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Psychotherapy in general practice

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PSYCHOTHERAPY IN GENERAL PRACTICE

Clyde E. Stanfield

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"Just as you ought not to attempt to cure eyes without head or head without body, so you should not treat body without soul."

--Socrates

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PREFACE

It is fashionable for members of specialties to urge their perspectives and wares upon the general practitioner, and to censor him for his shortcomings. From their pedestals in the hierarchy of medicine, specialists may scrutinize the general man's inadequacies trespassing their domain. Medical students almost without exception gaze with reverence upon the hallowed ground of the specialties.

But the conclusion which relegates a general man to mediocrity is far from valid. Such an attitude is, instead, a sort of defense mechanism. Virtually every man, I think, who limits his activities to gain relative superiority within his specialty, envies at least secretly the fortitude of those who struggle to encompass the entire field of medicine. In the face of ever broadening, ever changing responsibilities, he has courage who seeks to keep abreast the whole of modern medicine. That his lines stretch thin is inevitable and by no means to his discredit; it is far more paramount that his basic concepts be practical, inclusive, and at least temporarily accurate.

The ultimate value of any medical procedure lies in its efficacy when applied to actual patients and their associated situational problems. Clearly, morality in medicine can safely stem only from pragmatism*; i.e., a thing or act is

*Cf., William James, John Dewey, et al.

"good" if it works (accomplishes its purpose), "bad" if it doesn't--quite apart from its authority or theoretical basis. Thus any specialized branch of medicine which fails to orient itself with other branches and with the patient as a psychobiologic entity, risks stifling itself in its own impractical rites.

A preponderance of medical literature exhibits extensive infiltration in all directions, but devotes comparatively little effort to bringing up the main forces. Original research is deified while attempts to synthesize the innumerable fragments are too often neglected as savoring of plagiarism. It is, for example, a rare university whose departmental heads are chosen because of ability to synthesize and teach general concepts--rather than on the basis of original research, frequent contributions to the literature, or seniority.

The general practitioner, it seems to me, holds a key position. He is usually in a position to survey his patient as a unit; according to the Gestalt concept (13, pp. 446-48), to see him as a "total configuration," as a living, functioning organism in his environment. Ideally, the physician is objectively familiar with his patient's evolutionary, developmental, and social backgrounds, and the man in general practice has therein the best opportunity to judge total results of therapy.

I have attempted, therefore, to review the more practical phases of a therapeutic agent which is neither new nor well understood, but one which is almost universal in its applicability. Its potentialities for effective use are greatest in the hands of the general practitioner, provided he has the prerequisite attitude and working knowledge of its principles.

No originality, of course, is claimed for the material used. In seeking to abstract the more useful contributions, I have borrowed heavily from the current literature and have endeavored to give specific credit to original authors wherever possible. Even the perspective in which this problem has been sketched must be credited in large part to those members of the Faculty whose indulgence and discernment of psychosomatic interrelationships have engendered it.

C. E. S.

April 1, 1942.

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PSYCHOTHERAPY IN GENERAL PRACTICE

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I. ORIENTATION

Psychotherapy is far from being anything new. Indeed, there is little doubt that it has constituted the basic-- if not the only--effective therapeutic agent throughout much of earlier medical history. Nor can the medical profession claim even major heritage. Appeals by and to the psyche by whatever means for the relief of real or fancied ills have formed an integral part of countless cults and practices, be they faith healers, osteopaths, priests, or governments.

Yaskin (51) suggests that "in a general way the term psychotherapy means the application of psychological science to the treatment of disease. It is obviously not a treatment of the mind but a treatment by the mind." Bennett's definition (2) will best serve to orient our discussion:

Any attempt to change the mental attitude an individual and thereby help him to overcome functional symptoms can be called psychotherapy. Scientific psychotherapy may be considered the attempt to find the psychic origin of functional symptoms and either to remove their causes or enable the patient to overcome or tolerate his symptoms. The treatment consists in re-education of the patient's harmful emotional attitudes, the development of insight and new understanding of mental causes of his maladjustment, and at times, by deliberate suggestion or persuasion, to help him regain self-confidence and better emotional control.

To psychology and psychiatry we owe the formulation of psychotherapy as a therapeutic agent of scientific dignity,

but the acceptance of psychosomatic concepts in medicine emphasizes its applicability to all branches of medicine concerned with treatment of the sick patient.

This thesis will seek to establish psychotherapy as an instrument of psychosomatic medicine and then to outline a working basis for the application of psychotherapy to general medicine.

Psychosomatic Medicine

Between psychiatry and the other branches of medicine, there has long persisted a chasm fostered by the ancient dualism of mutually exclusive mind-body components of man. This artificial dichotomy has, however, been repeatedly attacked in current literature (e.g., 6, 19, 24, 34, 39), and for our purposes here we may simply postulate the interdependence of psyche and soma and proceed to a few corollaries on which to base the subsequent discussion.

Adolf Meyer is credited with championing in America the biologic application of psychology. In 1915 he summarized his position in an article (34) entitled "Objective psychology or psychobiology with subordination of the medically useless contrast of mental and physical," as follows:

I urge the student to trace the plain life history of a person and to record it on what I call the life chart; the result is a record, a smooth or unbroken life curve of one of the main organs and functions, and in addition, a record of the main events of the life of the whole bundle of organs, that is the "individual as a whole" and of the facts which determined and constituted his behavior.

This realm of objective and determinable facts of the individual as a person constitutes what we as physicians need to know as psychology. The science dealing with these facts I call psychobiology, in order not to step on the toes of the introspectionist who might want to reserve the term "psychology" for the traditional type of subjective psychology.

It is scarcely practicable here to consider the many contributors to our present conception of psychosomatic medicine. Dunbar has done this in her monumental survey of the literature on psychosomatic interrelationships (18) for the period 1910 to 1933, and some of the more recent work is included in references cited at the end of this paper (pp. 71-74).

What, then, is psychosomatic medicine? A few terms need to be defined to establish its horizon:

Psychology deals with "certain aspects of the functioning of consciousness through which the neurologically integrated working is held together in the flow of total activity" (4, p. 15). Dashiell (13, p. 8) limits the term to "those interests in human behavior that take the form of true scientific inquiry."

Physiology, on the other hand, is concerned with essentially non-mental or infra-mental functioning of the soma; i.e., organs or systems (4, p. 15).

Biology is "the science of life; the branch of knowledge which treats of the origin, development, structure, functions, distribution, etc., of plants and animals" (from Webster's Collegiate Dictionary, G. & C. Merriam Co., 1934).

Psychobiology, therefore, is objective psychology which, in Billings' words (4, p. 16), "takes into account not only the individual part responses and functions but also considers them a part of the total and mentally integrated person's behavior...It is the physiology of the total man." It studies the meaning of functions, episodes, things in the total experience; realizing that "function" is inseparable from "organ" and that the function of the integrated nervous system comprises the behavior of man as a unit. Psychogenic malfunction, of course, comprises only one part of psychobiology; "healthy," average, or "normal" function are likewise included.

To recapitulate: Psychobiology is a science which applies the principles of psychology to biologic function. Psychotherapy is a therapeutic agent applied by and/or to the "mind" (psyche, consciousness, total-experience) in problems associated with psychobiologic malfunction. The application of psychotherapy to problems which are wholly or in part non-psychiatric implies a psychosomatic concept in medicine; i.e., one which recognizes the interdependence of both psyche and soma as they constitute the total organism.

Need for Psychotherapy

Few will deny that those unfortunates labelled "functional" or "psychoneurotic" need much more than palliative symptomatic management. Clearly, any curative therapy must be directed against the underlying causes if new symptoms are not to

crop up, hydra fashion, after ostensibly successful management.

Many men, however, question the practicability of curative treatment of psychoneurosis and allied disorders by the general practitioner. Quite advisedly, they feel safer if these patients are referred to the psychiatrist whenever circumstances permit--and in many instances, of course, this is highly desirable. But the great majority of patients remain to plague the physician with endless complaints until he desperately resorts to palliative measures, sedation, and placeboes ad infinitum lest they turn to quacks.

It is to be hoped that as the physician acquires greater familiarity with psychotherapeutic tools, a genuine interest in these patients will be engendered and he can offer brighter prospects of effective therapy. Billings writes.(5): "The real prevention of mental ill health lies in the hands of the family physician, internist and surgeon to whom the patient first goes for help, not in the hands of the psychiatrist specialist."

That the number of patients with apparently somatic symptoms but without correspondingly demonstrable organic disease is very considerable, is evidenced in every branch of medicine. Some representative data will varify this impression:

Mendeloff reviewed the occurrence of bodily disease as a result of disturbed psyche (31), of which a majority

suggested "nervous exhaustion." He quotes:

Moersch: Of 500 cases at the Mayo Clinic, 44% had psychogenic factors.

Stevenson: Of 150 cases at a gastrointestinal clinic, two-thirds reported a correlated emotional problem.

Reynolds: Of 935 private patients in internal medicine practice, 20% were psychoneurotics.

Davison, Lowlance, and Barnett (14) in seven years' practice of internal medicine diagnosed 445 cases as neuroses, constituting 10.7% of total new cases. The average age was 36 (4 - 81 years); 35% were males and 65% females.

Billings in a detailed survey of personality disorders admitted to the Colorado General Hospital and outpatient department (5) concludes that "one of every fourteen...is not sick because of primary organic disease. He is sick because of emotional and nervous difficulties...." Other data of interest here are abstracted from the same survey as follows:

The vast majority of adults had complaints referable to the abdomen, and one-third presented symptoms and signs referable to gastrointestinal malfunctions. Of these, the 26-year old females had averaged at least one abdominal operation attempted previously for relief of symptoms. One-half of male psychoneurotic patients averaged one abdominal operation before admission.

Patients (in this teaching hospital) ultimately requiring psychiatric care had:

- had five times as many physicians in consultation as those with other illnesses;
- been hospitalized twice as long for diagnosis as those physically sick;
- required four times more time of physician(s) than other patients; and
- required two to ten times as much laboratory work as other patients.

Harris (23) reports that "of 500 consecutive cases admitted to the medical clinic of the Boston dispensaries in 1935...36 per cent of the patients were suffering from symptoms due to emotional maladjustment."

Bennett and Semrad (3) reviewed one hundred patients finally diagnosed as psychoneurotic at the University of Nebraska Hospital, to ascertain the commonest errors in diagnosis and treatment. Of 100 psychoneurotic patients they found that:

- 72 had erroneous diagnoses of severe organic disease
- 29 had diagnoses of non-existent serious gastrointestinal disease
- 14 had diagnoses of endocrine dyscrasias (usually hyperthyroidism)
- 15 had erroneous diagnoses of organic cerebral diseases
- 73 had 173 surgical operations, of which at least one-half would have been unnecessary.

They conclude: "These mistakes in diagnosis come largely from lack of general understanding of the principles of psychopathology, failure to elicit adequate history and to consider situational and psychogenic factors and failure to appreciate the importance of personality make-up of the patient."

Young writes (52): "That there is a need for better understanding of these cases is well evidenced by the fact that \$125,000,000 is being spent each year on such treatment as is provided by osteopathy, chiropractic, Christian Science and allied forms." And to physicians who demand somatic pathology of their patients, Houston warns: "It is as though one said, 'I don't like feces,' and refused to treat dysentery or cholera.... It will tend to drive patients away and drive

many doctors to penury. In Germany this view-point has long existed.... The result of this credo in Germany has been that the offices of doctors are empty, while those of naturopaths overflow, that quacks abound as nowhere else; that finally the Hitler Government has set up the quack as the State Medicine. The Führer in medicine is a naturopath." (24)

Dunbar observes (18, p. 361): "The patient can not be blamed for turning to the quack as long as he gets blue pills and magnesium sulfate from the physician when what he needs is psychotherapy.... He [the physician] has, and always will have, an enormous advantage over the quack: the ability to diagnose scientifically. This, however, means little to the patient, and the patient will cease to turn to the quack only when and if the medical man is superior to the quack not only in diagnosis, but, above all, in therapy."

But lest we be led to think that only the psychoneurotic or "functional" patient deserves the pains of psychotherapy, it is important to point out its place in all therapeutics, although with varying degrees of necessity. Riggs points out (38), "There is no disease or disorder which does not in some degree affect the patient's emotional and mental life, nor is there any such condition which is not, in its turn, favorably or unfavorably affected by the patient's feelings and thoughts."

Most practitioners are well aware of the psychogenic etiology and aggravation so characteristic of such afflictions

as chronic eczema, bronchial asthma, angina pectoris, mucous colitis, peptic ulcer, and many others. Here, however, we shall mention only reports on a few diseases whose psychogenic aspects are less commonly recognized.

Wolfe (50) has studied the emotions with relation to organic heart disease, to find that "in no other cases are the psychic factors of such vital importance as in the presence of organic^[heart] disease." The psychogenic nature of "functional" (non-organic) cardiac complaints is, of course, obvious, but Wolfe observes that "what is new is a growing recognition among medical men of the practical importance of psychic aspects of so-called organic disease, along with the recognition of the necessity of finding and treating specific factors instead of vague things such as 'worry' or 'fear,' just as the medical man is not satisfied with finding an 'infection,' but wants to know the nature of the infection, and, therewith, the means of combating it."

Diabetes mellitus is not often realized to have psychogenic determinants. Menninger (32), Root (41), and Daniels (10) are among those to show the significance of personality and environmental stress in this disease. Daniels reports case examples (10) of diabetic onset and/or aggravation with emotional stress, despite the use or neglect of diet and medication. "It would seem," he writes, "that in cases in which an underlying neurosis is of importance there is present a basic physico-neurotic reaction (actual neurosis) like

anxiety neurosis. There is reason to believe a similar erotization of symptoms goes on in certain cases as in psychoneuroses; in diabetes it would be the metabolic process that becomes erotized."

Psychotherapeutic cure of a patient with ulcerative colitis associated with hysterical depression is reported by Daniels (11).

Two surveys of rheumatoid arthritis are significant in this connection. Smith (45) reports that 52 of 102 cases gave evidence of "depleting and unbalancing experiences" which were closely related to the onset of the arthritis. Four years later, in 1936, Thomas (49) concludes that "significant emotional disturbances precede the onset of rheumatoid arthritis, not only in a certain number, but in a surprisingly large proportion of cases--in this series, in all of them."

After an analysis of "The psychic component of the disease process (including convalescence), in cardiac, diabetic, and fracture patients," Dunbar, Wolfe, and Rioch conclude (19):

First, much of the present-day medical treatment of somatic ailments is purely palliative and symptomatic in the sense that many somatic ailments are merely symptoms of an underlying disease process developing in psychic and somatic aspects...

Second, the psychic component may be determinative in illness, no matter how "organic"...

Third, from the point of view of the hastening of convalescence and the guarding against relapse, the role played by the psychic factor is determinative in a considerable proportion of patients (as reported here for...cardiovascular disease, diabetes, and fractures).

Fourth, it is probable that the psychic factor is specific at least for certain disease processes or syndromes, such for example as "essential hypertension."

"Expensive as psychotherapy is," they add, "it is less expensive than caring for the invalidism that is inevitable without it."

There is still one other reason--albeit subjective and even egocentric--for the physician to cultivate a psychobiologic perspective and a psychotherapeutic technique. Campbell's remarks about psychoanalysis (6) may well be applied to the broader psychobiologic concept of medical therapy:

The general physician will find a study of psychoanalysis to be gratifying to his professional outlook as well as to his everyday enjoyment of life... He is in an ideal position to observe a family over a period of years... And the family physician, who has insight into these important relationships, is in an enviable position to suggest here and there and perhaps save a susceptible child from a miserable life of neuroticism.

He who coldly follows an organic "history-examination-diagnosis-treatment" routine under the guise of scientific objectivity forfeits much of the warmth and satisfaction inherent in medical practice. The patient who has been led with tact and understanding to achieve satisfactory readjustment is apt to be far more appreciative than the one who has been temporarily relieved of pylorospasm, peptic ulcer, or recurrent appendicitis. This vaunted "patient-doctor" relationship so suddenly santified before the specter of socialized medicine is nonetheless a respectable entity, potentially laden with dividends

for both patient and doctor--if it be used, rather than
prated about. There is infinitely more in medicine for the
physician of whom Loomis writes in Consultation Room, "who
sees his patients as troubled human beings who have come to
him for help, rather than a succession of aches and pains."

II. DIAGNOSIS

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Hazards

The results of therapy directed against any illness are obviously heavily dependent upon accuracy of diagnosis. The statistical averages of five-year cures of malignancy, for example, differ widely in different clinics depending in part upon whether the pathologist is "cancer-minded" in his interpretation of border-line metaplasia.

It is incumbent upon the physician who would treat psychogenic ills, therefore, to diagnose, evaluate, and treat not only the "functional" component of his patient's disorder, but also any significant organic component. The term psychosomatic medicine, itself, may be taken to imply that human ills, like human beings--the "Aryan" race to the contrary--rarely appear in pure culture. Failure to perform a competent, unprejudiced examination for all pathology is almost indefensible. Hamman wisely cautions (21):

I wish to point out a real danger to one-sided emphasis. The most crushing disgrace a doctor can suffer is mistakenly to treat a patient with organic disease under the assumption that his disorder is due entirely to functional causes. ... It must be remembered that the distinction between organic and functional disease is always difficult and sometimes calls for the very highest skill of the physician.

Nor are we justified in seizing upon a diagnosis of functional disease, neurosis, etc., as we would ^{for} a gauze pack--

merely to fill a diagnostic cavity. Psychoneurosis is not, as often taught, a diagnosis made in vacuo and confirmed by the exclusion of all demonstrable organic causes for symptoms. While the persistence of symptoms in the absence of organic causes may be presumptive evidence of a functional disorder, a diagnosis which indicts personality function must be confirmed by positive findings of maladjustment, emotional immaturity, etc. "The physician," observes Campbell (6), "is rationalizing when he dismisses a patient by saying 'she is just another neurotic.' The physician who has been trained in cellular pathology and bacteriology finds it difficult to understand the psychoneurotic patient in the light of this training. He must learn to analyze the neurotic symptom. It...is a dysfunction, involving to a varying degree the endocrine system, the sympathetic nervous system and the psyche (mind or central nervous system)."

Assuming, then, that the presence or absence of demonstrable organic pathology has been determined, one has still to evaluate its relative importance in the patient's total problem. Frequently we are forced by circumstances to neglect otherwise desirable forms of therapy because their importance is overshadowed by more pressing needs, somatic or psychic. One is tempted to suggest, however, that orthodox medicine since Virchow has been far less apt to neglect fundamental needs of organic nature than those of psychic origin. Nevertheless, selection of therapy to fit individual cases is one phase of

the art of medicine. Often we can hope for only relative cures, when many of the ills to which man is heir are more wisely endured than emphasized.

Harrington (22) classifies disorders for which psychotherapy is indicated as follows:

- I. Neurosis. Those conditions in which there is no demonstrable pathology and in which the complaints of the patient are looked upon as due in part at least to "psychic" causes.
- II. Conditions with demonstrable pathology which are due in part at least to psychogenic causes.
- III. Problems in mental adjustment occurring as results of physical deformity or disease.

The differential diagnosis and evaluation of psychosomatic pathology is a formidable responsibility. One longs for the confidence and finality resident in, say, the radiologic diagnosis of fracture or the microscopic diagnosis of tuberculosis. Schilder states the problem when he writes (42, p. 83):

I think that the knowledge of attitudes of organic and psychogenic diseases is of primary diagnostic importance. We have also to understand the specific attitudes connected with specific organic diseases. We shall then better understand the psychogenic pictures and their specific relations to beginning organic disease. We still lack a symptomatology of internal diseases from a psychological point of view. I think that such a symptomatology of internal diseases, evaluating the psychological structure of the pathological experiences of the organically sick, will be of indispensable value, not only for the diagnosis but also for the treatment of the patient. It is trite to say that every sick person needs psychological help.

We have implied that the psychosomatic patient whom we wish to help is commonly a "borderline" patient, being

neither frankly somatically nor psychically pathologic. Because of the difficulty of confirming the diagnosis, they not infrequently raise the suspicion of malingering. Only with the greatest caution, however, should such a conclusion follow, even in the face of apparently patent motives.

Ackerly warns (1):

I think we are fooled not on the basis of missing a clear-cut malingerer, but because the patient is making a sick adjustment to life or he would not go to the extreme lengths he does to gain such relatively small advantage... Among students we find that one of the common errors is to widen the concept of malingering to include those neuroses associated with somatic complaints. This erroneous concept sets up an impassable barrier to treatment.

Etiology

The paucity of objective findings in psychogenic disorders compels the diagnostician to rely heavily upon the history, particularly to discern what endogenous or exogenous factors may have caused an alleged maladjustment. Four predisposing factors which may operate in the production of mental ills are enumerated by Harrington (22):

- I. Situational factor
- II. Constitutional factor
- III. Factor of bodily ill health
- IV. Factor of wrong education or training

Actual precipitation of symptoms is ascribed by most authors to a mechanism involving basic errors of personality function. Lorand declares (28): "The basic problem of the patient is his lack of adaptability. Being unable to accept

reality the patient seeks to escape it. The neurotic symptoms are therefore a means of justifying the flight, as well as the demands for support, guidance, and attention."

Rado writes (36), "The neurotic ego is thus driven by its morbid fears to carry out unnecessary emergency measures which reduce both the range and the efficiency of its functioning." He subdivides these "emergency measures" into three levels of consciousness with a dominant symptom for each:

1. Intellectual level (fear)
2. Affectomotor, subintellectual, level (anxiety)
3. Subaffect level (pain)

Although such a hierarchy may be an oversimplification and artificial, the concept seems useful for orientation.

It is perhaps also academic to attempt anatomic localization of psychologic drives with our present lack of experimental data, but the attempt may still be valuable in clarifying our ideas of psychologic mechanisms. The trend of ethics since the cave man has been to abhor emotional motivation and satisfaction, but to applaud intellectual domination as the ultimate good. Cannon's monumental experiments,* however, were the beginning of a

*Cannon, Walter B., Bodily changes in pain, hunger, fear and rage. D. Appleton & Co., 1915.

scientific movement proving emotions to be a fundamental physiologic necessity, clearly correlated with anatomic

and chemical function. Concerning the source of basic psychologic drives, Houston, an internist, graphically writes (24):

Their chief seat is in the thalamus, the basal ganglia; their expression is through the autonomic nervous system. The intellect, the cortex, is their servant; its mission is to find means for their satisfaction. If the mind is the steering wheel, the emotional life is the motor, or, a better analogy, the vital tendencies dictate the direction and the goal while the mind finds the path that leads thither.

It is time we ceased to be prudish about recognizing emotion as the sine qua non of human motivation, with intellectual devices as convenient instruments for obtaining its satisfaction. Then we could more truly appreciate the plight of the neurotic patient, whose drives have temporarily overwhelmed his capacity for their utilization.

Symptomatology

In considering the symptomatology of psychogenic illness it is imperative to remember that we are here using the terms "neuroses" and "neurotic syndrome" to denote symptomatic manifestations of psychogenic malfunction--not to denote a pathologic entity, per se. As Davison, Lowlance and Barnett point out (14), "Symptoms occurring in neurotic individuals occur also in so-called normal individuals at times, varying in degree of intensity. With the exception of some forms of hysteria, the normal counterpart of every neurotic symptom can be indicated to the patient... In neurotic individuals the same symptoms occur as in normal people, only without

evident cause, and patients misinterpret the symptom and assign it to an organic disease."

Schilder offers a table of symptoms for orientation of body ailments from a "psychotherapeutic point of view" (42, pp. 33-34):

1. Symptoms of the surface of the body:
 - a. Swelling (addition to the image of the body)
 - b. Mutilation (subtraction from the image of the body)
 - c. Change
 - d. Loss of integrity (bleeding)
2. Symptoms of the openings of the body:
 - a. Occlusion (constipation, difficulties in breathing, absence of sweating, absence of menstruation)
 - b. Excessive discharge from the openings (vomiting, diarrhea, excessive menstruation, hyperhydrosis)
3. Symptoms of the senses (impairment of sensory intake).
4. Symptoms of the inside of the body:
 - a. Increased heaviness (general, localized, fullness, densification)
 - b. Diminished heaviness (general, localized, holes, emptiness)
 - c. Change in quality, from the point of view of physics (solid, liquid, gas)
5. Symptoms of motility:
 - a. Diminution (paralysis, weakness, fatigue, general and local)
 - b. Increased (fits, cramps, twitchings, tension, restlessness, general and local)
6. General symptoms:
 - a. Anxiety
 - b. Dizziness
 - c. Nausea
 - d. Pain
 - e. Inhibition
 - f. Fatigue
 - g. Weakness
 - h. Restlessness
 - i. Tension

(According to this table, the general symptoms and the motility symptoms have close relations to each other.)

"Every one of these symptoms," Schilder adds, "can occur in the course of an organic disease as well as by psychogenesis. If one of the symptoms occurs from an organic point of view, it will carry with it specific psychological attitudes... If ...on a psychogenic basis...we find a similar psychological attitude as a causal factor in the formation of a neurosis."

(Vide supra p. 15.)

Given a set of symptoms common to both "somatic" and "psychic" disorders, the physician may then examine the underlying attitudes of the patient, both general and specific, as a means of differentiating and evaluating organic and/or "functional" components. Every physician is repeatedly subjected to vast differences in the attitude with which patients regard their afflictions, varying from an interminable "organ recital" of complaints to a cold and discouraging indifference toward attempts at therapy.

From Stern's work (48) have been abstracted some of the commoner determinants of neurotic attitudes:

1. Narcissism. Predisposition by "affect mal-nutrition."
2. Psychic bleeding. Patient collapses when subjected to "trauma," instead of recovering normally. Failure of "rebound."
3. Inordinate hypersensitivity. Is in keeping with deeply rooted insecurity, which necessitates undue caution and awareness of danger.
4. Psychic rigidity. The "rigid personality." Exhibited before four or five years of age; aggravated at periods of stress (puberty, marital adjustment, menopause, etc.). Maternity fraught with great "danger" (anxiety).

5. Negative therapeutic reactions. Depression, anger. Therapeutically, there is a narrow margin of safety: danger of suicide, self-injury.
6. Feelings of inferiority. Lack of insight. Immature traits.
7. Masochism. "Wound-licking." Self-pity.
8. "Somatic" insecurity or anxiety. Failures taken to mean basic incompetence.
9. Use of projection mechanism. Defective judgment.
10. Difficulties in reality testing.

Demonstration of one or more of these attitudes is significant only in degree of emphasis and in relation to other findings, and not in their detection alone. When we can recognize the same attitudes in ourselves, we can scarcely throw the first stone.

It may be of value to list specifically the more frequent manifestations of the neurotic syndrome. For this purpose a table prepared by Kraines (27, p. 37) is reproduced:

| <u>Symptoms usually Symbolic but not exclusively so:</u> | <u>Symptoms expressive of General Tension</u> |
|--|---|
| Muscle paralysis | Irritability |
| Muscle tics | Anxiety |
| Anesthesias | Egocentricity |
| Hyperesthesias | Concentration difficulties |
| Paresthesias | Worry |
| Tubular vision | Overconcern about the self |
| Phobias and fears | Anorexia |
| Obsessions, compulsions | Insomnia |
| Abnormal sex interests | |
| Impotence | |
| Hallucinations | |
| Delusions | |

(Table continued)

Symptoms usually expression of
a Focal Tension or of a disturbed
Autonomic Nervous System

Weakness, "being run down"
Easy fatigability
Cardiac symptoms
Gastric difficulties
Intestinal spasms
Bladder irritability
Uterine dysfunction
Pains and aches in limbs
Headaches
Perspiring palms
Cold hands and feet
"Eyestrain"
"Ringing in ears"
Stammering and stuttering
"Lump in throat"

Because the patient is usually seen first by his family doctor, the latter should remember the possibility of an early schizophrenic basis for neurotic symptoms. To quote Ackerly (1), "It is well to recognize that the first stage of dementia praecox is often accompanied by physical symptoms not unlike the symptoms of a hypochondriacal psychoneurotic. These patients are generally emotionally apathetic, indifferent, and unresponsive. They should be given institutional treatment for the underlying psychosis as early as the condition is recognized. The earlier treatment is given, the better are the chances of improvement." As Campbell points out (6), "The meagerness of psychotic material expressed by some well-developed schizophrenic patients is a thing not generally realized. It is said that some paranoid praecox patients are to be recognized as much by what they fail to say as by what they do say."

In summarizing this entire section on diagnosis, we are obliged to confess that such a discussion can hope to contribute little concrete help in detection and evaluation of neurotic and psychogenic trends. Accurate diagnosis, like so much else in clinical medicine, necessarily stems from actual practice; discussion can merely seek to suggest presumably desirable perspectives, to be translated into action if practicable. We have, therefore, considered more or less at random certain concepts underlying psychosomatic diagnosis, essaying to stimulate a healthier approach to psychogenic illness as it exists.

III. METHODOLOGY

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Attitude of Physician

In no other type of therapy is the attitude of the physician more determinative of success or failure than in psychotherapy. While the therapist should inject his own personality into the picture as little as possible, he nevertheless must maintain his patient's confidence in his interest, competence, and objectivity. We frequently underestimate the impressionability of patients to off-hand remarks or to transient moods, and the neurotic patient magnifies this propensity many times. Coon and Raymond have observed the tendency of sanatorium patients to seize upon chance remarks of their physicians for guiding maxims (8, p. 30).

"The general practitioner," writes Menninger (33), "responds with varying types and degrees of emotional reactions to the individual afflicted with a nervous break-down, often in contrast to his cold, scientific and unemotional attitude toward physical illness. The average physician's reaction to these problems depends chiefly on his own interest in and knowledge of psychologic illnesses." He tabulates these responses as:

1. Irritation and annoyance. Nothing to treat, but patient persists in returning.
2. Curiosity and incredulity. Physician may recognize psychologic nature, but use physical treatment.

3. Exasperation, contempt, anger. Patient is either a liar or a malingerer.
4. Oversolicitousness, pity, anxiety. Tells patient of "elevated blood pressure," "extra-systoles," or "trace of albumen."

That patients with psychogenic illnesses do greatly try one's tolerance is undeniable. Their histories are interminable, their moods infectiously depressing; they return with the same tale of woe instead of a gratifying report of improvement; they distrust the therapeutic measures or the doctor himself. And yet if the physician can not desensitize his own emotional reaction to such patients, he is seriously handicapped--even exposed as similarly maladjusted--in his relations with a large proportion of patients.

Campbell's words (6) are helpful in struggling to forgive these unfortunates:

It is erroneously supposed that the neurotic individual could prevent or forget his symptoms if he only cared to do so. The neurotic symptom is itself a by-product of a sincere attempt to overcome a more serious problem. It is a substitution, a replacement of a formidable difficulty by a simpler one. One cannot accuse the neurotic patient of not trying to overcome his illness. The fact is, he attacks a much more serious, more deeply seated problem and is finally able to effect a compensation, so that when the physician is confronted with a simple neurotic symptom he should visualize the agonizing battle which occurred within that patient before the symptom was evolved.

"The neurasthenic," said Jastrow (25, p. 322), "has to fight for every inch of health and poise, and, when he wins, deserves a hero medal, for he is a fighter under the unfairest handicaps that could be imposed; he has the hardest task with the least energies to meet it."

Billings comments (4, p. 224) that "Inasmuch as psychobiology is still probably in little more than the infantile stage of its development, the physician must recognize the known facts for what they are and be able to realize that there are still more to be formulated." The same author then stipulates three prerequisites for successful practice of psychotherapy (4, pp. 224-25):

The first prerequisite, therefore, is the acquisition of a type of clinical discipline which will enable the physician to keep accurate records and maintain a position wherein he can test his therapy constantly with incessant whys, hows, and whats. This presupposes in the physician a thorough knowledge of personality organization and functioning; of racial, community and family ideologies; and of the ever-present and changing socio-economic factors.

The second prerequisite is a healthy attitude toward the time factor in treating the psychiatric case. We still, and probably will continue to, include in our thinking and expectations some of the concepts that more properly belong to physical medicine. Insofar as the time factor is concerned, psychopathological disorders by their very nature, differ from the somatic disorders in that they are in general more extended. If the internist should expect a patient with typhoid fever to recover within two weeks, and as a natural result should try to hasten recovery, several new factors might enter the therapeutic problem. He would be unable to work with ease and therefore would work less efficiently; his patient would soon become subtly aware of his physician's attitude and so have an additional load with which to struggle; and, lastly, the physician, in his disappointment and resultant drive to force the issue, would be apt to overlook important features of the case, to come to rely too much on dangerous tricks and possibly, in an indirect way, to influence the lay concept of the malady.

The third prerequisite is, of necessity, the acceptance of a broad definition of what constitutes treatment--a definition that can be accepted with

ease and relative satisfaction, whatever the state of our knowledge may be, and one that will include new data without requiring a complete change in the general schema.... Webster's International Dictionary probably offers as good an interpretation as we could ask for, viz., treatment is "the management and care of a patient or the combating of his disorder."

This quotation has been taken from Billings at considerable length because of its fundamental importance to our discussion.

Obviously, reconstruction of the physician's attitude toward psychogenic patients is scarcely to be accomplished on paper. It may be of value, however, to summarize the more common errors committed in treatment of such disorders. The following is a list of therapeutic "don'ts" compiled from contributions by Rodis (40); Ackerly (1); and Davison, Lowance, and Barnett (14):

1. Don't hurry. The necessity of "a healthy attitude toward the time factor" was emphasized in Billings' prerequisites (vide supra, p. 26). Psychogenic illness is characteristically chronic in onset; therapy must be "chronic" to permit readjustment of deeply rooted behavioral patterns. Resistance to therapy attempted on a given day may spontaneously disintegrate if time be allowed for readjustment of attitudes.

2. Don't cheat. The importance of complete clinical study--history, physical, laboratory, neurologic, and psychiatric--is a hackneyed but vital point. It is dangerous

to disregard unexplained findings; unusual or unlikely complaints, sudden unaccountable changes in behavior may, if traced, obviate weeks of fruitless, wasted effort.

3. Don't make snap decisions. It is well to answer no questions until the entire examination is completed. One cannot erase early impressions given the patient; if erroneous they will require laborious counter-suggestion in the face of an ever-heightening threshold of receptivity.

4. Don't be squeamish. Patients are often far less reluctant than their physicians to discuss sexual, marital, and family problems. Tact and patience are keys.

5. Don't judge. Physicians are scarcely qualified moral tribunals; we should not attempt to lead others down the avenue of our own prejudices. A human being, regarded in an unbiased, scientific spirit, is an "experiment of nature, rather than a person with good or bad ideas, good or bad morals" (1).

6. Don't be a mystic. It is unwise to mystify the patient with unusual terms, unexplained procedures. Davison et al (14) even read prescriptions to their patients, pointing out indications and probable effects. Above all, don't commit the most opprobrious sin of all by saying, "There is nothing wrong with you--but here is a prescription."

7. Don't argue. Argument, "reasoning," persuasion, and even advice are seldom useful in fostering insight (vide infra, pp. 53-54). Instead, search openly for the cause of resistance. One "argues" emotionally for prejudices, beliefs--not facts.

8. Don't coddle. Independent insight is one aim of therapy (vide infra, pp. 30-32). Sympathy, head-patting murture only a parasitic dependence of patient on physician; it may temporarily prolong the physician's income but hardly helps the patient.

9. Don't play God. Patient and doctor alike are mere human beings. The physician is superior professionally by accident of specialized training, but the advantage does not necessarily extend beyond his own field. He must scrupulously avoid pompousness, obsequiousness, and condescension lest he set up additional barriers to treatment.

10. Don't tell patient he's improving. If true, he will find out for himself. Patients rightly resent such allegations unless first convinced of their truth.

Aims of Psychotherapy

One hears it said that certain physicians have a "way" with patients, that these are the ones best qualified to manage psychogenic disorders. Observation suggests that the popularity (i.e., "patient-appeal") of a man in practice bears little relation to his academic or technical assets. It is probable, however, that the adaptation of psychologic principles to therapeutics will lift from these particularly gifted clinicians the aura of mysticism. In fact, it appears that the therapeutic influence exerted by these personalities is not necessarily curative although temporarily beneficial.

The mechanism is that of suggestion (vide infra pp. 49-52), and because it is directed at symptoms instead of causes, the benefit is usually short-lived or dependent upon continued influence. The application in faith-healing, osteopathy, chiropractic and allied practices is obvious.

Successful psychotherapy, however, is a procedure capable of being learned and perfected by practice, founded upon perfectly legitimate and objective psychologic tenets which we shall endeavor to outline. Although often palliative and symptomatic, it is fundamentally curative, attacking the roots of personality disorders which only secondarily nourish the neurotic symptoms.

"The mainspring of modern psychotherapy," writes Schilder (42, p. 153), "lies in the desire to help the patient to a better emotional and intellectual adaptation on the basis of insight." In support of this contention, the same author declares (42, p. 20):

The modern approach to psychotherapeutic problems stresses the necessity of gaining insight into the patient's personality and conflicts. In this respect, Janet, Freud, Jung, and Adler are of the same opinion. There is the underlying conviction that suffering due to psychic reasons is dependent on conflicts which the individual is not only unable to solve, but is not even aware of. The psychotherapeutic process therefore must reveal the personality and the conflicts not only to the physician but also to the patient himself.

Discussing insight as an aim in psychotherapy, Cleckley (7) points out that prejudice is a formidable block to insight; witness religion, for example. Logic is clearly

powerless to demolish such a barrier. To illustrate the mechanism of blocks to insight, the author uses the example of a miser who fails to see the fallacies in his scale of values because of:

- (1) necessity to admit wasted, misdirected effort;
- (2) loss of face entailed in admitting one has been wrong in the past;
- (3) necessity of change of habits;
- (4) ordinary pleasures having lost their appeal to;
- (5) pleasure of self-denial and self-punishment.

Loss of insight, Cleckley concludes, like euthanasia is protective--commendable when the situation is irreparable, but tragic when it blinds one to the solution. Regaining insight is painful, but so is lancing a boil or realigning a comminuted fracture.

Once insight is achieved it is necessary to crystallize its benefits by practical application. In comparatively mild disorders, of course, the mere attainment of insight may be sufficient to correct spontaneously the disoriented behavior. Other behavioral patterns are developed and fixed by life-long responses to external stress plus inherent constitutional determinants. "These general patterns of behavior," Kraines attests (27, pp. 172-73), "once established continue to perpetuate themselves; and even when the original irritations and forces have long ceased to be disturbing to the adult person, the habit factor will keep these general reaction patterns in action."

It is essential, therefore, that old attitudes be replaced by others which fit the newly acquired insight, and that the new response patterns be exercised until they become as automatic as were the pathogenic responses. Ideologies and goals may require examination and evaluation, and attitudes sought compatible with both ideals and reality. Energy may require redirection consistent with maximum efficiency and economy of effort and appropriate to the formulated goals. In harmony with Pavloff's theory, the entire process represents a reconditioning of responses to old stimuli--but to stimuli which exist in the present reality and not in a smoldering residuum of immaturity.

"It might be said," Ackerly writes (1), "that treatment starts when the doctor stops talking and the patient begins, and that treatment flourishes when talk finally gives way to thought, and ends when thought and insight break into action."

The aims of psychotherapy, then, are fundamentally two:

- I. Development of insight, and
- II. Retraining attitudes.

Tools* of Psychotherapy

*This term applied in psychotherapy by Schilder (42, Ch. VIII).

A. Distributive analysis

The analysis of personality background and function seeks to effect the first aim of psychotherapy, viz., insight. It is performed with this end in view, although secondarily the analysis serves to acquaint the physician with the basic problem and thereby to suggest means of effective management. Major attitudes and reaction patterns are determined and openly scrutinized in their relation to the dominant goals. Those attitudes found to be undesirable for presumably normal personality function are examined to determine their causes; i.e., to make their causes known to the patient.

In considering personality analysis one thinks first of the classical Freudian psychoanalysis. But while the Freudian method has its inherent advantages, the fact that special instruction is usually prerequisite and that a maximum of ten or fifteen patients can be handled in a year clearly places it beyond the scope of the general practitioner.

Distributive analysis and synthesis were originally outlined by Adolf Meyer. They are described by Diethelm (15, p. 111) as "the most natural approach to the correction of personality difficulties on a psychobiologic basis... The analysis is distributed by the physician along the various lines which are indicated by the patient's complaints and symptoms, by the problems which the physician himself can recognize, by the patient's imaginations concerning the present and the past as well as by actual situations, attitude to

the future and outstanding features of his personality."

Distributive analysis should not be carried out dogmatically in a preconceived pattern. It must be adapted individually to the needs and capacity of the patient. It is for this reason that we shall be admittedly vague in this discussion as to the specific use of given procedures. Use of a particular tool must be appropriate to the problem at hand; therefore, the available tools will be enumerated with only general comments as to their application, and final selection left to the therapist:

1. Intensive anamnesis. An attempt is made to trace the significant developmental history from a psychobiologic point of view. The "life chart" devised by Adolf Meyer (4, p. 60; 35, p. 39) is convenient for this purpose, enabling one to plot disturbances graphically in their respective integration levels. Schilder in group therapy instructs the patient to write a detailed biography (vide infra, p. 62).

Gallinek (20) states that in a large majority of cases the intensive anamnesis is an essential part of treatment, interrupted only by spontaneous associations of the patient; in others, the flow of narration quickly ceases and one must resort to the association tests and other forms of analysis.

In any case, an adequate psychobiologic history is indispensable for orientation and beginning analysis. According to Diethelm (16), "Situational factors receive attention,

but the main effort is directed to the determination and understanding of dynamic factors and constitutional make-up.⁸

2. Direct discussion. One of the commonest of therapeutic tools, its effectiveness is profoundly dependent upon the personal equation. Kraines emphasizes that there is a technique and art in interviewing patients which, properly exercised, may not only facilitate acquiring information but also get material held back consciously or unconsciously (27, p. 137).

The prerequisites have been mentioned earlier (vide supra, pp. 24-29). Briefly, the physician must maintain an everyday, common-sense attitude which is logical, objective, and relatively free of emotional color. He should inject himself into the discussion only enough to keep it directed constructively and to point out fallacious trends. Affective blocks, unusual reactions (weeping, anger, blushing), rationalization, and other evidences of stress are brought into the discussion for desensitization and development of insight.

Schilder (42, pp. 104-07) suggests the following general topics:

- a. Social, economic situation: ambitions, disappointments.
- b. Relations with friends.
- c. Relation with father, mother, siblings, family in general. Dependence.
- d. Sex, love.
- e. Diseases; associated attitudes.
- f. Attitudes toward one's children.

The same author has devised a series of questionnaires to guide the physician when compelled by resistance to use direct and

specific questions. A study of these questionnaires (42, pp. 204-55) is strongly urged, although, as Schilder points out, questions must be reformulated for the patient in words appropriate to his attitudes and degree of insight.

The examination of ideology, basic goals, and social adaptation is properly an important part of direct discussion. While the physician is in no position to judge the ethics of his patient's fundamental ambitions, he may, by virtue of his objectivity, lead his patient to consider the appropriateness (i.e., compatibility) and relative importance of his several goals, as well as his means and the possibility of their achievement. Ideals which are irreconcilible to reality or plainly incapable of attainment tend to dissatisfaction and accumulation of tension.

3. Association. This term applies to certain procedures used to uncover repressed material inaccessible to simpler means. They have the disadvantages of requiring considerable time and interpretation because of the abundance of irrelevant material introduced. Nevertheless, resort to the method is valuable when barriers can not be penetrated by more direct means.

(a) Free association (cf., 27, pp. 141-46; 42, pp. 113-18; 15, pp. 62-65) is the method suggested by Freud, to which he turned from hypnosis because of the former's greater tendency to foster insight. Free association constitutes the basis of present day psychoanalysis.

Ideally, the patient lies quietly upon a couch exposed to a minimum of external stimuli, with the physician just out of view. The patient is instructed to say whatever comes to mind, without preliminary discretion; that even though much will seem silly, even shameful, still he must omit or change nothing.

"Normal" thinking may be described as consisting of a procession of word- or thought-images through awareness (consciousness), guided by a process of selective association toward a certain goal. In the presence of strong emotional conflict (in or out of awareness) there is vacillation in the progress of associations between the two poles of conflict as well as toward the immediate goal of thought. If, therefore, one permits one's attention to wander freely (i.e., "free associates") his associations will exhibit a trend which may be interpreted to denote a source of conflict.

Manifestly, patients will often experience great difficulty in relating uncensored thoughts; some must be frequently reassured and repeatedly asked, "What are you thinking now?" Others will talk irrelevantly at great length, perhaps defensively, and must be directed and limited by provocative stimuli--the term "free" association being only relative and not necessarily meaning "undirected."

Much is dependent upon the alacrity with which the physician detects the often vague hints denoting emotional trends, and upon his discrimination in limiting or guiding

association.

(b) Word association tests (42, p. 188; 27, p. 152) were devised by Jung. They represent an interesting but cumbersome method of determining associational blocks or incongruous associations, by the use of fifty to one hundred stimulus words. Reaction time, association word, and reproduction word are noted for each stimulus; causes of delay and incongruity are then sought and discussed with the patient. Thus, if he responds "devil" to the stimulus word "wife," or can not think of a word on hearing the word "poverty," he provides the physician with clues. A list of words and explanation of the test are furnished by Muncie (35, pp. 59-61) and Diethelm (15, pp. 104-109).

Word association tests are not currently popular, because of their difficulty of application and interpretation. Free association would seem more reliable and convenient, according to the authors cited (42, 27, loc. cit.)

(c) Ink blot (Rorschach's) test. This is an association test with image-stimuli provided by variously shaped "ink blots" (15, p.109). It is open to the same disadvantages and difficulty of interpretation as word association tests.

4. Interpretation of dreams, daydreams, and everyday life mistakes. (42, pp. 122-35; 27, pp. 146-51). These are evidence of "subconscious" (i.e., outside awareness) activity which on occasion escapes suppression and crops into consciousness. Their interpretation is sometimes useful when

apparent and capable of comprehension by the patient, but is subject to the unreliability and other disadvantages of restricted association.

Schilder's opinion regarding dream interpretation is of interest (42, pp. 132-34): Although Freud interpreted dreams as symbols of wish-fulfillment they are not true symbols, being disguised to pass the "censor" and representing composites of at least several factors:

- a. Present situation (social, sexual elements)
- b. Infantile situation
- c. Concepts of body, body-image (sexual material, especially)
- d. Relation to past, future.

"Interpreting dreams...has to be subordinated to the total situation. It has a value only when it sooner or later increases the insight of the patient into his present and past situation."

5. Play technique (42, pp. 118-120; 47) is an alternative means of eliciting associations when verbalization is inadequate; e.g., in analyzing children of less than nine or ten years of age. Free association, on the other hand, is communicated in words. To obviate the necessity of verbalization, play-situations may be constructed and the patient's associations inferred from his response.

Dolls and toys are most effective for children over five years of age. The child should have a choice of toys or objects, but not too great a variety. Toys should not move of their own accord but should permit of manipulation

by the patient; their selection, use, and any spontaneous remarks offered during play may help to suggest conflicts.

Solomon (47) states that an insecure home setting leads the child to feel that his parents do not love him. A feeling of grave danger ensues, accompanied by fear and subsequently by anxiety (chronic fear). If flight is not possible, the child has the alternative of "fight," as expressed overtly in an antagonism toward some object (toy, doll) which temporarily represents the cause of his dissatisfaction. The use of dolls or toys encourages (a) objectivity, and (b) release of emotions (vide infra, pp. 60).

Schilder (loc. cit.) describes the use of specific situations to elicit sexual conflicts: nude dolls with sex characters added with clay (Bender, Wechsler, Schilder); dolls with removable parts, representing the mother nursing a child who is said to be a sibling of the patient's to determine jealousy (David Levy).

Associational responses to pictures, puppet shows, and plays when possible may offer helpful material as well as inducing emotional release.

Opinions, stories, and discussion elicited from the child are useful but not often obtainable by a strange physician; interpretation is usually difficult.

6. Hypnotic anamnesis; hypnotic catharsis. The application of hypnosis to analysis lies primarily in its use

to release traumatic material which has been "protectively forgotten," as in amnesias and other forms of repression, when resistant to more direct means of analysis.

Lorand relates (28) that "Freud was the first investigator to call attention to the true nature of hypnosis which he stated 'is to be found in the unconscious fixation of the libido on the person of the hypnotist.'" According to Diethelm (15, p. 49), "In hypnosis the patient's attention is drawn to the physician's procedure and drawn away from the stimuli of the surroundings and from stimuli arising within himself. Therefore his field of consciousness becomes gradually narrower, and in a certain stage there does not exist anything else for him but the hypnotizing physician."

Techniques of induction are described by many writers (e.g., 27, pp. 227-33; 42, pp. 147-50; 15, pp. 51-54); only a general outline is necessary here. Ideally, the patient reclines comfortably in a quiet room with subdued lighting. He is directed to relax completely and to permit impressions to float in and out of consciousness without fastening his attention on any. Some object (key, coin, light) is held near his eyes and eye fatigue is suggested along with gradual drooping of eyelids, agreeable warmth and numbness of limbs, drowsiness, onset of sleep, inability to move extremities, and so on, monotonously repeated.

The majority of patients ~~of patients~~ are capable of being hypnotized, probably all who accord at least minimal

cooperation and especially if previously impressed by the physician's reputation and ability. Barbiturates or other hypnotic drugs are occasionally desirable to facilitate the initial induction. After the first induction, subsequent hypnosis is usually accomplished with ease even under distracting circumstances; subjects may be conditioned to certain specific stimuli for later induction before being awakened.

Once hypnosis is induced, the patient is instructed to recall or enact episodes, problems, etc., associated with certain crucial periods prior to the onset of the present illness. Information gained through hypnosis, however, should be accepted with certain reservations. Freud discarded hypnosis, turning to free association in psychoanalysis as more reliable. There is an ever-present danger of feigned responses to the physician's inadvertently expressed wishes, the patient under hypnosis being guided almost exclusively by a desire to please the hypnotist (42, p. 112).

The value of traumatic material obtained under hypnosis is proportional to its ability to promote insight. While post-hypnotic amnesia is seldom complete unless so directed, it is often difficult to induce the patient in a waking state to accept his previous utterances as significant. The trends obtained by free association, on the other hand, are more easily demonstrated to the patient.

Schilder concludes (42, p. 112) that the therapeutic results of hypnotic catharsis (release of forgotten material

under hypnosis) are in the long run unsatisfactory (cf. infra, p. 52), according to Breuer's, Freud's, and his own cases, "although the theoretical basis of the procedure is sound." Diethelm agrees when he declares (15, p. 58), "Hypnotic clearing up of hysterical amnesia has been abandoned for the more direct psychotherapeutic approaches because they offer the patient an understanding of the working factors.... Physicians who still retain cathartic methods combine them now with analysis in the hypnosis. To this they may even add the method of free association under hypnotic influence.... This modern cathartic-analytic procedure may be desirable in patients who are unable to discuss their problems and where a waking analysis can proceed only very slowly."

By distributive analysis, then, we have guided the patient "through an analysis of his conative and cognitive attributes and functional characteristics, his affective and his diffusely automatic regulative functions, the range and fluctuation of his fitness and efficient-economical performance, the familial and social influences and factors that have made up his environment and his sex development and functioning as manifested in the various situations and under the manifold circumstances of everyday life" (Billings--4, p. 235).

We are now prepared to consider the use of material and insight gained by distributive analysis, to personality synthesis. The distinction, of course, between analysis and synthesis is an academic one for purposes of convenience, not because the two comprise separate stages in therapy. Actually, the insight acquired in analysis is, at the same time, a potent factor in re-shaping attitudes and developing personality integration. It is necessary that the interdependence of the two approaches be remembered; manifestly, there is little reason to probe extensively into sources of affect which are related to the total problem only incidentally, or which cannot be constructively utilized in therapy. As Daniels warns (12):

In psychosomatic medicine, as in surgery, there are certain walled-off diseases that should be opened up only, if at all, under the most scrupulous application of technique... The physician may unwittingly, because of a desire to be sympathetic, have the whole neurosis plopped into his lap without knowing what to do with it. The result may be a hopeless emotional tangle... One does not cure cancer by sticking a knife into the center of the diseased process.

B. Synthesis.

Personality synthesis represents the plastic repair which is obligatory when once personality dissection by analysis is undertaken. Synthesis seeks to fulfill the second aim of psychotherapy, viz., retraining attitudes. If achievement of the first aim (i.e., developing insight) fails of its

own accord to reorient the individual in a practical way, the physician may turn to additional psychotherapeutic tools for the fulfillment of the second aim.

"In many instances," Kraines writes (27, p. 185), "the most important element in successful therapy is to have the patient willing to change. The very attitude of setting up as a goal a new type of attitude is in itself corrective. Learning, in general, is the result of practice directed toward a certain goal. As long as the goal is there, the number of failures is in itself unimportant. There are bound to be failures in adopting a new attitude, particularly in the beginning."

Throughout all the methods to effect synthesis, run three objectives: (a) desensitization, (b) reconstruction, and (c) adaptation. Old sources of personality conflict are rendered avirulent by a process of desensitization, thereby releasing harmlessly their suppressed affective charge. Reconstruction of attitudes, ideals, and goals is essentially a process of education or re-education and objective selection. Adaptation is the final test of all that has gone before, wherein the new principles are put into practice until their use becomes as automatic as was that of their inefficient or pathogenic predecessors.

1. Discussion. This is a tool which was included under distributive analysis, but so indispensable is it to synthesis

it is repeated here for emphasis. By means of discussion the material from analysis can usually be reformulated so as to effect reorientation of the patient's dominant tendencies.

While the physician must guide the discussion along useful and productive channels, he should be careful to remain at least ostensibly in the background. Fundamentally, it is the patient who must take the responsibility of the discussion, who must ultimately arrive at his own conclusions, before they will have both an emotional and an intellectual hold upon him.

Rapport between physician and patient is prerequisite to successful therapeutic discussion. Ackerly (1) was quoted above (p. 28) to suggest that the human being is best regarded as an "experiment of nature rather than a person with good or bad ideas, good or bad morals." He also recommends that the physician insure rapport by saying to the patient: "I respect your adjustment. You are not satisfied, since you are here; but you too must respect it as an adjustment made under the particular circumstances..." And since the patient is not to be expected to give up his original adjustment until a better alternative is found, Ackerly adds:

"I have no intention of forcing another method of life upon you, but I am here to help to examine all the possibilities and see what might best fulfill your needs."

That the value of an adjustment is not measurable in terms of its source, is pointed out by Schilder (42, p. 145):

Interpretation generally cannot mean devaluation. The value of the things cannot be decided upon psychogenetic principles but is dependent upon one's final relation to the reality and to the world.

If psychoanalysis shows the importance of pregenital and genital sexuality in child and adult, and has traced it into manifestations which do not seem sexual, it should be aware that the value of cultural and social phenomena does not depend upon the value we give to the infantile drive which it "sublimated." If cleanliness and hygiene are sublimations of anal tendencies, their value is still greater than the value of the pleasurable actions of the child with its feces, since the primitive experience is now in the service of an adaptation to reality.

In an attitude of unbiased realism, then, the patient should be led via discussion to examine his basic ideals and goals, then his adjustments to them. If insight has been adequately developed, he can perceive for himself the need and means of readjustment. The physician, in the background, affords a stimulus, a source of reassurance, and a check to insure constructive readjustments compatible with efficiency and reality.

Since much of the discussion hinges upon re-education, it is often possible to resort to accessory tools for aid. References to books, pamphlets, educational lectures or other sources may be helpful, and relieve some of the burdens of the physician. Ultimate personal responsibility for all conclusions, however, must rest squarely upon the patient; his acceptance of printed authority must not allow him to shift the onus of choice and thus to escape exercise of independent

action. Certain patients derive considerable benefit from the many books written on the order of "Wake up and Live," "Outwitting your Nerves," and the like. Of particular merit are the pamphlets (privately printed) distributed to sanatorium patients at the Austen Riggs Foundation, "to supplement personal conferences," and entitled (37; 8, pp. 161-264):

- I. The individual (elementary mental mechanics)
- II. Sensation and emotion (sensory symptoms)
- III. The problem of adaptation (maladaptation)
- IV. The technique of adaptation (efficiency)
- V. Rest

A study of these pamphlets by the physician as they are reproduced in Coon and Raymond's review (8, pp. 161-264) would be of immeasurable value in facilitating his psychotherapeutic discussions. They are admirably written (originally by Austen Fox Riggs) to develop the patient's insight into psychogenic illness and its treatment.

From a practical point of view, the time factor in psychotherapeutic discussion poses a serious dilemma. Extended interviews are not usually economically or otherwise feasible, yet adequate therapy demands that the patient does not feel he is rushed or that his doctor is inaccessible. During active therapy, conferences require at least a half-hour, once or twice weekly. It is helpful if both parties adhere to strict punctuality in beginning and terminating interviews, and if intervals between appointments be lengthened rapidly as progress is made until finally the patient reports only

when confronted by a problem he can not handle. By summarizing the progress accomplished at the end of each conference, one may emphasize the necessity for constructive results from each meeting. Occasionally, it is wise to terminate a given interview early if serious resistance bars useful discussion; the circumstance should be pointed out openly without censure, explaining that additional time will permit readjustment.

With the development newer psychotherapeutic techniques, it is to be hoped that the physician may soon be able to delegate many of the time-consuming re-educational procedures to competent auxiliary agencies. Experiments in group psychotherapy (vide infra, pp. 60-62) constitute a promising step in this direction.

Some of the other factors related to use of this rather all-inclusive tool of discussion have been dealt with earlier in this paper. It is, paradoxically, the most useful and yet the most elusive (at least from an academic point of view) method available to psychotherapy, but constitutes the vehicle or point of departure for all other devices.

2. Suggestion (27, pp. 219-27; 42, pp. 150-53; 15, pp. 44-48) is a method of influence utilized consciously or unconsciously by virtually every human being who deals with others of his kind. As a form of therapy it is utilized alike by Christian Science practitioner, osteopath, priest, faith-healer, and physician.

A consensus of opinions of the authors cited implies that suggestion is essentially the influence exerted by certain symbols which in turn are accepted on faith. The symbols may be authority, offensive medicine, impressive ritual, or complicated-looking gadgets. The suggestion may be direct, such as telling the patient that he will be cured; or implied, such as an optimistic attitude on the part of one's nurse, or the sudden summoning of one's distant relatives to the bedside.

The capacity for misuse is as obvious as it is limitless. If the physician would escape the stigma of quackery he must constantly evaluate the value of his suggestion "in proportion to its effect on general reorientation and change in attitude" of his patient, "rather than in terms of symptom disappearance" (27, p. 223). He risks, of course, the danger that a less scrupulous man across the street may effect a highly publicized and miraculous cure with ovarian tablets or a course of colonic flushes. He may see his osteopathic competitor fatten and flourish while he waits for the inevitable train of other symptoms to induce his patient to return to the fold for more basic therapy. Nevertheless, the fact that a man chooses professional medicine implies that he has a certain modicum of respect for scientific, objective fact--quite apart from its financial merit.

But this by no means implies that most of us in medicine can not legitimately profit from a working knowledge of suggestion as it operates in everyday practice, but only that the use of suggestion should be rational and generally in accord with facts. It is, after all, symptomatic therapy--a crutch which, without constant reinforcement, will surely collapse and leave the patient without support.

Judicious use of suggestion is entirely justifiable, however, as adjuvant therapy to reinforce curative measures, just as all symptomatic therapy is important in treatment of acute disease processes. In fact, if we are to "beat the cultists at their own game," as Bennett demands (2), we must take care to insure at least favorable suggestion from attitudes of personnel, use of necessary technical procedures, and other sources of oft-neglected influence. Certainly the implied suggestion which is inevitably present should be at least an asset to treatment.

According to Kraines (27, p. 222), constructive suggestion produces its effects:

- (a) by increasing the patient's confidence that his illness can be cured or adequately dealt with, and increased confidence is associated with increased ability to carry out the physician's treatment;
- (b) by directing his thoughts and attention towards pleasant possibilities and away from unpleasant ones;
- (c) by reorienting his psychobiologic attitude so that the decrease in emotional tone is associated with decreases in smooth muscle spasm, decrease in hypersecretion, etc., and

(d) by raising the threshold of pain and discomfort (probably by diversion of attention) so that he is better able to withstand his own symptoms.

Suggestion, then, may constitute a valuable tool, provided the user remembers that it is only a temporary aid and not the essence of therapy.

3. Therapeutic hypnosis is a method to which one may resort for suggestive therapy when suggestion by more direct means is ineffective. Schilder (42, pp. 146-50) views hypnotic suggestion with considerably more favor than he does hypnotic catharsis (vide supra, pp. 42-43), although recognizing it nevertheless as symptomatic therapy.

Hypnosis is induced as described above (vide p. 41), but instead of eliciting information the physician makes simple therapeutic suggestions. To the patient with an hysterical anesthesia he may say: "The arm which I am touching feels warm and agreeable; feeling has returned. When you wake, you will be able to use your arm perfectly and all feeling will have returned." To the patient with insomnia: "When you go to bed this evening, you will feel fatigued and completely relaxed. Your nervousness will give way to calm, and you will go promptly into restful sleep until time to arise. This will happen every night ..." (Abstracted from 27, pp. 227-33; 42, pp. 146-50; 28.)

Lorand's remarks (28) well summarize the use of hypnosis in therapy:

We must not forget that in hypnosis we are "smuggling" into the patient's mind ideas and desires for action by employing his belief in our power to cure him. But this condition cannot last forever. If he has not acquired insight into the difficulties and the structure of his personality which permit such symptoms to arise, he will not have the strength to combat them...

The golden mean in this form of therapy would be...to follow hypnotic suggestions which have improved the symptoms, by modified analytic approach to make him understand the origin and basis of the symptoms; how they are linked up with life experiences, especially fixations and childhood pattern formation and emotional inhibitions. During the treatment we have to pave the way for a gradual dissolution of the emotional tie.

4. Advice, persuasion, appeal to "will power" (42, pp. 107-09). These devices are mentioned only to be condemned. Dubois (17) worked out a method of persuasion, seeking to explain rationally to the patient the source of his symptoms, and then appealing to him as an intelligent human being to convince himself of their unreality. Psychotherapy, of course, seeks to show the facts to the patient, but it does not ideally exhort him to mend his ways. The desire must stem from the patient himself.

Failures in applying the newly acquired insight and attitudes to actual situational problems are inevitable. Hence, if the physician relies upon his authority to "appeal" to the patient's reason, will power, or what not, he thereby plants the seed of feelings of guilt in the patient to flourish when errors do occur. The patient who has been categorically advised to do thus and so will be reluctant to admit failures. The frankness of his relationship with the

physician is impaired; new barriers arise to thwart rapport.

Furthermore, when the physician undertakes to advise, he makes the patient's decisions for him--a procedure which, as we have said, is undesirable even if not always unavoidable. Not only does the physician foster the patient's dependence upon him; he also accepts a rather considerable responsibility, as for example when he recommends marriage or divorce. There is a real danger of overrating one's own capacity to advise in matters whose ultimate significance can scarcely be foreseen. It is far safer and more effective to guide the patient to a realization of the facts involved, their relative importance, and the possible alternatives of action. The patient can then draw his own conclusions, while the doctor remains neutral and not directly associated with the success or failure of the particular venture.

5. Relaxation-concentration. Schilder (42, p. 153) declares that in his opinion Jacobson's method of therapeutic "progressive relaxation" is "merely a suggestive method."

Tension as a symptom of neurosis is only too frequently apparent as a non-organic cause of such disorders as spastic colitis, paroxysmal tachycardia, peptic ulcer, and the like. Kraines sees these patients as perfectionists, suffering from unreleased energy (tension) with strict patterns of social and ethical standards (27, p. 245). "Their supply of energy exceeds the amount required...hence meticulous attention

is given to detail. The pattern is a vicious circle: the more demands they make on themselves, the more energy they generate, and the more there is a demand to express the energy ..."

Training such patients to relax is less a matter of relaxing muscles (Jacobson), than it is of relaxing mental attitudes. Several methods to achieve this end are suggested by Kraines (27, pp. 244-55): Reduce the number of unfulfillable desires, and by light hypnosis suggest relaxed attitudes--both to reduce energy mobilization. To handle the excess energy mobilized, one may encourage vocalization of emotions (where inhibition is excessively strict), socialization, and sublimation in recreation, physical activity, constructive work, and hobbies.

6. Change of environment. Recommendations of this sort are generally to be avoided by the physician. We have mentioned the hazards involved in advising changes; the ultimate effects of such changes from either a personal or therapeutic point of view can scarcely be anticipated. It is unwise for the physician to associate his reputation (as far as the patient is concerned) with the success or failure of any proposed venture, over which, after all, the physician has no control. When a change of marital, occupational, social, or geographic status seems desirable, it is best to induce the patient to consider the facts and alternatives himself, and then to make his own decision (42, p. 154).

7. Activity is the final tool to which we turn when insight and new attitudes have been effectively developed, at least in theory. With exercise the patient practices application of his newly acquired modes of response with a view to more efficient living. It is, after all, difficult to attack practical problems with academic procedures, and sooner or later the principles must be tested by expression in action.

The new insight and attitudes are of value in direct proportion to the degree to which they influence habitual responses to ordinary stimuli. In accordance with Pavloff's theory of conditioned reflexes, the new responses must be repeatedly conditioned to the old stimuli until they become as automatic as were their undesirable predecessors. Only by sustained practice will the new modes of response completely displace the pathologic responses.

As Schilder declares, "It is to the credit of psychoanalysis to have shown that mere exercise does not lead very far unless it increases the insight" (42, p. 145). For this reason, insight and re-education should have progressed to the point that the patient is capable of responding to the old affect-laden stimuli on an objective, rational, and independent level, before he is encouraged to apply the new principles.

Care must be taken to pave the way for handling the inevitable failures. The physician should by all means encourage acceptance of responsibility on the part of the

patient for dealing with actual problems, but he can not demand successful adjustment. Lest the patient's sense of guilt impair rapport, both he and the physician should attempt to analyze dispassionately the significance of both successes and failures--without elation or recrimination, but solely to profit thereby.

If, then, a patient has an anxiety neurosis he is ordered to walk a block, then two blocks. As confidence increases, he is instructed to attend church, go to a luncheon. While we can demand action (always within the present capacity of the patient), Schilder points out (42, pp. 145-46), we can not demand that the patient exert will power or that he does not become frightened. And, for that matter, unless one maintains the patient's confidence, he can not demand anything. The use of activity, therefore, as a therapeutic tool carries with it two cautions: (a) require of the patient only things which are within his power to control; and (b) imply no moral stigma to failure.

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We have sought to outline a variety of devices available to psychotherapy. Their most effective use, obviously, lies not only in technique but also in the proper selection of procedures to fit the particular problem at hand, as emphasized by Schilder (42, p. 158):

One sees that modern psychotherapy has a great number of technical tools at hand. But one should not forget that no technical tool is of any use unless one knows what to use it for. If one does psychotherapy, one needs more than technical tools. The man who does psychotherapy must have a plan and a system of coordinates with which he brings the experiences of himself and of his patients into relation.

Psychotherapy of Children

We have thus far discussed the application of psychotherapy without special regard to age groups, except to suggest that procedures must be individualized to fit the capacity and attitudes of the patient. It is desirable, therefore, to consider specifically what factors obtain in the treatment of child behavior problems, which do not necessarily apply generally.

Personality (behavior) disorders of children are, of course, of relatively shorter duration, and their genesis from environmental influences can more often be demonstrated than in like disorders seen in the adult. But there are handicaps in therapy to offset the ease of diagnosis: the child's capacity for insight is constitutionally less than that of the adult; rapport between patient and physician is often exceedingly difficult to secure and maintain. Fortunately, the therapist has two important advantages: he sees the disorder early while still developing and while acute; also, he can more easily influence the environmental factors confronting a child.

Pediatricians well recognize the importance of rapport in dealing with children, quite irrespective of the procedure being undertaken. Apparently the initial approach and attitude of the physician in talking to the child (of more than three years of age, at least) is all-important--and surprisingly difficult to perfect. Solomon writes (47): "The National Committee for Mental Hygiene, which furnished fellowships for the training of physicians in child psychiatry, has recognized that many men and women whose backgrounds have been essentially in adult psychiatry require at least one year before they learn how to talk to a child." Despite the difficulties of direct therapy, however, the alleviation of pediatric behavioral disorders in their incipience can be immeasurably gratifying to the practitioner who has therein been instrumental in preventing a life of asocial or neurotic maladjustment.

Because of the importance of immediate situational problems, the indirect approach assumes major significance in pediatric psychotherapy. Kanner has pleaded for a "practical psychotherapy" (26),

uniquely adapted and readapted to a unique person and a unique situation. It rests on the knowledge of the relevant facts pertaining to the person and situation and aims at the best attainable composure and smoothness of functioning....

Practical psychotherapy goes further than limited attention to the complaint or "symptom." It comprises work with the family and work with the community on behalf of the child. Correction of major or minor physical disorder may be needed,

not because of direct cause-and-effect connection with the symptom but because a child is better off without the elicited disturbance than with it. A balance may have to be struck between a child's capacities and his own or parental ambitions.

Following a general outline provided by Solomon (47), we may summarize a "practical psychotherapy" for children thus:

- A. Indirect therapy, concerned with unhealthy environmental attitudes, such as rejection by or hostility of parents who in turn may be quite unconscious of their existence or effect:
 1. Child guidance clinics.
 2. Psychiatric social workers.
 3. Direct psychotherapeutic of parent or other maladjusted persons associated with patient.
 4. Placement of children: foster homes, institutions.
- B. Direct therapy. Play techniques (vide supra, pp. 39-40) may be substituted for discussion and association procedures when inadequate verbalization and ideology so require.
 1. Distributive analysis for:
 - a. Mental catharsis.
 - b. Overt expression of hostilities.
 - c. Diagnosis.
 2. Synthesis.
 - a. Alleviation of guilt by expression.
 - b. Expression of love fantasies.
 - c. Desensitization by repetition.
 - d. Incorporation of therapeutic suggestions in the direction of growth.

Group Psychotherapy

One other special application of psychotherapy should be mentioned, perhaps not because of its present value to the individual physician but rather because it points the way toward eventual solution of the problem of re-education in psychotherapy. From our preceding discussion it is perfectly obvious

that the greatest present obstacle to effective psychotherapy generally is the economic and practical impossibility of enough time being devoted by the physician to treat each patient individually. The general practitioner rightly protests against any attempt to make him responsible for the extended re-education of patients; he has, after all, other demands upon his time. And yet an effective retraining program is for many patients the sole hope of cure, anything short of this being merely palliative.

In an attempt to cope with the problem of retraining and re-education, programs of group or "mass" psychotherapy have been undertaken primarily in conjunction with larger outpatient departments and sanatoria. Harris reports (23) that "thought control groups" have been conducted by the medical clinic of Boston Dispensary, as well as classes for exercises and patients suffering from such chronic diseases as tuberculosis, diabetes, and cardiac disease. "The thought control groups, started by Dr. Joseph H. Pratt in 1930...have demonstrated beyond question their intrinsic value to the large outpatient clinic" (therapeutic results cited below (p. 69)).

Schilder reports group therapy at Bellevue Hospital's psychiatric outpatient department (43; 42, p. 200), but has limited his groups to six or seven patients at the most, preferably to two or three patients in the group. In England, Snowden has shown that promising results can be obtained in

with very large groups of outpatients--the majority of whom were anxiety neuroses (49). Probably the most detailed outline of group sanitorial management is represented by Coon and Raymond's A Review of the Psychoneuroses at Stockbridge (8).

A composite picture abstracted from the several authors may help to describe the methodology of group therapy:

A. Distributive analysis.

It is assumed that all organic pathology has been evaluated and is being properly dealt with by the time psychotherapy is instigated. Even for purposes of group therapy, analysis remains essentially an individual problem. The patient must be seen in personal conferences until he can be properly evaluated and until sufficient insight is developed to induce him to follow the prescription of group attendance. Schilder (42, pp. 198-99) expedites analysis by obtaining a detailed written autobiography, instructing:

"When you write down the history of your life, you must not keep back anything. There may be situations and experiences which you would prefer not to write about. Still you have to write them down. Do not attempt to make a masterpiece...do not polish it. Contradictions and repetitions may finally help us to an important insight."

He asks for particular emphasis on "first memories," relations with parents and siblings, emotional crises, ambitions, ideals, work and school records, etc. "The patient," he comments, "is often helped already by the necessity of letting his whole life pass before his eyes. However, almost any

part of the life history will need an interpretation in the course of the treatment." Elsewhere (43) Schilder refers to questionnaires by means of which specific material may be elicited; e.g., questions as to emotional attitudes toward father, relatives; castration; masturbation, coitus, breasts, defecation, urination, disease, etc. Such methods can not entirely obviate the necessity for personal analytic conferences, however, to elaborate upon significant findings.

B. Synthesis.

As soon as he has developed minimal insight, the patient is told of group treatment program and the desirability of its use in his own case, emphasizing his personal responsibility for efforts at rehabilitation and the advantages of availing himself of the opportunity to study with others similarly ill. Attendance being a privilege and not obligatory, he may attend as long as he derives benefit. Should individual problems arise, the physician still remains accessible for help.

Group meetings are usually scheduled weekly at a time determined by the convenience of the members. Sessions are informal but strict punctuality observed. The following program for meetings is adapted from the routine used by Harris (47):

1. Assigned seat for each member, with an "honor bench" at front for members who have achieved outstanding progress in adjustment.

2. Roll call. Anonymously written reports by each patient on week's progress or failures.
3. Brief introductory talk by leader.
4. Reading of selected anonymous reports.
5. Relaxation exercise (vide supra, pp. 55-56).
6. Short talk on some neurotic aspect.
7. Oral reports of adjusted members (honor bench), recounting their original symptoms, etc.

Snowden (41) schedules a series of eight lectures, of which the first three pertain to anxiety states; four to depression, experience and phobias, mental conflict, and physical and mental introspection; and finally a lecture devoted to application of the principles discussed. He recommends that each patient be given an individual interview of two or three minutes after each lecture, while the patients talk among themselves as they await their turns. Special and final interviews are given with each series as required.

Such topics as included in pamphlets of the Austen Riggs Foundation (vide supra p. 48; 8, pp. 179-264) are well suited for lectures to develop knowledge of mental mechanics and bases for rehabilitation.

Harris (23) enumerates several principles which evidently operate in group psychotherapy; they have been abstracted as follows:

1. Loss of self-consciousness by:
 - a. Group association, demanding change from an introvertive to an extrovertive attitude.
 - b. Desire for approval of leader, promoting spirit of rivalry for maximum improvement.
 - c. Identification of patient with leader.
 - d. Realization that others have like problems.
 - e. Increase in sense of importance from promotion for faithful attendance and successful readjustment, to the honor bench.

- f. Appeal to immature emotional side of patient's nature.
- g. Early establishment of a goal in life, i.e., good emotional habits.
- 2. Sthenic suggestion to whole group by:
 - a. Reading progress slips.
 - b. Testimony of members who adjusted themselves to their problems.
 - c. Informal talk following relaxation when receptivity is at a maximum.
- 3. Establishment of rapport with leader by:
 - a. Roll call.
 - b. Enthusiasm of readjusted members for leader.
 - c. Occasional personal chats with leader following meeting.
- 4. Reinforcement of all factors operative, by:
 - a. Heightened suggestibility of group.
 - b. Removal of extraneous stimuli through relaxation.
 - c. Constant repetition of chief thought chosen for the particular class session.
- 5. Friendly relations established among members --of special value for those with limited social opportunities.

It may be thought that such procedures as "roll call" and "honor benches" are too juvenile to appeal to the average patient. One should remember, however, that psychoneurosis and other psychogenic disorders are the product of emotional or personality immaturity. The seemingly juvenile devices resorted to in group therapy have, according to Harris and others, a surprisingly profound influence in sustaining individual efforts toward improvement. Much, of course, depends upon the atmosphere in which sessions are conducted and upon the attitude of the leader.

The leader may or may not be a physician. In the projects referred to, some lectures were delegated to laymen particularly versed in the subjects. It is desirable, of course, that

conferences and over-all supervision of sessions be in the hands of a physician in a position to correlate the entire program.

It is entirely possible that the method of group psychotherapy, now in its infancy, will prove to be not only a substitute for but an advance over the individual therapeutic procedures for synthesis. In a group, Schilder points out (43), patients come to realize with astonishment that the thoughts which have seemed to isolate them are common to all members of the group; they are helped to understand that the aggressive instincts and social conduct are compatible.

IV. PROGNOSIS

In probably no other field of medicine is it more hazardous to attempt to anticipate the results of therapy than in the treatment of psychogenic disorders. We have mentioned that the very patients to whom we most frequently apply psychotherapy are the border-line variety who, as Stern points out (48) are much more difficult to treat than the frank psychoneurotic or the frankly organically ill patients, and who in consequence carry a graver prognosis. Marquardt suggests (30) that the course and prognosis of neuroses are dependent upon the possibility of controlling environmental factors, which he regards as their common cause; he also reiterates that disappearance of symptoms cannot be considered a cure of the underlying cause.

Certainly, one should never set a date for the complete cure of the patient. This encourages him to shift responsibility to the physician for performing a cure and impairs confidence should symptoms persist. Nor is an unqualified statement of expected cure warranted. It is better to say, "If you follow these procedures persistently, you will surely recover;" leaving final responsibility in the hands of the patient.

A few statistics, however, will suggest the results which may be expected in psychotherapy, bearing in mind that criteria of diagnoses as well as of therapeutic results vary widely among different authors:

Yaskin (51) treated 100 cases of neurosis and psychoneurosis in private practice between 1925-35. Treatment was directed "toward relief of symptoms and eradication of causes," and varying from suggestion and sedative drugs to partial analysis. Duration of treatment varied from two weeks to four and one-half years; 25% were hospitalized at some time during treatment. No traumatic-litigation cases are included:

| | Anxiety Neurosis | Conversion Hysteria | Anxiety Hysteria | Compulsive Obsessive Reactions | Total |
|---------------------|---------------------|------------------------|---------------------|--------------------------------------|-------|
| Recovered | 9 | 9 | 21 | 2 | 41 |
| Improved | | 3 | 30 | 8 | 41 |
| Not improved | | | 6 | 3 | 9 |
| Developed psychoses | | | 6 | | 6 |
| Recurred | 1 | 2 | 18 | 3 | 24 |

Of the failures, Yaskin notes that nine were very severe cases and that only poor co-operation was elicited. The other six which developed psychoses, of course, suggest erroneous (early) diagnosis. Two reasons for the 24 recurrences are suggested by the author: (a) new or reactivated precipitating causes of the neuroses occurred; and (b) inadequate treatment, because of refusal or inability to continue therapy.

From the outpatient psychiatric clinic of Bellevue Hospital, Schilder reports (43) preliminary results from the use of group psychotherapy in a series of severe neuroses:

Social neurosis (12): 3 cured, 7 decidedly improved, 2 not improved.
 Obsession (9): 2 cured, 1 lost symptoms, 6 improved.
 Anxiety (3): 2 cured, 1 improved.
 Hysteria (4): 2 cured, 1 unchanged, 1 ceased treatment too early.

Hypochondriasis (3): Not influenced.
 Organic vegetative symptoms (2): 2 better adapted but symptoms remain.
 Character problems (3): 1 well at present, 2 improved and under treatment.
 Depersonalization (6): 1 cured, 1 improved, 2 did not complete treatment, 3 unimproved of whom 1 was schizophrenic and 1 a depression.
 Depression (2): Unimproved. 1 suicide.
 Schizophrenia (4): 2 not influenced, 1 adjusted better, 1 complete recovery.

After use of group psychotherapy, Harris (23) reports that 68% of 187 patients reported improvement ranging from complete freedom to alleviation of one or two trying symptoms.

Of two groups:

- (a) 98 patients: 58% improved, 36% after first meeting
- (b) 78 patients: 53% improved, 36% after first meeting

The figures offered are far from being conclusive or even capable of reliable interpretation. They are reproduced only as preliminary results suggestive of the possibilities of psychotherapeutic procedures, and incidentally suggestive of how much we have yet to do to evaluate the entire problem. Until criteria are developed for accurate diagnosis, evaluation of therapy, and determination of improvement, we shall be incapable to judge statistically the "health-expectancy" of psychogenic patients.

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Summary

We can best summarize our consideration of psychotherapy as it applies to general practice by quoting the words which

Seligser (44) has applied to the extra-mural treatment of the alcoholic addict:

The treatment involves the individual study and personality formulation and treatment of the patient through distributive analysis and synthesis ... The goal of treatment is the synthesis of the various factors and strivings which will offer the patient security. In this, the patient's symptoms are considered and evaluated, his problems are talked over, and his memories, imaginations, urges, strivings, attitudes and actions and reactions to situations are thoroughly discussed. In this way the physician distributes the analysis along the various lines indicated by the symptoms, complaints, problems, etc. The physician translates general principles of living into concrete, simple, practical methods of altering life patterns and situations. In this way the patient, through a systematic ventilation, objectifies his problems and becomes desensitized to certain topics and factors. Through analysis one becomes aware of one's shortcomings and failures and the physician, therefore, must take a guiding hand in seeing that constant attention be paid to synthesis, thus making constructive use of what has been obtained through the dissecting procedure.

Personality disciplining, the teaching of intellectual domination to replace mood domination, the study and guidance of the minutae of life day by day through the analysis of concrete personal individual experiences and the discussion of the personality liabilities of the past are covered in the interviews.

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