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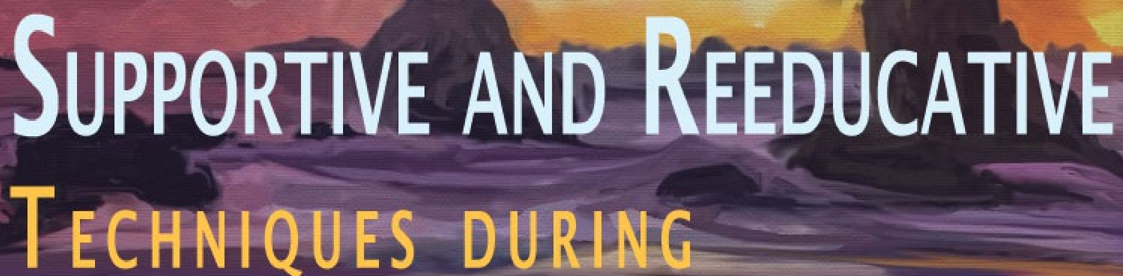

SUPPORTIVE AND REEDUCATIVE TECHNIQUES DURING MIDDLE TREATMENT PHASE

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Supportive and Reeducative Techniques during Middle Treatment Phase

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Supportive and Reeducative Techniques during Middle Treatment Phase

With the accent on cost-effectiveness demanded by third party payers, short-term therapy has been coming into prominence, and this has tilted the scales toward goals of symptom control and problem-solving. These necessitate supportive and reeducative interventions. There are still a substantial number of therapists who believe methods aimed at symptom control, while rapidly palliating suffering and perhaps even reinstating the previous psychological equilibrium, operate like a two-edged sword. Justifiable as symptom control may seem, these skeptics insist that it fails to resolve the *underlying* problems and difficulties that nurture the current crisis. Irreconcilable unconscious needs and conflicts continue to press for fulfillment, and, therefore, they insist, we may anticipate a recrudescence or substitution of symptoms. These assumptions are based on an erroneous closed-symptom theory of personality dynamics. Symptoms once removed may actually result in productive feedback that may remove barriers to constructive shifts within the personality system itself. Even though these facts have been known for years (Alexander, F, 1944; Alexander et al, 1946; Avnet, 1962; Wolberg, LR, 1965; Marmor, 1971) and have been corroborated in the therapeutic results brought about by active psychotherapeutic methods, the time-honored credo branding symptom removal as worthless persists and feeds lack of enthusiasm for symptom-oriented techniques. The supportive process, however, may become more than palliative where, as a result of the relationship with the helping agency, the person gains strength and freedom from tension, and substitutes for maladaptive attitudes and patterns those that enable one to deal productively with environmental pressures and internal conflicts. This change, brought about most effectively through the instrumentality of a relationship either with a trained professional in individual therapy or with group members and the leader in group therapy, may come about also as a result of spontaneous relearning in any helping situation. Some dependency is, of course, inevitable in this kind of a therapeutic interaction, the adequate handling of which constitutes the difference between the success or failure of the therapeutic relationship in scoring a true psychotherapeutic effect. Dependency of this kind, however, can be managed therapeutically and constitutes a problem only in patients who feel within themselves a pathological sense of helplessness. The sicker and more immature the patient, the stronger the dependency is apt to be. It is essential that

the helping agency be able to accept the patient's dependency without resentment, grading the degree of support that is extended and the responsibilities imposed on the patient in accordance with the strength of the patient's defenses.

The evidence is thus overwhelming that symptom-oriented therapy does not necessarily circumscribe the goal. The active therapist still has a responsibility to resolve as much of the patient's residual personality difficulties as is possible within the confines of the available time, the existing motivations of the patient, and the basic ego strengths that may be relied on to sustain new and better defenses. It is true that most patients who apply for help only when a crisis cripples their adaptation are motivated merely to return to the dubiously happy days of their neurotic homeostasis. Motivation, however, can be changed if the therapist clearly demonstrates to the patient what really went on behind the scenes of the crisis that were responsible for the upset.

Supportive approaches are employed during the middle phases of treatment under the following conditions:

As a Principal Form of Therapy

1. Where the patient possesses a fairly well-integrated personality but has temporarily collapsed under severe stress, a short period of palliative psychotherapy may suffice to restore the habitual stability. Supportive techniques may also be efficacious where the problem has not yet been structuralized, as in behavior disorders in children. Actually, supportive therapy under these circumstances may be the treatment of choice in a sizable number of patients who consult a psychotherapist.

2. Patients who require more intensive psychotherapy, but are temporarily too ill to utilize reconstructive therapy, may benefit from supportive approaches as an interim measure.

3. Supportive therapy is often mandatory in patients whose symptoms interfere drastically with proper functioning or constitute sources of danger to themselves and to others. Among such symptoms are severe depression, suicidal impulses, homicidal or destructive tendencies, panic reactions, compulsive acting-out of perverse sexual strivings, severe alcoholism, drug addiction, and disabling physical symptoms of psychologic origin.

4. Where motivation for extensive therapeutic goals is lacking in patients who seek no more than symptom relief or problem-solving, supportive treatment may prove sufficient. After

such partial goals have been achieved, it may be possible to motivate the patient to work toward reconstructive goals.

5. Where the personality has been severely damaged during the formative years so that there is little on which to build, the objective may be to stabilize the individual through supportive measures. Some patients with severe infantile, dependent personality disorders, and with borderline and psychotic reactions, may be unable to tolerate the anxieties of exploration and challenge.

6. Supportive treatment may be indicated where the available time and finances are limited, or where there is extreme character rigidity, or where the personality is so constituted that the patient can respond only to commanding authoritative injunctions. Even though manifest neurotic difficulties continue in force following therapy, life may become more tolerable and the individual may adopt a more constructive attitude toward reality.

As an Adjunctive Form of Treatment during Reeducative and Reconstructive Therapy

1. Where the coping resources of the ego are failing, as evidenced in feelings of extreme helplessness, severe depression, intense anxiety, and disabling psychosomatic symptoms, extension of support is usually necessary.

2. In cases where the environment is grossly disturbed so as to impede progress, supportive techniques like environmental manipulation may be required.

MODE OF ACTION OF SUPPORTIVE THERAPY

Supportive therapy owes its efficacy to a number of factors:

1. A correction or modification of a disturbed environment or other stress source may serve to strengthen coping resources.

2. The improvement that results may permit the individual to exact gratifications essential to one's well-being.

3. The patient may fulfill, in the supportive relationship with the therapist, important interpersonal needs, the deprivation of which has created tension. The supplying of emotional needs in the relationship constitutes what is sometimes known as *transference cure.* For instance, the patient, feeling helpless, may desire the protection and security of a stronger individual on whom one may become dependent. Finding this with the therapist, the patient feels the comfort akin to a child who is being cared for by

a loving and powerful parental agency. The patient is thus relieved of responsibility and filled with a sense of comfort and security. Reinforcing these effects are the influences of the placebo element and of suggestion.

4. In the medium of the therapeutic relationship, the patient may verbalize freely and gain a cathartic release for fears, guilt feelings, damaging memories, and misconceptions that have been suppressed or repressed, having no opportunity for such discharge in the customary life setting. The draining off of tension, which has been converted into symptoms, brings about relief and usually a temporary abatement of symptomatic complaints.

5. The patient may rebuild shattered old defenses or erect new ones that serve to repress more effectively offending conflicts. Supportive therapy is suppressive in nature, helping to keep conflicts from awareness or modifying attitudes toward the elements of conflict.

6. Under the protective aegis of the therapist, the patient is enabled to face and to master life problems that were hitherto baffling. Greater capacity to deal with these problems not only helps to rectify current sources of stress, but also gives the patient confidence in the ability to adjust to other difficult aspects of the environment. The resultant expansion of security may eliminate the patient's need to exploit inadequate defense mechanisms.

7. There may be alleviation of guilt and fear through reassurance or through prohibitions and restrictions, which, imposed by the therapist, are interpreted as necessary disciplines by the patient.

8. Certain measures, like drugs and relaxing exercises, may remove tension or moderate its effects.

9. An outlet for excessive energy and tension may be supplied through prescribed physical exercises, hobbies, recreations, and occupational therapy.

THE THERAPIST-PATIENT RELATIONSHIP IN SUPPORTIVE THERAPY

The different techniques employed in supportive therapy presuppose a relationship of therapist to patient that varies from strong directiveness to a more passive permissiveness. In most cases the therapist is essentially authoritarian.

Success in treatment usually is contingent on acceptance of the therapist as a wise or benevolent authority. A consistent effort is made to establish and maintain a congenial atmosphere. Because hostile

attitudes oppose the incorporation of therapeutic suggestions, it is essential to try to avoid a negative transference. An attempt is made to win the patient over to a conviction that the therapist is a helpful friend. Whenever the patient manifests attitudes that interfere with the relationship, therapy is focused on discussion and clarification in the attempt to restore the original rapport. Much skill may be required to halt negative feelings as soon as they start developing; but unless this is done, the therapist may encounter resistance that cannot be controlled.

Forcefulness of personality, and an ability to inspire confidence are important qualities in the therapist for this type of therapy. The ideal attitude toward the patient is sympathetic, kindly, but firm. The most successful therapists never derive sadistic pleasure from the patient's submission nor resent the latter's display of aggression or hostility. They do not succumb to blandishments of praise or admiration. A non-condemning, accepting attitude, shorn of blame or contempt, secures best results.

The neurotic patient may, of course, display provocative impulses and attitudes; but if the therapist is incapable of controlling his or her resentment, this practitioner will probably be unable to do productive work with the patient. The irritation cannot usually be concealed by a judicious choice of words.

The attitudes of the therapist are important because some of the patient's responses have been conditioned by antagonistic reactions of other people. At the start of therapy the patient will expect similar displays from the therapist, especially rejection or condemnation. When such responses do not appear even under badgering, the patient's attitude toward the therapist hopefully will change. Different from how he or she acts in other relationships, the patient may begin to feel accepted as is, and genuine warmth toward the therapist may begin to trickle through. The patient may then recognize the therapist as an ally with whom one can identify and whose values one may respect.

There are therapists who attempt, in a supportive framework, to deal boldly with pathogenic conflicts by manipulating the therapeutic relationship. Here they deliberately play a role with their patients in order to reinforce or subdue the parental image or to introduce themselves as idealized parental substitutes. Transference responses are deliberately cultivated by employing permissiveness or by enforcing prohibitions graded to a desire effect. Acting a "good" parental figure is considered helpful

with patients who need an accepting "giving" situation. Deprived in childhood of an understanding maternal relationship, certain patients are presumed to require a "living through" with another human being of an experience in which they are protected and loved without stint. Another role assumed by the therapist is that of a commanding, stern authoritarian figure. This is believed to be helpful in patients whose superegos are relatively undeveloped, who still demand control and discipline from the outside.

Sometimes role playing is arranged so that it simulates early patterns of parents, on the theory that it is essential for the patient to live through with the therapist emotional incidents identical in type with the traumatizing experiences of childhood. Only by dramatizing one's problems, it is alleged, can the patient be prodded out of the rigid and circumscribed patterns through which one avoids coming to grips with life. In order to mobilize activity and to release inner drives, the therapist attempts to create a relationship that is charged with tension. The ensuing struggle between patient and therapist is said to catalyze the breaking down of the neurosis.

One may rightfully criticize this technique on the grounds that the patient may actually experience too much frustration as a direct result of the therapeutic situation. The tension and hostility that are mobilized may eventually become sufficiently strong to break through repression, with an acting-out of impulses that are destructive to the patient and to the therapeutic relationship.

A misdirected positive use of role playing is also to be impugned. Even though open demonstrations of affection may seem logical in making the patient feel loved and lovable, such gestures are usually ineffective because of the patient's ambivalence. Love is so fused with hate that the patient may completely misinterpret affectionate tokens. This does not mean that the therapist must be cold and withdrawn, for a refrigerated attitude will even more drastically reinforce the patient's feelings of rejection.

Manipulations of the relationship call for a great deal of skill and stamina on the part of the therapist. They are responded to best by relatively healthy persons. Borderline patients, schizophrenics, paranoiacs, and profoundly dependent individuals may react badly to such active gestures, and perceptive patients easily see through the play acting as not genuine.

GUIDANCE

In the supportive technique of guidance the therapist acts as a mentor, helping the patient to evolve better ways of adjusting to the reality situation. Therapeutic interviews are focused around immediate situational problems. While the therapist may formulate an hypothesis of the operative dynamics, this is not interpreted to the patient unless the dynamics are clearly manifest and the interpretation stands a chance of being accepted by the patient without too great resistance. The employment of guidance requires that the therapist encourage the patient toward a better understanding and evaluation of the reality situation, toward a recognition of measures that will correct the patient's difficulty, and toward the taking of active steps in effectuating a proposed plan. The patient is usually required to make the choices, although the therapist may clarify issues, outline the problem more succinctly, present operational possibilities, suggest available resources, and prompt the patient to action. Reassurance is utilized in proportion to the existing need, while as much responsibility is put on the patient as one can take.

Guidance suggestions must always be made in such a manner that the patients accept them as the most expedient and logical course of action. It may be essential to spend some time explaining the rationale of a tendered plan until the patients develop a conviction that they really wish to execute it. In this choice the patients should always be led to feel that their wishes and resistances will be respected by the therapist.

There are, however, a few patients whose personalities are so constituted that they resent a kindly and understanding authority. Rather they are inclined to demand a scolding and commanding attitude without which they seem lost. Such patients appear to need punitive reinforcement of their conscience out of fear of yielding to inner impulses over which they have little control. At the start of therapy it may sometimes be tempting to respect the needs and demand of such personalities, but an effort must always be made later on to transfer the disciplinary restraints to the individual. Unless such an incorporation of prohibitions is achieved and becomes an integral part of the individual's conscience, one will demand greater and greater displays of punitive efforts on the part of the therapist. To complicate this, when one has responded to dictatorial demands, one will burn inwardly with resentment toward the therapist, and will feel self-contempt for being so weak as to need authoritative pressure.

One way of conducting the guidance interview is to try to avoid, as much as possible, the giving of direct advice. Rather, the therapist may couch ideas and suggestions in a way that patients participate in the making of decisions. Furthermore, advice should be proffered in a non-dictatorial manner so that patients feel they may accept or reject it in accordance with their own judgment.

The sicker the individuals, the more likely they will make erratic choices, and the more they will need active guidance and direction. How long the supportive relationship will have to be maintained will depend on the strength of the patient's ego. Usually, as patients gain security and freedom from symptoms, they will want to take more and more responsibility for their own destiny. Even those persons who offer resistance to assertiveness and independence may be aided in developing incentive toward greater independence. This may require considerable time and patience, but in many instances such constructive motivation can be achieved.

ENVIRONMENTAL MANIPULATION

The special environment in which the individual lives may sponsor conditions inimical to mental health. This does not mean that mental health will be guaranteed by a genial atmosphere because personal conflicts will continue to upset the individual even under the most propitious circumstances. One may be burdened with blocks that obstruct taking advantage of available opportunities. One may initiate and foster a disturbance of the environment where none has existed in order to satisfy inner needs. Be this as it may, the therapist has a responsibility to help rectify discordant living conditions so as to give the patient the best opportunities for growth. Though the effort may be palliative, the relief the patient experiences, even temporarily, will provide the most optimal conditions for psychotherapy. It is obviously best for patients to execute necessary changes in the environment for themselves. The therapist, however, may have to interfere directly or through an assistant by doing for the patients what they cannot do for themselves.

Conditions for which environmental manipulation may be required are the following:

1. *Economic situation.*

   a. Location of resources for financial aid.

b. Budgeting and managing of income.

c. Home planning and home economics.

2. *Work situation.*

a. Testing for vocational interests and aptitudes. (Referral to a clinical psychologist may be required.)

b. Vocational guidance and vocational rehabilitation. (Referral to a clinical psychologist or rehabilitation resource may be required.)

3. *Housing situation.*

a. Locating new quarters.

b. Adjusting to the present housing situation.

4. *Neighborhood situation.*

a. Moving to a new neighborhood.

b. Locating and utilizing neighborhood social, recreational, or educational resources.

c. Adjusting to the present neighborhood.

5. *Cultural standards.*

a. Interpreting meaning of current cultural patterns.

b. Clarifying personal standards that do not conform with community standards.

c. Clarifying legality of actions.

6. *Family and other interpersonal relations.*

a. Consulting with parents, siblings, relatives, mate, child, or friend of patient.

b. Promoting education in such matters as sexual relations, child rearing, and parenthood.

c. Helping in the selection of a nursery school, grade school, camp, or recreational facilities for the patient’s children.

d. Referring patient to legal resources in critical family or interpersonal situations.

7. *Daily habits, recreations, and routines.*

a. Referring patient to resources for correction of defects in dress, personal hygiene, and grooming.

b. Referring patient to appropriate recreational, social, and hobby resources.

8. *Health.*

a. Clarifying health problems to patient or relative.

b. Referring patient to hospital or institution.

c. Referring patient to resources for correction of remediable physical disabilities.

The therapist may have to interfere actively where the environmental situation is grossly inimical to the best interests of the patient. This usually implies work with the patient's family, since it is rare that a patient's difficulties are limited to himself or herself. Various family members may require psychotherapy before the patient shows a maximal response to treatment. Indeed, the cooperation of the family is not only desirable, but in many instances unavoidable. A good social worker can render invaluable service to the therapist here. In some cases family therapy may be required.

Where the immediate environment does not offer good opportunities for rehabilitation, the patient may be referred to resources that will reinforce the therapist's efforts, such as day-and-night hospitals, halfway houses, sheltered workshops, rehabilitation centers, and social therapy clubs. For instance, day-and-night hospitals manage even moderately disturbed patients in the community and help support their work capacities. Halfway houses serve as a sheltered social environment in which the patient's deviant behavior is better tolerated than elsewhere. The patient is capable of experimenting there with new roles while being subject to the modifying pressures of group norms. Discarding of disapproved patterns and adoption of new attitudes may become generalized to the social environment (Wechsler, H, 1960b, 1961). Sheltered work programs have been shown to help patients make a slow adjustment to conditions and conflicts at work (Olshansky, 1960). Tolerating an individual's reactions allows the individual to restructure defenses at his or her own pace without countenancing violent or rejecting

responses on the part of supervisors and employers. A reconditioning process that prepares the patient for a regular occupation in the community may in this way be initiated. Rehabilitation centers, such as Altro Health and Rehabilitation Services, provide a variety of benefits that are made available to patients and that permit them to achieve the best adjustment within the limitations of their handicaps. At such centers the following may be accomplished:

1. Handling the patient's lack of motivation and resistance to work.

2. Helping patients in their efforts at reality testing.

3. Educating patients in methods of coping with daily problems as well as in developing working skills.

4. Aiding patients in recognizing early signs of emotional upset and suggesting means of removing themselves from sources that upset them before they go to extremes.

5. Working with the patient's family to secure their cooperation and manage problems within the family structure.

6. Providing aftercare services to prevent relapses (Benney et al, 1962; Fisher & Beard, 1962).

Social therapy clubs provide an extraordinary medium for a variety of experiences, either in themselves or as part of a therapeutic community (Bierer, 1948, 1958; Ropschitz, 1959; Lerner, 1960; Fleischl, 1962, 1964; Waxenberg & Fleischl, 1965).

EXTERNALIZATION OF INTERESTS

The turning of the patient's interests away from the self may be considered important in planning a supportive program. Hobbies, occupational therapy, and recreational activities may be considered here.

A most effective hobby is one that provides an acceptable outlet for impulses that the person cannot express directly. The need to experience companionship, to give and to receive affection, to be part of a group, to gain recognition, to live up to certain creative abilities, and to develop latent talents may be satisfied by an absorbing hobby interest.

External activities can provide compensations that help the individual to allay some inferiority

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feelings. Instead of concentrating on failings, patients are encouraged to develop whatever talents and abilities they possess. For instance, if they are proficient as tennis players or have good singing voices, these aptitudes are encouraged so that the patients feel that they excel in one particular field. Whatever assets the individual has may thus be promoted. Calisthenics and gymnastics, even setting-up exercises, act as excellent outlets for tensions that have no other way of being drained off.

Some patients harbor within themselves strong hostilities with needs to vanquish, defeat, and overwhelm others. These drives may have to be repressed as a result of fear of retaliatory rejection or punishment. Sometimes even ordinary forms of self-assertiveness may be regarded as aggression. The device of detachment may be used in order to avoid giving expression to what are considered forbidden impulses. For such patients hobbies that do not involve competition will be most acceptable, at first. The ultimate object is to evoke interest in a hobby that has some competitive element. The patients may come around to this themselves. For example, one patient chose photography as an outlet principally because it involved no contact with other people. Gradually, as she became more expert, she exhibited her work to friends, and, finally, she entered pictures in various photographic contests. Later on, with encouragement she learned to play bridge, which acted as a spur to an interest in active competitive games and sports.

The ability to relieve tension through activities that involve the larger muscle groups permits of an effective way of helping disquieting aggression. Boxing, wrestling, hunting, archery, marksmanship, fencing, and such work as carpentry and stone building can burn up a tremendous amount of energy. In some individuals the mere attendance at games and competitive sports, such as baseball, football, and boxing, has an aggression-releasing effect. It must be remembered, however, that this release is merely palliative; it does not touch upon difficulties in the life adjustment of the person that are responsible for the generation of hostility.

Many other impulses may be satisfied through occupational or diversional activities. Hobbies may foster a sense of achievement and can help the individual to satisfy a need for approval. Energy resulting from inhibited sexual strivings may gain expression sometimes in an interest in pets or naturalistic studies. Frustrated parental yearnings may be appeased by work with children at children’s clubs or camps.

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One must expect that patients will try to employ hobbies as a means of reinforcing the neurotic patterns that rule their lives. If they have a character structure oriented around perfectionism, they will pursue their hobbies with the goal of mastering intricate details. If they are compulsively ambitious, they will strive to use their interest as a way to fame or fortune. The same driving need holds true for any other prevailing character traits.

Most patients gain some temporary surcease from neurotic difficulties during the period when they are working at a new interest; however, their troubles escalate when the hobby fails to come up to their expectations. In spite of this, diversions may open up avenues for contact with others that neutralize this reversal.

Neurotic difficulties often cause individuals to isolate themselves from the group. Pleasures derived from social activities do not lessen the tensions and anxieties incurred in mingling with people. Occupational therapy, hobbies, and recreations give the person an opportunity to regulate the degree of participation with others in a project of mutual enjoyment. Pleasure feelings to some extent help lessen defenses against people. They may even lead to the discovery of new values in relating to a group. Once the patient has established a group contact, sufficient pleasures may sustain interest. It is to be expected, nevertheless, that customary withdrawal defenses may create tension. But the benefits derived from the group may more than make up for the discomfiture.

In some instances it may be possible to convince the patient to engage in activities or work that contribute to the general welfare of the community. This can stimulate a feeling of active participation with others and a conviction of social usefulness.

REASSURANCE

Reassurance may be necessary at certain phases of psychotherapy. This is sometimes given in verbal form; more commonly it is indicated through nonverbal behavior, as by maintenance of a calm and objective attitude toward the patient's feelings of crisis whenever they burst out.

Verbal reassurance, when used, should not be started too early, since the patient at first may not have sufficient faith in the therapist to be convinced of the latter's sincerity. The patient may imagine that

the therapist is secretly ridiculing him or her, or does not know how serious the situation really is, or is merely delivering therapeutic doses of solace without deep conviction.

In practicing reassurance, the therapist must listen to the patient with sincerity and respect, pointing out that the difficulties may perhaps seem overwhelming at present, but that there are undoubtedly more solutions than appear on the surface. Under no circumstances should the patient be disparaged for illogical fears. The patient often appreciates that worries are senseless, but is unable to control them.

One of the most common fears expressed by the neurotic person is that of going insane. Panicky feelings, bizarre impulses, and a sense of unreality lead to this assumption. There is great fear of losing control and perhaps inflicting injury on oneself or others. Fear of insanity may be justified by revelations of a mentally ill relative from whom a taint was believed inherited. It is essential to accent the facts that fear of insanity is a common neurotic symptom and that there is scarcely a family in which one cannot find cases of mental illness. A presentation may be made of the facts of heredity, with an explanation that insanity is not inevitable even in families that have a history of mental illness. Further reassurance may be given that the patient's examination fails to reveal evidence of insanity.

Another ubiquitous fear relates to the possession of a grave physical disease or abnormality. Patients may believe that through physical excesses, or masturbation, or faulty hygiene they have procured some irremediable illness. A physical examination with x-ray and laboratory tests should be prescribed if necessary, even though negative findings may not convince the patients that their fears are founded on emotional factors. Assurance may be given to the patients that anxiety and worry can produce physical symptoms of a reversible nature. Where fears are not too integral a part of the patient's neurosis, these explanations may suffice. Even where fears are deep, as in obsessional patients, and where patients do not accept the results of the physical examination, their more rational self will toy with the idea that they may be wrong. At any rate, the absence of manifest physical illness will give the therapist the opportunity to demonstrate to the patients that their problems are not really just a physical one and that feelings of being ill or damaged may serve an important psychologic function.

Masturbatory fears are often deep-seated and operate outside the awareness of the person. Patients

may, through reading and discussions with enlightened people, rationalize their fears, or they may conceal them under an intellectual coating. Either because of actual threats on the part of early authorities, or through their own faulty deductions, they may believe that their past indulgences have injured them irreparably. They may shy away from masturbatory practices in the present or else engage in them with conscious or unconscious foreboding. Assurance that they have misinterpreted the supposedly evil effects of masturbation, coupled with assigned reading of books that present scientific facts on the subject, have remarkably little effect on their qualms. They are unable to rid themselves of childish misapprehensions that seem invulnerable to reason. Nevertheless, the therapist's point of view should be presented in a sincere and forthright manner, with the statement that the patients, for emotional reasons, may not now be able to accept the explanation. Eventually, as they realize the depth of their fears, they may be able to understand how victimized they have been all their lives by faulty ideas about masturbation absorbed during their childhood.

Reassurance may also be needed in regard to other aspects of the individual's sexual life. Frigidity, for instance, is the concern of many women who often expect that it will disappear automatically with marriage. Projecting their disappointment, some women tend to blame their mates for sexual incompetence. In therapy misconceptions will have to be clarified carefully with a focusing on possible causes of guilt and other provocative conflicts.

In men, reassurance may be required in conditions of temporary impotence. Many males are excessively concerned with their sexual prowess and have exorbitant expectations of themselves in sexual performance. Discussions may be organized around the theme that episodes of impotence are quite natural in the lives of most men. Temporary feelings of resentment toward a marital partner or attempts at intercourse during a state of exhaustion, or without any real desire, will normally inhibit the erective ability. On the basis of several such failures, the individual may become panicky, and his tension may then interfere with proper sexual function thereafter. The patient may be shown the necessity for a different attitude toward sex, treating it less as a means of performance and more as a pleasure pursuit. Reassurance that his impotence is temporary and will rectify itself with the proper attitude may suffice to restore adequate functioning.

Another concern shown by patients is that of homosexuality. Fears of homosexuality may be

disturbing. It is helpful sometimes to reassure the patient regarding homosexual fears or impulses which are equated with a devalued self-image. Elucidation that a liking for people of the same sex may occasionally be associated with sexual stimulation, that this impulse is not a sign that one is evil or depraved, and that it need not be yielded to, may be reassuring. An effort may be made to explain how, in the development of a child, sexual curiosities and sex play are universal and may lead to homosexual explorations. Usually this interest is later transferred to members of the opposite sex, but in some persons, for certain reasons, an arrest in development occurs. The patient may be informed that when homosexuality represents a basic attitude toward people as part of a neurotic problem, it need not be considered any more significant than any other problem that requires psychological treatment.

Reassurance is often necessary in the event of infidelity of one's marital partner. Where a man or woman is extremely upset because a spouse has been unfaithful, one may feel not only a threat to security, but, more importantly, a shattering of self-esteem. The therapist may affirm that infidelity on the part of one's marital partner is indeed hard to bear, but that it is far from a unique experience in our culture. The patient must be urged not to be stampeded into a rash divorce simply because of feelings of outrage. It is natural that knowledge of a spouse's infidelity does justify indignation, but in one's own interest, one must not act precipitously, even though encouraged by friends, family, and public opinion to hate and cut off from the erring spouse. There is good logic in resisting a dramatic act and not precipitating a divorce over an affair that is in all probability quite insignificant. Such reassurance may convince the patient to try to work out a better relationship with the spouse and perhaps discover why a drift from each other had occurred.

One use of reassurance practiced by some therapists is toward helping the process of ego building. Patients become so preoccupied with their defects that they are apt to lose sight of constructive aspects of their personality. The therapist here selects for emphasis positive aspects of the individual's life adjustment and personality that the patient has underestimated. Qualities of the patient may be highlighted with emphasis on how these have been sabotaged by the patient's preoccupation with troubles. Reassurance in response to inferiority feelings, however, is generally futile. One of the most common symptoms of neurosis is devaluated self-esteem, which fosters inhibitions in action, perfectionistic strivings, and feelings of worthlessness, inadequacy, and self-condemnation. Any attempt here to inflate the patient's ego by reassurance accomplishes little.

Self-devaluation may be a symptom that serves a useful purpose for the patients, protecting them from having to live up to the expectations of other people or of their own ego ideal. Rebuilding their self-esteem by reassurance, therefore, threatens to remove an important coping mechanism. Many persons who devaluate themselves insidiously do penance for forbidden strivings and desires. Reassurance here may actually plunge the person into anxiety. If patients have sufficient ego resources, reassurance even though necessary should be tempered, the patients being apprised that responsibility for investigating their patterns has to be borne by themselves. If this precaution is not taken, the patients will lose initiative in getting at the source of their difficulties, and they will tend to seek more and more reassurance from the therapist.

PERSUASION

Persuasive techniques are sometimes helpful as supportive measures, particularly in obsessive-compulsive personalities. The object is to try to master conflict by forces of will power, self-control, and powers of reasoning. Positive results are contingent on accepting the therapist as a wise benevolent authority whose mandates must be followed, (see also Chapter 9).

Persuasive suggestions have arbitrarily been subdivided into several categories. They represent a point of view and a slant on life that may not always be accurate but that, *if accepted by the patient,* may help alleviate distress. In genera}, suggestions tend toward a redirection of goals, an overcoming of physical suffering and disease, a dissipation of the “worry habit,” “thought control” and “emotion control,” a correcting of tension and fear, and a facing of adversity. These suggestions consist of home-spun bromides, slogans, and clichés. But their pursuit is considered justified by some therapists as a means of helping the patient control symptoms. The following suggestions are a summary of a number of different “systems” of persuasion. Superficial as they sound they are sometimes eagerly accepted by patients, who are not amenable to other approaches and seem to need a wise authority to structure their lives.

Redirection of Goals

If the patient’s goals in life are obviously distorted, the patient is instructed that the most important

aim in living is inner peace rather than fame, fortune, or any other expedient that might be confused with real happiness. In order to gain serenity, one may have to abandon hopes of becoming rich, famous, or successful. One may be causing oneself much harm by being overambitious. If one is content to give up certain ambitions, and to make an objective in life that of mental serenity and enjoyment, one should try living on a more simple scale. It is important to give up struggling for success. Health and freedom from suffering are well worth this sacrifice.

One can attain happiness and health by learning to live life as it should be lived, by taking the good with the bad, the moments of joy with the episodes of pain. One must expect hard knocks from life and learn to steel oneself against them. It is always best to avoid fearsome anticipations of what might happen in the future. Rather one should strive for a freer, more spontaneous existence in the present. One should take advantage of the experiences of the moment and live for every bit of pleasure that one can get out of each day. The place to enjoy life is here. The time is now. By being happy oneself, one can also make others happy.

It is profitable to concern oneself with the problems of other people. Many persons who have suffered pain, disappointment, and frustration have helped themselves by throwing their personal interests aside and living to make others happy. We are social creatures and need to give to others, even if we must force ourselves to do so. Thus, we can take a little time out each day to talk to our neighbors, to do little things for them. We can seek out a person who is in misery and encourage one to face life. In giving we will feel a unity with people.

A person may be enjoined to avoid the acting-out of a sense of despair. A pitfall into which most “nervous” people fall is a hopeless feeling that paralyzes any constructive efforts. One must not permit oneself to yield to feelings of hopelessness, for life is always forward moving. Hopelessness and despair are a negation of life. If we stop holding ourselves back, we will automatically go forward, since development and growth are essential parts of the life process.

Overcoming Physical Suffering and Disease

The patient, who may be suffering from ailments of a physical nature, may be told that physical

symptoms are very frequently caused by emotional distress. Studies have shown that painful thoughts can affect the entire body through the autonomic nervous system. For instance, if we observe an individual's intestines by means of a fluoroscope, we can see that when the person thinks fearful or painful thoughts, the stomach and intestines contract, interfering with digestion. On the other hand, peaceful, happy thoughts produce a relaxation of the intestines and a restoration of Perlstaltic movements, thus facilitating digestion. The same holds true for other organs.

Understanding the powerful effect that the mind has over the body lucidly demonstrates that physical suffering can be mastered by a change in attitudes. By directing one's thoughts along constructive lines, by keeping before the mind's eye visions of peace and health, a great many persons who have been handicapped by physical ailments, and by even incurable diseases, have conquered their suffering and even have outlived healthy people. This is because a healthy mind fosters a healthy body and can neutralize many effects of a disabling malady.

Physical aches and pains, and even physical disease, may be produced by misguided thoughts and emotions. The body organs and the mind are a unity; they mutually interact. Physical illness can influence the mind, producing depression, confusion, and disturbed thought process. On the other hand, the psyche can also influence the body, causing an assortment of ailments. In the latter instance the institution of proper thought habits can dispel physical distress.

It is natural for persons who are suffering from physical symptoms to imagine that there is something organically wrong with them. They cannot be blamed if they seek the traditional kinds of relief. But palliation is not found in medicines or operations. Relief is found in determining the cause of their troubles and correcting the cause. Worry, tension, and dissatisfaction are causes for many physical complaints; the treatment here lies in abolishing destructive thoughts.

The first step in getting relief from physical suffering is to convince oneself that one's troubles are not necessarily organic. The difficulties may lie in one's environment, but usually they are due to improper thinking habits. If there is a remediable environmental factor, this must, of course, be remedied. Where it cannot be altered, the person must learn to change oneself so that one can live comfortably in one's difficult environment. In the latter case one has to reorganize one's patterns of thinking.

Where patients actually have an organic ailment that is not amenable to medical or surgical correction, an attempt may be made to get the patients not only to accept the illness, but also to change their attitudes toward it. It is essential to help the patients reorganize their philosophy so that they can find satisfactions in life consistent with their limited capacities.

In physical conditions of a progressive nature, such as coronary disease, cancer, or malignant hypertension, the patients may be in a constant state of anxiety, anticipating death at any moment. Here it is wise to emphasize the fact that death is as much a part of living as is life and that the horrors attached to it are those that come from a misinterpretation of nature. Life must go on. Babies are born, and people pass on to a peaceful sleep that is death. The chances are that the one still has a long useful life ahead that can be prolonged by adopting a proper attitude toward one's condition. If suffering and pain do not exist, this should be pointed out as a fortunate occurrence. The person should think about the present and avoid dwelling too much on the future. No one can anticipate what the future may bring. Accidents can happen to anyone, and even a young person in the best of health does not know when an illness or accident will strike. The only rational philosophy is to glean whatever pleasure one can from the moment and to leave the future to take care of itself. Hypnosis and self-hypnosis may be employed as aids for the alleviation of tension, pain, and physical distress.

The patients are encouraged to develop hobbies and to engage in activities that will divert their thinking from themselves. A list of diversions that the patients can pursue may be prepared and the patients guided into adopting new interests.

Dissipating the "Worry Habit"

Patients who are obsessed with worrying about themselves may be urged to remember that much energy is expended ruminating about one's problems and fears instead of doing something positive about a solution. Worry tends to magnify the importance of petty difficulties; it usually paralyzes initiative. The worrier is constantly preoccupied with ideas of fear, dread, and morbid unpleasantness. These thoughts have a disastrous effect on the motor system, the glands, and other organs.

In order to overcome the "worry habit," it is first necessary to formulate in one's mind the chief

problem with which one is concerned. To do this it will be necessary to push apprehensions boldly aside. In a seemingly insurmountable problem, one should attempt to reformulate the situation to bring clearly to mind the existing difficulty. If one is honest with oneself, one will realize that most of one's energy has been spent in hopeless despair, in anxiety, or in resentful frustration rather than in logical and unemotional thinking that can bring about tranquility.

First, it is necessary to review all possible answers to the problem at hand. Next, the best solution is chosen, even though this may seem inadequate in coping with all aspects of the problem. A plan of action must then be decided on. It is necessary to proceed with this design immediately and to abandon all worry until the plan is carried out as completely as possible. Above all the person must stick to the project, even if it is distasteful.

If the person cannot formulate a scheme, the therapist may help to do so. The patient should be told that it is better to be concerned about a constructive partial plan than to get tangled up in the hopelessness of completely resolving an apparently insoluble problem. Until the patient can work out something better, it is best to adjust to the present situation, striving always to externalize energy in a constructive way.

The patient may be urged to stop thinking painful thoughts. He or she may be told that forgetting is a process that goes on of its own accord if one does not interfere with it. Worry is a process that has been learned. One can, therefore, help oneself by controlling one's thoughts and avoiding painful ideas. If action is impossible for the moment, one can try to crowd out apprehensions by simply resolving to stop worrying.

Discussing painful topics with other people should also be avoided. If the patient must ventilate disturbing feelings, this should be done with the therapist. "Blowing off steam" and relating troubles to friends often does more harm than good because the suggestions offered are usually unsound. It is better for the patient to understand one's difficulties than to become too emotional about them. It may be necessary to ask friends and relatives to stop talking about the patient's personal problems, if such discussions are aggravating. It is understandable that people close to one will be much concerned with the patient's illness, but they must be reminded that their solicitude may aggravate the patient's

condition. Trouble may often be forestalled by insisting that one “feels fine” when questioned by others about one’s health.

"Thought Control" and "Emotion Control"

Patients who seem to be at the mercy of painful thoughts and emotions may be enjoined never to permit their minds to wander like flotsam, yielding to every passing thought and emotion. It is necessary to try to choose deliberately the kinds of thoughts to think and the kinds of emotions to feel. It is essential to eschew ruminating about resentments, hatreds, and disappointments, about “aches and pains,” and about misery in general.

One must think thoughts that nourish the ego and permit it to expand to a better growth. A woman with multiple complaints unresponsive to various types of psychotherapy was told by her therapist that if she wants to be without pain, she must fill her mind with painless ideas. If she wants to be happy, she must smile. If she wants to be well, she must act as if she *were* well. She must straighten her shoulders, walk more resolutely, talk with energy and verve. She must face the world with confidence. She must look life in the face and never falter. She must stand up to adversity and glory in the struggle. She must never permit herself to sink into the quagmire of helplessness or give herself up to random worries, thus feeling sorry for herself. She must replace thoughts of doubt and fear with those of courage and confidence. She must think firmly of how she can accomplish the most in life, with whatever resources she has. She must feel those emotions that lead to inner harmony.

She must picture herself as above petty recriminations, avoiding the centering of her interest around herself. Even if she suffers from pain and unhappiness, she must stop thinking about her daily discomforts. She must give to others and learn to find comfort in the joys of giving. She must become self-reliant and creative. Emancipation from tension and fear can come by training one’s mind to think joyous and peaceful thoughts. But new thought habits do not come immediately. One must show persistence and be steadfast in one’s application. One must never permit oneself to be discouraged. One must practice, more and more. Only through persistent practice can perfection be obtained so that the mind shuts out painful thoughts automatically.

It is not necessary to force oneself impetuously to stop worrying or feeling pain. Will power used this way will not crowd out the painful emotions. One must instead substitute different thoughts or more appropriate actions. If one starts feeling unhappy or depressed, one should determine to rise above this emotion. One should talk cheerfully to others, try to do someone a good turn; or one may lie down for a short while, relax the body and then practice thinking about something peaceful and pleasant. As soon as this occurs, unhappy thoughts will be eradicated. A good practice is to think of a period in one's life when one was happiest. This may have been in the immediate past or during childhood. One may think of people one knew, the pleasant times one had with them. This substitution of pleasant for unpleasant thoughts may take several weeks before new thinking habits eventuate.

These injunctions had an almost immediate effect on the patient. Instead of preoccupying herself with her symptoms she concentrated on putting into practice the suggestions of her therapist, with a resultant dramatic cessation of complaints.

Correcting Tension and Fear

Where undifferentiated tension and fear exist, the patient may be told that difficulties may come from without, but that one's reactions to these difficulties are purely personal and come from within. By changing these reactions, one can avoid many of the consequences of stress. If one is confronted with tension, anxiety, or feelings of inner restlessness, it is best to start analyzing the causes. Are these emotions due to disappointment or failure? Or are they the product of a sense of hopelessness? Once the cause is found, it is necessary to face the facts squarely and take corrective steps. It is urgent to plan a course to follow and to execute this immediately. If facts cannot be altered, one must change attitudes toward them. It is essential to stop thinking about the painful side of things and to find instead something constructive on which to concentrate.

One may be unable to prevent anxious thoughts from coming into one's mind, but they can be prevented from staying there. The person must stop saying, "I can't," and think in terms of "I can." As long as one says, "I can't," one is defeated. Being resolute and persistent in saying "I can" will eventually bring results.

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The first step in overcoming tension is to stop indulging oneself in self-pity. Tension will drag one's life down if not interrupted. It is necessary to learn to love life for the living. One must learn not to exaggerate troubles. One must let other people live *their* lives, and one should live one's own.

Many people suffering from tension and fear have helped themselves by saying, "Go ahead and hurt all you want; you will not get me down." Fears are best faced by courageously admitting them. They can be conquered by stopping to fight them or by refraining from trying to master them by sheer will power. Acknowledging that one is afraid is the first step. Thereafter one must determine to rid oneself of fear by developing the conviction that one will overcome it. A sense of humor is of unparalleled help here. If one laughs at one's fears instead of cringing before them, one will not be helpless and at the mercy of forces one cannot control.

Practicing relaxation sometimes is useful. Each day one may lie on one's back, on the floor or on a hard surface, for 20 minutes, consciously loosening up every muscle from forehead to feet, even fingers and toes. The individual may then start breathing deeply, with slow, deep exhalations through pursed lips. At the same time the individual may think of a peaceful scene at the mountains or seashore. Mental and muscular relaxation are of tremendous aid in overcoming states of tension, (see also Chapter 56).

Facing Adversity

In the event patients have an irremediable environmental difficulty, they may be reminded that there are many dire conditions in one's environment that cannot be changed no matter how diligently one tries. Poor financial circumstances, an unstable mate, overactive youngsters who make noise and tax one's patience, a physical handicap, or an incurable physical illness can create a great deal of worry, tension, and anxiety. It is not so much these difficult conditions that are important as it is the reaction of the person to them. Life is usually full of struggle; but individuals need not permit themselves to get embroiled in the turmoil and misery of the world. There are many persons who are deformed, or deprived of sight, hearing, and of vital parts of their body, who live happily and courageously because they have learned to accept their limitations and to follow the rule to live life as it is right now. There are many persons who, forced to exist under the most miserable conditions of poverty, with no resources or education, are not distressed by worry or nervousness because they have not yielded themselves to their

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emotions.

It is a human tendency to exaggerate one’s plight. If one compares oneself with many other people, however, one will discover that one is not so badly off. Individuals may not be able to achieve all of the ambitions that they have in life. They may not be as intellectual as they want to be, or as strong, or successful, or rich, or famous. They may have to earn a living at work they detest. As bad as they imagine their state to be, if they were to be faced with the possibility of changing places with some other persons, they would probably refuse to do so. They might be dissatisfied with their appearance, and may long for features that would make them look more handsome and distinguished or beautiful and sophisticated. If this were possible, they might instead find their health had become impaired or their intellect was not up to its present level.

It is necessary to make the most out of the little one has. Every person possesses weaknesses and must learn to live with them. Each of us must pattern our life so as to make our weaknesses as little manifest as possible. We must expand all of our good qualities to the limit. One’s facial appearance may not be handsome, but one may have nicer hair and teeth than many other people. These may be emphasized in hair style or proper facial expression. One can appear well groomed with well-tailored clothing. If one’s voice is good, one should cultivate it. In this way one may take advantage of every good feature one possesses.

Instead of resigning oneself to a sense of hopelessness, it is wise to turn one’s mind toward creative activities and outlets. It will take much perseverance to conquer feelings of helplessness and frustration, but this can be done, particularly by living honestly and courageously. The wealthiest person is one who has not riches but strength of spirit. If individuals are dissatisfied with themselves, they may try to imagine themselves as the kind of person who they would like to be. They may then find that they can do those things that they have hitherto felt were impossible. They must never yield to despair or discouragement. Crippled persons have learned to walk by sheer perseverance of will. On the other hand, one should not set goals for oneself that are impossible of fulfillment. Thwarted ambition can give rise to bitterness and greed.

A sign of character is to change those conditions that can be remedied and to accept those that

cannot be changed. To accomplish this one must face the problem squarely. What is to be done about a difficult situation? What can be done? How will one go about accomplishing the change? This calls for a plan of action that, once made, must be pursued diligently without discouragement.

There are always, of course, situations one must accept. Unalterable facts must be faced. If one cannot change things as they are, one can change one's own attitude so that one will not overreact to one's difficulties. As soon as a person has decided to make the best of things, his or her condition will improve immediately. If one is unable to possess the whole loaf, one must learn to content oneself with part of a loaf. One must disregard minor discomforts, and pay less and less attention to them. One's symptoms may be annoying, but they are not fatal. Keeping two written lists, outlining on one side the things that have troubled one, on the other side the things that have gone in one's favor, will often convince the person, after a while, that the balance is on the positive side.

It is particularly important to train oneself to overcome the effects of frustration and disappointment. These may be expressed in the form of quarreling, or holding grudges against others, or by depression or physical symptoms. There are many dangers associated with permitting oneself to become too discouraged. It is best here to forestall despair before it develops, by adopting the attitude that one will not allow oneself to get too upset if things go wrong. One must force oneself to regard all adversity dispassionately, with the idea of modifying the cause if possible, or changing one's point of view, if the cause cannot be removed.

The above persuasive suggestions do not represent a scientific point of view. However, their use is believed, especially by nondynamicalty oriented therapists, to be consonant with a pragmatic approach to therapy in certain patients who do not respond well to insight of other more sophisticated approaches.

EMOTIONAL CATHARSIS AND DESENSITIZATION

Release of painful feelings and desensitization to their effects constitutes an important supportive technique. Patients are encouraged to talk about those things in their past life or in their present-day relationships that bother them most. Their responsiveness will depend on the confidence and trust they have in the therapist.

The patient may be told that most people have bottled up within themselves memories and experiences that, though seemingly under control, continue to have a disturbing effect on them. The attempt to obliterate emotional experiences by banishing them from the mind is not ordinarily successful. Disturbing ideas keep obtruding themselves into the stream of thought. Even when will power triumphs and suppression succeeds, casual everyday happenings may remind one of one's conflict. In addition to memories, there are also impulses and desires of which one is thoroughly ashamed and which one dares not permit oneself to think about. Among these are desires for extramarital sexual gratification, homosexual interests, hostile strivings, and impulses of a fantastic and infantile nature.

Emotional catharsis must never be foisted on patients. To force them to reveal inner fears of a traumatic nature prematurely may cause them such panic that their resistance to further revelations will be increased. Actually, the patients have built up so hard a crust of repression that it keeps them from admitting their deepest fears even to themselves. It is essential to let them feel their own way and choose their own pace with casual encouragement.

In continued discussions with the patients it may be emphasized that every individual has difficulties and problems to be ashamed of, that they also probably are no exception and may have had experiences that make them feel that they are wicked. Discussing the patient's problem in this roundabout way makes it possible to talk about worries more openly. For instance, where it is obvious that the patient has a suppressed homosexual wish, the therapist may weave into the discussions the fact that every person, at certain times in life, develops friendships with and crushes on people of the same sex. This is by no means abnormal; it is merely a developmental phase in the life of the individual. Some persons, for certain reasons, continue to have ideas that were normal at an earlier phase of growth. As a matter of fact, most people have fears of homosexuality. The patient may be told that it would be unusual not to have such ideas at one time. The patient may then casually be asked whether or not this is so. In opening up discussions about latent tendencies there are certain risks that must be countenanced. Sometimes patients prevent themselves from acting-out their desires by not thinking about or exposing them. Such persons may interpret the therapist's interest as condonation of their suppressed impulses, particularly where the therapist relieves them too freely of their guilt. Guilt, of course, is, not too trustworthy an opposing force, but it may be the only deterrent to rebellious tendencies that the patient has. An effort to supply the patient with rational deterrents should be made where cravings may involve

the patient in unforeseen dangers.

The ability of the patient to discuss impulses, fears, and experiences openly, without encountering condemnation, enables the patient to tolerate the implications of the suppressed material.

In the event patients confess to a truly reprehensible incident in their lives, the ventilation of these facts may have to be followed by active reassurance. They may be reminded that the incidents they have revealed do not necessarily pollute them, that many persons are compelled, for neurotic reasons, to do things that they regret later, and that their subsequent actions can fully neutralize what they have done. Patients may be urged to spend their energy doing something positive in the present rather than to wear themselves out regretting the past. They may, if they desire, make some restitution to any person who has been injured by their acts, or to society in general.

In cases where individuals have irrational feelings that issue out of their relationships with people or where they have phobias, they repeatedly may be urged, for purposes of desensitization, to talk about if not to expose themselves to those situations that incite painful emotions. Their experiences are then subjected to discussion, and the patients are trained to face those situations gradually, without quaking. For instance, if patients have a fear of closed spaces, they may be instructed to lock the door of their rooms for a brief instance for the first day, to increase the interval to the count of 10 the next day, then to one-half minute, extending the time period daily, until they discover through actual experience that they can tolerate the phobic situation. Other phobias may be treated in a similar way with selected pertinent suggestions. The therapist must appreciate, of course, that the patient's fears may be rooted in established conditionings and may not yield to such desensitization techniques until a behavioral analysis is instituted and tactics sensibly organized. These tactics actually are reeducative and therefore will be discussed in the next chapter on Behavior Therapy.

MISCELLANEOUS SUPPORTIVE MEASURES

See also Chapter 56 "Adjunctive Aids in Psychotherapy"

Relaxation exercises and massage may be prescribed for muscle tension, spasms, contractures, and tremors, the patient being referred to a physiotherapist when this is necessary. Enforced rest is

sometimes advised for fatigue and exhaustion in the form of a prolonged vacation or a sojourn in a spa or country place. Subcoma insulin therapy is sometimes prescribed for unyielding anxiety states, delirium tremens, and confusional syndromes. Electrical (convulsive) therapy is helpful in bipolar disorders, endogenous depression, and senile depression. Drug therapy is employed where indicated; for example, sedatives, hypnotics, and tranquilizers in excitement or insomnia, antidepressants in depression or listlessness, Antabuse in alcoholism, and glandular products in endocrine disorders. These somatic therapies will be discussed later. Inspirational group therapy is a helpful procedure in certain problems, for instance, for dependent, characterologically immature, alcoholic, drug addictive, and mentally ill patients.

Supportive measures during reconstructive treatment must be employed cautiously because the patient may invest the therapist with directive, authoritarian qualities that interfere with a good working relationship. Moreover, alleviation of symptoms and suffering may remove a most important motivation for continued treatment in some patients.

There are, nevertheless, certain circumstances under which support is necessary. The challenging of one's defenses exposes basic conflicts and may revive the early anxieties that inspired them. A period of some instability and turmoil is to be expected with reconstructive procedures, and the therapist may, where the reactions are severe, temporarily have to assume the role of a helping authority.

The specific kinds of supportive measures implemented here vary according to the patient's needs. Where severe environmental disturbance exists, the therapist may suggest available resources that hold forth promise of mediation. The therapist may also aid the patient in resolving resistances toward utilizing the prescribed resources effectively. Active reassurance may be dispensed where the patient harbors gross misconceptions or where there is a threat of a dangerous shattering of the ego. There may be a cautious extension of advice when the patient is thoughtlessly embarking on a potentially destructive course of action. Encouragement certainly may be voiced when the patient does a significant job in thinking through a problem or in effectuating insight into action.

The degree of emotional support employed will depend upon the strength of the patient's ego. A withholding of support by the therapist, when the patient actually needs it, may be harmful. On the other

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hand, excessive support may interfere with assertiveness and activity. The person's reactions to support will depend on its symbolic meaning to the person. The most common response is an abatement of symptoms and a cessation of anxiety. Occasionally, however, anxiety breaks out due to fears of being overwhelmed and mutilated in a protective relationship. These reactions will have to be handled promptly, should they emerge.

REEDUCATIVE APPROACHES

See also Chapter 56 Adjunctive Aids in Psychotherapy

Reeducative measures are employed both as a complete goal-limited form of treatment and as interventions that are strategically incorporated into a reconstructive therapeutic program.

Current interest in cognitive therapy (Beck AT, 1971, 1976) accents the value of certain reeducational techniques during psychotherapy. The individual's cognitive set often determines what one feels and how one interprets reality. Utilizing this paradigm, patients are enjoined to examine how their *interpretation* of an event determines their feelings and whether the interpretation is based on facts or insubstantialities. Sometimes patients are asked to keep a diary and jot down the thoughts that immediately precede certain feelings. In this way they learn first to identify provocative thinking patterns that inspire upsetting feelings and then to challenge the validity of their ideas.

The value of examining the connection of events with succeeding disturbing emotions is shown by the pilot study of A. T. Beck and Kovacs (1977), in which depressed patients who were treated with cognitive therapy did better than those who were given antidepressant drugs. Some forms of cognitive therapy focus on the various ego states of individuals during their daily operations. There is exploration of the interfaces of these states, elaboration of the dissimilar roles assumed during these states, explication of the multiform self-representations, and differentiations between self and object, and identification of the values and needs emerging with each ego state. In this way individuals become aware of habitual shifts in their orientations, some of the forces producing the shifts, and perhaps tactics through which control may be achieved before their emotions take over. During therapy, an integration of dissociated self- and object representations is attempted, with the aim of bringing the patient's self-concepts to a more mature level. Sicker patients, such as those who are borderline cases and those who

have narcissistic character disorders, are apt to show splitting and confusion of self-object identities. Here the patients may utilize the therapist as an aspect of themselves during transference. This will call for therapeutic interventions, such as interpretations, that are more attuned to reconstructive than reeducative premises.

In some forms of reeducative therapy efforts are made to rehabilitate the individual as rapidly as possible by discovering and modifying factors that provoked the emotional illness and by surveying the available assets and liabilities in order to mobilize positive forces of the personality. In the medium of a warm relationship with the therapist, the patients are brought to an awareness of certain interpersonal conflicts that have contaminated their adjustment. Maladaptive attitudes are explored to point out to the patients the difficulties that these create for them. Individuals get viewpoints of how their reactions became conditioned and why they persist. Finally, they are helped to adjust with new, healthful, more adaptive patterns. In behavior and conditioning approaches, there is a minimization of insight and a concentration on learning and reconditioning.

In reeducative therapy less weight is placed on exploring the origins of patterns, while more emphasis is put on reorganization of habits, regardless of their sources in constitution or in specific inimical experiences. During the process of retraining, early difficulties that originally produced disturbing character traits may spontaneously be remembered by the patient. As part of their schooling, the patients must be taught to face early childhood experiences and, if necessary, to change attitudes toward them.

The patients are encouraged to rectify remediable environmental difficulties, to adjust to irremediable handicaps while finding adequate compensations and sublimations, to enhance personality resources through education and activity, to abandon unrealistic goals, and to coordinate ambitions with capacities. The therapist concentrates on all of the healthy personality elements, actual and potential, that can neutralize, control, or rectify pathologic adjustment.

In dealing with abnormal traits and patterns, the therapist may strive to bring patients to where they can reason unemotionally, facing facts bravely, adjusting to painful memories and impulses without panic, meeting stresses of life with courage, and forsaking fantasy in thinking. Each trait that the patients

exhibit may be taken up in detail, discussing its origin, purpose, value, and the ways it interferes with their happiness and adjustment. More adaptive substitive patterns may then be explored, and the patients may be urged to take positive courses of action.

A discussion of the patient's life history may reveal to the therapist that the patient has an awareness of the inordinate attachment to a domineering parent or parental surrogate who continues to infantalize him or her. Evidences of how dependency undermines the patient are brought to his or her attention, and the patient may be shown how some symptoms are produced by conflict over dependent need. If the patient evidences a desire to overcome dependency on the family, the wisdom of making decisions and of finding outlets for energy and interests may be indicated. It is to be expected, because neurotic reaction patterns are so deeply imbedded, that this advice will not be heeded at first; but as the patient constantly experiences untoward emotions associated with the giving up of independence, the patient may agree with the therapist's observations and gradually experiment with new modes of adjustment.

Where patients are too compliant and recognize their compliance, it may be pointed out that they have probably always felt the need to be overrespectful to authority. Their security is perhaps bound up with this reaction. However, they have a right, as a human being, to their own opinions, and they need not accept the wishes or orders of other people unless they want to do so. They can review in their mind the pros and cons of any advice given them, and they may then accept or reject it as they see fit. If they do not wish to abide by the orders or judgments of other people, they can try to explain to them why their own plans seem best. Should they decide to conform with the wishes of others, they must be sure that this is what they really want, and that it is not what they feel forced to want. Above all, they must be logical rather than emotional in their choices of action. Specific ideas on how to function independently may be advanced. The help of other people with whom the patient lives may be enlisted in this training process.

An individual who is aware of a power drive may be shown how this is a dominating force in life, preoccupying thoughts and actions. Individuals may be partly aware of how they strive for power and strength in all of their interpersonal relationships. What they may not realize is how mercilessly their drive rules them and how it results in their forfeiting normal goals. The person may be advised how a power trend brings him or her into conflict with others and evokes retaliatory hostilities. It is necessary to

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get the patients to see the need of adopting a more mature attitude and of readjusting their standards in line with the reality situation. Other outlets than power may then be suggested to satisfy the patient's drive for self-assertiveness and self-esteem.

The same technique may be used in dealing with other compulsive neurotic patterns, such as detachment, aggression, and perfectionism. Their manifestations are repeatedly brought to the patient's attention, and the patient is shown why they stir up difficulties. The patient is challenged in his or her assumption that these are the only means adjusting to life, and substitutive responses are suggested.

Patients may be acquainted with the ways in which their character drives operate insidiously. They may be shown that, unknown to themselves, they lash out at others, or vanquish them in actual deeds or in fantasy, or render themselves invulnerable and strong, or retreat from competition, or engage in any number of facades that become for them basic goals in life, making average pursuits meaningless.

Such unhealthy attitudes perhaps might be understandable were we to insist on what is probably not true—that they really are an inferior persons who have to eliminate adult and realistic methods of dealing with their problems. The patients must be shown the need to stop taking refuge in childhood defenses, and they must be apprised of the wisdom of facing their difficulties with decision and courage. However, because they have utilized their defenses for so many years, they must understand that these will not vanish immediately. Indeed, defenses will keep cropping up from time to time. Above all, there is no need for discouragement. When they become sufficiently strong, their defenses will no longer be required. Yet, they must not abandon their patterns out of a sole conviction that orders must be followed, or to please the therapist. Rather, as they realize the implications of their neurotic drives, they will want to substitute creative goals and patterns for those that have resulted in their present unhappiness.

The therapist should, in this way, actively encourage a conscious analysis by the patients of their customary trends as well as stimulate them to substitute new ways of thinking and acting. If the old patterns reappear, it may be necessary for the patients to try to bring them to as complete a halt as possible by deliberate effort. The patients should be encouraged to feel that they have the capacity to change, that others sicker than themselves have done so successfully.

Usually the patients will be dismayed to find that their character patterns are regarded as problems

because they have accepted them as natural and normal. As they realize that these constantly bring them into difficulties with people and are responsible for much of their turmoil, they are supplied with a valid motivation to alter their scheme of life. They are confronted with a choice for which they, themselves, will have to assume a full measure of responsibility.

Many persons faced with this choice are unwilling or unable to give up their destructive drives. The knowledge that frustration or pain will follow observance of their patterns is not enough to make them give up the gratifications that accrue from the propitiation of neurotic goals. Extreme examples of this are the alcoholic who appreciates the physical, social, and moral hardships that inevitably follow the bouts of drinking but seems unable to do anything about it, or the smoker who developing emphysema continues to live in an atmosphere of tobacco fumes, or the obese individual with hypertension who overstuffs with fattening foods. In cases where patients refuse to abandon their destructive habits or immature objectives, the knowledge that they are responsible for their own plight is healthier, from a therapeutic viewpoint, than the conviction that may have existed previously, to the effect that the sources of their misery lay outside of themselves.

Where one is convinced that one's adjustment is eminently unsatisfactory, where one realizes that one's gratifications do not compensate for the suffering that comes from indulgence of one's immature drives, where one is aware of how one's patterns interfere with mature goals, one may be motivated toward experimenting with new reactions toward people and toward oneself.

Once patterns that are inimical to adjustment are clearly defined and more adaptive substitutive reactions are suggested, a long period of experiment and training is necessary before unhealthy attitudes are replaced by those of a more mature nature.

Even where patients have the motivation to change, a struggle will be necessary to achieve reeducative effects. In spite of all good resolutions, the patients, at first, will find themselves responding automatically, in line with their customary habits. They will, however, become more and more conscious of their reactions, and, as they occur, they will better be able to subject them to analysis and control. Even though this may fail to stop them from following their usual patterns, they will become more and more aware of their irrational motives, and they may develop greater determination to substitute more

constructive behavior tendencies.

For instance, perfectionistic persons may become conscious of the fact that the impulse to do everything meticulously extends itself into every aspect of their lives and poisons relationships with people. They will see, as the therapist brings it to their attention, that the slightest failure to perform flawlessly suffices to create tension and panic. They may learn that the reason for their disturbance lies in the fact that when they are not perfect, their image of themselves is shattered and they feel unloved and unlovable. Life then becomes a constant series of frustrations, since it is obviously impossible to do things perfectly every minute of the day and still be human. The patients will, as they become aware of their inordinate expectations, find themselves toying with a more self-tolerant philosophy, which they will not wish to accept at first, probably because being mediocre is equivalent to being no good at all, and because they are unconvinced that perfectionism is not really the keynote of life. As they test the truth of the therapist's exhortations and as they realize the extent to which their perfectionistic strivings dominate them, they may attempt to restrain themselves before yielding to perfectionistic impulses. They will review in their mind the reasons why they must be perfect on every occasion. They may eventually even try to substitute for this impulse the attitude that they can do things casually without needing to be perfect.

To expedite these reeducational aims, behavior therapy may be helpful, a description of which follows in the next chapter.

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