difficult to pronounce. They may then practice enunciating words several times during the day. Some persons find it helpful to talk for a short time daily in front of a mirror,

watching their facial movements as they utter sounds. Along with these reconditioning techniques, environmental therapy may be used, geared toward an expansion of the assets of the individuals and a remedying of liabilities in themselves and their situations.

If these techniques do not yield desired results, patients may be taught ways of postponing word attempts, of starting difficult words or of releasing themselves from blockages. They may also be taught a substitutive stuttering pattern, deliberately prolonging or repeating themselves in an unhurried, tenseless way. For instance, Van Riper's cancellation technique enjoins stutterers to pause immediately after they experience a stuttering block and to ask themselves what they did (pressed their lips together? pushed the tongue against the roof of their mouth? felt panic? diverted their gaze from the listener?). They are then to cancel their failure by "stuttering" on the same word deliberately in a new way with prolonged relaxation, maintaining eye contact with the listener. This starts a reconditioning process so that the stutterers may begin to change their behavior during the fist attempt and then to manipulate preparatory sets prior to the attempt "to facilitate the production of a 'fluent' pattern of stuttering" (Bloodstein, 1966; Van Riper, 1971).

Three important adjuncts in speech therapy are behavior therapy, self-hypnosis, and group therapy. Assertiveness training may be extremely important. Other behavioral approaches can be quite valuable (Brady, 1968) particularly utilizing a metronome. In metronome-conditioned speech retraining (MCSR) a miniaturized electronic metronome is worn behind the ear like a metronome (Brady, 1971, 1972). This may be especially helpful when patients are confronted with a speaking engagement. The metronome allows the speaker to pace the speech. Prior to the use of the ear metronome, the therapist may expose the patients to an ordinary desk metronome, such as used in piano practice. At first as few as 40 beats per minute may have to be used, the patient pronouncing one syllable for each beat. As soon as the patients are fluent in pronouncing several syllables at this speed, the rate is gradually increased to 90 to 100 per minute. A metronome should be procured for practice at home, at first alone, then when feeling

confident, with a friend or parent in the room; then with more than one person present. Pauses are introduced to some beats and then more than one word to each beat. What can be helpful is practicing while fantasizing progressively more anxiety-provoking scenes. When reaching a satisfactory fluency, the patients practice with the miniature metronome and then utilize the fluency outside the home, at first in low-stress situations and then in high-stress situations. Should difficulty be experienced under some conditions, they may reduce the speed of the metronome and speak more slowly. Gradually, as the patients gain confidence, they may practice speaking without turning on the metronome, first in low then higher stress situations.

Another method is to listen to a transistor radio, using earphones while talking to a cassette tape recorder. The radio is played so loudly that one's voice is not heard. At first this is done after practicing relaxation. Then situations of increasing anxiety are imagined. The patient articulates feelings and thoughts at the same time and particularly pronounces his or her name and the words over with which difficulties have been experienced. As the stutterer gains confidence in speaking, he or she may turn the radio off while speaking, turning it back on should non-fluency return.

Persuasive autosuggestions in a self-induced trance reinforce the patient's desires for self-confidence and assertiveness. Group therapy in which the patient comes into contact with other persons suffering from speech problems removes the sense of isolation. The fact that companions experience the same trepidations as the patient does help the patient reevaluate his or her reaction. An opportunity is provided to speak and to recite in a permissive setting. The identification with the group, along with the growing confidence in the ability to speak fluently, may have a most positive .effect on speech performance.

As the patient begins to experience improvement in his or her interpersonal relationships, the speech problem will plague the patient less and less. Utilizing the speech group as a bridge, one may be able to integrate with other groups and to consider oneself on an equal plane with its constituent members. In some cases reconstructive therapy may be possible to deal correctively with the personality disorder

(Barbara, 1954, 1957, 1958, 1963). This, however, is associated with many vicissitudes as Glauber (1952) has pointed out.

In situations of strong anxiety, such as speaking before a group, some therapists advise taking 40 mg of Inderal shortly before the assignment, which will cut down on the anxiety without impairing cognition.

SLEEP DISORDERS (DYSSOMIAS)

Among the sleep disorders are the *Dyssomias*, which include primary insomnia, hypersomnias, and sleep-wake schedule disorders, and the *Parasomnias* identified as dream anxiety disorders (nightmare disorder), sleep terror disorder and sleepwalking disorder. By far, Primary Insomnia DSM-III-R Code 307.42 is the most common sleep disorder encountered in practice.

Insomnia is a ubiquitous symptom which more than one-third of the population experiences periodically. In most cases episodic sleeplessness is accepted philosophically, especially if it does not interfere too much with everyday functioning. In some persons, however, it is a persistent phenomenon for which help may be sought. Causes are heterogeneous, ranging from physical ailments, to depression, to environmental crises, to psychiatric stress. Sometimes insomnia is a consequence of prolonged consumption of hypnotics and sedatives, in which case the buildup of tolerance inspires wakefulness.

Patterns of insomnia are individual: (1) some people find it difficult to fall asleep but once slumber occurs do not awake until morning; (2) some fall asleep easily but awake in a few hours, fall asleep again, and go through the sleep-awakening cycle several times during the night; (3) some doze off readily but awaken at 4 to 6 a.m. and then cannot return to sleep; (4) others sleep throughout the day lightly, fitfully, restlessly, and get up in the morning as exhausted and tired as when they went to bed.

In recent years, research in sleep laboratories and clinical experience has yielded important information that is valuable in treatment planning (Kales, 1984). The following points are important to consider:

1. Insomnia is not as ruinous to health as the victim imagines. People can go without sleep for even several days without being damaged physically or becoming psychotic.

2. The amount of sleep required for optimal alertness the next day varies with the individual. Not everybody needs 8 or 9 hours; some persons do well with 4 ½ or 5 or 6 hours. Aging lowers the requirements to as little as 4 hours in some people, and older people normally sleep lightly.

3. People generally underestimate the hours of true sleep they get. Thus, many subjects on testing in sleep laboratories will show no sleep disturbance yet will complain of insomnia.

4. Insomnia is only a symptom. Its causes can be diverse. In all cases, treating the causes if possible is primary: Physical ailments such as coronary artery disease, which produces nocturnal anginal pain; duodenal ulcer, which stimulates gastric acid especially at night, driving the person to seek antacids; prostatic enlargement, which produces arousal because of the frequency of urination; bronchial asthma; hypothyroidism, sleep apnea, myoclonus, and other physical conditions that cause discomfort and pain requiring proper medical or surgical help. Depression may need antidepressive medications; anxiety reactions often do well with simple relaxation therapy; environmental disturbances may be helped with counseling and milieu therapy; and psychiatric stress necessitates psychotherapy and behavior therapy.

5. Certain medications such as beta blockers and tranquilizers can make a person feel sleepy and fatigued during the day, which may falsely lead a person to think he or she is not getting enough sleep. Other substances may actually cause insomnia. These include Dexedrine, Ritalin, Tenuate, Proludin, and coffee, tea, soft drinks containing caffeine, and alcohol taken late in the day or evening. Steroids, Inderal, and other beta blockers, may also create problems.

6. Once insomnia develops for any reason an added deterrent to sleeping well is anticipating being awake during the night and suffering fatigue and exhaustion as a consequence. This whips the person into a state of self-defeating alertness.

7. Markedly irregular hours of retiring interfere with the bodies built-in time clock. People who go to bed late at night usually, often to their dismay, wake up at their regular morning hour.

8. Hypnotic drugs used over a long period lose their effectiveness and therefore are for short-term (no longer than 3 to 4 weeks) or periodic use. Continued employment creates tolerance and addiction without added benefits. Withdrawal of these drugs, taken over a period, produces a "surge" of dreaming, jitteriness, and more insomnia. Such withdrawal must be done slowly and in some cases may require hospitalization to deal with unpleasant sequelae.

9. Over-the-counter sleep medications contain methapyrilene and/or scopolamine. Prolonged use is neither safe nor effective at current dosage levels.

The treatment of insomnia will depend upon whether or not it is acute, the provocative factors that keep the patient awake, and the degree of addiction to hypnotic drugs.

Acute temporary periods of insomnia produced by situational stress are usually readily handled by reassuring the patient that sleeping less than his or her usual quota will not cause damage, by permitting the patient to verbalize his or her fears and resentments, and perhaps by prescribing a hypnotic substance for 1 to 3 nights if necessary. Short-term insomnia due to work and family problems, bereavement, or illness requires education about insomnia, helping the development of proper sleeping habits, and, if necessary, prescription of a benzodiazepine hypnotic for no more than 3 weeks.

The treatment of chronic insomnia is a more difficult matter, largely because the patient has established faulty habits and has probably incorporated the insomnia into his or her neurotic superstructure. The primary treatment is behavioral (Hauri, 1979), and hypnotics should be avoided if possible.

The therapy for established insomnia starts with exploring its history and manifestations, the patient's attitudes toward it, what he or she has done about it in the past, and what is maintaining it in the present. In many cases the demoralization of the patient will have to be dealt with by supplying scientific facts about insomnia to displace as much as possible unfounded myths and fears. If the patient

has not had a good physical examination in the past, he or she should be asked to get one to rule out any organic causes. The patient should also be asked to keep a diary of his or her sleeping habits and working schedule for at least 24 hours, including bedtime routines, use of medications, sleep disruptions, and daytime fatigue, which may or may not yield important clues.

The next procedure is to instruct the patient in proper sleeping habits. These can serve as effective alternatives to drugs. Among measures to be recommended are the following:

1. Rearranging sleeping habits.
2. Reassuring the patient about sleep needs.
3. Getting the patient to accept insomnia.
4. Teaching the patient relaxing exercises.
5. Treating hypnotic drug dependence.
6. Prescribing medication.

Rearranging Sleeping Habits

(1) The patient should attempt to establish a regular bedtime, avoiding naps during the day. If sleep does not come easily, one may try relaxing exercises (or deep breathing, audiotapes, self-hypnosis, or meditation) or imagery with object counting ("counting sheep"). Should sleep not follow, one should go to another room to read or watch television until drowsiness develops instead of tossing around. (2) excessive smoking and drinking should be eliminated. (3) In some patients a change of mattresses should be made from hard to soft or vice versa, attention being paid to the bedcovers so that the patient is neither over- nor underheated, to the wearing of more comfortable night apparel, and to the regulation of the room temperature. Simple as this may sound, it may be all that is required. (4) A change in position during sleep may be indicated if the patient is in an uncomfortable repose. Superstitions such as that one must not sleep on the left side because the heart may be damaged, should, if this position is a preferred one, be corrected. Patients with asthma or orthopnea are more comfortable propped up in bed

rather than lying prone. An elevation of the head and upper trunk is sometimes a preferred position. In married persons a change from a double to twin beds, or the reverse, may be considered. (5) A bedtime snack (warm milk, sandwich, cocoa) is reassuring to some people, as is a glass of beer or ale or a small tumbler of sherry, port, or an aperitif. (6) Tea or coffee should be excluded from the evening meal and not taken before going to bed. (7) Reading in bed concentrates the attention away from inner concerns. Television programs selected before bedtime should not be too stimulating. (8) Daily exercise and a brisk walk in the evening followed by a hot bath are recommended by some. (9) Should the patient desire to experiment with it, an oscillating mattress is available in "sleep shops" or department stores that rhythmically rocks some people to sleep. (10) Ear plugs, antisnore masks, and eye shades may be used to control situations disturbing to sleep. If necessary, one may sleep in a separate room away from a snoring partner. (11) Making up for lost sleep during weekdays by sleeping longer over weekends or on holidays can be disruptive to establishing proper sleeping patterns. Regular wake-up times should be observed even after a poor night's sleep.

Reassuring the Patient About Sleep Needs

The individual's estimate of how much sleep he or she must have for health reasons is usually far above his or her true physiological requirements. As people get older, sleep needs decrease. A reduction of deep sleep stages (III and IV) is normal. Because lighter stages (I and II) occur, older people get the feeling they do not sleep a wink. They also awaken several times during the night and fall asleep again, which is normal. If the patient can be convinced that merely reposing in bed and not forcing oneself to sleep is not damaging to one's health and if the patient can develop the philosophy "If I sleep, so much the better; if not, it doesn't matter," he or she may be able to stop worrying himself or herself into wakefulness. The patient may be told that merely lying in bed and relaxing are usually sufficient to take care of the physiological needs. If the patient does not sleep as much as he or she believes is necessary, no real harm will befall the patient. Of course, he or she may be driven to distraction by worrying about not sleeping. Worry will actually cause the insomniac more difficulty than not sleeping.

Relaxing Exercises

Progressive muscle relaxation with deep breathing exercises and self-hypnosis are valuable adjuncts in insomnia. The techniques of relaxation and self-hypnosis have been outlined previously in this volume (q.v.). They may advantageously be taught to the patient. Repeated suggestions are made that he or she will be able to "turn one's mind off," to focus on a pleasant scene, and to feel himself or herself getting more and more drowsy and relaxed. This may reestablish the sleep rhythm more effectively than any other measure. A useful pamphlet on ways to approach sleep may be prescribed for the patient (*Better Sleep*, 1963). An interesting article called "The science of sleep," by Joan Arehart-Treichel (1977) in *Science News*, may be recommended, as may the book by Coates and Thoresen (1979).

Acceptance of Insomnia

Several unusual methods of controlling sleep have emerged that may be suited for certain patients. One technique deliberately restricts the hours spent in bed fruitlessly attempting to fall asleep. Persons appear to "sleep better if they spend fewer, rather than more hours, in bed" (JAMA, 1985). Subjects are enjoined to stay awake later but to arise at their customary times. They are not permitted to nap during the daytime. Another method that has been employed with patients who drive themselves frantic during the day with the fear that they will not be able to sleep that night is paradoxical intention (Ascher and Efran, 1978, Ascher et al. 1980). Here suggestions are given that the person "try to remain awake as long as possible, rather than attempt to fall asleep." A rapid reduction of sleep onset latency can result.

Should insomnia continue to be distressing, referral to a sleep disorder clinic may be considered. Such may be the case in phase-shift sleep-wake (in which the patient seems to be able to sleep only during the daytime and is awake at night). Chronotherapy, a specialized procedure, is best done in such clinics.

Some therapists try to get insomniacs to accept their insomnia as something with which they can learn to live. Indeed, insomniacs may, as Modell (1955) has pointed out, successfully exploit their

symptom. Once they are convinced they need less sleep physiologically than their mind dictates, patients may be encouraged to accomplish something useful during their waking hours at night. Instead of tossing about fitfully in bed and brooding about problems, they may read or write in bed. Or they may get up, take a shower, and, for an hour or two, apply themselves to useful work, particularly work that worries them if it goes undone. They may then return to bed.

Drug Treatment

Prescription of a hypnotic should be given only when behavioral or psychosocial therapy fails to relieve sleeplessness. In cases of depression, antidepressants may eliminate the insomnia. If stress exists, the only logical intervention is to deal with its sources. Hypnotics temporarily given for no more than 3 weeks, and preferably less, may be of great help. If there is a history of alcohol or drug abuse, hypnotics should not be prescribed because the patient will almost invariably refuse to give them up or, worse still, will take them with alcohol or other depressants, which may be fatal. When hypnotics have been used for more than 2 weeks, withdrawal should be gradual to avoid rebound sleeplessness or such neurological symptoms as twitching.

Many substances have been used, abused, and then discarded in humans' quest for a harmless substance that can hasten and sustain sleep. We still do not have such a substance, but currently the benzodiazepines, the least harmful, though still not perfect, solution, have replaced alcohol, bromides, opiates, barbiturates, ethclorvynol, glutethimide, and methaqualone as the most frequently prescribed drug for insomnia. Chloral hydrate is still employed by some as a safe and effective hypnotic.

Taken occasionally when stress distracts the normal sleep tendency, hypnotic benzodiazepines are useful aids. When taken regularly as sleep insurance, all hypnotics eventually betray their purpose by fostering cognitive and psychomotor impairments. Without a pharmacological "straight jacket," the individual anticipates a sleepless night with the feared consequence of not being able to function well or

at all the next day. On the other hand, if benzodiazepines are not prescribed, a stressed individual may resort to alcohol or more dangerous drugs that cannot be monitored.

The most popular benzodiazepines employed as hypnotics are the long-acting flurazepam (Dalmane), with a half-life of about 100 hours, the short-acting temazepam (Restoril), with a half-life of 9.5 to 12.5 hours, and the ultrashort-acting triazolam (Halcion), with a half-life of only 1.6 to 5.4 hours. Diazepam (Valium), 2 to 5 mg (and up to 10 mg), is an old standby; it has a half-life of several days. Lorazepam (Ativan), 2 to 4 mg, is also popular and has a shorter half-life of up to 18 hours. Doxepin (Sinequan), 25 to 50 mg, is another choice. It is a dibenzoxepin tricycle compound used in depression and hence less prescribed for insomnia although it may be effective in some cases.

The drug to use will depend on the type of insomnia the patient is suffering. In transient situational stress with a carry over of anxiety during the day, Valium (2 to 5 mg) is a good alternative, especially if one wants its anxiety-reducing effects (with its accompanying slight hangover) to continue through the daytime. Dalmane has its advocates. Its sedative effects continue in the daytime because of its long half-life. Here one starts with a 15-mg dose but informs the patient that it is more effective on the second, third, or fourth night of consecutive use than on the first night. Should 15 mg fail to work after a week, 30 mg may then be given. In severe chronic insomnia one may start initially with the 30-mg dosage. Elderly persons who require daytime alertness and good psychomotor performance are best given 0.125 mg of Halcion, which may be increased to a limit of 0.25 to 0.5 mg. Halcion (0.25 to 0.5 mg) is also valuable for persons with jet lag or who awaken in the middle of the night and need a short boost to fall back to sleep. Restoril (15 to 30 mg) is also tolerated well by young and old and is especially suited to those who anticipate sleep difficulties. For early morning awakening, doxepin (25 to 50 mg) is sometimes quite effective. The amino acid L-tryptophan has been shown to reduce sleep latency without distortions of psychological sleep (Hartmann, 1977), but it has not been consistently used as a hypnotic because of its mild effect.

Should these medications fail and it is judged that the patient truly needs a stronger temporary hypnotic, the choice of drug will depend upon whether short action is desired (i.e., 3-4 hours), in which case pentobarbital (Nembutal) 1.5 grains (100 mg) is prescribed; intermediate action (i.e., 4-6 hours) will require butabarbital (Butisol); 1.5 grains or long action (i.e., 6-8 hours) for which 1.5 grains of phenobarbital will be necessary. Sometimes a combination drug is used such as Tuinol (1.5 grains), which contains Seconal and Amytal, for short and intermediate action. Should a "hangover" result the next morning, the doses should be halved. Under no circumstances should a stimulant such as amphetamine be prescribed to alert the patient the next day since a vicious sedating-stimulating habit may be established. The non-barbiturates are also popular. Among these chloral hydrate is preferred (7.5-15 grains). This is available in capsule form (Noctec), which consists of 3 or 7.5 grains of chloral hydrate and is taken in doses of one to two capsules nightly; or in syrup form, which contains 7.5 grains of chloral hydrate per teaspoonful. Other non-barbiturates are also occasionally employed but must be used with caution. These include Placidyl (500 mg), Doriden (500 mg), and Noludar (300 mg).

The use of hypnotics should be confined to at most 3 weeks because beyond this time habituation is likely. If long-term use is anticipated, the patient may be enjoined to skip medication several times during the week. Many patients are comfortable with a hypnotic every 3 days, which enables them to catch up on their desired quota of sleep. In spite of everything that can be done to deal with the causes of insomnia, it may be impossible to stop it. This is especially the case if the patient has an intractable medical condition with pain and debility. In these cases, the therapist may have to prescribe long-term periodic hypnotic medication as adjunctive therapy.

When hypnotic drugs have been used over a long period, they usually become less effective and REM sleep is markedly reduced. Therapy is much more difficult since the patient will resist going off hypnotics. Should drugs be abruptly withdrawn, disturbing rebound insomnia will eventuate. The brief snatches of sleep that do occur are interrupted by a rebound in REM sleep, upsetting dreams, and

nightmares. Consequently, slow withdrawal is necessary (a good rule is reducing by one nightly dose every 5 or 6 days). The patient should be warned about the possibility of a temporary increase in insomnia, vivid dreams, and nightmares. Relaxation exercises or self-hypnosis are prescribed or biofeedback employed if the therapist has the apparatus. Other principles outlined above should be followed.

In absolutely refractory insomnia, multidimensional treatment in an inpatient psychiatric unit may be most helpful.

EATING DISORDERS

Overweight and Obesity (Psychological Factors Affecting Physical Condition, DSM-III-R Code 316.00)

The pursuit of thinness has become an obsession, especially in prosperous societies, but often it is a futile gesture. Obesity is a refractory condition whose cure rate is less than for many kinds of cancer. If grossly excessive, overweight leads to many physical disabilities, but even more important to untold hours of self-reproach and suffering on the part of even its less overweight victims. Recent studies have shown that such physiological factors as fat cells that are enlarged in size and number and a low metabolic rate are prominent among some obese persons. These factors, probably genetically determined, make it difficult and for some individuals impossible to lose weight even on a prescribed low-calorie diet. There is also a small group of persons who have serious personality problems dating back to infancy and early childhood associated with an overvaluing of oral activities, in whom overeating becomes a compulsive mechanism that defies all methods of control except long-term psychotherapy (Bruch 1957, 1961, 1973; Caldwell, 1965). Even here the food compulsion may defy correction. Most overweight persons do not fit into these sub-types of obesity, however, and may be helped by modern methods of treatment to lose weight for cosmetic if not health reasons.

The basic therapy that has been commonly employed is behavior modification that takes into consideration the prevailing eating patterns of the patient (Stunkard 1972, 1985, Craighead et al, 1981). Detailed questioning is essential regarding not only the kinds and preparation of foods the patient prefers to eat, but also the time of day when overeating occurs, the availability of the food, the exact circumstances under which the appetite is stimulated, propensity for sweets, late-evening snacking, social pressures, and so on. What is essential is control of environmental eating cues that excite temptation. Once these factors are identified, the patient is instructed in how to rearrange eating routines and given homework assignments to practice the new orientation.

Standard forms of therapy involve (1) following a diet of around 800 to 1000 calories daily, carefully recording the food consumed, (2) keeping a chart, daily or weekly, of one's weight, (3) eating meals preferably at home with no distractions such as radio, television, or reading, (4) chewing each mouthful of food very slowly and spending at least 20 minutes at each meal, (5) forbidding snacking between meals, (6) food shopping from a list of essential items and no more, (7) exercising daily and walking rather than riding, and (8) being rewarded with money or gifts for losing weight and being penalized by a fine for gaining weight. Such programs are often executed in groups for a number of sessions, among which Weight Watchers and Overeaters Anonymous are especially popular.

Except for a small group of physiologically and psychologically handicapped persons, overweight individuals who follow the principles of these programs will lose considerable poundage. The real problem is maintenance, because most people are constantly plagued with temptation and sooner or later will abandon their new eating styles. Fantasies of the good life—the tinkle of beautiful crystal, the feel of fine silver, and the smell and taste of gourmet cooking will haunt the most dedicated soul. And, in an incredibly short time, to the great consternation of the dieter, the old weight has been restored. Anyone who operates under the illusion that weight loss is simply a matter of discipline and diet and that a few

behavioral strategies can dissolve fat and ensure permanent weight loss will be subject to disappointment.

For many people, food is a pacifier. It alleviates tension and acts as a means not only of gratifying hunger and securing great pleasure but of quelling anger and restoring one's adaptive equilibrium. The driving impact of hunger is kept alive by inner forces of which the individual may not be entirely aware. This fact has led to a broadening of behavioral strategies to include cognitive elements. We are interested not only in what the patient does but in the thoughts and impulses that stir up the craving for food and especially for those foodstuffs that are fattening.

In some cases, particularly if physiological factors exist and constant dietary attempts have led to failure, the individual should not be forced to reduce. The lesser of two evils is to accept one's body size and try to lessen the overconcern with achieving thinness. Society does discriminate against overweight people, and even those who are mildly plump get to hate their bodies and to despise themselves for loss of willpower. Psychotherapy may not be able, especially with short-term methods, to get to the provocative psychological factors responsible, and the most we will be able to accomplish is to help people to stop tormenting themselves with their obsessional dieting preoccupations.

If a patient comes to therapy principally for help for emotional and adjustment problems and obesity is a secondary concern, the focus at first will be on the primary complaint factor. In the course of therapy, the patient may bring up the matter of overweight, in which case techniques may be used similar to those used when obesity is the initial complaint. Generally the patients will already have experimented with weight-loss measures on their own. The therapist may inquire about those that have proven temporarily successful. In some cases no more has to be done than to encourage the patient to continue on these diets and to join Weight Watchers, Overeaters Anonymous, or similar groups. Commercial weight-loss clinics must be selected carefully since some employ potentially dangerous drugs, have minimal medical supervision, and neglect essential exercise, which is an important

ingredient in a good program. In treating the average adult who is less than 40 percent overweight and who probably does not possess serious psychological problems, some clarification about diets will usually be necessary. Though the patient has been exposed to years of dietary information and may profess to know all about dieting, there are usually large gaps in knowledge that have been filled with old wives' tales about food and feeding as well as faddist whimsies extracted from magazines and newspapers. Information on what constitutes a good dietary regime (7 calories per pound of ideal weight with proper protein, mineral, and vitamin content) that can act as the basis of a living diet to be followed faithfully may have to be supplied. In some patients alcohol, taken to appease tension, constitutes a block to dieting. One ounce of drink of any spirit contains about 135 calories. An average martini has as many calories as three slices of bread! Considering that several highballs or cocktails supply 500 to 750 calories and that the appetite is in addition stimulated by alcohol, food control for the drinker becomes a non-existent entity. The matter of exercise will also require explanation. A 250-pound man climbing 20 flights of stairs will lose the equivalent of one slice of bread. Exercise firms up muscles, but it cannot take off sufficient poundage without strict dieting. When suggesting a proper diet, the therapist may have to give the patient a basic nutritional list of essential daily foods. This consists of a helping of fresh fruit twice daily; a small helping of cooked vegetables; a salad; lean broiled meat, fish, or fowl twice daily; a glass of milk or cheese twice daily; 2 to 3 eggs weekly; and little or no alcoholic beverages (Tullis, 1973). Fats, nuts, candy, cake, and all desserts are to be avoided. Low-calorie salad dressings, low-calorie sweeteners, and sugar-free drinks may be permitted.

A report released by researchers in a study supported by the National Institutes of Health has lauded the substitution of fats in the diet with 60 mg of sucrose polyester per day. This reduces caloric intake by 23 percent (JAMA, 1982) and contributes to weight loss. Meals should be taken at regular hours with no snacking allowed.

In most cases, however, the lack of success with these routine methods will necessitate an aggressive therapeutic program on either an individual or group basis. Assessment should include an evaluation of the patient's goals. Sometimes these are unrealistic, for example, if the patient expects to lose 20 pounds in 4 weeks. The patient's dietary and eating habits should be recorded as well as any stress factors of which the patient is aware. Many patients believe that they can lose weight by having little or no breakfast and skimping on lunch. In this case, most of the eating occurs at nighttime, when a ravenous appetite is set loose. Some patients desire medications that will act as appetite suppressants. Information should be supplied that experience with these chemical adjuncts has been disappointing. Their effect is temporary at best, and when they are discontinued, the patient is worse off than at the beginning.

An evaluation of social support systems is vital since many tensions are the product of social isolation and lack of family and group contacts. Because the relationship with the spouse is especially important, the spouse should become a vital part of the treatment program from the start. As the patient loses or fails to lose weight, the attitudes of the spouse will influence what happens, and the spouse's relationship with the patient may change for the better or worse. Not infrequently, the spouse will subtly encourage the patient to go off the diet as body changes in the latter occur. Obesity may be a way of locking the patient into a neurotic relationship that the spouse needs for his or her personal stability. There may be fear that greater physical attractiveness will motivate the patient to abandon the spouse or make the spouse attractive sexually to others or seek activities away from home. Some men find obese wives more sexually stimulative and thus may discourage weight loss in their wives. These additional reasons for sabotage of the patient's therapy make the husband's presence at some of the sessions a desirable part of the treatment program.

It is obvious that motivation to lose weight is crucial to the success of any treatment program for obesity. Certain patients come to therapy with the expectation that some miracle will happen and that their appetites for food will somehow disappear as a result of magical tactics like hypnosis (Krogar,

1970; Stanton, 1975). Because motivation to participate actively in the assigned program is essential, an initial screening process may be used. Patients are told that unless they are ready to follow the routines prescribed, they are not ready for the program. They are then given a few routines to follow during the first and second session, such as keeping a record of their weight and their food intake each week.

Simple tactics such as chewing food very slowly, putting the fork down between bites, sitting in the same place for each meal, and avoiding distractions like television while eating may be advised. Should the patients fail to do these simple things nor be disciplined enough to lose at least 2 pounds during the first 2 weeks of therapy, it is doubtful that the more burdensome tasks that come later will be executed. Such reluctant patients may be told bluntly that they are not yet ready for the program the therapist has to offer. Motivation may sometimes be helped by imposing financial penalties for non-attendance at sessions (Brownell & Foreyt, 1985). At the University of Philadelphia and Baylor College of Medicine, for example, patients are required to deposit $100 in addition to a treatment fee of $200. If the patient attends at least 80 percent of the sessions, the deposit is returned.

Included in the weight-reducing directives are definite instructions regarding routine exercise. Physical exercise is prescribed not so much for its weight-reducing potential, which is low, but for its general effect on the well-being of the patient, which reflects back on the patient's ability to follow a sensible weight-loss maintenance regime. Moreover, exercise helps prevent the loss of essential muscle tissue and the lowering of the basal metabolic rate as dieting proceeds. The therapist must be firm about insisting that graded exercises be carried out daily. Most obese patients will resist exercising for many reasons, including shame of exposing their bulky bodies to others and the torpor that excessive poundage imposes on them.

According to some authorities on obesity (Stunkard, 1984; Garrow, 1981), different degrees of obesity call for different approaches. Mildly obese people (30-40 percent overweight) are best helped with behavioral methods. Moderately obese people (40-100 percent overweight) require a very

low-calorie diet as well as behavior modification. Severely obese people (more than 100 percent overweight), which is rare, may need an intestinal bypass operation after having failed with a very low-calorie diet and behavior modification. Such intractable cases usually display a combination of basic defects in metabolism and poor motivation, which results in lack of cooperation. A "short-circuit" procedure (ileal bypass) results in a reduction of the length of the small bowel lowering the absorptive surface for nutrients. While weight loss occurs, serious malabsorption, diarrhea, gallstones, and susceptibility to infections may impair health. The operation is consequently done as a last resort.

It is important to remember that weight will rapidly be regained if a reducing diet is markedly different from the diet the individual will return to later. Some nutritionists therefore advise patterning a diet around the patient's customary one but substituting non-fattening for fattening items, eliminating high-calorie foods, and introducing more vegetables, fruits, and cereals. It is essential that the organization of a dietary regime take into account the need for the person to continue to eat healthful foods to maintain his or her ideal weight. How fast one should lose weight is also important. Obese people want to reduce rapidly. They have previously tried to do this with crash diets. This has not worked because returning to previous food habits nullified their accomplishment. The rate of weight loss during the active period of dieting is best maintained at a low level, perhaps no more than 1 to 1 ½ pounds weekly, which gives the individual a chance to reorganize food habits. If however, obesity is pronounced, if morale demands it, and especially if the metabolism of the individual is sluggish, a drastic reduction of food intake (to 400 to 700 calories) or outright semi-starvation (Genuth et al, 1974) *under medical supervision* may be undertaken to foster the loss of 3 to 5 pounds weekly. Naturally, there is great danger here of rapid return to the original weight once professional supervision if terminated.

In recent years a very low-calorie diet mainly of protein (lean meat, fish and fowl, vitamins and minerals) has been popularized for patients who are at least 40 pounds overweight. Patients have initial physical examinations and are seen regularly by their physicians for checkups and laboratory tests.

Supervision is essential, and if the patient adheres to the diet, and in addition receives behavior modification, impressive weight loss is possible in most cases. Unless a continuing maintenance program exists, however, relapses are the rule. Satisfactory maintenance may often be achieved when patients are continuously supervised, preferably in a group setting.

Weight-loss maintenance is a key issue and, as has been mentioned, the involvement of a spouse at the point when the patient has lost enough weight to make a difference in appearance may spell the difference between a successful and poor outcome. Most patients will require personal individual or group therapy for a year. Thereafter, some patients do better in a continuing group, but this is not always the case. The patient should be forewarned to contact the therapist should there be danger of slipping back into the old habits. Any stress situations are apt to cause a patient to overeat to appease tensions. Often fantasies of gourmet foods may tempt or upset the patient. Patients who have irreverent thoughts about luscious foods must be taught to correct self-statements that keep undermining their resolve. The emphasis in such a cognitive approach must be on their strengths not weaknesses. Hunger may be explained as a good sign, indicating that the patient is consuming excess body fat. Mastering hunger then becomes a virtuous act of caring about themselves and safeguarding health, longevity, and appearance.

One should not overlook the damaging psychological consequences of having been overweight. Obese people often have a depreciated self-image and believe their bodies to be misshapen, grotesque, and contemptible. They sustain a loathsome hatred of themselves. This is most often the case in juvenile obesity in which extraordinary efforts may be made to conceal body fat. Some of these residues remain even after weight loss. Or an attractive body may confront the individual with new challenges, for example, coping with sexual gestures from members of the opposite sex which they are not equipped to handle. Continued psychotherapy may then be in order.

Psychoanalysis and psychoanalytic therapy have little impact on the isolated symptom of obesity. Correcting disturbed personality factors may, however, have an impact on overeating patterns. When successful, they can significantly improve the quality of life of their beneficiaries in a broad spectrum of behaviors.

Anorexia Nervosa (DSM-III-R Code 307.10)

Anorexia Nervosa usually invites desperate expediencies. In their anger, anguish, and dismay, patients and therapists may take recourse in such measures as cajolery, bribes, tube feedings, and even electroconvulsive therapy. These may have an immediate ameliorative effect, but since they circumvent the core problems they ultimately aggravate self-starvation. Anorexia nervosa mainly affects young adolescent girls of well-to-do families who defend their avoidance of food with a captious logic that does not yield to common-sense arguments. Even though they are emaciated, they still insist on losing weight by restricting food intake, forcing themselves to vomit, and driving themselves mercilessly in forced exercise. Sometimes obsessive-compulsive behavior takes place. Interludes of binge eating (bulimia) and vomiting are followed by self-hatred. If some motivation exists, behavior therapy by itself sometimes brings temporary benefits (White JG, 1964). Follow-up studies, however, have been discouraging, with relapse and alarming substitutive symptoms being the rule rather than the exception (Bruch, 1973). The malady appears to be on the increase throughout the world, as the pursuit of thinness remains a chief obsessive concern.

Theories of its cause range from genetic predisposition, to hypothalamic dysregulation, to exaggerated dopamine activity, to an affective disorder, to reaction to psychosexual conflict, to an extraordinary stressful experience. Psychological studies often reveal an erstwhile “perfect” child struggling to maintain her stature with abstemious relentlessness. Basic is the search for identity and a struggle for independence and control. Paradoxically, short-lived bouts of uncontrollable eating binges

further undermine the anorexic's self-esteem and incite an exaggerated refusal to eat. A pathological distortion of the body image is universal.

Therapy is thus understandably difficult. It hinges on two objectives: (1) improving nutrition (the use of high-calorie diet is sometimes helpful but must not be forced (Maxmen et al, 1974); and (2) rectifying the instrumental psychological causes. In mild cases, where the family warfare is not too extreme, treatment may be achieved at home. In most instances, separation from the home environment (usually with hospitalization) is mandatory in order to remove the patient from the highly charged family situation and from the aversive entourage surrounding the prevailing eating atmosphere. The relationship with the therapist is primary, with a minimum of pressure employed. Focus on food stuffs and calories is avoided.

Certain medications have a positive effect on anorectic patients. The most important of these is the antidepressant group, such as amitriptyline (Elavil), which is started in a low dose and worked up to 150 mg daily. Another drug with antidepressant qualities is cyproheptadine (Periactin). Chlorpromazine (Thorazine) has also been used with good results in some cases. Behavior modification is used freely to reinforce corrective eating patterns. If family difficulties are prominent, family therapy can be helpful. Psychoanalysis in the classical from has not been found to be too useful, one reason being the lack of motivation for depth therapy. A modified form of dynamic therapy reinforced by family therapy (Liebman et al, 1974) and supportive measures has yielded the most encouraging results and has helped to rectify identity problems, temper cognitive distortions, and expand autonomy and self-control in relation to eating habits. Continuing psychotherapy with the patient, and perhaps family therapy, is required after hospitalization (Bruch, 1973, 1975).

Bulimia Nervosa (DSM-III-R Code 307.51)

The episodic unrestrained incorporation of large quantities of food, which sometimes occurs along with anorexia nervosa, is also an isolated pattern that is increasingly being encountered in adolescent girls of normal weight. Occasionally it occurs in obese people who seemingly resent the strictures of dietary control, and periodically indulge themselves in compulsive eating. A recent survey of tenth-grade students has also revealed an alarming number of children who engage in binge-purge activities (Killen et al, 1986). The activity is usually followed by guilt feelings, self-recrimination, and forced vomiting. Laxatives and diuretics are taken for the purpose of trying to regulate weight. A good deal of secrecy may accompany the habit, spasms of wild food intake being confined to stealthy visits to the refrigerator or to the privacy of one's room, where sweets and other goodies have been stowed away. Depression accompanies the disorder either as a primary or secondary factor. Indulgence in such substances as barbiturates and amphetamines may sometimes occur. Periods of frantic dieting are often pursued. Concern with one's body and appearance mingled with distortions of the body image make for a peculiar picture, although in all other respects the individual appears normal. Most victims of this illness do not spontaneously seek therapy, but they may be referred by concerned parents or friends.

The association of bulimia and depression is an interesting one. A disproportionate number of bulimics have a positive dexamethasone suppression text, reflecting a relationship between bulimia and major affective disorder (Hudson et al, 1983a). A number of reports have detailed the successful treatment of bulimia with tricyclic antidepressants such as imipramine (Hudson et al, 1983b) and MAO inhibitors, such as phenelzine (60-90 mg daily) (Walsh et al, 1982).

The fact that binge eating may be controlled by antidepressants does not reduce the impulse to engage in this abnormal food activity. For this reason, individual therapy plus short-term therapy groups should be held with a focus on nutrition, expanding self-esteem, and finding alternatives to binge eating and purging. Indeed, some studies show that a multifaceted group approach produces results equivalent

to the taking of antidepressants. Connors et al. (1984) has shown that utilization of a treatment approach incorporating education, self-monitoring, goal setting, assertiveness training, relaxation, and cognitive restructuring can lead to significant attitudinal and behavioral change. Following the initial improvements with antidepressants and with brief group therapy, prolonged dynamic psychotherapy may be needed if personality disorders require restructuring.

HABIT DISORDERS

A number of symptomatic complaints are commonly encountered among patients that serve either as a prime reason for seeking therapy or become so distracting that they obstruct the therapeutic effort. Their resolution consequently will concern the psychotherapist, who, having satisfactorily managed to overcome them, may proceed with any underlying personality problems of which the symptoms are a surface manifestation. Many of the techniques for habit modification come from the behavioral field. The effectiveness of reinforcement therapy has been validated even with chronic psychotic patients (Gottfried & Verdicchio, 1974).

Functional Enuresis (DSM-III-R Code 307.60)

Once urologic or general causes for enuresis (a good physical examination is a necessity) are eliminated (for instance, local irritation around the meatal or urethral area, phimosis, adherent clitoris, balanitis, cystitis, urinary tract infections, pinworms, diabetes, cerebral dysrhythmia, and systemic diseases), its sources in psychological conflict may be explored. If the patient is not mentally defective or of borderline intelligence, the presence of enuresis probably indicates improper habit training, emotional immaturity, or conflicts related to sexuality or aggression (Bakwin, 1961). Frequently enuresis has positive values for the individual as a masturbatory equivalent. In some instances it represents a form of aggression against the parents or against the world in general. Often it signifies an appeal for dependence on the basis of being a childish, passive, helpless person. In this context, enuresis

may symbolize for the boy castration and the achieving of femininity. In girls it may connote aggressive masculinity and symbolic functioning with a penis.

For children a record is kept of dry and wet nights, the former being rewarded by praise and the record marked with a star. Rewards like ice cream may also be used. When the child wets, he or she should be responsible for changing the bed clothes and for seeing that they are washed. One-third of the children presenting with enuresis may be cured by this regimen alone (McGregor HG, 1937).

Strong emotional stress sometimes produces enuresis in persons who are ordinarily continent. This was brought out during World War II when certain soldiers subjected to the rigors of induction or warfare displayed the regressive symptom of bedwetting. Most soldiers who showed this symptom had a history of early bedwetting or of periodic attacks of the disorder prior to induction.

In treating enuretic children, they may first be requested to empty their bladder at bedtime; then awakened 2 hours later and induced to urinate again. This interval may gradually be prolonged, and, if enuresis stops, the evening awakening may be discontinued after 6 months. Positive praise and encouragement are given the children when they control their bladder; however, there should be no scolding or punishment for wetting. Exciting play or activity prior to bedtime is best curtailed, and fluids restricted after four o-clock. Coffee, tea, cocoa, sweets, salts, and spices should be avoided. Sedatives, amphetamine, methyl testosterone, anticonvulsants, belladonna, and other substances have been administered with varying results. Imipramine (Tofranil) has been used (Poussaint & Ditman, 1964; Stewart MA, 1975) one-half hour before bedtime and the results have been promising. The dose is 25 mg for children of 4 to 7 years, 35 mg for children of 8 to 11 years, and 50 mg for children older than 11 years. Countering improvement are side effects in certain cases. Friedell (1927) obtained an 80 percent cure rate with intramuscular injections of sterile water. W. A. Stewart (1963) described how Zulliger cured a young man of 19 with lifelong enuresis in one session by convincing the patient that he, the therapist, sided with the patient against his father. The fact that so many treatments have yielded positive

results indicates the presence of a strong suggestive and placebo element in the management of enuresis (English OS & Pearson, 1937; *Hospital Focus*, 1964).

Enuresis developing in an adult is usually a regressive phenomenon connoting a desire to return to a childish adaptation and a defiance of the adult world.

The treatment of enuresis will depend upon whether one wishes to deal with the symptom as an entity, disregarding the emotional undercurrents, or to work with the intrapsychic structure in hopes that the symptom will eventually resolve itself (Pierce, 1975). Focusing on the symptom as preliminary to working with more fundamental dynamic factors is preferred by many since the symptom is an undermining element that robs the individual of self-confidence and vitiates interest in searching for conflictual sources. Accordingly, concomitant counseling and carefully conducted psychotherapy should, if possible, be employed.

A rapid effective conditioning technique, which, according to the British journal *Lancet* (1964), brings a relief yield of 75 percent, involves a buzzer or bell which sounds off when there is wetting of the bed (Mowrer & Mowrer, 1938). There are advocates and critics of this method. Sidetracking the issue of whether symptom removal is rational or irrational (Winnicott, 1953; Eysenck, 1959) or whether the buzzer treatment is a form of classical or operant conditioning (Lovibond, 1963), this approach to enuresis in controlled studies has been shown to be superior to other therapies (Werry, 1966). While the relapse rate is about 30 percent, relapses respond rapidly to a second course of treatment. There is little evidence that symptom substitution or precipitation of a neurosis develops with the removal of enuresis; on the contrary, the emotional well-being seems benefited (Bailer & Schalock, 1956; Behrle et al, 1956; Bostock & Schackleton, 1957; Gillison & Skinner, 1958; Lovibond, 1963; Werry, 1966). The apparatus consists of two foil electrodes separated by thin gauze placed under the child. The covering over the electrodes should be as thin as possible. Parents and child are reassured there will be no shock, and the child is to prepare the bed and set the alarm. Should the alarm go off, he or she must get up and go to the

bathroom. On return the child is to remake the bed and reset the alarm. Eventually the child will awaken before the alarm goes off. Should the child fail to awaken when the alarm sounds, the parents should awaken the child and see to it that he or she goes to the bathroom. A 90 percent cure is reported in 6 months (Dische, 1971). An improved form of apparatus is the Mozes Detector invented and used in Canada and tested at the Toronto Hospital for Sick Children with impressive results (*Medical World News*, 1972). Another conducting apparatus consists of a moisture pad worn inside the underwear (jockey pants or stretch-type bikini). The reported success rate is more than placebo. It may be obtained through Nite Train'r Enterprises, P.O. Box 282, Newberry, Oregon 97132.

Hypnotherapy is sometimes a useful adjunct (Stanton, 1979). Elsewhere (Wolberg LR, 1948), a full recording of the hypnotic treatment of enuresis is described. Actually, there is no single hypnotic method suitable for all patients; the specific suggestions and stratagems will depend upon the problems and personality characteristics of the patient. One method is to train the patient to enter as deep a trance state as possible. In the trance, an attempt is made to show the patient that he or she is able to produce various phenomena, such as paralysis and muscle spasm, and that he or she can shift or remove these by self-suggestions. Fantasies related to the most pleasurable thing that can happen to a person are obtained for the purpose of reinforcing the conditioning process later on. The patient is then requested to experience a sensation of slight bladder pressure such as occurs immediately prior to urination. As soon as he or she feels this sensation, it will inspire a dream or will make his or her hand rise to the face, which will cause the patient's eyes to open and to awaken. Even though no dream or hand levitation occurs, it is suggested that the patient's eyes will open, nevertheless. At that moment he or she will experience an urgency to get out of bed. Going to the bathroom will be associated with a feeling similar to that accompanying the fantasy of the best thing that can happen to a person. These suggestions are repeated a number of times.

The next stage in therapy is teaching the patient to control sensations that arise inside the bladder so that urine can be retained without needing to awaken until morning. Suggestions to this effect are given the patient as soon as he or she establishes a habit of getting out of bed and going to the bathroom. The positive relationship with the therapist may be utilized as a reinforcing agent in reconditioning, praise and reassurance being offered when suggestions are followed.

In patients who have expressed a willingness to undergo dynamic psychotherapy, conditioning procedures may be delayed until they are deemed absolutely necessary. This is because the symptom may disappear as the origins of bedwetting are explored, and the unconscious fantasies associated with it clarified. There is, however, no reason why psychotherapy cannot be combined with a conditioning approach.

Nail Biting and Hair Plucking

Nail biting and finger sucking are common outlets for tension in preadolescence and adolescence and may persist as a neurotic symptom into adult life. Among other things, nail biting serves as a substitutive release for masochistic, sadistic, and repressed masturbatory needs. If no other serious emotional problems coexist, the treatment may be symptomatic (Pierce, 1975), or therapy may be focused on outer emotional factors that generate tension, particularly environmental family problems. Most nail biters have little motivation for real psychotherapy, seeking mere measures of control because of embarrassment about their habit. They are usually unaware that the nail-biting symptom has a meaning, and they are often puzzled by the persistence of the urge to chew their fingertips.

If psychotherapy is resisted, the therapist may have no alternative but to treat the symptom. Hypnosis may be useful here. In hypnosis, strong authoritarian suggestions are made to the effect that the patient will have a desire that grows stronger and stronger to give up the childish habit of nail biting. Patients who put their fingers into their mouths will discover that their fingernails taste disgustingly

bitter. They may even develop nausea with the mere desire to bite the nails. Daily hypnotic sessions are best, but since this is usually impractical, a tape recording may be made that the patient may use twice daily (see Induction of Hypnosis, Chapter 56). Some therapists teach the parents of nail biters to activate the machine while the child is asleep to reinforce suggestions through sleep conditioning. Self-hypnosis may be employed in an adult. If these tactics fail, aversive conditioning (q.v.), a small shocking apparatus or a heavy rubber band around the wrist that can be painfully snapped may be tried (Bucher, 1968). A strong desire to control the symptom must be expressed by the patient and cooperation secured.

An assessment of the patient's problems will determine whether further reeducative or reconstructive therapy is indicated after the nail biting is brought under control.

Hair plucking (trichotillomania) (DSM-III-R Code 312.39) of the head, eyelashes, eyebrows is often a manifestation of a severe personality problem, often of an obsessive-compulsive or schizoid nature. It may serve as an outlet for revenge and self-punishment, and it is often accompanied by frustration, guilt feelings, and remorse. Psychotherapy is notoriously ineffective in dealing with this symptom. Hypnosis and particularly aversive conditioning may score some successes.

AFFECTIVE DISORDERS

MOOD DISORDERS. DSM-III-R Codes/BIPOLAR DISORDERS: bipolar disorder manic [296.4X]; bipolar disorder depressed [296.5X]; bipolar disorder mixed [296.6X]; cyclothymia [301.13]; DEPRESSIVE DISORDERS: major depression, single episode (296.2X); major depression recurrent [296.3X]; dysthymia *or depressive neurosis* [300.40]; Atypical Disorders: *Bipolar Disorder* not otherwise specified [296.70]; Depressive disorder not otherwise specified [311.00]).

Depression is a generic term that embraces a variety of syndromes ranging from normal grief at the passing of a loved one, to reactions of prolonged distress out of proportion to the intensity of the traumatic stimulus, to paralyzing inhibition and retardation arising spontaneously from endogenous sources, to psychotic manifestations with intense melancholia and nihilistic, somatic, or paranoid

delusions or hallucinations. A number of syndromes are classified under the category of affective disorders. At the top of the scale in intensity are *major depressive disorder* and *bipolar disorder*. The latter is characterized by alternating moods of elation and depression and is constituted by three subtypes: (1) *bipolar disorder, manic*, in which expansiveness and overactivity are dominant; (2) *bipolar disorder, depressed*, in which sadness and retardation are prominent; and (3) *bipolar disorder, mixed*, in which one or the other mood occurs within a short span. *Cyclothymic disorder* is a mixed affective disorder of lesser intensity. Depressive reactions that often follow psychosocial stress and promote sleep disturbance, fatigability, social withdrawal, and ahedonia are classified as *dysthymic disorder* (depressive neuroses, reactive depression). Atypical features of a mixed reaction merit the diagnosis of *atypical bipolar disorder*; or if the mood is primarily depression without the usual characteristics of a major depression or dysthymic disorder, they are regarded as signs of an *atypical depression*. Shadings of depression with schizophrenic symptoms have been called *schizoaffective disorder*.

According to some researchers, bipolar and unipolar disorders are two distinct entities. There is some controversy about the precipitating factors that activate a bipolar disorder. In some cases, stress seems to initiate an attack. In other cases, endogenous causes are implicated that appear to have little relation to environmental or inner conflictual sources. Typical of the manic phase are euphoria, irritability, grandiosity, hyperactivity, pressure of speech, and flight of ideas. After recovery and a varying interval of relative calm, a depressive phase may intervene, marked by sluggishness, retardation, loss of appetite, insomnia, and somatic distress. Symptoms vary in intensity from being so mild and under control that the illness is overlooked to being floridly psychotic. It is important to distinguish major depressive disorder from bipolar disorder. To establish the unipolar diagnosis, there must be at least three episodes of depression without a manic episode. Atypical symptoms may confuse the diagnosis, such as when mania masks itself as a personality problem in spurts of creative overactivity and productiveness and depression is concealed by dry humor and a smiling countenance. The search for

biological markers goes on, but the Dexamethasone Suppression Test (DST), the TRH Stimulation Test, catecholamine metabolite levels, urinary phenylacetic acid levels, and sleep EEG studies are still inconclusive.

Depressive Reactions

Depression is one of the most common syndromes encountered in psychotherapeutic practice. Approximately 20 to 26 percent of women and 8 to 12 percent of men will be affected by at least one episode of depression in their lifetimes. Symptoms of this illness vary, but most often it is manifested by listlessness, fatigability, loss of interest in practically all activities, diminution of the sexual drive, disturbances in appetite and sleep, feelings of worthlessness, self-reproach, and, in severe cases, psychomotor agitation or retardation and suicidal ideas or impulses. Bipolar depressions are characterized by periodic manic phases with swings toward hyperactivity. In most severe depressions, psychotic ideation is not uncommon. Once a depression occurs, there is a 40 to 50 percent likelihood of a second attack, and in the majority of these cases, subsequent attacks are possible. The person may then be plagued by recurrent depressions throughout his or her life. Some depressions seem to persist over a period of years with varying degrees of intensity; others apparently disappear; still others disappear only to recur at some time later.

Depression is a common reaction to separation and bereavement. It may become especially intense after the loss of an important person, such as a spouse, parent, child, or love object, inspiring grief and mourning. In most people the depression, after a period, is resolved. Its continuance or appearance and persistence when there is no adequate stimulus to account for it has a pathological significance and may require clinical intervention. Sometimes depression accompanies a severe physical illness, particularly if its chronic quality makes the person feel hopeless or proper functioning is impaired. Thus cancer, crippling arthritis, Parkinson's disease, cardiac failure, and other enduring medical and neurological ailments may sustain a prolonged depression. Aging, with its effect upon one's health, appearance,

memory, and work capacities, is an especially provocative depressive stimulus. Substance abuse and detoxification (alcohol, amphetamines, barbiturates, narcotics, etc.) are frequently followed by a spell of depression that drives the person to more drinking or drug indulgence. The intake of certain medicinal agents such as antihypertensives (Reserpine, Diuril, Hygroton, etc.) and beta blockers (Inderal, Corgard, etc.) may also produce depression.

Depression sometimes merges with anxiety, making it difficult to distinguish the two. Confusing also is "masked depression" that is camouflaged by such somatic symptoms as headache, backache, facial and limb pains, dysuria, dyspareunia, dysmenorrhea, and sundry other complaints. A puzzling relationship exists between certain psychiatric syndromes and depression. Some observers consider conditions such as anorexia nervosa, bulimia, panic attacks, and obsessive-compulsive neurosis to be manifestations of neurotransmitter abnormalities akin to those of depressive illness, and, most important, they are relieved by antidepressants. Depression in childhood often takes the form of somatic illnesses such as headaches and abdominal pain mingled with a dysphoric mood. Aggressive and hyperactive children may also actually be suffering from depression. Depression among the elderly is common and is accompanied by relatively frequent somatic concerns, memory and cognitive deficits, and occasional paranoid delusions.

The diagnosis of depression is not difficult to make with a good clinical interview. Some physical ailments, however, mask themselves as depression. Gianninni et al. (1978) list 91 such ailments, and Hall (1980) lists almost as many. Consequently, a physical examination and laboratory tests should be done on all depressed patients. Similarly, substance abuse may produce depressive symptomatology and if suspected will justify urine and blood drug abuse screens. Some clinicians recommend the Dexamethasone Suppression Test if there is a problem in differential diagnosis. The DST can identify at least 50 percent of severe depressions (major depressive disorder) but is less accurate in detecting mild to moderate depressions. Certain medical problems, commonly prescribed medications, and some

psychiatric disorders can distort DST results, and a negative DST does not rule out severe depression. At this stage, therefore, the test should not be employed as a routine diagnostic procedure although it still has some utility in research.

In reactive or neurotic depression (dysthymic disorder) some ostensible blow to security or self-esteem seems to set off the depressive pattern. The stress stimulus may be loss of a love object, of status, or of worldly goods. The meaning to the individual of the traumatic incident is the key to whether or not depression will result. The depressed patient organizes his or her thinking around the precipitating incident. If a love object has died or abandoned the patient, he or she is preoccupied with the image of the departed one. If status is impaired, the patient considers that he or she is "a nothing." Loss of worldly goods sparks off a poverty complex. The question is still not completely answered as to why some people respond with depression to a crisis in their lives, whereas others marshal their adaptive resources and overcome the vacuum created by the incident. Dynamically, reactive depression is related to (1) feelings of loss of a love object (expressed as feelings of isolation and emptiness), (2) a feedback of hostility blocked from external expression (expressed in self-deprecatory comments) in a masochistic maneuver, and (3) a converted form of anxiety (here anxiety and depression may alternate, depression apparently serving as a means of dealing with anxiety).

Major depressive disorder and bipolar disorder spring from biological disturbances presumably hereditary in nature and can develop periodically without identifiable exogenous or internal conflictual provocations. Social and psychological disruptions consequent to such biological depressions in turn can aggravate the symptoms. Depression in such conditions is often ushered in by feelings of loss of self-confidence, the absence of initiative, and fatigability. The depressive mood itself may not be apparent; it is often covered by an overlay of hollow humor in what has been called the "smiling depressions." As the depression deepens, loss of appetite, insomnia, diminution of the sexual drive, and a general anhedonia (lack of gratification in the pursuit of pleasure strivings) follow. There are

difficulties in attention and concentration and variations in mood, the intense depression during the morning lifting as the evening approaches. Interference with work and interpersonal relationships follow. Extreme suffering and regression to early dependency with masochistic behavior then develops in the course of which suicidal thoughts, impulses, and acts may erupt.

Principal goals in therapy consist of the following:

1. Removal of symptoms and a relief of suffering.
2. Revival of the level of adaptive functioning that the patient possessed prior to the outbreak of the illness.
3. Promotion, if possible, of an understanding of the most obvious patterns that sabotage functioning and interfere with a more complete enjoyment of life.
4. In motivated patients, recognition of conflictual patterns and exploration of their meaning, origins, and consequences.
5. Provision of some way of dealing with such patterns and their effects in line with a more productive integration.

Unfortunately, depressions are singularly resistive to treatment in that the mood change imposes a barrier to three of the most important elements in therapy: faith, hope, and trust. Lost is the expectancy of getting well that so often powers the machinery of cure. Gone is the feeling that someone cares, so essential in establishing a therapeutic relationship. Yet beneath the isolation and hopelessness, the depressed individual seeks a restoration of his or her ties with humanity. The person resists relationships, and then credits the feelings of isolation to the fact that he or she is unloved.

Among the therapeutic measures that are most effective are the following:

1. *Establish as rapidly as possible a relationship with the patient*. This is precarious as has been mentioned before. Yet winning the patient over in spite of inertia, gloom, sluggishness, despair, hostility, and self-recriminations is urgent. Depressed patients are insatiable in their demands for help and love. No matter how painstaking are the therapist's attempts to supply their demands,

they will respond with rage and aggression, often accusing the therapist of incompetence or ill will. The patients should, nevertheless, be approached with the attitude that the therapist understands and sympathizes with their suffering. Such measures as active guidance and externalization of interests may be attempted. The basis of treatment is a warm relationship between the patient and the therapist. The relationship that the patient establishes with the therapist will, however, be extremely vulnerable. Much leniency and tolerance are needed, and an attempt must be made to show that the therapist realizes the depth of the patient's fears and misgivings. This, however, is more easily said than done, since the depressed patient has a distrustful nature.

Distrust springs from the fusion of hate with love. Hostile feelings generate guilt that may be so disabling that the person will want to discontinue treatment. The slightest frustration during therapy, such as the unavoidable changing or canceling of an appointment, may be equivalent to rejection and will mobilize a tremendous amount of anxiety. Under the surface there is always fear of abandonment, and there is a tendency to misinterpret casual actions. The patient seeks reassurance but may resent its being called psychotherapy.

The aim in treatment is to develop and reinforce all positive elements in the relationship. This will involve much work, since the attitudes of the patient are so ambivalent that he or she will feel rejected no matter what the therapist does. It is best to let the positive relationship take root in any way it can without attempting to analyze its sources.

One of the means of maintaining the relationship on a positive level is by communicating empathy and by avoiding arguments. It is essential to convey to the patient non-verbally the idea that he or she is liked and that the therapist is a friend in spite of anything that happens. An attitude of belittling, harshness, ridicule, or irritation must be avoided. The therapist must maintain an optimistic outlook and express the sentiment that although the patient may not believe it now, he or she will get over the depression in a while.

Hypnosis may be of help for some of the milder depressions as a means of establishing a relationship primarily as an avenue toward inducing relaxation and toward giving persuasive suggestions to stabilize the person. A number of depressed patients appear to thrive under hypnotic therapy, probably because it appeals to their dependency needs.

2. *Use drug therapy when necessary*. Benzodiazepines such as Valium and Xanax may be of help in patients with mild depressions, especially those associated with anxiety, in elevating the mood and supplying energy. Simple mild depression occasionally is helped by methylphenidate (Ritalin) but should be taken for no more than 3 weeks. More severe inhibited depressions may be approached with imipramine (Tofranil) (100-200 mg daily), while agitated depressions appear to respond better to amitriptyline (Elavil) (100-200 mg daily) combined, if anxiety is especially strong, with Librium (30-40 mg). In very severe anxiety 20-25 mg 3 or 4 times daily may be given. The effects of the latter drugs may not be felt for several weeks. The MAO inhibitors (Nardil, Parnate) are also of some value, especially for atypical or neurotic depressions. Bupropion (Wellbutrin) is an antidepressant with a minimal effect on sexual functioning. Some experimental drugs for depression are being tested, which have low side effect profiles. These include idazoxan and S-adenosylmethionine.

   If side effects are intolerable, some of the newer depressive agents may be tried, such as trazodone (Desyrel) and maprotiline (Ludiomil). Mellaril has been employed for depressions of the schizoaffective type. If a schizoid element is present, a phenothiazine drug (Trilafon, Stelazine) may be combined with Tofranil and Elavil. In bipolar depressions, lithium has been given, but in almost one-third of cases it is ineffective or produces bad side effects or sparks of manic attacks. Alternative therapies have been tried, including anticonvulsants such as carbamazepine (Tegretol), valproic acid, (Depakene), tryptophan, thyroid medications, calcium channel blocking agents, and propranolol. Carbamazepine has been increasingly employed because, unlike combined tricyclic-lithium and neuroleptic-lithium treatments, it does not encourage more rapid cycling. Haldol and Navane are often used for psychotic depressions. Depression during medical illness often responds well to triglycerides. (See also Chapter 56, Somatic Therapy for a detailed description of antidepressant medications.)

   If drugs are used, patients should be told about the side effects to encourage the continuation of the medications in spite of them. Side effects are the chief reason why antidepressants are discontinued. The need for sleep may be reduced without harmful effect, and the patient may, if not forewarned, take excessive hypnotics. Constipation and weight gain may occur and require remedial measures. Mouth dryness may be counteracted partly by chewing gum or glycerin-based cough drops. Postural hypotension of a severe nature may be handled by advising the patient not to arise suddenly, to avoid standing unmoving in one place, and for women to wear elastic stockings and a girdle. Neuralgias or jactitation of the muscles may require 50 mg

vitamin B6 and 100 micrograms of vitamin B12 twice daily. Coffee intake should also be reduced. The troublesome insomnia in depression is best handled by chloral hydrate (Noctec, 1 ½ gm) or the benzodiazepine hypnotics (see Insomnia). The patient may be given a mimeographed form about the side effects of drugs (see Appendix T). In older people, antidepressants such as Elavil may be effective, but the dose after the age of 60 must be cut down to 25-100 mg daily. Tetracyclic antidepressants are useful in this group because of the minor anticholinergic and cardiovascular effects. Maprotiline, for example, may be started with 25 mg to 50 mg daily, increasing by 25 mg every third day until 75 to 100 mg is reached, which can then be given in a single-evening dose. Some drugs have been introduced to reduce intolerable anticholinergic effects, e.g. bethanechol, and cyclic tremor, e.g. propranolol.

3. *Administer electroconvulsive treatments immediately in severe depressions, or if there is any danger of suicide*. Electroconvulsive treatments are superior to any of the present-day drugs. (See section on Electroconvulsive Therapy in Chapter 58.) The effect is rapid, 8 ECTs generally eliminating the depression; however, more treatments may be required. In very severe agitated depression, 2 ECTs daily for 2 or 3 days may be followed by 1 ECT daily, and then by treatments twice or three times weekly. Following ECT, energizing drug therapy may be instituted (Tofranil, Elavil) and, if agitation continues, Thorazine or Trilafon can be prescribed. Unilateral ECT may be employed if even temporary memory loss cannot be countenanced. The superiority of ECT over drug therapy for psychotic depression is without question.

4. *Hospitalize patients with severe depression*. Mild depression may be treated at home, preferably under the supervision of a psychiatrically trained attendant or nurse, or, better still, and especially if family problems exist, the patient should be admitted to a rest home. Isolation from parents and friends, bed rest, and constant care by a motherly attendant may prove very beneficial. Because of anorexia, efforts should be made to bolster the diet with high caloric and high vitamin intake in the form of small but frequent feedings. In severe cases of malnutrition, a few units of insulin before meals may be helpful. If the depression is more than mild, hospitalization is advisable. Suicidal attempts in depression are made in almost one-third of the cases, and deaths resulting from these attempts occur with great frequency. The patient's complete loss of interest in himself or herself makes mandatory the establishment of definite daily routines, such as a hospital can best supply. Electroconvulsive therapy, the treatment of choice, can best be instituted in a hospital setting, and, if the patient requires tube feeding, nursing care is available.

5. *Institute psychotherapy as soon as feasible*. Psychotherapy is usually ineffective during extremely depressed phases. The only thing that can be done is to keep up the patient's morale. Patients should not be forced to engage in activities that they resist because this may merely convince them of their helplessness and inability to do anything constructive. If there is little suicidal risk, patients should be encouraged to continue their work, if they feel at all capable of managing it, since inactivity merely directs their thinking to their misery. In many cases, contact should be regulated with the patient's family and environment. This is necessary since the family of depressed patients often chides them for "not snapping out of it" and constantly reminds them that they must make up their mind to get well. The family members may be told that recovery is more than a matter of will power, and they must be urged to avoid a nagging and critical attitude.

6. Sleep deprivation therapy is still in an experimental state with varied reports attesting to its efficacy (King 1980), uncertainty of benefit (Pflug 1976), and possible worsening of the depression (Vogel et al, 1973). Different procedures have been employed, including sleep deprivation for only one night totally, one night weekly, several nights weekly, and partial sleep deprivation in which the patient is awakened repeatedly during sleep.

Exactly how to conduct psychotherapy is difficult to say. Much depends on the training and skill of the therapist and his or her ability to establish a therapeutic alliance (Arieti, 1978). In general, during the acute depressed stage a supportive, reassuring manner is best, shying away from probing for unconscious material, which may increase anxiety and heighten the possibility of suicide. The patient is given an opportunity to verbalize his or her fears and feelings. Guidance, support, reassurance, and persuasion are used. The patient is told that no matter how bad things seem and how depressed he or she feels, patients with depression recover. There are, however, steps that can be taken to speed recovery: It is essential that the patient get involved in his or her usual activities to the extent that available energy will allow, but not beyond this. Because initiative may be lacking, the patient may require a daily routine for retiring, arising, meals, working, and social and recreational contacts. One difficulty encountered is dealing with the tendency for denial regarding the severity of the problem and the need for treatment. Regardless of the therapy employed, the countertransferences of the therapist are apt to be brought into play and will have to be handled appropriately. The tendency of the patient to employ the therapist as a

replacement for an object of loss has to be handled with tact and understanding, avoiding rejecting the patient without supporting too enthusiastically a dependency relationship and without draining oneself too much with givingness and empathy.

Dealing with the depressed patient calls for a good deal of optimism, support graded to the patient's requirements, and need to control the tendency to be overprotective and overly reassuring. The patient must be made to feel that the therapist understands him or her and will do everything possible to help. The self-limited nature of depression should be repeatedly pointed out and the patient reminded that eventually he or she will feel much better, as others before have. Depressive ideas should never be ridiculed or accepted at face value. The therapist should point out that the situation is not as hopeless as it seems. If the patient harbors suicidal thoughts, a frank aeration of these feelings should be encouraged. It may be essential to extract a promise from the patient that he or she will not try suicide. If suicide is more than a passing fancy immediate ECT is necessary. A physical basis (biochemical, for example) for the depression may be presented and the patient told that there are medications that can help. "When an emotion of depression develops everything seems gloomy, but this will pass." Much of the benefit from psychotherapy is due to the relationship with the therapist. Appreciation of the therapist as a person who cares is important in securing cooperation. Family therapy may be indicated to manage guilt feelings in the members and to educate them regarding factors that can create a more harmonious relationship with the patient. Marital therapy can also be important, as may group therapy and behavioral therapy. Termination of therapy will have to be managed carefully because of the depressed person's sensitivity to loss. Adequate time must be given prior to terminating psychotherapy to allow for the working through of grief and rage reactions, which if neglected may spark off another round of depression. If a transfer to another therapist has to be made, the therapist must be careful not to give the patient the impression he or she is being rejected and pushed off into the hands of substitutes, which may be interpreted as another object loss and precipitate a deeper depression.

In depressions that have followed in the wake of actual or fantasied loss of a love object we may expect a rapid, positive transference as a means of object replacement. The substitution, however, is often rooted in magical expectations with desires for a giving, loving, nurturing, and omnipotent object reincarnation. The immediate reaction may be a temporary lifting of one's spirits, an overidealization of the therapist, and a stimulation of hope and anticipation that all will be well.

Inevitably, as the relationship with the therapist develops, the patient becomes aware of some failings in the therapist, a realization that the therapist is not the all-giving, all-powerful figure he or she imagined. What will emerge then is hostility and a feeling that the therapist has failed in anticipated obligations. The patient may try to vanquish his or her hopelessness by repressing doubts about the therapist, and passively submitting to the therapist with a sadomasochistic dependency. The hostility is usually suppressed by guilt feelings or in response to disapproving or attacking maneuvers on the part of the therapist. Depression may then return in full force or even become greater than before. Yet the patient will cling desperately to the therapist out of fear of undergoing another object loss.

The countertransference of the therapist will determine the fate of these transferential shifts, the proper handling of which will enable the patient to work through the termination phase of therapy. This involves resolution of the separation and grief reactions associated with loss of the love object that had initiated the depression. Some impact may also be scored on the original separation traumas sustained during the developmental years that sensitized the patient to later object loss.

Klerman has described a brief interpersonal psychotherapy (IPT) (12-16 weeks) for ambulatory, non-bipolar, non-psychotic depressed patients aimed at symptom relief and enhanced interpersonal adjustment, rather than at personality change. The treatment is organized around the premise "that clarifying and renegotiating the (interpersonal) context associated with the onset of symptoms is important to the person's recovery and possibly to the prevention of further episodes" (Klerman et al, 1984b). A procedural manual (Klerman et al, 1984a) designating the rationale and techniques has been

prepared and the method tested against some other treatments for depression. IPT rests on the assumption that depression issues out of stress induced by life events, especially social adjustment and interpersonal relations. Predisposing to the depressive reaction are personality factors, especially those involving self-esteem and the handling of guilt and anger. Therapy consists of exploring immediate interpersonal difficulties and then clarifying and modifying them. Alteration of maladaptive perceptions is attempted without delving into unconscious conflict or childhood antecedents or developing and exploring transference. Four interpersonal precipitants are particularly dealt with, namely, grief, role disputes, role transitions, and interpersonal deficits. Controlled studies have shown that IPT significantly lessens symptoms and after 6 to 8 months, social impairments. The final appraisal of IPT awaits further replication studies.

Cognitive therapy for depression can also be helpful and in some cases is superior to drug therapy. In cognitive therapy an attempt is made to rectify conceptual distortions in order to correct the ways that reality is being experienced. Interviewing techniques analyze defects in a patient's views of the world (cognitive assumptions or "schema"), methods of stimuli screening and differentiation, and the erroneous ideas that mediate destructive response patterns. Homework assignments reinforce the patient's ability to deal constructively and confidently with adaptive tasks. The treatment is short term, consisting of approximately 20 sessions on a twice-a-week basis. Cognitive therapy for depression is organized around a number of assumptions (Rush & Beck, 1978; Rush et al, 1977). As a consequence of early events, the patient retains a "schema" that makes him or her vulnerable to depression. Among such events is the death of a parent or other important person. What results is a "predepressive cognitive organization." Operative here is a global negative attitude on the part of the patient. Thus the patient misconstrues situations to a point where "he has tailored facts to fit preconceived negative conclusions" (Rush, 1978).

Depressed patients regard themselves as unworthy and assume this is because they lack essential attributes to merit worthiness. They assume their difficulties will continue indefinitely in the future, that failure is their destiny. These characteristics constitute the "cognitive triad" in depression. In treatment these patients are enjoined to keep a record of aspects of their negative thinking whenever this occurs and to connect these episodes with any associated environmental events that trigger them off. The simple quantifying of any symptoms—in this instance negative thinking—tends to reduce them. Whenever the patient during a session brings up a negative thought, the therapist asks the patient to reality-test it and then to do this away from therapy. Through this means patients are helped to see how they make unjustified assumptions ("arbitrary inferences"), how they magnify the significance of selected events ("magnification,") and how they use insignificant situations to justify their point of view ("overgeneralization"). Other "cognitive errors" are identified, such as how offensive details are used out of context while ignoring more important constructive facts ("selective abstraction"), how circumstances and thoughts that do not fit in with negative "schemas" are bypassed ("minimization"); how unrelated events are unjustifiably appropriated to substantiate their ideas ("personalization"). The patient is encouraged to review his or her record of thoughts, to identify past events that support his or her faulty schemas. Point by point, the therapist offers alternative interpretations of these past events. By so doing, the therapist hopes that sufficient doubt will develop in the patient so that he or she will engage in experimental behaviors, recognizing the fallaciousness of his or her hypotheses, and arrive at different, less destructive explanations for events. A marital partner or family may also be involved in cognitive therapy to reinforce correction of distorted negative meanings.

Step by step the patient is encouraged to undertake tasks that he or she hitherto had considered difficult ("graded task assignment") and to keep a record of his or her activities ("activity scheduling") and the degree of satisfaction and sense of mastery achieved ("recording a mood graph"). Discussions in therapy focus on the patient's reactions to his or her tasks and tendencies at minimization of pleasure

and success. Homework assignments are crucial. These range from behaviorally oriented tasks in severe depression to more abstract tasks in less severe cases oriented around correcting existing schemas. Should negative transference occur, it is handled in the manner of a biased cognition.

The material elicited during the periods of active depression, both as to mental content and as to the character of the relationship with the therapist, may yield important clues to the inner conflicts of the patient. Although notes may be made for later reference, all confrontive interpretations during the active period should be suspended. Only during a remission can interpretive work of any depth be helpful. In most cases interpersonal and cognitive therapies are useful, but depth therapy is avoided in patients with major depressive disorder. Some patients with dysthymic disorder spontaneously express a desire to know more about their illness. Here, a dynamic insight approach may be used. Many patients, however, show an unwillingness to go into their difficulties and resist insight therapy. Having recovered, they are convinced they are well, and they desire no further contact with the therapist. Without the "wish" to get well, little can be accomplished in the way of reconstructive psychotherapy.

Following recovery, the patient should be guided regarding the possibility of further depressions. If the patient has been on medications, half to two-thirds of the effective dose should be continued for at least 4 months. An excellent discussion on therapies helpful for severely depressed suicidal patients may be found in the paper by Lesse (1975). Insofar as prophylaxis is concerned lithium presents promise. Controlled studies have shown that lithium can substantially reduce the long-term morbidity of both unipolar and bipolar disorders. Unipolar patients with endogenous and psychotic features, a family history of depression, and minor disturbance in personality respond well. Prophylactic treatment should be started after 3 episodes in unipolar depression and after the second episode in bipolar depression. Lower lithium plasma levels (0.45-0.6 mEq1) are maintained best to reduce side effects.

Manic Reactions

The immediate objective in manic reactions is to quiet the patient. This is best achieved with neuroleptics, such as chlorpromazine (Thorazine), which must be administered in ample dose (up to 1600 mg daily or more). In wild excitements, intramuscular injections (25-50 mg repeated in an hour if necessary) are indicated, followed by oral administration. (See also Chapter 58 on Emergencies.) Dangerous overactivity may call for electroconvulsive therapy (ECT). This may be given twice daily for 3 or 4 days, followed by a treatment every other day. Following this, Thorazine or other neuroleptics may be substituted. Lithium carbonate (see Chapter 56 on Pharmacotherapy) has been employed with considerable success for recurrent manic states. The most effective treatment for mania is reported by Black et al., (1987) to be ECT. Almost 70 percent of patients who did not respond to lithium had marked improvement with ECT.

Psychotherapy is usually ineffective in most manic conditions. The patient's attention is too easily diverted; acting-out is too unrestrained; emotions are too explosive. Because of this, hypomanic and manic patients are extremely difficult to manage in the office. They will seek to involve the therapist in all of their fantastic plans. They will make demands which, when unfulfilled, will release great hostility or aggression. They will try to overwhelm and dominate those around them, and they may become uncontrollable when their wishes are not gratified.

One of the chief reasons for hospitalizing overexcited manic patients is to prevent them from involving themselves and other people in projects that issue out of their overconfidence. Because they are inclined to be erotic, they must be protected from sexual indiscretions and from a hasty marriage that they may contract on the crest of an ecstatic wave. Another reason for early hospitalization is that some manic cases will go into a state of delirium when they are not treated intensively at the start. These delirious attacks may be fatal if they give rise to exhaustion, dehydration, and hypochloremia. Sedation, tranquilization, and electroconvulsive therapy are most easily administered in a hospital setup.

SCHIZOPHRENIC DISORDERS

(Types and DSM-III-R Codes: Catatonic 295.2X, Disorganized 295.1X, Paranoid 295.3X, Undifferentiated 295.9X, Residual 295.6X)

Schizophrenia, in spite of the massive amount of accumulated data, remains psychiatry's greatest challenge (Bleuler E, 1950; Bleuler M, 1984; Arieti, 1959, 1974; Redlich & Freedman, 1966; Cancro, 1985). The question of whether it is a special disease entity or a unique way of experiencing is still being debated. Although it affects less than 1 percent of the population, its devastating influence on the patients and its cost to society are astronomical. Efforts to understand it along neurophysiological, biochemical, genetic, psychosocial, epidemiological, psychoanalytic, existential, anthropological, cultural, and communicative lines have been heroic. But many aspects of the illness are still unclear. Neither biochemical nor analytic-psychological investigations have brought us closer to its real essence.

While we do not have a complete picture regarding the etiology and pathology of schizophrenia, it is reasonable to assume from all the available evidence that a genetic factor exists. For one thing, the fact that the concordance ratio for schizophrenia is three times greater in monozygotic than in dizygotic twins suggests a hereditary component. But the finding that in 50 to 75 percent of monozygotic twins one member *does not* become schizophrenic when the other twin develops the disease indicates that a genetic deficit is not enough to produce schizophrenia. Non-genetic constitutional factors must also be considered, for example, flaws through damage to the brain during intrauterine life or as a result of birth trauma. In short, while schizophrenia appears to be a genetically determined disease, its phenotypical expression is, at least in part, influenced by life experience.

Among the life experiences that have a destructive impact is the use of the child by the parents as a foil for their own neuroses. When parents are themselves emotionally unstable and mentally confused, they are unable to provide sensible and temperate learnings. The child thus receives training in irrationality, as Lidz (1973) has remarked. Communication patterns are distorted and the child is

exposed to contradictory messages. There is defective gender identity and a crushing of the child's efforts at autonomy. The parents offer poor role models for the child. The consequence of the personality deficits that eventuate out of these conditionings is a deficiency in ways of interpreting reality and of handling and resolving stressful life events.

Of all speculations advanced to account for the outbreak of schizophrenia, the stress hypothesis seems to many to be the most feasible. Postulated here is the idea that stress activates in the schizophrenic individual anomalous biochemical and neurophysiological mechanisms as a result of faulty enzyme action. It is avowed that the end product of this action is hyperactivity of catecholamines, especially dopamine, as well as the release of pathological psychotogenic metabolites, resulting in a disorganization of brain function. Some authorities have also conjectured the existence of increased numbers of dopamine brain receptors to account for dopamine hyperactivity. In some cases, computed tomography shows ventricular enlargement in the brain, which has been correlated with such negative symptoms as emotional flattening, social withdrawal, and lack of energy.

When we search for stress sources that may have precipitated a schizophrenic breakdown we often find it to be environmental events that have a special traumatic meaning for the individual. Perhaps the most powerful sources of stress are disturbed family interactions, and there is ample evidence of difficulties in families of schizophrenic patients. A provocative question is why all members of a family in which there is a schizophrenic member are not affected with schizophrenia. The answer is that there is no such thing as the same environment for all family members, even for identical twins. Some are more protected than others; some are chosen for projective identification by a mother or father; some are scapegoated, or subjected to contradictory demands, or exposed to discriminatively defective communication signals. The consequence is an interference in the character organization, making for conflicts that in themselves become sources of tension. The stresses that impose themselves on the individual therefore are environmental difficulties from without and disturbances from within

(biochemical and cognitive). Such stresses may become critical at certain periods in the developmental cycle (as during adolescence) and when pressures and demands both from without and within exceed the individual's coping capacities.

Many schizophrenic patients were exposed to *selective illogic* in early development, which made for irrational thinking around specific areas. The consequence is that the patient can think seriously about certain subjects and disjointedly about other subjects. He or she can deal better with selected stresses and be completely unable to manage other stresses to which he or she is singularly sensitive.

Among the deficits that emerge from a difficult childhood are an overwhelming sense of helplessness, a defective self-image, and overpowering hostilities. These impulses are handled by defenses organized around different levels of reasonableness. Helplessness may be managed by either a dependent clinging to some magical protective figure or movement, or by denial manifested in compulsive independence. Ambivalence toward objects will make for varied responses to people and be so disturbing to the individual that he or she will become apathetic and detached from people to avoid being rejected, hurt, or completely engulfed in a relationship. A defective self-image gives rise to a host of coping devices, ranging from inferiority feelings on one end to grandiosity on the other. The hostility may be turned outward in sadistic attitudes and aggression, or turned inward in the form of masochistic self-punishment. In part, reactions are the product of a massive biochemical upset set off by stressful stimuli with which the individual cannot cope. Impulses are fed through neurophysiological channels disorganized by these biochemical alterations. This produces changes in the transmission messages in the subcortex, ultimately influencing thought processes. Because of the existing pockets of irrationality, the manifestations of these impulses and the defenses that control them may in cases of extreme distortion become highly and even psychotically symbolized and distorted. Thus dependency may be expressed by feelings of being influenced and manipulated by powerful or protective or malevolent agencies or machines. A devalued self-image may take the form of being accused by voices of emitting

a foul odor or of having changed into an animal. Or it may be neutralized by the defense of a grandiose delusion. Hostility may be acted out directly in terms of paranoidal delusions and of violence toward persecutory enemies. Periods of rationality may alternate with those of irrationality, and the nature of the symbols may vary. When emotional stability is restored, pathological manifestations may temporarily vanish, only to reappear under the further impact of stress.

Most people who are able physiologically to deal with stress are threatened with periodic irrationalities but are able to process these cognitively and to control them without distorting reality. Yet psychotic-like impulses may appear in fantasy or in dreams. Other persons maintain their stability by circumscribing and isolating areas of psychotic or psychotic-like thinking or behavior, for example, by paranoidal ideation which serves as an outlet for hostility. This defense permits them to function and to maintain some adaptive capacity. Still other persons decompensate temporarily under the impact of stress and show overt psychotic behavior from which they rapidly recover (*schizophreniform disorder*). If there is a specific genetic vulnerability, however, the cognitive distortion may be extensive and prolonged, resulting in the syndrome of schizophrenia.

The onset of schizophrenia varies. Often it is insidious, becoming apparent only in late adolescence or in early adult life. The individual shows behavioral changes such as isolation and withdrawal and may drop out of school or quit work. Emotionally the schizophrenic may be unstable and depressed and resort to drugs or alcohol for relief. Unhappy at home, the schizophrenic may run away, seeking out groups of other isolated children or young adults with whom he or she may establish an unstable affinity. Affiliations are shallow, ideation more or less fragmented, the self-image devalued, and the boundaries between reality and fantasy blurred. The expression of needs is chaotic, and often fulfilled only in fantasy. Omnipotent, grandiose, and paranoidal ideas prevail. There is constant moving about as the person seeks some refuge in relationships that eventually are distrusted and abandoned. There is

repeated experimenting with disorganized ways of regaining control, solving problems, bolstering security, and enhancing self-esteem.

Once a genetic vulnerability exists, the individual always is at high risk. The avoidance, removal, or palliation of environmental situations that have a stress potential for the person, the identification and mediation of faulty behaviors through psychotherapy, the building of self-esteem through positive achievements and productive work, the presence of accepting role models with whom the patient can identify, the utilization of support systems where necessary, and the administration of neuroleptics when a breakdown threatens may bring the individual back to his or her customary equilibrium.

The big problem for the therapist at this early stage is that the patient has little or no motivation for treatment. He or she distrusts people and resists any kind of close relationship, the vehicle through which psychotherapy is done. If treatment is attempted, it will take all the tact and resourcefulness a therapist can muster to keep a patient coming for sessions in the face of his or her detachment, suspiciousness, fear, and hostility. The therapist should try to avoid giving commands and orders because the patient will resist them. Nor should any mention be made of the need for or direction of change. Clues as to focus are gathered from what the patient is interested in and wants to deal with. No judgments should be expressed about the patient's behavior or dynamics except when the patient asks. Even then, interpretation must be carefully and reassuringly made. Attempts to alter the patient's attitudes, to plan goals, and to offer suggestions on how best to manage one's personal affairs will usually be resisted. Breaking of and lateness in coming for appointments call for great flexibility in time arrangements. The therapist concentrates on ways of solidifying the relationship with the patient and on introducing some reality into the patient's perceptions of what is happening to him or her. In spite of remedial interventions, the schizophrenic process may proceed to an adaptive breakdown that defies all efforts at resolution. An external precipitating factor may or may not be apparent, but a search for it should be instituted.

Removing the Stress Source: Hospitalization

If the patient's psychosis has been precipitated by an *overwhelming* external traumatic situation, simple environmental manipulation may help, if not suffice, to bring the patient back to his or her pre-psychotic level of adaptation. Most schizophrenic reactions, however, are associated with such great weakness of the ego that the person is unable to withstand even average pressures. There is variation in the degree of stress that can be tolerated. In some, ordinary responsibilities of living and relating to people cannot be mediated. Environmental manipulation may not suffice to restore the patient because he or she senses menace everywhere, even in the most obviously congenial atmosphere. There is faulty information processing.

Fears rooted in past inimical conditionings and damaging conflicts seem to generate anxiety continuously and prevent the ego from emerging from its regressed level. The patient erects a wall of detachment and isolation as a protection from further hurt; it is this wall that interferes so drastically with any attempted therapy.

If the patient feels threatened in his or her present environment in spite of efforts at regulation, if his or her responses constitute a potential source of danger to the patient and others, and if the patient cannot be treated satisfactorily in the existing milieu, temporary hospitalization may be inevitable. The employment of psychotropic drugs and consultation with the patient's family in an effort to get them to be less critical, hostile, demanding, and demonstratively emotional toward the patient may enable the patient to adapt outside of an institutional setting. There will still be acute emergencies, however, for which no other alternative is available than hospitalization, either on the psychiatric ward of a general hospital or in a mental institution.

On the other hand, there are certain disadvantages to hospitalization. The most insidious feature of "institutionalization" is that the patient's tendencies to regress will be reinforced enormously by any lack of stimulation in the hospital. As one of a large group of patients, the individual may lose his or her

identity. The patient becomes dilapidated in appearance and oblivious to customary habit routines. There may be little in the environment to encourage latent desires for growth and development. This unfortunate feature is due, to a large extent, to the overcrowding of institutions and to the lack of enlightenment and education of the personnel. The motives governing an employee's choice in working in an institution may not be those helpful to restoring the patient to active participation in society.

That hospitalization can prove to be a stimulating rather than a retarding influence is illustrated in institutions with a progressive administration and well-trained personnel. Selected occupational therapy and crafts, carefully chosen to meet the patient's interests and aptitudes, can help prevent the abandonment of reality. Exercises, games, entertainment, dancing, music, social affairs, and group discussions can also be of inestimable benefit. When it is practiced in an empathic setting, group therapy of a short-term non-psychoanalytic nature (Parloff, 1986) may be helpful. The benefits of such therapy help convince the patient that he or she is not considered hopeless, in this way building up a feeling of confidence in the therapist and in oneself. It is probable that the old-time Aschner treatment for schizophrenia, with its emphasis on detoxification, stimulation, exercise, baths, sweats, venesection, catharsis, emesis, and hormone therapy, was mostly psychological in effect. At any rate, hospitalization should be regarded as a temporary measure, and the patient should be moved back into the community as soon as possible.

Milieu Therapy

Regulation of the environment so that it is therapeutically constructive, meaning that it provides stress relief and gratifying experiences, is important in treating schizophrenia. Occupational, recreational, and social therapy may be gainfully instituted in a hospital or outpatient setting. The atmosphere of a day-and-night hospital, halfway house, or community rehabilitation or recreational center also lends itself to environmental control and social skills training. A total therapeutic community program (e.g., with a suitable group) may prove rewarding. Settlement in the community and

encouragement to engage in productive work is much better for the patient than assignment to the barren hinterlands of a mental hospital ward.

As part of a milieu therapy program, family therapy and individual psychotherapy with other members of the family may put a halt to many destructive stimuli within the household. Schizophrenia, more and more, is being regarded as a manifestation of family pathology. Relationship distortions are not only with the mother, but also with the father and other significant persons in the family constellation (Wynne et al, 1958; Bowen, 1960; Lidz & Fleck, 1960). The importance of the "double bind" as a basis for schizophrenia has been underscored by Bateson, Jackson, Haley, and Weakland (1956). These authors, describing the family interactions in schizophrenia, contend that the "victim" who succumbs to schizophrenia is exposed to (1) a repetition of prescriptive themes or experiences, (2) conflicting injunctions in relation to these "themes" with threats of punishment for disobedience, and (3) further restricting "commands" that prevent the "victim" from escaping the field of communication.

The "victim" arrives at a perception of his or her life as based on a number of key double-bind interactions with family members. For example, a mother's reaction of hostility to her boy may be concealed by overprotecting him. The child may be aware of this deception, but to retain her love, he cannot communicate this knowledge to her. "The child is punished for discriminating accurately what she is expressing, and he is punished for discriminating inaccurately—he is caught in a double bind." Incongruence between what is said and what is intended is the essence of the faulty communicative process: "…the more a person tries to avoid being governed or governing others, the more helpless he becomes and so governs others by forcing them to take care of him" (Haley, 1959a & b, 1961). Family relationships alternate between overcloseness and overdistance; the members become intrapsychically "fused" so that differentiation of one from the other is often impossible. A psychosis may constitute a mirror image of the patient's unconscious. These factors have focused attention on family therapy as a preferred approach in schizophrenia (Midelfort, 1957; Boszormenyi-Nagy & Framo, 1965). Family

psychotherapy increases the chances of breaking the schizophrenic's communication "code" (Jackson J, 1962).

Psychotherapy

Psychotherapy with schizophrenics is an art that graces few therapists. In the face of the patient's stubborn resistance, suspiciousness, withdrawal tendencies, and inability to communicate appropriately, most therapists are apt to throw their hands up in surrender. Yet there are a few experiences as gratifying to a therapist as providing an empathic bridge to reality for a withdrawn patient. It is difficult to define the qualities a therapist must possess for such a successful eventuality. I once asked Frieda Fromm-Reichmann what she considered the most desirable characteristic for work with schizophrenics. She replied, "Humility, persistence, sensitivity, compassion, and [*she added drolly*] a good deal of masochism." It is only human to respond with frustration at repeated therapeutic efforts that slide off the patient with little or no apparent effect. But I am convinced that when such efforts are sustained, with warmth and sincerity, they ultimately will be rewarded.

In my training as a psychiatrist I spent 13 years of my early career working in a state hospital, principally with schizophrenics. Those were the days before psychotropic drugs, and the only tools available to the therapist (other than wet packs and hydrotherapy) were his or her skills in establishing a meaningful relationship with patients. No matter how severely withdrawn the patients were from external stimuli (and sometimes our catatonic citizens retained their frozen, statue-like behavior for years), it seemed obvious to me that they craved and needed consistent and kindly communication, even though this seemed to register no impact on them. When some of the patients "spontaneously" emerged from their deathlike repose, it astonished me to hear them recount in minutest detail some of the things they had observed going on around them, with virtual playbacks of my one-way conversations with them. They particularly recalled the little kindnesses bestowed upon them by the nursing staff and

myself, which I am now convinced had a more penetrating effect on them than the most mighty of miracle drugs.

Even wild paranoidal individuals seemed to respond to quiet sympathy and lack of retaliation for their abuses. I remember one of the most disturbed patients I had ever encountered, a middle-aged, distraught and disheveled, hallucinating woman, who accosted me the first day I was put in charge of the disturbed ward on which she had been sequestered for more than 10 years. Blood-curdling shrieks and cries for the police came from her at the first sight of me as I walked through the ward protected by a bodyguard of nurses and attendants. She identified me positively as her tormentor—the man who had for years been making indecent proposals to her and who had been sending electrical impulses up her rectum and genitals. It was all my bodyguard could do to keep her from assaulting me.

Despite the daily indignities that she heaped on me, I took pains each day briefly to talk quietly to her, expressing my concern at her upset and assuring her that if there were anything I could do to help her, I would be happy to do it. Her response was stereotyped—anger, vilification, and occasionally expectoration. On one occasion as I left her, she managed to find a flower pot, which she hurled at me, barely missing my head. Slowly, after many months, her response to my consistent reassurances became more attenuated, although she daily repeated her resentment that I had the temerity to persist in talking to her when I was the last person on earth she wanted to see.

And then something dramatic happened. On one occasion I was in a hurry to get ward rounds over with to attend a special meeting, and I breezed through the ward without talking to her. Her reaction was electric. She became more highly disturbed than before, upbraiding the nurses for their neglect in directing me away from her, and accusing me of having no respect for her and her feelings. The next morning, for the first time, I was able to talk to her without fear of bodily harm. We spoke quietly about matter-of-fact subjects, and although she was still psychotic and hallucinating, she spoke calmly and with good sense about many matters, apparently enjoying her exchanges with me. Shortly thereafter, the

patient became ill with lobar pneumonia and was transferred to the acute medical unit. Sick as she was, she refused to allow anyone except myself to treat her. With persuasion, I convinced her that she could trust the regular staff members of the unit. Upon her recovery from pneumonia, she returned to her old building and was transferred to a quiet, open ward.

My final victory occurred when the patient requested that I cut her toenails! Since her admission she had not trusted anyone to get near her feet. Her nails had become thickened like horns, and I had to borrow special shears from the tool shop to do a half-decent job. To my delight and surprise, the patient recovered from her psychosis and was able to leave the hospital. I am not certain what other forces were responsible for the patient's improvement, but I am convinced that the relationship I developed with her was a prime vehicle in bringing her back to a reasonable contact with the world.

The ability to enter into the patient's life and to share his or her anguish and dispair, to refrain from making demands that would ordinarily seem justified, to persist in showing friendship and respect in the face of outrageous and irresponsible behavior may ultimately win out. To carry out this formidable task, a therapist needs to possess a good deal of stamina and an undaunted optimism that the healthy elements in a sick human being will eventually bubble through. Obviously, the average custodial unit and the average therapist are not equipped to render ideal psychotherapeutic care for these vulnerable human beings. Because some therapists can engage effectively with schizophrenics and others cannot, the literature on psychotherapy in schizophrenia is ambivalent. For example, May's 1968 research indicates that psychotherapy had little to offer schizophrenics in comparison with medication. The Massachusetts Mental Health Center study by Grinspoon, Ewalt, and Shader (1972) also cast doubts on the value of psychotherapy. The studies by Rogers et al. (1967) and case reports of Vaillant, Semrad, and Ewalt (1964), Kayton (1975), and McGlashan (1983) are more optimistic. May's research was flawed, however, by the use of only inexperienced therapists and supervisors who were dubious about the use of

psychotherapy with schizophrenics. The other studies could also be criticized for faulty design and controls.

There are many pitfalls in working psychotherapeutically with schizophrenics, not the least of which is provoking and nurturing a hostile dependency that cannot be resolved. Transference is frequently a problem, and if it is not dealt with in the early stages, it may evolve into a disturbing transference neurosis or transference psychosis. No less troublesome are the therapist's irritation and anger at the patient, which is understandable considering the vexations inherent in dealing with the patient's obstinacy, querulousness, uncooperativeness, contentiousness, belligerence, and detachment. Such emotions on the part of the therapist must be controlled. Countertransference mismanaged can interfere with the therapist's objectivity and ability to provide an empathic relationship.

While there may be some advantage to working exclusively with psychotherapy in the few instances when the psychotherapist is especially dedicated and skilled in working with schizophrenics (Laing, 1960, 1967; Arieti, 1974), the vast majority of therapists find antipsychotic drugs most helpful, if not indispensable if a thinking disorder exists. Drugs are capable of keeping many chronic schizophrenics operating so that they can reasonably maintain their responsibilities, of preventing them from regressing to a state of work disability, and of restoring their capacity to communicate. The disadvantages that drugs impose by masking defenses are more than offset in many cases by their ability to make hospitalization unnecessary and to foster better cooperation with the therapist. Nevertheless, one must keep in mind the possibility, of untoward side effects and sequelae such as tardive dyskinesia.

The immediate objective of psychotherapy in schizophrenia is to enhance the adaptive reserves of the patients so that they will be able to come to a rapid equilibrium, to discern their chief sources of stress, and either to help resolve or remove themselves from them as expeditiously as possible. While the schizophrenic's vulnerability will not be eradicated, the patient may be strengthened so that he or she does not shatter so readily upon exposure to stressful stimuli. In extremely uncooperative and withdrawn

patients, behavior therapy, employing operant conditioning, has been used with some success (see Chapter 51). When the patient becomes accessible, formal psychotherapy may begin. Sometimes supportive and reeducative group therapy is utilized adjunctively with individual therapy; at times, it constitutes the sole psychotherapeutic modality.

The key to the treatment of schizophrenia lies in the ability to establish some sort of contact with the patient. Most schizophrenics desperately fear relationships with people and erect various obstacles to any interpersonal threat. The withdrawal from reality and the archaic type of thinking and symbolism enhance the individual's isolation, since there is no common means of communication. Yet, beneath the surface, the patient yearns for a friendly and loving relationship. The patient wards it off, however, because he or she has been injured by past interpersonal contacts. He or she does not wish to encounter further rebuffs. The patient's apathy, detachment, and expressed hostility and aggression are means of protection from the desire for a closer union with people. Establishing rapport with the patient is in line with two objectives: first, to reintegrate the patient in more intimate relationships with people to where he or she can obtain at least partial gratification of personal needs without fear of abandonment or injury and, second, to bring the patient back to the realistic world by proving that reality can be a source of pleasure rather than pain.

The technique of developing rapport varies with the patient. A great deal of activity is essential. In very sick patients whose productions are seemingly irrelevant and incoherent, a careful analysis of the productions will disclose a language that is very meaningful to the patient. The ability to show the patient that his or her words and gestures are understood may be the first constructive step. Sullivan (1931) has stressed the need to communicate understanding of the patient's language and gestures as a means of solidifying the interpersonal relationship. To do this, it may be necessary to talk to the patient on his or her own regressed level. J. M. Rosen (1947, 1962) has interpreted the utterances of the patient in terms of their symbolic meaning and has been able to develop a relationship with some of his patients

through this method. Entering into the psychotic world of the patient, Rosen and his followers attempt to make contact by intensive daylong sessions, overwhelming the patient with direct interpretations of his or her unconscious. How valid these interpretations are may be challenged, but the fact that the patient is showered with attention and is shocked with statements coached in harshly frank and sometimes sexually explicit terms may in a relatively short time bring the patient out of his or her regressed state. This approach has been practiced in foster homes, where the patient is provided with a therapeutic environment throughout the day and night. It is, consequently, an expensive form of therapy and one that can be indulged by a limited clientele. Moreover, follow-up studies are not encouraging.

Employing symbolic objects, Sechehaye (1951) evolved a non-verbal method of communicating with a regressed schizophrenic girl. This was necessary, Sechehaye believed, because the primary trauma occurred before the stage of verbal language. For example, only by realizing that apples symbolized mother's milk was it possible to offer the patient love through drinking "the good milk from Mummy's apples." In ways similar to this, the therapist may gather clues to essential needs and conflicts from the bizarre symbolic thought content, translating it the same way as if it were a dream. Cryptic as these utterances may be, they contain important messages that may well be heeded by the sensitive therapist, who will answer them in ways that indicate to the patient that his or her plaints are recognized and acknowledged.

Using an existential approach as well as family therapy, Laing (1960) and Laing and Esterson (1971) have explored the despair of patients, siding with them against their families and the environment and, in this way, establishing intimate contact. The relationship is utilized as a vehicle for recasting patients' concepts of themselves. The approaches of Harry Stack Sullivan (Mullahy, 1967, 1968), Frieda Fromm-Reichmann (Ballard, 1959), Otto Will (1967, 1970), and Harold Searles (1960, 1966) also make worthwhile reading.

In patients, therapy may consist of nothing more than sitting with them, without prodding them to express themselves. The very fact that the therapist refrains from probing their trends, avoids discussing the causes of their breakdown, and accepts them as they are may help these patients to regard the therapist as a less threatening force than other people. In many cases therapy may consist of working with the patient at occupational projects and playing games, such as cards, checkers or chess. Sometimes a more positive approach is made to the patient by giving him or her food, such as milk, candy, and cake. For a long time it may seem that these gratuities are the only reason that the patient desires to see the therapist. In querying the patient after recovery, however, one becomes convinced that the patient actually had a desire for closeness and was testing the therapist constantly.

Any relationship that the patient is able to establish with the therapist is at first bound to be extremely unstable. The schizophrenic individual feels very vulnerable and helpless. His or her level of frustration tolerance is inordinately low. Schizophrenics are distrustful, suspicious, and inclined to misinterpret the motives of the therapist in accordance with their inner fears and prejudices. They feel incapable of coping with life and resent the intentions of the therapist to return them to reality, which holds unbounded terrors. Schizophrenics fear injury and frustration from people, and it may be months, sometimes years, before they are willing to accept the therapist as a friend. Even then they will sense rejection and neglect in the most casual attitude. Anxiety with a temporary return to regression will interrupt therapy repeatedly, and it must be handled by a consistently reassuring and friendly manner. Violent reactions may punctuate treatment from time to time, especially when the patients sense that liking the therapist will force them to leave the relative security of their reality retreat.

Fromm-Reichmann (1939) has commented on the unpredictable nature of the schizophrenic's relationship to the therapist. A sympathetic, understanding, and skillful handling by the therapist of the relationship is far more important than an intellectual comprehension of the operative dynamics. She

ascribes difficulties in therapy to the fact that the therapist is unable to understand the primitive logic and magical reasoning that governs schizophrenic thinking.

Unless we analyze our own reactions repeatedly, our sense of frustration may arouse strong aggression that will interfere with treatment. It is manifestly impossible to treat any psychotic person if one does not genuinely like him or her. If we are able to regard the actions of the patient as essentially childlike, we shall best be able to understand the patient's outbursts. Cold logic fails miserably in explaining the reactions of the schizophrenic. Despite his or her age, the patient seeks an infantile relationship to the therapist and desires unlimited warmth, understanding, protection, and help. He or she seeks a mothering affiliation rather than a give-and-take encounter between two equals. At the same time, the patient distrusts the therapist and resents his or her own helplessness in seeking nurturing.

The therapist should try to be as sympathetic and reassuring as possible, approaching the patient casually and informally and conveying an interest in him or her and in matters of immediate concern. Sometimes it is desirable to encourage the patient by touching a shoulder or arm as a gesture of friendship. I have found that I have been able to establish a relationship in a remarkably short time by offering to show the patient how to relax his or her tensions, utilizing a simple hypnotic relaxing technique (q.v.). Even frightened patients can be helped, but, obviously, they must be willing to cooperate. The therapist may say, "It's been rather tough on you, and you can't avoid being upset by all that has happened. If you'd like, I can show you how to relax yourself, which should make you feel a lot better." Patients who respond positively are asked to make themselves comfortable in their chair and to shut their eyes while relaxing suggestions are made.

It is important not to cross-examine the patient or subject the patient to questioning. An attitude of acceptance without reserve is best while conveying sincere interest in his or her needs and problems. Sicker patients will usually flood the therapist with their irrational ideas and delusions. One way of handling this situation is to focus as much as possible on matter-of-fact reality items. This is not as

difficult as it sounds, although the therapist must avoid giving the impression of being bored with or disbelieving the patient's irrational concerns.

Probing for conflicts is taboo, as is the lying-down couch position. Only when the patient brings up topics for discussion is it desirable to discuss them, but this should be done in as a matter-of-fact way as possible. This does not mean that depth interpretations are always to be avoided; they may be made once the therapist-patient relationship is solidified and the patient brings up a conflictual topic and shows some awareness of its nature. It may be reassuring to the patient to have a dynamic explanation for some distressing problems. This may relieve the patient of the mystery of what is happening to him or her.

Therapy in schizophrenia must, in summary, be oriented around the immature ego of the patient. The patient's emotional reactions to people, like those of an infant, are unstable and ambivalent. Schizophrenics are easily frustrated and feel rejection without ostensible cause. They are unreasonable and demanding. Their concept of reality is unreliable; they often confuse inner mental processes with outside reality. They may assume that the person on whom they depend is omniscient and will supply their every demand, expressed or unexpressed. They will react with hostility if they are not granted what they believe to be their due. Alone, their egos are so weak that they are unable to tolerate complete responsibility. They need help and support, and yet fear and resist assistance.

Federn (1943) has advised enlisting the aid of a relative or friend, preferably a motherly person who can look after the patient. He stressed that schizophrenics should not be allowed to depend on their own resources. They should at all times be surrounded by an atmosphere of love and warmth. Their stability and strength grow as a result of positive identifications with loved ones. If they are at all able to develop to self-sufficiency, their independence will grow best in the soil of this positive identification. The hope is to bring them to a point where they can function satisfactorily without the aid of a parental figure. In many cases the latter stage of self-sufficiency is never attained, and all one can do is adapt the individual to reasonable social functioning while attached to some kindly person.

The need to surround schizophrenic patients with a favorable atmosphere necessitates work with their families or with people with whom they live. This is essential to relieve the burden induced by demands and responsibilities that the patient imposes on the members. Often the inertia and apathy of the patient stir up resentment on those present, and when the patient is aware of their hostility, he or she may retreat further from reality. Considerable work with the patient's relatives may be required before they are sufficiently aware of the dynamics of the patient's reactions and before they are willing to aid the therapist in the treatment plan.

The chief emphasis in treatment in chronic schizophrenia must be on the creation of a human relationship with the patient that has pleasure values for him or her. Only by this means will the patient relinquish the safety and gratification of regression and, utilizing the relationship with the therapist as a bridge, return to reality. The handling of treatment, however, requires considerable tact. No matter how detached the patient is, he or she is extremely sensitive to everything that the therapist says or does. An avoidance of situations that evoke anxiety in the patient is essential. This is often a very difficult task because the most casual remark may stir up powerful emotions.

The patient may choose to remain silent throughout the treatment hour and will appreciate it if the therapist refrains from challenging refusal to talk. It is expedient with such a mute patient to point out occasionally that perhaps there is abstinence from talking because of a belief that the therapist is interfering or because there is fear of what he or she might say. The patient may feel more at ease with such remarks and may finally break through the silence.

In most cases schizophrenic patients at first will feel alone, helpless, and misunderstood. They resent the intrusion of the therapist into their private lives and believe that the therapist, like everyone else, is unable to understand them. The initial task is to show them that their impulses and wishes are respected and that they are not required to comply with demands that are unreasonable. Usually in all of their previous interviews they have been bombarded with questions about their breakdown, and, even when

they have responded to these questions in a more or less frank manner, they have sensed disapproval. The fact that the therapist accepts them as they are may eventually build up their self-respect and strengthen the desire to return to reality.

Constantly, during treatment, the patient may react with detachment or withdrawal or may subject the therapist to a testing period during which he or she is recalcitrant and hostile. The purpose may be to find out whether the therapist is the kind of person who can be trusted or whether the therapist, like all other people in his or her experience, makes unfair stipulations or react to expressed hostility with counterhostility. The patient may believe that what the therapist demands is that a person be "good." This "goodness" means to the patient that it is urgent to comply with standards that all other people impose. At first he or she will act as if the therapist actually expects unyielding submission to these standards, threatening the patient with rejection or aggression if he or she resists. The testing period may be a trying one for the therapist, since it may continue for many months during which the patient constantly rejects the therapist's friendship. When the patient realizes that the therapist does not expect compliance with certain things, that the therapist sides with the patient against unreasonable demands made by the family, the patient may begin to regard the therapist in a new light.

The beginning of a feeling of closeness can precipitate panic; the patient may try to run away from therapy, or he or she will exhibit aggression toward the therapist. The ability to see the patient through this stage may finally succeed in breaking down the patient's reserve and in establishing for the first time an identification with a person based upon love. There exists within schizophrenics a psychic tug of war between the spontaneous forces of mental health that drive them to seek gratifying relationships with people and the security of their regressed state that harbors them from the imagined dangers of a hostile world. The therapist's attitudes will determine which of these impulses will triumph.

The method of handling the treatment hour is of signal importance. It is best not to cross-examine these patients because they may interpret this as censure. They must be convinced that the therapist does

not want to invade and remove them from their private world, but rather seeks to participate in it with them. This does not mean assuming a cloying sweetness during sessions, because the patient will be able to see through this. It must be expected that the patient's attitudes will be ambivalent. He or she may profess little interest in the interview, yet resent its termination at the designated time. There may be attempts to defy or to provoke the therapist or refuse to cooperate. If the therapist becomes ill and cannot keep an appointment, the patient may react with rage and refuse to continue treatments. If the therapist is unavoidably late for an appointment, peevishness can occur. The patient may resent the therapist's taking any vacation or assigning another person as an assistant. Where customary routines have to be interrupted, it is best to prepare the patient far in advance and, if necessary, to enlist the help of family members with whom the patient has an attachment. If the patient becomes hostile toward the therapist, every attempt must be made to explore why there is suspicion the therapist has failed. Should the patient persist with hostility and insist on seeing another psychotherapist, these wishes should be respected, for it is futile to do any work with a patient while being governed by feelings of resentment.

Once a positive relationship has been established, it is necessary to cherish it carefully. Nothing must jeopardize the relationship. For example, the patient must never be led to feel that cherished delusions are ridiculous. Any fanciful feelings and attitudes must be respected at all times. It is unnecessary to reinforce these attitudes by agreeing with them; but they should be accepted as something that the patient believes in sincerely. It may be impressed on the patient, however, that there might possibly be another explanation for a certain experience than the one that he or she supports. All probing for dynamic material must assiduously be avoided at this point. This is one of the most frequent errors in the handling of psychotic patients. It is also an error to interrogate the patient regarding previous mental upsets.

Because the aim in the psychotic patient at first, at least, is to increase repression, since the ego is already too weak and permits the filtering through of disturbing unconscious material, such techniques

as free association are to be discouraged. Rather, the patient should be enjoined to talk about everyday reality happenings. In general, the past had best be avoided, and the patient may be aided in any expressed desire to regard it as a “bad dream” or something that should be forgotten. Under no circumstances should a positive relationship with the therapist be analyzed. If the patient exhibits inhibitions or phobias, these too should be respected, since they probably have protective values. All resistances the patient uses to repress psychotic material must be reinforced, although the symbolisms employed may sometimes be interpreted to the patient. Unlike the treatment of neurosis, analysis of resistances should be avoided to prevent the release of the unconscious content that will upset the patient more. When the patient brings up delusional material or symptoms and spontaneously talks about the connection with traumatizing circumstances in his or her past, an effort may then be made to explain in uncomplicated terms how these manifestations originated. The rule never to dissolve resistance does not apply to resistances to getting well or to integrating more closely with the therapist and with reality. These impediments should be analyzed and removed if possible. Guilt feelings may be met by reassurance and hostilities dealt with in a manner that does not put responsibility or blame on the patient.

One of the ways in which a positive relationship with the therapist may be used is to try to show the patient that his or her thoughts and ideas often appear to be realistic but that it is necessary always to differentiate between what seems to be real and what actually is real. In the patient’s case, too these may have been confused, even though there is no question of doubt in his or her mind that the two states are identical. An excellent sign of restoration of ego strength is the ability of schizophrenic patients to recognize the irrational nature of their ideas while they were in an upset condition.

While some patients achieve a fairly good grasp of reality and tend to return to their pre-psychotic habitude, and even to tolerate relationships with other people along the lines of the close attachment they establish with the therapist, it may be necessary to continue the treatment process to prevent a relapse. The problems of some patients are kept alive because they harbor bloated ambitions of what they should

accomplish in life. Their grandiose expectations inevitably lead to constant frustration. Under such circumstances it is essential to help the patient modify exorbitant goals through the careful use of the therapeutic relationship. It may be possible, for instance, to convince the patient that it is better to devote his or her life to the attainment of happiness in the immediate present than to strive for things in the unknown future. Character disturbances may exist that make relationships with people fraught with anxiety. An active manipulation of the patient's environment through consultation with interested family may enable the patient to function more comfortably. Attempts should also be made to motivate the patient gradually toward making contacts with other people.

In spite of such corrective measures, hostility, tension, and anxiety may constantly be created by inner cognitive, affective, and autonomic derangements. The intensity of untoward emotions may again tend to shatter the patient's ego. The danger of another schizophrenic collapse may, therefore, be imminent. *It is best here, as mentioned before, not to attempt probing for conflicts until the patient evinces an interest in understanding his or her own problems*. Schizophrenic persons are remarkably intuitive and can grasp the dynamics of their disorder better than most neurotics. This is probably because they live closer to their unconscious and because ego barriers to deep impulses and fears are not so strong. It is for this reason that one must proceed very carefully in analyzing the patient's deepest impulses (Bychowski, 1952; Eisenstein VW, 1952; Fromm-Reichmann, 1952; Bruch, 1964). Haley (1961) has outlined some excellent suggestions for the practical handling of schizophrenics. Other suggestions, namely the use of projective techniques, may be found in the section on the treatment of the borderline patient.

Although the therapist assumes a directive role, it is the patient who is expected to uncover the meaning of ongoing communications (Bruch, 1964). This fact has been stressed by many therapists working with schizophrenics, particularly Sullivan (1962), Fromm-Reichmann (1954), and Lidz and Lidz (1952). In this way the therapist avoids bombarding the patient with useless interpretations or

confronting the patient with a road map of his or her unconscious that will lead the patient nowhere. Inevitably, the relationship between therapist and patient will begin to stir up feelings and impulses that the patient will have to clarify with the help of the therapist. For example, if the patient identifies the therapist with his or her mother, interpreting this may mean little. Exploring in what way the therapist *acts* like a mother may, on the other hand, become meaningful.

The realization of unconscious guilt, hostility, and erotism has a dual effect on the psychic apparatus. On the one hand, it floods the ego with destructive emotion; on the other, by forcing a more realistic cognition, it attempts to liberate the psyche from incessant conflict. In this way the dynamic probing is like a two-edged sword; the ego has to be traumatized by the liberated emotions before it is able to mobilize defenses less destructive to the person than regression. In neurosis and character disorders this may prove helpful. In schizophrenia however defenses are so fragile and ego so weak that it collapses under the impact of emotion before it can adapt itself in a more adequate manner. This is always a danger in psychotic and pre-psychotic conditions. All interpretations must, therefore, be very cautiously applied. Reconstructive techniques should be abandoned if any excitement or great hostility develops, for only when the patient is positively attached to the therapist will it be possible to bear the suffering brought out by a realization of the deeper stirrings within.

Summary of general psychotherapeutic rules in schizophrenia:

1. *Establishing a relationship*.

    a. The initial task is to establish a relationship and not to collect information. Asking the patient if he or she hears voices or believes someone is against him or her is a poor tactic. Nor should the patient be grilled about previous attacks or hospitalizations. The therapist should act attentive and reassuring. Sitting behind a desk is not as good as facing the patient directly. Walking with the patient, having coffee together, and touching the patient occasionally are not contraindicated.

    b. Do not argue, cajole, or try to reason with a delusional or hallucinating patient, no matter how absurd the ideas or fantasies may seem. Not only will the effort be useless, but it

may also convince the patient that you are aligned with the forces of evil against him or her. Listen respectfully to what the patient has to say. If he or she complains about something and if you must make a comment, simply say reassuringly, "This must be upsetting you."

c. If the patient is perturbed or agitated, one may say: "I certainly understand how upset you must feel, If such a thing happened to other people they'd be upset too."

d. If the patient prefers to remain silent, accept this, and do not try to bully or shame the patient into talking.

e. If an upset patient asks you for help in allaying tension or anxiety, you may reassure the patient that you will do everything you can. If the patient is not taking medications, ask if he or she would like to have some medicine to quiet the restlessness. You also may suggest teaching the patient how to relax his or her tensions. If he or she responds positively, utilize relaxing exercises or relaxing hypnosis. This may rapidly expedite the relationship.

f. Give the patient regular sessions, and be sure you keep the appointment times. If you will be late for a session, notify the patient in advance if possible and tell him or her you will make up the lost time. Anticipate the patient's breaking appointments and being tardy. If this happens do not chide the patient—merely say you missed him or her.

g. Bizarre behavior or attitudes may strike the therapist as humorous. To succumb to ridicule or laughter may shatter the chances of a relationship.

2. *The treatment process*. I have found the following 20 suggestions useful in working with schizophrenics:

a. Any activity that can bolster the patient's self-esteem should be supported. This includes the patient's grooming and clothing habits and positive achievements of any kind. These should be talked about and encouraged; the patient should be praised for even slight accomplishments in work, hobbies, and creative activities.

b. The best way to handle delusional or hallucinatory material is to listen respectfully and never ridicule or make light of them. One may even act as if uninterested in the hope of discouraging the frequency of these pathological responses. On the other hand,

reasonable talk should command alert attention and active responses in an effort to reinforce rationality. If the patient is disturbed by what he or she brings up, the therapist may agree that if matters were as the patient reported, anybody would be disturbed. Then the therapist may gently offer an alternative explanation as a possibility, not pressing the point if the patient does not agree.

c. No matter how truculent, neglectful, disrespectful, or hostile the patient acts toward the therapist (even if the patient throws a tantrum), punitive, scolding, or rejecting responses should never be indulged. The patient may be merely testing the therapist. Nor should the therapist encourage any regressive behavior or talk to or treat the patient as if he or she were a child. In other words, irrespective of how "crazy" the patient acts, he or she should be treated with dignity and respect as an adult. After their recovery, many patients talk about how they appreciated the therapist's manner.

d. For a long time direct interpretation may have to be delayed and projective techniques used instead. The therapist may by illustration make comments such as: (to a patient in despair at being rejected) "*Most* people feel hurt if people neglect them"; (to a patient with fantasies of death and killing) "It often happens that when a person feels angry he may imagine that the person he is angry at will hurt him, or will die"; (to a woman who felt her looks repelled men) "I knew a woman once who felt she was so ugly, no man would want her and she would get furious if a man wanted to date her because she believed he was teasing her." These comments illustrate how one does not directly confront the patient with his or her actions, but uses other individuals as examples. The patient may or may not then pick up the implications. If the patient applies what is being said, the interpretations can be made more directly.

e. With paranoidal patients who have fixed delusions, disagreeing with these delusions will put the therapist in the class of all other persons who have tried to argue the patient out of what he or she believes to be true. Thus, a therapeutic relationship may never get started. Yet, to support the patient's delusion completely may not be wise. Here the therapist may give credence to the patient's right to believe what he or she knows to be true and express an interest in all the facts that have led to the patient's conclusions. One should not directly support the patient's conclusions but merely state: "I can understand how facts like these lead you to feel the way you do." For example, a patient felt he was being

pursued by the Mafia, who wanted to steal his business away from him. As evidence, he cited seeing an automobile with New Jersey license plates in the area of his apartment. He was sure he was being watched and followed by New Jersey gangsters who were out to kill him. His complaints to the police and district attorney were greeted with amused disdain. Instead of challenging the patient, I asked him to be sure to keep a diary of all of his daily observations that pointed to his persecutions. At every visit he would bring many sheets of written matter containing detailed rambling "observations," which I would greet as interesting and important and which I promised I would later read in studied detail after our visit. I would then put the material aside and we would talk about his other interests and daily activities, avoiding the psychotic area as much as possible. The volume of the reports gradually dwindled to a single sheet and then stopped altogether, the patient apologizing for his neglect in bringing in this material. With the cessation of his reports he began to concern himself with immediate problems in his daily life and work and soon lost interest in the Mafia delusion.

f. The management of transference reactions will call for fortitude on the part of the therapist. The range of how the patient regards the therapist is great: God, mother, father, sibling, the devil, seducer, lover, persecutor, friend. Dependency reactions must be expected and these release other impulses and defenses such as sexuality, hostility, masochism, devalued self-esteem, and detachment. Different phases of these reactions express themselves at varying times and the patient will try to involve the therapist in his or her schemes. The therapist must resist acting out with the patient and becoming countertransferentially rejecting, seductive, overprotective, or punitive. Yielding to the patient's importunate transferential demands will breed more irrationality. Yet, an honest careful explanation of why it is impossible to fulfill the patient's demands must be given so that the patient does not feel rejected as a person.

g. Expressed hostility will be especially difficult to handle, since it can be like a never-ending spring issuing out of depths that have no bottom. So long as it remains on a verbal level, the therapist may be able to tolerate it, realizing that some of the rage is in the way of a test, some a means of warding off a threatened close relationship with the therapist, some a belated effort to resolve a needed breaking away from the maternal figure, some a rebellious desire to assert and be oneself. We may suspect that the patient retains a ray of hope that the therapist will handle the patient's anger and not respond in

an expected retaliating way that would justify a continued withdrawal. If the therapist can stand this test, feelings of unthreatened love and closeness may bubble through. On the other hand, should rage take the form of expressed violence that does not cease when met by a calm and self-assured manner on the part of the therapist, and by statements that the patient should try not to lose control, it will require firm but kindly and considerate action or physical restraint to protect the patient, the therapist, and others. The patient should later be given an explanation for the preventive action. The therapist here must act in a composed but determined way without giving the impression of retaliating for the patient's behavior. One way of diluting transference reactions is by involving the patient in some group activity—a hobby, social group, or therapeutic group.

h. If there is no desire to work intensively with the patient (which will happen in a majority of psychotic patients), visits are gradually lessened in 12. frequency once improvement is stabilized but never discontinued completely. Rather, the patient is given the option of seeing the therapist once in two weeks, then once a month, and then at longer intervals.

i. False promises should never be made to a patient because they will inevitably be broken and with this the therapeutic relationship may terminate. Nor should deception be utilized as a way of escaping a difficult situation because here too the patient somehow will divine the deceit. Sometimes it is necessary to withhold the true facts temporarily from the patient since the patient may not be prepared to deal with them but may be able to handle them later when his or her ego gets stronger. Whatever explanations or interpretations are given the patient, these should be coached in frank but reassuringly optimistic terms.

j. Whether to engage in deeper insight therapy is a decision one must reach after working with the patient for a long period, seeing how he or she handles interpretations and observing the buildup of ego strengths. Schizophrenics live close to their unconscious and are often first in arriving at insights themselves. Whether such insights can help the patient is another matter. When stress becomes too strong, the patient will collapse, insight or no insight.

k. The greatest use of therapy is to increase the patient's stress tolerance, and this means doing a careful assay of current and future stressors, preparing and helping the patient to

cope with them. Behavior therapy can be of great value when properly employed (Agras, 1967).

l. Avoid language the patient cannot understand. If possible, use the dialect of the patient.

m. Point out in a non-accusatory and non-judgmental way patterns the patient exploits that can prove harmful and that tend to make others withdraw. The message should be given in as reassuring a manner as possible, reflecting the therapist's confidence in the patient's ability to change.

n. Avoid interpreting the dynamics of the patient's symptoms. Without a firm working relationship with the patient and evidences of his or her trust, this will be counterproductive. Do not belittle or ridicule the patient's delusions, no matter how foolish they may seem.

o. Do not take notes while with the patient. This will enhance suspiciousness, especially if there is some paranoidal tendency. Notes can be made after the patient leaves.

p. Credit the patient's disturbed behavior, if he or she shows it, to the fact that he or she is being frightened and upset and not to the fact that the patient is a difficult violent person. The patient may be responding to the environment as dangerous and will need reassurance and support, not condemnation.

q. Before prescribing medications, explain why drugs are useful in quieting a person down, helping one sleep, and so on.

r. As soon as the patient's symptoms subside, reduce medications to as low a level as will control symptoms. When the relationship becomes firm, the medications may even be discontinued. If symptoms reappear, drug dosage may be increased.

s. Start family therapy as soon as the patient quiets down, building a relationship with the family and counseling them as to steps each member can take to improve communication. Establish a contact with the most stable family member, who will act as a liaison. Instruct this member when to increase medications. Invite this member to telephone you if problems occur.

t. There is no reason why patients cannot be taught to medicate themselves when they feel their equilibrium threatened. Having the proper medications on hand and utilizing such medications to quiet and stabilize oneself can often nip a psychotic break in the bud.

u. Flexibility in approach is the keynote of good therapy with schizophrenics.

General rules such as I have cited here are useful but they will have to be adapted to each patient and modified according to individual reactions. Similarly, the use of aftercare services will depend on what special needs each patient has and the availability of services in the community in which the patient lives.

Somatic Therapy

The introduction of neuroleptics has introduced a new and more hopeful outlook in the therapy of many schizophrenics. Phenothiazines (e.g., Thorazine, Mellaril, Prolixin), butyrophenones (e.g., Haldol), thioxanthenes (e.g., Navane), and dihydroindolones (e.g., Moban) in proper dosage may, when indicated, rapidly resolve psychotic states and render the individual more accessible to social demands. (The choice and dosage of neuroleptics have been outlined extensively in the section on Pharmacotherapy in Chapter 56).

Useful as they have proven to be, neuroleptics unfortunately have their drawbacks since, apart from the side effects and serious sequelae (e.g., tardive dyskinesia) with prolonged employment, they tend to discourage the application of psychologically based therapies. Too frequently, young people suffering an initial psychotic break are saturated with massive amounts of drugs, which, while restoring homeostasis, prevent them from integrating the significance of the psychotic experience, which may, with the help of an empathic therapist, have a beneficial impact on their future development. This in no way minimizes the value of the neuroleptics, but it does necessitate some restraint in their use. With rare exceptions in the initial stages of therapy, patients with acute schizophrenia manifesting thought disorders will need neuroleptics. Once the patient's symptoms are brought under control and environmental stress factors regulated, the patient should be slowly taken off drugs but rehabilitative and psychosocial therapies

continued. Should the patient decompensate again, medications may be resumed, although a considerable number of patients can be managed solely with counseling, milieu therapy, group therapy, family therapy, and other psychosocial treatments. Only if stress factors in the environment cannot be controlled satisfactorily or the stress from internal sources is unmanageable will the patient require prophylactic drug therapy. If neuroleptics are resorted to after the acute phase is over, interruptions of drug intake with drug holidays are in order. While the utilization of insulin coma therapy has practically disappeared, some authorities still believe it has a utility in younger patients who have been ill for less than 6 months. Electroconvulsive therapy is also considered to be helpful under certain conditions, such as when a severe depression develops during a schizophrenic episode.

Aftercare

The aftercare of hospitalized schizophrenic patients constitutes a serious problem because of the large numbers of such persons in the community as a consequence of deinstitutionalization and the high rate of relapse. Good facilities for aftercare rehabilitative services are lacking in most communities. Those that are available provide the patient with an important means of retarding relapse because of the many modalities offered and the opportunities for patients to establish relationships with a case manager and rehabilitation counselor. If organized services are not available, some patients are able to take advantage of self-help groups such as Recovery, Inc., and Schizophrenics Anonymous. Different therapies are required at different stages of a schizophrenic illness. The proper choice of interventions can best be assured in an organized outpatient setting. Long-term social, behavioral, and problem-solving groups are of special importance, Additionally, social skills training, psychoeducation, supervision of maintenance drugs, resocialization techniques, work adjustment counseling, family therapy, and a variety of other activities geared to the special needs of patients can help many attain stability and lead more rewarding lives. We have seen this happen repeatedly in the Social Rehabilitation Clinic of the Postgraduate Center for Mental Health. What is outstandingly absent are residential facilities where patients without families and those whose homes are too riddled with

stressors can be securely housed. But what is even more confounding is that those patients who most need rehabilitation services do not seek them for many personal reasons, including fear of new strange surroundings and of being sent back to a mental institution.

Chronically ill patients, especially when they are hospitalized for a long period and then deinstitutionalized, lose their independent living and practical problem-solving skills, so essential for adaptation. Rehabilitative procedures designed to equip the individual to live independently and cooperatively in the community are important and pitifully lacking in programs of deinstitutionalization.

Examples of how chronic mentally disabled patients may be trained in community living skills have been described in the literature (Hersen & Bellack, 1976; Trower et al, 1978; Wallace et al, 1980). More recently, Wallace et al. (1985) have detailed a program organized into 10 modules designed to teach conversational skills, vocational rehabilitation, medication management, self-care and grooming, personal recordkeeping, how to find and maintain housing, leisure/recreational skills, food preparation, use of public transportation, and money management. How to obtain the necessary resources to implement the skills taught in each module is also included in the training, as well as how to adapt oneself to unexpected or unsatisfactory outcomes for the performance of the different community survival skills and problem solving under various contingencies. Such a program calls for staff who are empathic, resourceful, and capable of tolerating small increments of progress with difficult clients who are confronted with unique personal, environmental, motivational, and other deficits. The use of role playing, modeling, rehearsal, feedback, reinforcement, and homework assignments must regularly be employed as part of the training in social and independent living skills.

Some therapists believe that work rehabilitation is “more powerful than drugs, psychotherapy, social therapy or any other kind of intervention” (Greenblatt, 1983). The vital role of sheltered workshop programs in the rehabilitation of the mentally ill has been amply demonstrated (Black & Kase, 1986). Though a sheltered workshop is a valuable modality, we must realize that some patients will probably

never be able to return to a normal competitive work role. Short-term hospitalization should be available should this be necessary. The psychiatric unit in a general hospital is adequate for this purpose. Psychotherapy on some level, ranging from supportive to behavioral, will be most effective if the above priorities are adequately fulfilled.

The use of maintenance medications as a routine procedure in aftercare has undergone challenge in recent years (Marder & May, 1986). Neuroleptics, once regarded as the greatest advance in the treatment of schizophrenia, have now become more conservatively evaluated in aftercare programs. They have not altered the long-term outlook of the disease; some patients do refuse to take the medications; some fail to respond to them; and there are side effects, some of which may be permanently disabling (e.g., tardive dyskinesia). All in all, neuroleptics are more carefully and selectively employed; acute active symptomatology such as excitement, for example, (hallucinations and delusions) responds best to drugs. On the other hand, their influence on symptoms such as withdrawal, apathy, and anhedonia is minimal. Prescribed prudently, drugs are an important asset, especially in patients with a poor prognosis whose ability to adapt to a stressful environment is enhanced through a regulated drug maintenance program. Contrarily, for patients with a good prognosis, neuroleptics may be detrimental. One of the problems produced by long-term maintenance neuroleptic therapy in aftercare is that the sensitivity of the dopamine receptors is so increased that any withdrawal of the drug causes a rebound of symptoms. On the whole, good psychosocial treatment is still the preferred approach in the average case of chronic schizophrenia. Psychosocial treatments operate under a handicap if the environment is irreparably stressful, and in this case one may be forced to employ supplementary drug maintenance to avoid a critical psychotic break.

A compromise solution for the maintenance drug dilemma considers that patients who have recovered from an attack of schizophrenia be withdrawn from medications and then watched carefully for symptoms of relapse, which may be detected at least for a week before the break occurs. These

consist of tension, loss of appetite, problems in concentrating and sleeping, withdrawal tendencies, and depression. If these symptoms appear, appropriate pharmacotherapy is immediately instituted along with psychosocial treatment and family therapy, the intensity of such interventions being titrated to the seriousness of the patient's condition. In many cases the relapse may be aborted by these measures (Herz et al, 1982; JAMA, 1984).

In some patients continuing external or internal stress will put the individual on the brink of a relapse. In these cases, maintenance drug therapy will be needed. Some patients spontaneously take medications or increase the dose when their tensions increase or when they feel reality slipping away. But most patients will go off drugs if they are not closely supervised. Cooperation of the family is necessary to ensure that the patient takes the medications. Periodic visits to an outpatient clinic may help the patient maintain the proper drug balances and arrange for drug holidays.

One of the great problems in aftercare is that the schizophrenic is so often used as a foil to hold his or her parents or the rest of the family together. Even when a patient has been removed from a home where there is highly expressed emotion or continuing criticism, the family will not let go. As long as a vehicle for projection exists in the form of a sick child or young adult, hostility and other disturbed feelings are focused on the assigned target and disguised by overconcern. The patient's illness becomes a valuable investment, and signs of recovery threaten the tenuous family balance. A sabotage of treatment may then be expected. Under such circumstances it is vital to get the parents or the entire family into couples, family, or individual treatment to safeguard the patient's treatment. The combination of family treatment and medication has been shown to lower the relapse rate greatly (Hogarty et al, 1986).

Rehospitalization

Rehospitalization for severe psychotic disorganization may be mandatory not only to provide the patient with an atmosphere of protection and to dispense therapeutic measures, but to get the patient

away from the family and other environmental stressors that may have initiated the relapse and tend to sustain it.

More and more patients are being admitted for treatment of acute attacks to selected wards of a general hospital rather than to mental institutions. To an extent this is due to the regulations governing compensation by insurance companies and other third-party payment resources. It is due also to the growing de-emphasis on institutionalization in mental hospitals. One disadvantage is that payments for hospitalization may be restricted to a limited number of days. This encourages massive tranquilization to bring the patient speedily out of the psychotic state, resulting in discharge before the patient has had an opportunity to establish a relationship with a therapist who may carry on treatment in the post-hospital period. What is sorely needed are units strong on psychosocial treatment in which the patient can live for 5 or 6 weeks. This provides the patient with sufficient time to work through his or her experience, in part at least, and to consolidate a continuing therapeutic plan.

To prevent another relapse as much as possible, the home to which the patient returns must be relatively free from stress. If members of the patient's family continue to be hostile, unconcerned, or disturbed, the chances of a further relapse are great. Under such conditions, the patient, if possible, should be housed elsewhere. If this is not feasible, provision should be made to get the patient out of the house, to a day hospital or rehabilitation unit, for instance, for a good part of the day. Maintenance drug therapy is more essential for these patients than for those whose families are loving and understanding. In either instance, psychosocial treatment is important.

Continued hospitalization over a long-term period may be required for certain patients and is preferable to depositing those lacking in social skills in a furnished room where they will languish in psychotic isolation, refusing to participate in social rehabilitation programs on an outpatient basis and, if they are on maintenance drugs, eventually giving them up.

Prognosis for Schizophrenia

Among patients discharged to families with high degrees of emotion, we can expect a rate of relapse of about 68 percent within the first year of discharge. Maintenance drug therapy will cut this high relapse rate to about 41 percent. A controlled study by Hogarty et al. (1986) has shown that adding psychoeducation and other family-oriented treatments for families, as well as social skills training for patients, lowers this figure to 20 percent. In households where the high degree of emotion has been reduced, the relapse rate has been brought down to negligible percentages. Beyond the first year, the relapse rate rises even among treated patients and families, probably because many schizophrenic patients have psychobiological deficits in dealing with what would be ordinary life experiences for those not affected by the disorder. Internal stress factors include faulty information processing and inherent affective and autonomic dysregulations that over a period of time can override maintenance drug and psychosocial therapies, although the latter interventions may, as indicated above, reduce the relapse rate.

The outlook for chronic schizophrenics is not nearly as gloomy as it was once believed to be. In Third World countries, where schizophrenics are more socially accepted in the community and family and where they do not suffer rejection, discrimination, and degradation for manifesting their symptoms, the illness runs a relatively benign course. In Western industrial countries, however, patients do not have opportunities for appropriate work, social acceptance, or means of improving their status or integrating into community life. These deficiencies tend to interfere with emergence from the psychotic illness and to promote retreat from relationships so characteristic of this group of patients (Warner, 1985). But even in the United States, long-term studies have shown that many patients released from institutions somehow, after years have gone by, adjust to the outside world and even do productive work, marry, and have children. A 30-year longitudinal study by a group of researchers from Yale University and the University of Vermont have shown that “one-half to two-thirds of 82 subjects released from a State mental hospital and rehabilitation program in the mid-1950’s now live in the community, care for themselves, act as productive citizens involved with their families and friends, and show few or no signs

of schizophrenia" (*Psychiatric News*, 1985). Other long-term studies of 1400 schizophrenics observed over two decades have revealed that more than half are significantly improved or recovered. This argues for a change in our traditional pessimistic attitude about chronic schizophrenia toward a more favorable outlook.

Psychosurgery

Psychosurgery has been prescribed with variable results for seriously ill schizophrenic patients who have failed to show improvement after 2 or 3 years on psychotropic drugs and psychotherapy. This form of treatment is said to yield the best results where the pre-psychotic personality was fairly well integrated, there is no emotional deterioration, and the patient's current symptoms include tension, restlessness, motor activity, combativeness, and destructiveness. Catatonic and paranoid reactions respond best; hebephrenic reactions poorly. After schizophrenia has existed for 10 years or more, psychosurgery is rarely of value. (See the section on Psychosurgery in Somatic Therapy.)

MISCELLANEOUS PSYCHOTIC REACTIONS

A number of other categories of psychotic disorder are included in DSM-III-R Codes: *schizophreniform disorder* (295.40), *brief reactive psychosis* (298.90), *atypical psychosis* (298.90), *schizoaffective disorder* (295.70), and *induced psychotic disorder* (297.30). There are also a number of organic mental disorders in the form of dementias arising in the senium and presenium, as well as a host of psychoactive substance-induced organic mental disorders, and those associated with physical disorders or conditions.

In *schizophreniform disorder* the duration of the illness is less than 6 months; there is a rapid onset and a high degree of confusion and emotional turmoil, but there is also a good likelihood of recovery to pre-morbid functioning. A *brief reactive psychosis* must be differentiated from schizophrenia. Here the psychosis follows a strong stressful environmental stimulus and there is recovery within 2 weeks. If no

such psychological stress has occurred and there is still a psychosis (disturbed behavior, hallucinations, delusions, associational disorganization, etc.) that disappears in less than 2 weeks, the diagnosis of *atypical psychosis* is often given. The diagnosis of *schizoaffective disorder* is more difficult to make since it is a wastebasket for combinations of affective and schizophrenic symptomatology in the form of mood-incongruent psychotic features that do not fit into any of the other categories.

Induced psychotic disorder occurs when a dominant psychotic person, the primary patient, influences others in the family to display the same delusional beliefs. One form of this disorder is *folie a deux* involving two persons. The intensity of the psychotic symptoms in these conditions may necessitate hospitalization during which antipsychotic drugs are administered. In schizoaffective disorder antidepressants and lithium may additionally be needed and, if medications are ineffective, occasionally ECT.

Symptoms of psychosis may occur with various organic brain diseases of neurological origin or as a toxic effect of drugs (alcohol, hallucinogens, etc.). Among the most common of these neurologically based disorders is primary degenerative dementia, especially Alzheimer's and Pick's diseases, which are characterized by progressive deterioration of intellectual, social, and occupational functioning.
Multi-infarct dementia presents similar symptoms, combined with focal neurological disease and cerebrovascular residues. Impulsiveness, poor judgment, memory loss, and personality problems create difficulties for the patient and those around the patient. A variety of other organic brain syndromes may be seen in which the symptoms are delirium and dementia, clouding of consciousness, disturbances in psychomotor activity, memory impairment, aphasia, and other disturbances of the higher cortical functions. Persistent delusions and hallucinations, appearing in a normal state of consciousness, may also develop as a consequence of organic illness and are diagnosed according to the symptoms (organic delusional syndrome, organic hallucinosis, organic personality syndrome). Management of these conditions depends on the symptoms. Restlessness and uncontrollable hostility may be helped by

Thorazine or Mellaril (10-50 mg or more in divided doses). Sometimes a beta-adrenergic blocker like Inderal (60 mg daily) or an antidepressant like Desyrel (200-400 mg daily) may be found useful. Delirious overactivity, confusion, agitation, and paranoidal excitement call for antipsychotics (Haldol, 5 mg, or Navane, 4 mg, intramuscularly) repeated as needed. Cogentin (1-2 mg) intramuscularly to offset extrapyramidal complications is sometimes coordinately given as a precautionary measure. Intravenous benzodiazepines (Valium, 10 mg; or Librium, 50 mg; or Ativan, 2 mg) repeated every 2 hours until symptoms are under control are often preferred as an alternative. When the delirium has abated, oral medications may be employed. A search for causes of both delirium and dementia is imperative, and, when found, specific and non-specific therapies should be instituted. Supportive and directive psychotherapy may be required, bolstered by antianxiety, antipsychotic, and antidepressive medications as needed. Needless to say, family counseling will usually be adjunctively required.