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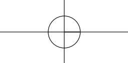
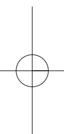
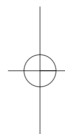
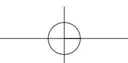


PART I

Foundations

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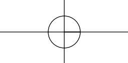
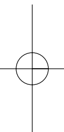
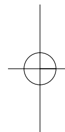
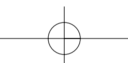

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CHAPTER ONE

A Brief Review of Modern Treatment Modalities

Current theories and known facts about human behavior are the product of a long and continuing history of curiosity and achievement. Although dependence on the past cannot be denied, progress also occurs because dissatisfaction with the "truths" of yesterday stimulates our search for better answers today. Hopefully, a perspective of historical trends will enable us to decide which achievements are worthy of acceptance and which require further investigation.

As we look back over the long course of scientific history, we see patterns of progress and regress, brilliant leaps alternating with foolish pursuits and blind stumblings. Significant discoveries often were made by capitalizing on accidental observation; at other times, progress required the clearing away of deeply entrenched but erroneous beliefs.

Despite these erratic pathways to knowledge, scientists have returned time and time again to certain central themes: What are the causes of abnormal behavior? How can we best conceptualize the structure and dynamics of psychopathology? Are there but a few basic processes underlying all behavior? What therapeutic methods are best for alleviating these disorders? As the study of the sciences of psychopathology and psychotherapy progressed, different and occasionally insular traditions and terminology evolved to answer these questions. Separate disciplines with specialized educational and training procedures developed, until today we have divergent professional groups involved in the enactment of psychotherapy, for example, the medically oriented psychiatrist with a tradition in biology and physiology; the psychodynamic psychiatrist with a concern for unconscious intrapsychic processes; the clinical-personology psychologist with an interest in cognitive functions and the measurement of personality; and the academic psychologist with experimental approaches to the basic processes and modification of behavior. Each has studied these complex questions with a different emphasis and focus. Yet, the central issues remain the same. By tracing the history of each of these diverging trends, we will clearly see how different modes of thought today have their roots in cultural ideologies and accidental discoveries, as well as in brilliant and creative innovation.

Until that day in the distant future when practitioners can specify exactly which "pill" will dissolve the discomforts of psychopathology, patients will continue to be treated with drugs whose mode of action is only partially understood and whose effectiveness is highly limited. Unfortunately, this state of confusion and minimal efficacy is paralleled among the equally perplexing psychosocial therapies.

Beset with troublesome "mental" difficulties, patients are given a bewildering "choice" of therapeutic alternatives that might prove emotionally upsetting in itself, even to the well-balanced individual. Thus, patients may not only be advised to purchase this tranquilizer rather than that one, or told to take vacations or leave their jobs or go to church more often, but if they explore the possibilities of formal psychological therapy, they must choose among myriad "schools" of treatment, each of which is claimed by its adherents to be the most efficacious, and by its detractors to be both unscientific and ineffective.

Should a patient or his or her family evidence a rare degree of "scientific sophistication," they will inquire into the efficacy of alternative therapeutic approaches. What they will learn, assuming they chance upon an objective informant, is that the "outcome" of different treatment approaches is strikingly similar, and that there is little data available to indicate which method is "best" for the particular difficulty they face. Moreover, they will learn the troublesome fact that many patients improve *without benefit of psychotherapy.*

This state of affairs is most discouraging. However, the science as opposed to the art of psychotherapy is relatively new, perhaps no older than three or four decades. Discontent concerning the shoddy empirical foundations of therapeutic practices was registered in the literature as early as 1910 (Patrick & Bassoe), but systematic research did not begin in earnest until the early 1950s and has become a primary interest of able investigators only in the past thirty to forty years (Frank & Frank, 1991; Garfield & Bergen, 1994; A. Goldstein & Dean, 1966; Gottschalk & Auerbach, 1966; Hoch & Zubin, 1964; Lazarus & Messer, 1991; Norcross & Goldfried, 1992; Rubinstein & Parloff, 1959; Shlien, 1968; Stollak, Guerney, & Rothberg, 1966; Strupp & Luborsky, 1962)

It may be appropriate to comment on the reader's desire to find a single, preferred "definition" of psychotherapy. It should be evident from the foregoing discussion of treatment traditions that no single description will do. Wolberg (1967), for example, listed 26 different definitions in the recent literature, and Corsini (1981) proposed over 200 others. Obviously, psychotherapy means different things to different people. Definitions of psychotherapy cannot be formulated by reference to an abstract set of principles; rather, therapy is more or less whatever data, goals, setting, and process a therapist employs in his or her practice. Thus, a behaviorally oriented therapist who adheres to an action-suppressive process will define psychotherapy differently from an intrapsychically oriented therapist who is inclined to follow an insight-expressive procedure. Definitions follow, then, rather than precede the orientation adopted by the therapist. No single definition can fully convey the variety of philosophies and techniques with which psychotherapy is executed.

Because there is no simple way to define therapeutic techniques, it may be argued that it would be best simply to catalogue the myriad approaches currently in use, leaving their classification to some later date when a clear-cut organizational logic may have evolved. However, as was noted in earlier books (Millon & Davis, 1996a) concerning the classification of pathological syndromes, no format will ever be fully satisfactory because it is impossible to encompass all of the many dimensions and features by which a complex set of phenomena can be grouped.

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Despite the inevitable limitations of classification, there are certain logical relationships among therapies that enable us to coordinate techniques in a reasonably systematic fashion. Unless we employ some rational format, advances in therapeutic science will become lost in a sea of incidental and scattered observations. Some frame of reference must be employed, then, to ensure that alternative techniques will be differentiated; in this way, we may accumulate a body of evaluative data that will enable therapists to determine the methods that are "best" for different types of psychopathology.

For the remainder of this section of the chapter, we will classify psychological therapies into several categories. The first, termed environmental management, refers to procedures that are designed to change the patient indirectly by manipulating and exploiting the surrounding conditions of his or her life for therapeutic purposes. The second, labeled supportive therapy, focuses directly on the patient; however, these procedures seek only to reestablish the patient's equilibrium without altering his or her premorbid makeup. The next sections comprise techniques that are designed to promote fundamental changes in the patient. Most deal with therapies that are practiced most often in the setting of an individual patient-therapist relationship.

The varied settings, goals, processes, and orientation that differentiate psychological treatment methods may lead one to conclude that the field of psychotherapy comprises a motley assemblage of techniques. However, despite substantive differences in verbalized rationales and technical procedures, psychotherapies "sound" more dissimilar than they are in practice. Close inspection reveals that the aims of many are fundamentally alike and that their methods, although focusing on different facets or levels of psychological functioning, deal essentially with similar pathological processes.

Given the confusing picture that prevails among psychological treatment methods, it may appear that a logical ordering of techniques at this time would be both unwise and premature. Nevertheless, it is necessary that we set forth as clearly as possible the basic rationales that differentiate the alternative traditions of therapies as we practice them today. To accomplish this in a reasonably useful pedagogical fashion requires first that we review briefly the historical development of psychotherapy. With this as a foundation, we will have a perspective from which modern schools of treatment may be more completely described and evaluated.

A BRIEF HISTORICAL PRÉCIS

Psychotherapy has a long history, although the concept of treatment by psychological methods was first formally proposed in 1803 by Johannes Reil. In this section, we review some of the relevant highlights of the history of psychotherapy, arranging them into several phases or periods, some of which extend into the present. With this as a base, we then elaborate the traditions of this history in a more formal manner.

"Psychological" treatment was first recorded in the temple practices of early Greeks and Egyptians in the eighth century B.C. In Egyptian "hospices," physician-priests interpreted dreams and suggested solutions to both earthly and heavenly problems. In the Grecian Asclepiad temples, located in regions remote from sources of stress, the sick were provided with rest, given various nourishing herbs, massaged, and surrounded with soothing music. During the fifth century B.C., Hippocrates suggested that exercise and physical tranquillity should be employed to supplant the more prevalent practices of exorcism and punishment. Asclepiades, a Roman in the first century B.C., devised a variety of measures to relax patients and openly condemned harsh

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"therapeutic" methods such as bloodletting and mechanical restraints. The influential practitioner Soranus (A.D. 120) suggested methods to "exercise" the mind by having the patient participate in discussions with philosophers who could aid him or her in banishing fears and sorrows. Although doubting the value of "love" and "sympathy" as a therapeutic vehicle, Soranus denounced the common practices of keeping patients in fetters and darkness and depleting their strength by bleeding and fasting. The value of philosophical discussions espoused by Soranus may be viewed as a forerunner of many contemporary psychological therapies.

Humane approaches to the treatment of the mentally ill were totally abandoned during medieval times, when witchcraft and other cruel and regressive acts were employed as "therapy." In the early years of the Renaissance, medical scientists were preoccupied with the study of the body and its workings and paid little attention to matters of the mind or the care of the mentally ill. Institutions for the insane were prevalent throughout the continent, but they continued to serve as places to incarcerate and isolate the deranged rather than as settings for medical or humane care.

A second phase of psychological treatment, what may be termed the period of "hospital reformation" and "moral treatment," began with the pioneering efforts of Philippe Pinel following the French Revolution. Guided by the belief that institutionalized patients could be brought from their state of degradation and depravity by exposure to a physically attractive environment and by contact with socially kind and moralistically proper hospital personnel, Pinel initiated an approach to mental hospital care that took hold, albeit gradually and fitfully. Moral treatment as practiced by responsible and considerate hospital personnel failed to take root for many years. This occurred for several reasons: there was a decline in the nineteenth century of psychiatric "idealism"; innumerable practical difficulties prevented the staffing of institutions with adequately motivated workers; and there was a resurgence from the mid-nineteenth to the early twentieth century of the medical disease model, turning the attention of psychiatrists to methods of physical rather than psychological treatment.

The practice of office psychiatry, characterized by treatment techniques that focus on one patient at a time and attempt to uncover the unconscious basis of problems, may be said to have begun with Mesmer's eighteenth-century investigations of *animal magnetism,* that is, hypnotism. Although the concept of magnetic forces was soon dispelled, Mesmer's occult procedures set the stage for a more scientific study of unconscious processes and strengthened the view that *suggestion* can be a potent factor in influencing mental symptoms. Moreover, Mesmer's enormous success with well-to-do "neurotics" in his private salon may be viewed as a precursor of modern-day office practice.

Charcot, the great French neurologist, explored the use of hypnotism in his studies of hysteria. Exposed to the ideas of Charcot and Bernheim and to the discovery by Breuer of emotional *abreaction,* Freud elaborated an intricate theory of psychic development and a highly original system of therapeutic practice, both of which he termed *psycho-analysis.* Subjected soon thereafter to dissenting views, even among its early adherents, the practice of psychoanalysis splintered into numerous subvarieties. Despite these deviations, the focus on unconscious processes and the office practice model with individual patients remained well entrenched as a major treatment model until quite recently.

Concurrent with the development of "office psychoanalysis," laboratory scientists were gathering a body of empirical data on basic biological processes and methods of learning and behavior change. It was many years, however, before the early work

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of biochemical studies and the concepts of learning theory were translated into principles and procedures applicable to therapy. By the mid-1950s, a variety of pharmacologic and behavior modification techniques, employing technical procedures of neurochemistry and systematic desensitization and eschewing notions such as *unconscious forces,* were devised and promulgated by medical and learning researchers. The emergence of these biological and behavioral treatment methods, in contrast to other psychological techniques, grew not so much out of clinical need and observation as out of systematic research. Although less than four or five decades old, biomedical and behavior techniques quickly rose to the status of major alternatives of psychotherapy.

As just noted, the most recent stage in this historical progression has been not only the development of new therapeutic procedures, but the application of research methodology in the evaluation of the *efficacy* and *process* of established procedures. Until the 1970s, the efficacy of alternative therapies was, for the most part, an article of faith rather than proof. At best, the merits of these techniques were "demonstrated" in crudely designed and easily faulted clinical studies. "Success" was gauged subjectively by the therapist according to ambiguous criteria rather than through objective measures undertaken by independent judges. Rarely were controls employed, and improvement rates were presented without reference to such relevant variables as chronicity, symptomatology, and so on. In short, what little had been done was done poorly. Despite questions concerning effectiveness, proponents of each technique were not only convinced of the utility of their cherished procedures, but prospered and confidently inculcated each new generation of fledgling clinicians. Disputes among "schools" of therapy were evident, of course, but they were handled by verbal polemics rather than empirical research.

As long ago as 1910, Hoche noted that therapists were not scientists but cultists, willing promulgators of dubious measures that rested on the most unreasonable of assumptions. Despite these early warnings, it was not until the late 1940s that clinicians such as Carl Rogers and J. McV. Hunt, trained both in scientific method and therapeutic practice, pioneered the first controlled studies of psychological therapy (Hunt, 1952; Rogers & Dymond, 1954). Spurred further by the critical reviews of Eysenck (1952), Zubin (1953), and Levitt (1957), increasing numbers of investigators began to reexamine the empirical underpinnings of psychotherapy and set out to design efficacy and process studies that employed proper controls, criteria, and measurement techniques. The fruits of this newest phase in the history of psychotherapy have only recently begun to materialize, but the seeds of the "scientific" era of psychotherapy were finally well planted.

It must be noted that psychotherapy is a constantly changing science of treatment. As new research, theory, and clinical experience enlarge our range of knowledge, many of the treatment techniques described in this book may call for modification. The text is intended exclusively for graduate students and clinical professionals; moreover, the reader is not expected to utilize its suggestions without an extensive range of information about a patient to guide his or her treatment. Although every effort has been made to furnish guidelines that live up to medical and psychological standards, the author makes no warranty with regard to the effectiveness of the methods contained herein. This caveat is especially addressed to the nonprofessional who may be seeking methods for self-treatment: nonprofessionals are urged to consult their psychologist and/or physician for advice and treatment.

We now turn to a more comprehensive elaboration of the preceding, organizing them into the foundations of modern and contemporary schools of therapy.

ENVIRONMENTAL MANAGEMENT

Little progress can be expected in therapy if the patient's everyday environment provides few gratifications and is filled with tension and conflict. Like the proverbial high-priced automobile that uses up gasoline faster than it can be pumped in, an unwholesome life situation may set the patient back faster than therapy can move him or her forward. For these reasons, it may be necessary to control or modify disruptive home or work influences or perhaps remove the patient entirely from these disorganizing effects.

Beyond relief and protection, environmental manipulation may be employed to achieve positive therapeutic ends such as *releasing* potentials or developing social skills. These two elements, the alleviation of situational stress and the exploitation of situational opportunities for constructive change, constitute the chief goals of environmental management.

The profession of social work has traditionally played a central role in planning and controlling extratherapeutic elements of patient life that influence the progress of formal treatment; appropriately, social workers are viewed as integral members of the total therapeutic team. Among the numerous goals of clinical social work is to assist either the patient or the family in removing deleterious economic and interpersonal conditions. More recently, social casework is oriented to facilitate the patient to cope with significant affairs of life.

Achieving these ends may entail direct counseling on practical matters such as daily habits and routines and the budgeting of family finances. More important, mental health workers can be of considerable assistance in pointing out to relatives how they may be contributing to interpersonal tensions and resentments within the family. The one or two hours of face-to-face therapy with the patient may be completely negated by the attitudes of relatives whose verbalized good intentions are no guarantee that they will be carried out. Where necessary, then, direct intervention in the form of weekly counseling sessions may be recommended for relatives who precipitate difficulties. The efforts of a skillful mental health worker can be of inestimable value in this regard.

Where occupational or social problems exist, mental health workers may be instrumental in arranging patient participation in community agencies such as sheltered workshops and recreational centers. In sheltered occupational programs, the patient may learn to cope with tensions he or she may have experienced in relating to fellow employees and employers; the understanding and tolerant attitudes of the professional supervisory staff at these centers ensure against harsh reprimands for poor performance, which reinforce feelings of self-inadequacy. For essentially similar goals, clinicians may recommend participation in recreational clubs to remotivate social interests and develop interpersonal skills; these settings are relatively free of the personal and competitive tensions of normal group relationships.

Clinical staff can be of invaluable service in smoothing the transition of patients from hospital to home and community. Practical arrangements may be made for the patient's employment, follow-up therapy, and guidance to the family as to their expectations and ways of reacting to the patient. To ease the strain of resuming normal responsibilities that may be too taxing for the patient, arrangements may be made for halfway house or night or day hospital programs.

Except in cases of transient situational stress, environmental vexations and complications are often only precipitants, tending merely to aggravate deeply established pathological patterns. In other words, the source of the patient's difficulties either are *internal,* ingrained personal attitudes and interpersonal habits that persist and perpetuate themselves, or *relational.* Thus, clinicians often find that following the removal of one environmental irritant, the patient involves himself or herself in another relational problem that is as destructive as the first. Without modifications of the patient's pathological expectancies and behaviors, the benefits of surface "management" alone, in all likelihood, will prove short-lived.

Until the past three or four decades, institutionalized patients were provided with kind and thoughtful custodial care at best, and at worst were incarcerated in filthy wards, shackled, crammed together, and isolated from the interests and activities of the larger community. Even in the better hospitals, little effort was expended to see that the setting, routines, and personnel of the institution provided more than a comfortable asylum, a refuge from strains of everyday existence, a place where patients could withdraw quietly into themselves. Despite the pioneering efforts of Pinel in the eighteenth century and Dorothea Dix in the nineteenth, Deutsch (1948) could report in his book, *The Shame of the States,* that most hospital patients in the mid-twentieth century sat out their lives in dreary environments, abandoned by unsympathetic families and exposed to uninterested personnel.

The change from inhumane to custodial to genuine therapeutic environments came about, not through public outcries, but through the fortuitous advent of psychopharmacological treatment. These drugs "contained" difficult patients, encouraging and enabling hospital workers to turn their attention from problems of restraint to those of therapy. At the same time, state legislative bodies became convinced that a massive infusion of funds for psychopharmaceuticals might ultimately unburden the taxpayer of costly long-term patient incarceration. The increased ease of patient management, together with the influx of additional funds, combined to spur a new attitude on the part of both public and hospital personnel.

SUPPORTIVE THERAPY

Whereas the procedures of environmental management focus on the situational context of the patient, seeking to exploit the persons and activities surrounding his or her daily life for therapeutic purposes, the procedures of supportive therapy focus directly on the patient. In contrast to other individual treatment approaches, however, supportive therapy does not seek to make fundamental changes in patients' premorbid attitudes and strategies, but to strengthen these patterns so that patients can again function as they did prior to their current disorder.

Supportive procedures are employed either as the principal mode of therapy or as adjuncts to other treatment methods. Central to the varied techniques that constitute supportive therapy is the patient's acceptance of the therapist's "benevolent authority," as Wolberg (1967) put it. The therapist must maintain a sympathetic but firm attitude, exhibiting a tolerance of the patient's deviance, yet inspiring strength through the force of his or her authority and forthright honesty. As a consequence, the patient will be inclined to trust the therapist's judgments and view the therapist as

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an ally worthy of identification and respect. With this as a foundation, the therapist may achieve the ends sought.

Supportive therapy may be separated into three basic procedures: *ventilation, reassurance,* and *persuasion.* These may be employed separately, concurrently, or sequentially. Let us examine each.

Ventilation

People often gain a measure of emotional relief by simply unburdening their woes to a sympathetic listener; the therapeutic value of much of what a friendly physician or minister achieves is obtained by the expedient of listening without reproval as the troubled person "gets things off his chest."

Emotional ventilation comprises an important element of supportive therapy. Distressing ideas and impulses often cannot be banished from one's thoughts and keep cropping up to disrupt one's daily life. To relieve the pressure of these "bottled-up" emotions, patients are encouraged to share their thoughts with the therapist and to feel free to express the pent-up tensions these thoughts generate. Patients are assured that everyone experiences disconcerting impulses and ideas, and that they can feel confident that they will be accepted and understood by the therapist without reproach. It is hoped that exposure of these suppressed conflicts and urges will not only serve to decrease tension, but also assist the patient in learning to accept them and develop a more constructive approach to their solution.

Where therapeutic goals are limited to the restitution of equilibrium without changes in premorbid behavior and personality, the patient is *not* urged to reveal more than he or she is inclined to do. Although patients are encouraged to express whatever they desire, the therapist refrains from probing and uncovering repressed emotions and thoughts that can aggravate the very discomforts therapy is seeking to relieve.

Reassurance

The mere act of participating in therapy is a form of implicit reassurance that all is not hopeless, that there is someone knowledgeable and understanding who can be turned to for solace and strength in moments of anxiety and despondency.

Supportive therapists provide reassurance in more direct ways by pointing out how baseless are the patient's beliefs and feelings, such as unwarranted apprehensions of "going insane," and how unjust the patient has been in condemning himself or herself for minor social digressions or excesses. Therapists divert patients' preoccupations with past regrets, ask them to recall their more commendable achievements, and direct their attention to potentially constructive and self-enhancing activities in the present.

Although reassurance is part and parcel of every therapeutic encounter, its indiscriminate use can only backfire. A consistent Pollyanna-like approach to therapy will ultimately raise questions in the patient's mind as to the therapist's grasp and appreciation of his or her problems; even worse, it may lead the patient to doubt the therapist's sincerity or judgment. On the other hand, should the patient learn to accept these superficial pacifications, he or she may become unduly dependent on them and be unwilling to face reality or to examine genuine solutions to problems. Inevitably, the patient will be in for rude shocks when objective difficulties and personal inadequacies simply cannot be "reassured" away.

Persuasion

In this supportive technique, the therapist seeks to convince patients that they possess within them the will and the wherewithal to reorient their pathological attitudes and behaviors. By dint of authority and by the use of subtle ploys, the therapist enjoins patients to "get a hold of" themselves and reject the irrational assumptions and habits that consistently disrupt their life. By appealing to patients' reason and common sense, the therapist leads them to see the logic of abandoning deviant ways, developing a fresh outlook on life, and rebuilding a sense of self-esteem. Concrete suggestions are made to aid patients in redirecting goals, dissipating worrisome habits, mastering muddled thoughts, assuming responsibilities with confidence and authority, and facing adversity with an objective attitude. By the sheer force of the therapist's convictions and the picture of self-assurance and firm resolve that he or she paints, patients are inspired to see the virtues and rewards of a poised and outgoing style of life and to exhibit a high self-regard; hopefully, others will view them equally positively.

Persuasive measures often reap immediate benefits in that they strengthen the patient's self-confidence and brace weakened coping defenses. But not all patients possess the means for reorienting themselves successfully or the competence to master their distraught emotions effectively; moreover, for a variety of both conscious and unconscious reasons, many will resist the therapist's facile prescriptions. Although persuasion can serve as a fruitful if temporary expedient for well-integrated persons, the probability is small that its benefits can long be sustained even in these cases, or that mere exhortation can make any inroads with patients who suffer severe forms of pathology. As with reassurance, persuasion often backfires; thus, patients may lose their "faith" in all types of psychotherapy should the exhortations of their therapist come to naught.

BEHAVIOR MODIFICATION MODALITIES

Change behavior and you have "cured" the patient's problems.

It was the great Russian physiologist, Ivan Petrovitch Pavlov, who demonstrated experimentally that behavior is modified as a function of learning. Pavlov recognized late in his life that Thorndike had preceded him regarding the concept of reinforced learning by two or three years (1928). Pavlov was preceded also by Ivan Sechenov, the father of Russian neurology, who stated as early as 1863 that all animal and human acts were partly cerebral and partly learned or trained.

As is well-known, Pavlov's discoveries resulted from an unanticipated observation made during studies of digestive reflexes. In the year 1902, while measuring saliva secreted by dogs in response to food, he noticed that dogs salivated either at the sight of the food dish or on hearing the footsteps of the attendant who brought it in. Pavlov realized that the stimulus of the dish or the footsteps had become, through experience, a substitute or signal for the stimulus of food. He soon concluded that this signaling or learning process must play a central part in the adaptive capacity of animals. Because of his physiological orientation, however, he conceived these observations as processes of the brain. Initially, he referred to them as "psychic secretions." When he presented

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his findings in 1903 before the fourteenth International Congress of Medicine in Madrid, he coined the term *conditioned reflex* (cr) for the learned response and labeled the learned signal a *conditioned stimulus* (cs). As his work progressed, Pavlov noted that conditioned reflexes persisted over long periods of disuse. They could be inhibited briefly by various distractions and completely extinguished by repeated failure to follow the signal or conditioned stimulus with the usual reinforcement.

Pavlov's early experiments served to replace the focus on subjective introspection that had been favored by most psychologists at the turn of the century. In his substitution of measurable and objective reactions to stimuli, he laid the groundwork, not only for the next half century of Russian research, but for American Behaviorism and modern learning theory as well. But before we discuss the impact of Pavlov's ideas on others, we note two of his later contributions that are relevant to the history of psychotherapy.

Pavlov came to realize that words could replace physical stimuli as signals for conditioned learning. He divided human thought into two signal systems:

> Sensations, perceptions and direct impressions of the surrounding world are primary signals of reality. Words are secondary signals. They represent themselves as abstractions of reality and permit generalizations. The human brain is composed of the animal brain, the first signaling system, and the purely human part related to speech, the second signaling system. (1928, p. 88)

Pavlov noted that under emotional distress, behavior shifts from the symbols of the second signal system to the bodily expression of the first signal system. Not only did he recognize this "regression" as a part of pathology, but he also used the concept of the second signal to show how verbal therapy can influence the underlying first signal system it represents. Thus, words can alter defective or malfunctioning brain processes in the "neurotic" individual via persuasion and suggestion.

Another of Pavlov's important contributions to psychopathology, his studies of experimentally produced "neuroses" in animals, was prompted directly by his acquaintance with Freud's writings. In this work, agitation and anger are created in previously cooperative animals by presenting them with conflicting or intense stimuli. These studies generated a marked enthusiasm among a small group of American psychiatrists desirous of finding a more rigorous foundation for psychodynamic theory. The investigations undertaken by W. Horsley Gantt and Howard Liddell in the 1930s derive largely from their attempt to bridge the ideas of Pavlov and Freud.

Theories possessing a common basis in Pavlovian concepts and behavioristic objectivity provided new principles for understanding psychopathology and psychotherapy. Primary attention was given to the processes of conditioning and reinforcement because they are the mediating agents through which response habits are acquired and extinguished.

Although anticipated to some degree by William James's chapter on habits in his 1890 textbook *Principles of Psychology,* Knight Dunlap was in many regards the first systematic theorist utilizing behavioral and learning principles (Dunlap, 1932). Even John Watson in his autobiography acknowledges that Dunlap was the person who convinced him that behavior should comprise the basic data for psychology. A follower of Pavlov, Dunlap outlined a variety of processes that were significant to understanding pathological learning. Unfortunately, he restrained the impulse to report his methods until

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he felt they had been fully perfected; hence, his primary method, termed *negative practice,* remained largely unknown to the clinical world. Interestingly, however, Dunlap anticipated important trends in therapeutic practice (e.g., Bandura, 1969) by proposing that conditioning is invariably embedded in a cognitive context.

Another early behaviorist, preceding the work of Dollard and Miller (1950) by a year or two, was Andrew Salter (1949). A firm believer in the role of conditioning, he sought to build therapeutic methods on the scientific bedrock of Pavlov's conditioning research. Ranging across a broad variety of mental disorders, such as stuttering, shyness, anxiety, masochism, and the psychopathic personality, his well-organized techniques were firmly grounded in what he preferred to term "conditioned reflex therapy." In reading both Dunlap and Salter, one cannot help but recognize that the foundations of behavioral therapy were well set many decades earlier than we tend to think.

The small number of concepts employed in these theories to account for the diverse behaviors involved in psychopathology and psychotherapy was an achievement of considerable merit and made them especially attractive to psychologists tired of the obscure and complex explanatory concepts of the psychoanalytic schools. But of even greater importance was the hope that new insights regarding the development and modification of behavioral pathology could also be provided. For our present purposes, it will suffice to note briefly the major ideas of this approach to psychotherapy; more detailed illustrations will follow in later chapters.

Behavior therapists do not postulate the existence of underlying causes or intrapsychic conflicts to account for pathology. Rather, mental disorders are simply a composite of the person's response habits learned as a result of reinforcements experienced throughout life. Distinctions between adaptive and maladaptive behaviors reflect differences only in the reinforcing experiences to which the individual was exposed. There are no "neuroses," "repressions," or "diseases" underlying pathological symptoms, as symptoms are merely habits developed and maintained by environmental reinforcements.

The behaviorist's approach to therapy follows logically from a view of pathology; modify the behavior designated as the symptom and "pathology" is eliminated. Therapy, or behavior modification as it is called, specifies first which behaviors are maladaptive and which behaviors should be reinforced to supplant them. Psychodynamic statements such as *Strengthen the patient's ego* are translated into the question *What differences in behavior would enable the patient to function more adequately?* Once the desired changes are specified, a program of reinforcements to shape the new behavior is devised. These reinforcements are given in the form of words, images, or direct experience. By creating imaginary or real parallels to situations that previously had evoked maladaptive responses, these responses are extinguished and new, more adaptive ones learned in their stead. Through this *behavior modification,* the individual is "cured" of his or her disorder.

As we conceive the *behavioral* construct, it includes both concrete and observable actions, the prime subject for modification among *pure* behaviorists, as well as the expressive significance of these actions, and the transactive meaning of these behaviors in social interactions, the prime subject of *interpersonally oriented* therapists. In a later section, we discuss what is commonly referred to as *cognitive* therapists, those who are primarily concerned with how cognitive processes affect actions.

The feature that most clearly distinguishes pure behavior therapies from other approaches is their commitment to an action-suppressive process. Behaviorists consider emotional ventilation and insight, the bedrocks of other schools of therapy, to be of

dubious value; not only are these two procedures viewed as time-consuming digressions, but they are often thought to be counterproductive, that is, to strengthen rather than weaken maladaptive behaviors (Bandura, 1969; Davison, 1968; Goldfreid & Davison, 1976; Kahn, 1960; Linehan, 1993). As behaviorists see it, the task of therapy is to achieve as directly as possible changes in real-life action, not greater self-understanding or affective expression.

During the late 1950s, stimulated largely by the provocative writings of Skinner (1953), Wolpe (1958), and Eysenck (1959), the coalescence of learning and psychotherapy took a new turn. Instead of merely restating accepted forms of treatment in the vernacular of learning concepts, as was done by Dollard and Miller (1950), investigators began to utilize principles that were derived first in behavioral learning research to create entirely new forms of therapy. It is these new approaches, based on the direct application of experimental learning principles, that constitute the treatment methods discussed in this section.

In the following sections, we follow a classificatory format that emphasizes the primary *objectives* of therapeutic intervention. The first set of approaches, termed *behavior elimination methods,* consists of procedures that are limited to but especially well-suited for the task of weakening existent pathological responses. The second group, labeled *behavior formation techniques,* includes procedures that can fulfill several goals; they can be employed not only to eliminate pathological behaviors but also to strengthen existent and acquire entirely new adaptive responses. Although this twofold division is not without overlap, it possesses the merit of stressing the utility of methods as instruments for achieving the two primary objectives of behavior modification: the elimination of maladaptive behaviors and the formation or strengthening of adaptive ones.

Methods of Behavior Elimination

The most expedient and direct procedures for eliminating or overcoming maladaptive responses have been termed *counterconditioning* and *extinction.* Let us review some of the techniques classed under these labels.

Counterconditioning methods. The rationale of counterconditioning is based on the fact that incompatible responses cannot coexist; for example, you can walk forward or backward, but you cannot do both at the same time. Translating this into therapeutic terms, if a patient exhibits a maladaptive feeling or behavior in response to certain stimuli, that response can be neutralized or blocked by evoking responses that are antithetical to it; for example, if a particular stimulus habitually elicited an anxiety response in a patient, the therapist may train the patient to associate an incompatible response to that stimulus, such as intense pleasure or deep relaxation, in the hope of precluding or counteracting anxiety.

Counterconditioning methods have been employed to achieve two goals: eliminating feelings and thoughts, such as anxiety or fear, that inhibit desirable and adaptive behaviors; and eliminating personally objectionable or socially unacceptable behaviors, such as compulsive rituals or alcoholism. To countercondition an emotion that inhibits an adaptive response, the technique of *desensitization* may fruitfully be applied; to countercondition a maladaptive response itself, methods of *aversive learning* can be used. Let us examine both procedures.

Relaxation and desensitization. This technique, most fully developed by Joseph Wolpe (1958), seeks to counteract the discomforting and inhibitory effects of fear-producing stimuli by interposing and associating a relaxation response to these stimuli; hopefully, by repeated counterconditioning, the fear response will be replaced by its antagonist, relaxation. Not only are the discomforts of fear eliminated thereby, but the patient may now be free to acquire adaptive responses that had previously been blocked.

As noted, relaxation is a technique that is often used as a competing response to overcome the anxious arousal that patients experience when faced with stressful situations. In early work by Jacobsen (1929) and subsequent modifications by Benson (1975), the patient learns to alternately tense and relax all major muscle groups of the body (Bernstein & Borkovec, 1973). After relaxation methods have been practiced under nonstressful conditions, the counterconditioning and systematic desensitization procedures are employed to aid the patient in reducing anxiety during threatening situations. These techniques are central elements in most stress management programs.

Wolpe's procedure follows a precise and well-planned sequence. The logic of Wolpe's counterconditioning procedure is simple and straightforward: relaxation is incompatible with fear; by arranging a properly graded sequence, the previously conditioned association between each stimulus item and the response of fear is eliminated. Wolpe claims with some justification that the relaxed attitude acquired in the consulting room generalizes to real-life situations; that is, patients are able to face the actual, previously feared environmental event without reacting as they had in the past.

Although Wolpe considers his method to be a behavioral approach, it should be noted that his desensitization technique deals essentially with cognitive processes. His procedure employs the data of symbolic imagination, not overt behavior. Perhaps it would be more correct, therefore, to classify his therapeutic technique among the cognitive procedures. The status of Wolpe's formulations as a behavioral approach may be seriously questioned also on the grounds of his partial allegiance to a neurological etiology, a view that contrasts sharply with the "pure behaviorism" of Skinner, for example. Nevertheless, tradition, brief though it has been in this field, assigns Wolpe's methods to the behavior classification.

Aversive learning. Whereas desensitization attempts to eliminate responses (e.g., fear) that inhibit desirable behaviors (e.g., facing and solving previously feared situations), aversive learning seeks only to eliminate undesirable responses (e.g., aggressive sexual acts). This distinction may be seen more clearly by the fact that desensitization achieves its aims by counterconditioning an unpleasant response (fear) with a pleasant one (relaxation); in contrast, aversive learning counterconditions a formerly pleasant response (drinking or sexual excitement) with an unpleasant one (nausea or pain).

The classic example of aversion therapy is the use of nauseant drugs in the treatment of alcoholism. In this procedure, patients first ingest the drug. Then, moments prior to the onset of nausea, they are given a drink of liquor. Because the drink immediately precedes the sickening nausea and vomiting, patients learn over a number of such sessions to associate drinking with an unpleasant rather than a pleasant experience.

Extinction methods. Counterconditioning procedures eliminate inhibitory emotions and maladaptive behaviors indirectly; that is, they do not attack the response

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itself, but interpose an incompatible response to a formerly provocative stimulus. Extinction procedures, in contrast, work directly on the disruptive behavior itself, that is, without employing an antithetical response.

There is a parallel between the two major forms of extinction and the two methods of counterconditioning. *Implosive therapy* is akin to desensitization, in that it has as its primary utility the elimination of responses that inhibit adaptive behaviors. *Reinforcement withdrawal* is similar to aversive learning, in that it is most useful in eliminating socially undesirable behaviors. A forerunner of both methods was known as *negative practice* (Dunlap, 1932), a procedure in which the patient voluntarily produced the unacceptable response, time and again, until he or she "got tired of it" or began to think it was "pretty silly" or "stupid"; negative practice was employed most frequently in extinguishing speech difficulties and other motor disturbances, such as tics.

Exposure therapy. This technique is similar to desensitization in that it has as its goal the elimination of inhibitory responses such as fear and anxiety. The procedural steps of these two methods are quite alike also in that the patient's most disturbing thoughts and feelings are identified, and he or she is asked to imagine them during treatment sessions. In contrast to desensitization, however, Stampfl (London, 1964; Stampfl & Levis, 1967), the innovator of the *implosive* technique, the forerunner of exposure therapy, introduces the most anxiety-arousing event immediately, seeking thereby to frighten overwhelmingly rather than to calm and relax the patient. Stampfl argued that by flooding the patient's imagination with the very worst of his or her fears in a setting in which no actual harm does occur, the patient will gradually learn that those fears are unfounded (unreinforced) as nothing really detrimental happens.

A more modern variant of implosive therapy was developed by Agras, Leitenberg, and Barlow (1968) in which patients, under the supervision of clinicians, were involved in a series of situational in vivo exposure exercises (Barlow, 1988). Here, they were expected to engage in exposure practices in which they systematically ventured away from "safe places" and into situations (e.g., those presenting anxiety-arousing phobic objects) that they had been avoiding. The success rate for this procedure has been especially high with the anxiety-based phobias. The addition of certain cognitive techniques to in vivo exposure appears to add to its overall treatment efficacy.

Reinforcement withdrawal. Rather than forcing the patient to be flooded and overwhelmed by disturbing thoughts and feelings as in implosive therapy, the reinforcement withdrawal tactic allows the undesirable behavior to dissipate naturally, simply by failing to provide the reinforcements it previously evoked. In further contrast to implosive therapy, in which the therapist seeks to overcome inhibiting responses such as fear, reinforcement withdrawal is most suitable for combating behaviors that should be inhibited, such as aggression and compulsive acts. To illustrate, Walton (1960) was able to extinguish a woman's severe habit of scratching her skin by advising her family to refrain from providing sympathy and attention in conjunction with her ailment; withdrawal of these positive reinforcements led to a rapid cessation of the habit. In another study, the control of bedtime tantrum behavior was achieved in a child by advising his parents to pay no attention to him as he cried and raged; by the eighth night, the youngster not only failed to whimper, but even smiled as he quietly went to bed.

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Methods of Behavior Formation

Until recently, most types of therapy had as their principal goal the elimination of faulty attitudes, feelings, and behaviors. It was argued or assumed implicitly that when these symptoms were removed, the patient would be "free" to utilize or develop more adaptive habits. Such constructive consequences do follow for many patients, but not all. Many lack the means for acquiring new adaptive habits, for example, autistic children or other patients whose past experiences may not have supplied them with a repertoire of healthy behaviors that will flourish, so to speak, when their inhibiting fears and maladaptive responses are removed.

The notion of "forming" new constructive behaviors by direct procedures is an important departure from more traditional therapeutic methods. Although many therapies have positive growth as a desired aim, few are designed to achieve this goal explicitly and in a systematically planned fashion.

Our attention turns in this section to two behavioral methods employed to achieve the goal of response formation: *selective positive reinforcement,* including *self-assertion training* and *social skills training,* and *model imitation.* Although acquisition and strengthening of adaptive behaviors are the distinguishing objectives of these procedures, either may be used to eliminate maladaptive responses as well.

Selective positive reinforcement. "Pure" behaviorists believe that the patient's actions are best conceived as a product *not* of intrapsychic conflicts or cognitive attitudes but of observable environmental conditions. Accordingly, changes in behavior must be achieved by manipulating external events. Central to these manipulations are reinforcements, that is, environmental rewards and punishments. By a judicious arrangement of reinforcing consequences, behaviors can be either strengthened or weakened.

The most fully developed schema based on the selective reinforcement model is operant conditioning, a technique devised by B.F. Skinner (1938) and his many associates and disciples (e.g., Ayllon & Michael, 1959; Ferster, 1958, 1964). Briefly, operant methods provide rewards when the patient exhibits the desired behavior and withholds them when undesired responses occur. Through this selective application of positive reinforcement, present adaptive behaviors are fortified, and through sequences of *successive approximation* and *shaping,* new adaptive responses are built into the patient's behavioral repertoire.

Self-assertion training. The early and highly creative behavior therapist Andrew Salter (1949) was the first of the behavior theorists to identify personal assertiveness as an important positive goal for his patients. Although adhering rigidly to Pavlovian conceptions of cortical excitation and inhibition, he encouraged "inhibited" individuals to vent their emotions to others in a spontaneous and open manner. He suggested that his patients express their feelings verbally, that is, tell people when they felt good, bad, angry, or annoyed. For these persons, Salter recommended that they should openly disagree with others and to speak out when they felt unjustly treated or overlooked. Furthermore, they should focus on themselves and their wishes rather than the desires of others. Similarly, Salter further encouraged patients to respond with their feelings quickly, that is, at the moment their emotions surged forward and without reflection or hesitation. Although he anchored his model in Pavlovian classical conditioning, Salter

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believed that assertiveness would overcome the same reservations that self-actualizing therapists refer to in their treatment goals. Lazarus (1971), for example, extended Salter's ideas by developing assertion training groups. Here, the problems that unassertiveness may create for shy and inhibited persons is utilized in a setting in which assertion skills are discussed and rehearsed together.

Social skills training. Numerous patients, for one reason or another, have failed to develop adequate social skills. For example, activities involving interpersonal behavior (e.g., job interviews, dating inquiries, general social conversation) are seriously deficient in many personality disorders (e.g., avoidant, schizoid, schizotypal). In this model, patients rehearse relevant social behaviors together with their therapist, thereby practicing specific behaviors that will overcome their prior limitations. As with assertion training programs, group social skills training has been developed (J. Kelly, 1985). These groups are composed of individuals with comparable social limitations, enabling them to provide one another with opportunities to acquire new skills that may enhance their self-esteem as well as their social adequacy.

Model imitation. According to Bandura (1962; Bandura & Walters, 1965), the primary exponent of behavior modification through imitative modeling, selective positive reinforcement is an exceedingly inefficient method for promoting the acquisition of new adaptive learnings. Effective though operant procedures may be for strengthening and building on responses that *already exist* in the patient's behavioral repertoire, they demand extremely ingenious and time-consuming manipulations to generate new response patterns. Contributing to this difficulty is the fact that the patient must perform the desired response or some close approximation of it *before* the therapist can apply the appropriate reinforcement. Where the sought for response is highly complex (e.g., speaking meaningful sentences), the probability is likely to be zero that it will be spontaneously emitted. Approximations of complicated responses may be achieved by an intricate chain of reinforced steps, but this sequence is bound to be both laborious and prolonged. Rather than struggle through this tiresome and at best unreliable procedure, the task of forming new responses can be abbreviated and accelerated by arranging conditions in which the desired act is performed. Modeling sequences are often designed in combination with reinforcement; thus, in a typical procedure, patients obtain a reward when they imitate an act performed by a model.

Let us summarize our review of the behavior modification approach with the following observations. The techniques of behavior modification have been subjected to more systematic research, despite their brief history, than all other psychological treatment approaches combined. This reflects, in part, the strong academic-experimental orientation of those who practice behavior therapy; most behaviorists have sought to provide a firm link between the scientific discipline of psychology proper and the applied problems of clinical treatment. Because behavior therapies will continue to be rigorously examined at each stage of their development, it is likely that most of them, once established, will withstand the test of time.

Despite the fact that most published studies of behavior therapy represent reports of clinical rather than controlled experimental research, the overall picture of efficacy that emerges is extremely impressive. More specifically, the effectiveness of counter-conditioning methods for eliminating simple reactions and complex syndromes is well

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documented (see Chapters 5 through 9). Similarly, selective reinforcement and imitative modeling techniques have proved suitable for strengthening and forming adaptive social behaviors among several patient groups (e.g., severely decompensated and antisocial syndromes) that have failed to yield to other therapeutic approaches. That these attainments have been achieved rapidly, economically, and in the hands of only moderately sophisticated agents (e.g., nurses or attendants) adds further to the value of these methods.

On the debit side of the ledger, behavioral approaches have not demonstrated efficacy with diffuse and pervasive pathological impairments such as personality patterns, maladaptive coping strategies, and "existential crises." Many of these difficult-to-pinpoint problems simply do not lend themselves to the sharply focused procedures of behavior therapy. Although advances in treatment methodology may ultimately bring these forms of disturbed functioning within the purview of behavior therapy, for the present they seem more suitably handled by cognitive and intrapsychic approaches.

INTERPERSONAL AND RELATIONAL MODALITIES

It is how we change everyday relationships that matters most in therapy.

On the basis of his clinical observations, Alfred Adler (1929) concluded that superiority and power strivings were more fundamental to pathology than was sexuality. Although many of his patients were not overtly assertive, he observed that their disorder enabled them to dominate others in devious and subtle ways. Phobias and hypochondriasis, for example, not only excused a patient from disagreeable tasks but allowed him or her to control and manipulate others. Adler hypothesized that these strivings for superiority were a consequence of the inevitable and universally experienced weakness and inferiority in early childhood. In this conception, Adler attempted to formulate a universal drive that would serve as an alternative to Freud's universal sexual strivings. According to Adler, basic feelings of inferiority led to persistent and unconscious compensatory efforts. These were manifested as pathological struggles for power and triumph if the individual experienced unusual deficiencies or weaknesses in childhood. Among healthier personalities, compensation accounted for strivings at self-improvement and interests in social change and welfare. These compensatory strivings, acquired by all individuals as a reaction to the restrictions imposed by their more powerful parents, led to a general pattern of behavior that Adler called the *style of life.*

Adler's view that the character of human development is rooted in social strivings served to guide the ideas of Karen Horney and Erich Fromm. Although both took issue with Freud's biological orientation, preferring to emphasize sociocultural factors instead, they regarded themselves as renovators of rather than deviators from his theories. Along with Harry Stack Sullivan, they have been called neo-Freudian social theorists.

Horney's main contention was that disorders reflected cultural trends learned within the family; biological determinants were minimized and interpersonal relationships stressed. Anxiety and repressed anger were generated in rejected children and led to feelings of helplessness, hostility, and isolation. As these children matured, they developed an intricate defensive pattern of either withdrawal, acquiescence, or

aggression as a means of handling their basic anxiety. Although Horney felt that adult patterns resulted largely from early experience, she believed, in contrast to Freud, that therapy should focus on its adult form of expression. First, the intervening years between childhood and adulthood caused important changes in adaptive behavior. And second, present-day realities had to be accepted and the goals of therapy had to take them into account. Although many of Horney's ideas were presented in an unsystematic and unscientific fashion, the clarity of her expositions and their appropriateness to modern-day life influenced the practice and thought of psychodynamic psychiatry in many important ways.

Erich Fromm, a neo-Freudian social philosopher and psychologist, was the first of Freud's disciples to concentrate his writings on the role of society in mental disorder. He advocated the view that the impositions of social conformity force individuals to relinquish their natural spontaneity and freedom. To Fromm, neurotic behavior is a consequence of insufficient encouragement and warmth from one's parents, which could have strengthened the individual against the demands of society. Fromm perceived the goal of therapy to be a bolstering of the individual's capacities for self-responsibility, and not the facilitation of a conformist adjustment. Fromm's interest in societal influences led him to modify Freud's neurotic character types into social character types. Along with similar modifications formulated by Horney, these types depicted contemporary patterns of personality disorder with extraordinary clarity.

Dyadic Treatment Models

Broadening the therapeutic focus in significant ways are therapists who describe themselves as *interpersonally oriented*. Although they address the behavioral conduct of the patient, it is their assertion that behaviors that relate to and transact communications with others are by far the most significant. Preceded by several theorists around mid-century, there has been a marked upsurge in the use of formal interpersonal and relational therapies in recent decades (Anchin & Kiesler, 1982; L.S. Benjamin, 1993; Kaslow, 1996; Kiesler, 1997; Klerman, Weissman, Rounsaville, & Chevron, 1984).

Sullivan's interpersonal model. Foremost among the early interpersonal therapists was Harry Stack Sullivan (1953, 1954). He was influenced first by the American psychiatrists Adolf Meyer and William Alanson White, but later adopted many of Freud's concepts regarding intrapsychic processes and early childhood development. His emphasis on the interpersonal aspects of growth and his contributions to the communication process in therapy classify him properly among neo-Freudian social theorists. Because of Sullivan's exposure to the linguist Edward Sapir and the positivist philosopher Percy Bridgman, he became especially critical of the conceptually awkward and frequently obscure formulations of psychoanalysis. As a remedy, he created his own system and terminology. With few exceptions, his terminology has failed to replace that of Freud. However, his highly original studies, especially regarding early development, schizophrenia, and the process of therapy, have had a marked impact on the thinking and practice of contemporary psychodynamic psychiatry.

He directed his efforts not only to *parataxic distortion,* a process akin to the classical transference phenomenon, but to a host of other habitual maneuvers such as selective inattention, memory dissociation, and inaccurate social evaluations. The task of his therapy was to unravel this pattern of self-protective but ultimately self-defeating

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interpersonal measures. At times, Sullivan, a former psychoanalyst, sought to elicit childhood memories and dream materials; however, his focus was directed primarily to current interpersonal problems. Sullivan believed that the classical passive or blank-screen attitude should be replaced by a more natural expression of the therapist's *real* feelings and thoughts. Beyond this, he proposed that certain attitudes be simulated by the therapist so as to throw the patient off guard, thereby provoking interpersonally illuminating responses. In short, Sullivan tried to participate actively in an interpersonal treatment relationship, exploiting his own reactions and feigning others, both designed to uncover the patient's distortions and unconscious styles of behavior. The primary instrument of Sullivan's therapy was skillful interviewing. The interview interaction, then, rather than the passive free association technique, was considered by Sullivan to be the most fruitful means of disentangling the web of interpersonal distortions.

Berne's transactional analysis. A progressive shift from a biological to a sociocultural orientation may be seen in several therapies. Employing patient-therapist communications as their data and drawing their models from either mathematical game theorists or social role theorists such as Mead (1934), a number of modern therapists have formulated an approach to treatment that is best depicted by the label *transactional analysis.* Among them are Berne (1961, 1964), and Haley (1963); the best known of these men, due largely to the witty and phrase-making character of his popular works, was Eric Berne.

According to Berne, patient-therapist interactions provide insight into the patient's characteristic interpersonal maneuvers and mirror the several varieties of his or her everyday social behaviors. These maneuvers are translated into caricature forms known as "pastimes" or "games," each of which highlights an unconscious strategy of the patient to defend against "childish" anxieties or to secure other equally immature rewards. This analytical process is akin to that contained in the analysis of transference phenomena, although Berne dramatizes these operations by tagging them with rather clever and humorous labels (e.g., "schlemiel," "ain't it wonderful," or "do me something").

Berne contended that contradictory character trends coexist within the patient; however, no single trend or "ego state," as Berne puts it, achieves dominance. Three ego states were elicited as a consequence of these reciprocal maneuvers or "transactions": archaic or infantile behaviors, known as the *child* state within the patient; attitudes reflecting either both or one's parent's orientation, termed the *parent* ego state; and mature qualities the patient has acquired throughout life, termed the *adult* state. The unconscious attitudes and strategies of these conflicting ego states are exposed and interpreted in transactional analyses. To promote insight into the patient's more immature maneuvers, therapists allow their own parent, child, and adult states to transact with those of the patient.

Benjamin's structural analysis of social behavior. In perhaps the most detailed model of dyadic interactions, Benjamin bridges both intrapsychic and interpersonal realms of functioning. Her key medium for exploring these functions is the interview process, which Benjamin believes should contain several key features. First, a collaboration must be established in which the therapist can affirm the patient's views and responses. Second, unconscious processes should be tracked in a "free-form" flow of conversation. Third, the therapist should assume that the narrative story line that unfolds "makes sense." Fourth, Benjamin refers to gaining an awareness of patterns of

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interpersonal behavior as they relate to dimensions such as love-hate and enmeshment-differentiation. Fifth, the therapist should avoid reinforcing preexisting destructive patterns. Last, Benjamin enjoins the therapist to correct "errors" as quickly as possible. In Benjamin's model, the key role is that of establishing a collaboration, one in which empathic processes may or may not be appropriate. She stresses the importance of facilitating the patient's recognition of his or her interpersonal patterns of behavior. Equally significant is the task of "blocking maladaptive patterns" and the necessity of addressing the patient's underlying fears and wishes. Finally, new learning should be facilitated, that is, therapists should encourage the acquisition of interpersonal behaviors that are more adaptive and more gratifying than those previously employed.

Kiesler's interpersonal communication model. Employing what has been termed *interpersonal communication theory,* Kiesler (1986b, 1997) has centered attention on the transactions that occur between individuals and others throughout their life experiences. As he has formulated it, people transmit an *evoking message* to others through various verbal and nonverbal channels; the message is intended to create a particular encoder-decoder relationship. Kiesler conceptualizes the emotional and personality difficulties of individuals as stemming from problematic countercommunications they unknowingly elicit from others.

The goal of Kiesler's Interpersonal Therapy is for the therapist to assist patients to identify, clarify, and establish alternatives to supplant their established, frequently rigid, and typically self-defeating evoking style. The intent is to utilize the central, recurrent, and thematic relationships that emerge between patient and therapist during their sessions. The task is to replace a patient's constricted transactional messages with communications that are more flexible and adaptive to the changing realities of life. A major priority of the therapist is to stop responding in ways akin to the way others have responded to the patient in the past. These habitual *transaction cycles* that are activated by the patient's behaviors and communications characteristically intensify and aggravate the patient's problematic relationships.

Klerman-Weissman interpersonal approach. What sets the Klerman-Weissman (1982) approach apart from other interpersonal therapies is its emphasis on brevity and its proactive rather than reactive stance. Also distinctive is its narrow focus on resolving only interpersonal relationships and its attention to current rather than past events. Treatment sessions deal entirely with interpersonal transactions and social roles. Also notable is the avoidance of inner conflicts or the historic sources of difficulty. In addition to distancing from intrapsychic processes, little attention is given to the role of distorted thinking or cognitive schemas. Minimal note is made of the impact of non-interpersonal facets of everyday life, nor are efforts expended to appraise or modify personality traits and their disorders. Although recognition is given to the fact that interpersonal difficulties stem in part from personality characteristics, attention is not directed to their features or their contribution to interpersonal problems; rather, the focus is on the problems themselves. In short, unconscious mental processes, cognitive distortions, and personality traits are bypassed in order to effect short-term achievements. To illustrate their focus, Klerman and his associates write:

> The psychodynamic therapist is concerned with object relations while the interpersonal therapist faces interpersonal relations. The psychodynamic therapist listens for the

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patent's intrapsychic wishes and conflicts; the interpersonal therapist listens for the patient's role expectations and disputes. (1984, p. 18)

Group Psychotherapy

A small band of therapists had begun to employ group procedures almost a century ago. J. H. Pratt, a Boston physician, held special classes as early as 1905 for tubercular patients, advising them not only on proper habits of physical care, but on methods to deal with the emotional complications that accompanied their illness. In 1909, L.C. Marsh, a minister, delivered inspirational lectures to groups of state hospital patients; he noted that therapeutic benefits were greatly enhanced if patients were enjoined to participate in discussions following his talks. Similar group discussion therapies were instituted by J.L. Moreno, a Viennese psychiatrist, in 1910. In the late 1920s, S.R. Slavson initiated programs of *activity group therapy* for children between 8 and 15 years of age. In the early 1930s, L. Wender and P. Schilder employed a psychoanalytically oriented approach in the treatment of hospital groups. From their earliest development in the United States, methods of group treatment were enthusiastically embraced by Alfred Adler's disciples. Viewing humans as social creatures who need support and corrective opportunities from others, noting that many disorders stem from undo self-absorption to the neglect of social interests, Adlerians regarded group processes as an effective therapeutic setting. Although psychoanalysis, in general, was loath in midcentury to focus its attentions on group processes, Foulkes and Anthony (1965), two British therapists, sought to integrate psychoanalytic theorizing with the approaches of Lewin's Group Dynamic Approach; a similar effort was made by Bach (1954) in this country.

There has been growing support for the use of trained personnel to meet an increasing number of patients who cannot afford or are not adequately covered financially by an ever-tightening managed care environment. Spurred by these practical considerations, therapists appear to be turning increasingly to more expeditious ways of treating patients for whom individual therapy is neither available nor economically feasible. The manifest need for more efficient forms of therapy may lead to a rapid growth of group treatment methods in the 1990s.

Group therapists contend that in the semirealistic group setting, patients display most clearly those attitudes and habits that intrude and complicate their real, everyday relationships with others. The interplay among group members provides numerous opportunities to observe distortions in perception and behavior that aggravate and perpetuate interpersonal difficulties. Because the atmosphere and intent of the group are characterized by mutual support, these distortions can be rectified and more socially adaptive alternatives acquired in their stead. Moreover, because each patient expresses deep feelings and attitudes with the knowledge that similar experiences are shared by fellow group members, patients gradually learn to tolerate themselves and to be sympathetic to the needs of others. As a consequence, they develop greater self-acceptance, a capacity to view things from the perspective of others, a freedom from self-defeating interpersonal strategies, and the ability to participate more effectively in social relationships.

Let us relate the advantages of group therapy. First is the fact that patients acquire new learnings in a setting that is similar to their "natural" interpersonal world; relating to peer group members is a more realistic experience than that of the authoritarian therapist-patient relationship. It is easier to "generalize" to the extratherapeutic world

what one learns in a peer group setting because it is closer to "reality" than is the individual treatment setting. Second, because patients must cope with a host of different personalities in the group, they acquire a range of flexible interpersonal skills; in this way, they learn to relate not only to the neutral or uniform style of a single therapist, but to a variety of disparate personality types. Third, the semirealistic atmosphere of the group provides patients with ample opportunities to try out their new attitudes and behaviors; group therapy serves, then, as a proving ground, an experimental laboratory within which the formative stages of new learnings can be rehearsed and refined. Fourth, by observing that one's feelings are shared by others, patients are not only reassured that they are not alone in their suffering, but regain thereby some of their former self-confidence and self-respect. Fifth, no longer ashamed of their thoughts and emotions, patients can give up the barriers they have defensively placed between themselves and others, enabling them to relate to others without fear and embarrassment. Sixth, able to accept criticism and to forego their pathological interpersonal defenses, patients begin to see themselves as others do and develop a more realistic appraisal than heretofore of their social strengths and weaknesses. Seventh, concurrent with increased accuracy of self-perception, patients learn to observe others more objectively and gradually relinquish their previous tendencies to distort their interpersonal judgments. Eighth, now able to respect the feelings of others, patients can share others' perspectives and begin to assist others in resolving *their* difficulties.

An innovative way to differentiate the theories of group process was outlined by Parloff (1968). Each of the three perspectives that he outlined illustrated the unique benefits of group treatment relative to other modes of therapy. The first, termed *the intrapersonalists,* has as its primary goal the resolution of intrapsychic conflicts, given that the group is a particularly effective medium for dealing with issues of transference and resistance. In these intrapersonal settings, patients are able to recognize that they are not alone in experiencing deep unconscious problems and that they gain insight into the various ways in which people express their individual styles of relating a very concrete and efficient manner, as well as experiencing a measure of safety while they express impulses and feelings.

The second category of group theorists, according to Parloff (1968), *the transactionalists,* are characterized by their primary interest in member-to-member relationships. Here, the group is viewed as a unique setting for understanding how people relate to others. Much is gained, according to Parloff, by the opportunity to vicariously learn about their social selves by participating in this mini social setting. Similarly, each group member has the opportunity to be both a helper and a helpee, giving and receiving emotional and interpersonal feedback to other members in the group.

The third dimension in which group theorists may be differentiated according to Parloff is termed *the integralists.* Here the primary emphasis is on the group as a whole. From this vantage point, all members of the group share aspects of their unconscious world together, particularly their relationship to authority figures, including impulses related to aggression and intimacy. By interpreting these impulses to the group as a whole rather than to each individual, the impact of interventions will be broad and seen as appropriate to each patient's specific concerns. By speaking in therapeutic generalities, patients can selectively focus on those aspects of their shared experiences that are most relevant to themselves individually.

Some therapists employ group methods as adjuncts to concurrent individual treatment; others dispense entirely with individual sessions. Many recommend that group members meet in sessions without the therapist; others oppose such meetings. There are

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closed and open groups, the former maintaining the same group members through fixed periods of treatment, the latter continuing indefinitely with new members added as old members "graduate." Some groups are formed on the basis of a common problem such as delinquency or marital difficulties; others are planned to be as heterogeneous as possible. Obviously, no simple classification is possible (Dies, 1986; Rutan & Stone, 1984).

In contrast to analytical groups, no effort is made in open discussion therapies to uncover and trace the childhood roots of interpersonal distortions. Rather, the focus is on the here and now and, quite often, on just those events that take place in the ongoing interactions within the group itself.

Analytical groups take their inspiration from one or another of the many varieties of intrapsychic theory. In common with individual analytical approaches, the focus of group analysis is the exposure of unconscious attitudes and strategies, the discharge of repressed emotions, and the reconstruction of childhood-rooted pathological trends. This is accomplished, as in classical techniques, by the use of free association, the interpretation of dreams, and the analysis of the complex network of multiple transference relationships that emerge between patients.

Slavson, the founder of activity therapy, in both early and later writings (1943, 1964) contributed a systematic rationale for resolving the multiple transferences that arise in group settings. More recently, Wolf (1949, 1950; Wolf & Schwartz, 1962) advanced a step-by-step technique for uprooting early memories, penetrating unconscious conflicts and defenses, and working through the intricate pattern of group transference relationships. He contends that the exposure and resolution of unconscious materials and transference phenomena occur more rapidly and thoroughly in groups than is possible in individual analytical treatment.

Perhaps the original model for the analytic group approach is Moreno's technique of *psychodrama* (1934, 1946), a method designed to stimulate the open portrayal of unconscious attitudes and emotions through spontaneous playacting. In a typical procedure, several patients and therapists enact an unrehearsed series of scenes in which they assume roles simulating people who are significant in their real lives. Patients are encouraged to relive and express with dramatic intensity feelings and thoughts that ostensibly could not be tapped or vented through normal conversational methods.

The primary value of the role-playing group is that it simulates more closely than conversational expression ever can real problem situations; in other words, generalization from the therapeutic situation to the extratherapeutic world can readily be achieved. Additionally, patients can be "carried away" in their role portrayals, enabling their deepest emotions and attitudes to be brought to the surface. As a consequence, unconscious forces surge forth, come into sharp focus, and can be dealt with immediately and effectively through "on-the-spot" manipulations by therapeutic coactors. Thus, its exponents contend, psychodramatic methods are more powerful and efficient than are the "pallid" insight discussion techniques for exposing and resolving deeply repressed unconscious materials. An especially informative and eloquent portrayal of various group procedures may be found in Yalom (1986).

Family Therapies

The patient who seeks therapy is often but one member of a pathological family unit. Not uncommonly, interactions among family members form a complex of shared psychopathology, the patient being merely its most dramatic "symptom."

The *primary patient* is enmeshed in daily encounters in a system of interlocking attitudes and behaviors that not only intensify his or her illness, but sustain the pathological family unit. Each member, through reciprocal perceptual and behavioral distortions, reinforces pathogenic reactions in others, thus contributing to a vicious circle of self-perpetuating responses. It follows logically from this premise that therapy must intervene not only with the patient himself or herself, but with the total family; in short, what is needed is family therapy, not individual therapy.

Several variants in technique have been proposed to achieve the goal of disentangling these reciprocally reinforcing pathological family relations. Essentially, the therapist brings several members of the family together, explores major areas of conflict, and exposes the destructive behaviors that have perpetuated their difficulties. The therapist clarifies misunderstandings, dissolves barriers to communication, and neutralizes areas of prejudice, hostility, guilt, and fear. In this manner, the therapist gradually disengages the pathogenic machinery of the family system and enables its members to explore healthier patterns of relating. By recommending new, more wholesome attitudes and behaviors and by supporting family members as they test out these patterns, the therapist may succeed in resolving not only the difficulties of the primary patient, but pathological trends that have taken root in all members.

It may be useful to summarize some of the major thinkers who have contributed to the development of formal approaches to family therapy.

Bateson's communication model. In the late 1950s, Gregory Bateson led a group at the Mental Research Institute in California charged with the task of studying communication among schizophrenic families. Included in this group were future contributors such as Don Jackson, John Weekland, Jay Haley, and Virginia Satir. Influenced by the General Systems Theory of von Bertalanffy (1933, 1950), Bateson stressed the importance of circular causality in communication; he noted, however, that there were no right or wrong ways in which family communications should be expressed. As he and his associates stated, all human interactions depend on the key premises and assumptions that people hold, rather than fitting some ideal model. The goal of this form of therapy is to resolve problems emanating from faulty interpersonal communication. Efforts are made to reduce the likelihood of intensifying problems owing to errors of interpretation and their potential spiraling. The task of a therapist is to clarify erroneous communications by exposing their consequences and undoing repetitive errors of miscommunication.

Ackerman's psychoanalytic approach. Anticipating the emergence of the object-relations movement in psychodynamic theory in the mid-1950s, Nathan Ackerman (1958, 1966) instituted a nameless but formal technique that became one of the more well-received approaches to family treatment; a recent extension of his object-relations model has been formulated by D. Scharff and J.S. Scharff (1991).

Recognizing that all infants and children internalize their early perceptions and experiences with their parents, Ackerman and his associates conceived family therapy to be a replication of early gratifying and discomforting relationships between children and their parents. These internalized relationships form the basis for all subsequent intimate relationships, especially those that develop in later family life. It is the "unpacking" of these early templates that serves as the primary task of the family therapist. The disentangling of internalized experiences that have erroneously and

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distortingly created new family difficulties is what calls for Ackerman's approach. Following the traditional analytic model, therapists assume a neutral, blank approach so as to encourage patients to transfer their intrapsychic images; these can then be exposed and remedied within the family context.

Whitaker's modeling approach. The emphasis for Carl Whitaker was to facilitate individual autonomy, done best by eliciting the emotional feelings that patients experience regarding their relationships. Whitaker considered conceptual understandings to be of minor if not negative utility. The central focus of his treatment approach was himself, to utilize his own creativity and spontaneity as a model for family members to emulate. Behaving in an irreverent and joyful manner in the therapeutic setting, Whitaker hoped to demonstrate through his own behavior a style for dysfunctional families to use in their interactions. The objective was to undo the rigidity of their dysfunctional ways of relating, to create a toleration for free expression, and to liberate each member to be more self-fulfilling and expressive in the family context (Whitaker & Keith, 1981; Whitaker & Malone, 1953). In his freewheeling personal style, Whitaker spontaneously expressed his own feelings, exposing the absurdity of his own impulses and thoughts, as well as confronting family members to be liberated from their "emotional deadness" and thereby promote their individual growth.

Satir's conjoint approach. Drawing upon the Human Potential Movement, then popular in California and elsewhere in the 1960s, Satir generated a variety of innovative in-session techniques to illustrate the impact of family members on one another (Satir, 1972; Satir & Baldwin, 1983). For example, Satir utilized ropes and blindfolds to illustrate the constraints in which family members restrict and trap each other. Other methods of a more encounter and experiential nature were likewise employed, along with what she termed the *family sculpture* method; here, family members are arranged in a physical setting, using distance and body positions to illustrate the several ways in which they habitually relate to one another.

Although Satir was disinclined to utilize theory as a primary guide, she did enunciate several premises in her work. First, a strong emphasis was given to the potential of individual self-actualization, which, in turn, derived from high positive self-esteem. Next, she emphasized the clarity and character of communication patterns among members of a family. Additionally, she sought to expose the rules by which family members interacted with one another. Satir's concept of a *healthy family* is one in which individual members have positive self-esteem and intrafamily communications that are direct, honest, and clear. By contrast, Satir believes that *families in trouble* fail to encourage positive self-worth, express communications that are indirect and vague, impose rules are absolute rather than flexible, and function as a closed emotional system, highly defensive and negative in its outlook.

Minuchin's structural therapy. Beginning in the mid-1960s, Salvador Minuchin, an analytically trained child psychiatrist, developed an approach to family treatment based on his experiences with delinquent youngsters whose difficulties appeared to stem from the dysfunctional structure of the families in which they were raised. The model that he and his associates developed soon became a general framework for family treatment. As Minuchin views it, the task of therapists is to alter the formal or

structural relationships that exist within the family through a variety of in-session manipulations (Minuchin, 1974; Minuchin & Fishman, 1981).

Minuchin groups dysfunctional structures into two categories. In what he terms *enmeshed* families, the boundaries within the family are either highly permeable or absent. Conversely, Minuchin selects the term *disengaged* for families with rigid boundaries that prevent the necessary flexibility for warmth and sensitivity to develop. By modifying structural permeabilities and misalignments, Minuchin seeks to rearrange the entire pattern of communications and interactions that perpetuate the family system's difficulties. Only by modifying established boundaries and hierarchies into a more flexible schema can ultimate resolutions be achieved.

Haley's strategic therapy. Drawing on the ideas of Bateson and his communication model, as well as the methods of Milton Erickson and Salvador Minuchin, J. Haley (1973, 1987) developed an amalgam of techniques that have become a popular approach to family treatment. Emphasizing hierarchical structures and power relationships, Haley states that families are unable to resolve their difficulties because they are locked in a deeply embedded pattern of dysfunctional relationships.

Haley emphasized the *power struggle* for control in families. He viewed psychological symptoms as a strategy for obtaining control and recognized that the power struggle is typically implicit if not covert. As such, confronting these symptoms and manipulations is likely to be unwise and fruitless. Haley was willing to undo or bypass the family organization, and also to create conditions that produce chaos and disarray. This level of disorder, Haley hoped, allows for opportunities to reorganize the system more effectively. Haley states that difficulties within an individual cannot be modified unless the entire family system is altered. Tensions between any two persons become intensified or problematically diffused when third or fourth persons are brought into play. Haley recommends that a series of provocative challenges and paradoxical directives be employed to get patients to abandon undesirable attitudes and behaviors. Ambiguous tasks are assigned and conflict-generating directives are produced to demonstrate dysfunctional family styles so that they may be understood and serve as a basis for direct resolution.

Bowen's multigenerational model. Expanding on the object-relations notions of Ackerman, Murray Bowen (1976, 1978) traced the multigenerational transmission of family pathology as a continuing series of problematic relationships that persist through the years. Bowen's background was psychoanalytic in nature, but he developed his own comprehensive model of family systems theory, defining a number of concepts and specifying clinical approaches that are linked closely to the model. In contrast to most of his family therapy associates at the time, Bowen believed that if one person in a family could become free of the reactive processes and entrapment structures of the system, a potential chain reaction may help resolve the problematic character of the system. The central thesis of Bowen's approach relates to the "fusion" that emerges among family members, one that results in a lack of personal individuation from the family of origin, that is, an inability to differentiate self from others. This lack of differentiation, according to Bowen, leads the individual to cut all emotional bonds with parents, which, in turn, leads to an excessive degree of fusion in new family or marital arrangements. Utilizing genograms to outline multigenerational relationships, Bowen's goal is to assist members to become more self-differentiated and, hence, achieve greater

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personal expression. Differing from most other family therapists, Bowen prefers to work with only one family member at a time, while the others either are not present or are silently observing.

The Milan systemic approach. Although separating this past decade into two or more separate schools of practice, the primary one led by Mara Selvini-Palazzoli and Viaro (1988), there are sufficient commonalities among the systemic models to describe them as singular in their logic and methodology. Meeting with the family but a few times in total, often four to six weeks apart, the Milan approach assumes that any individual's dysfunction plays an important role within the problematic family system; as is often seen, one member of the family is typically "sacrificed" to enable the whole family system to survive intact. Paradoxical questions and injunctions are introduced by the therapist to disrupt established interaction patterns. In many circumstances, invariant prescriptions are specifically communicated to alter the so-called myths that family members hold regarding one another. New rituals are introduced to force the family to modify its pattern of interactions and to alter those myths the family has developed to maintain its dysfunctional system. In effect, interventions are designed to undo the "primitive" myths and rules that have intensified the family's established homeostatic pattern.

DeShazer's and O'Hanlon's solution-oriented approach. Borrowing from earlier ideas of Milton Erickson (deShazer 1982, 1988; O'Hanlon, 1987; O'Hanlon & Weiner-Davis, 1989), each family member is seen as possessing strengths that may facilitate the development of constructive attitudes and healthy styles of problem resolution. Both deShazer and O'Hanlon shift radically from the traditional focus of therapists on family problems and difficulties. Instead, primary attention is given to outlining examples where individuals successfully avoided or solved problems faced within the family interaction. Individual competencies and group effectiveness, not their dysfunctions, are the focus. The therapeutic task is to bring to the forefront latent capacities rather than latent conflicts and dysfunctions. Looking for "miracle" solutions to persistent difficulties serves to promote constructive outlooks and innovative changes. It is the task of the therapist to skillfully elicit from family members the positive resources necessary to achieve their mutual goals. No longer looking at their tensions and quarreling, family members can focus on what has worked previously and what can be implemented currently to create gratifying solutions.

COGNITIVE REORIENTATION MODALITIES

How we think about our lives calls for methods specifically designed to alter problematic beliefs and attitudes.

In this section, as previously in differentiating the clinical domains, we turn our attention to several spheres of pathologic structure and functioning that may be considered significant targets of therapeutic intervention, notably *cognitive modes* and, indirectly, aspects of the content areas of *self-image* and *object-representations.* Important modalities of intervention have been developed with each of the preceding in mind, albeit somewhat tangentially.

Cognitive reorientation therapies seek to address how patients perceive the events of their life, focus their attentions, process information, organize their thoughts, and communicate their reactions and ideas to others. They provide some of the most useful indices to the clinician regarding patients' distinctive way of functioning. By synthesizing these data, it may be possible to identify such general features as constricted thought, cognitive distractibility, impoverished thinking, and so on.

The philosophy underlying these procedures contrasts in emphasis with those of *self-actualizing* methods, to be discussed in the next section. They are not *primarily* concerned with nor do they limit their focus on the person's self-conception. Rather, their efforts are more general, to counteract the patient's erroneous or distorted ways of thinking, whatever realm may be involved.

Some Early Cognitivists

The first modern formulation of what may be called a direct approach to modifying a patient's cognitive assumptions was published by DuBois (1909) and Dejerine and Gawkler (1913), both of whom sought to impart *reason* to patients whose emotions had confused or distorted their capacity to think sensibly. It was their belief that mental disorders were irrational preoccupations with minor symptoms, causing these symptoms to become "mountains, instead of molehills."

In the mid-1940s, Thorne (1944, 1948), viewing the growth of what he considered to be the sentimentalistic practices of most therapists, proposed an approach that revived modern cognitive procedures. In contrast to DuBois, who sought to smooth over the strains and vexations of life, Thorne induced conflicts deliberately by confronting patients with their contradictory and self-defeating attitudes.

In the mid-1950s, George Kelly, Gardner Murphy, and Jerome Bruner revived the Functionalist idea that cognition and perception were learned and adaptive acts. To this they added the notion of unconscious motivation stressed by the psychoanalysts. Perception, as elaborated by these theorists, was an expression of the individual's cognitive schemas, which, in turn, reflected his or her unconscious drives and adaptive defenses. In attempting to maintain an equilibrium between inner strivings and objective reality, individuals develop cognitive hypotheses or expectancies that enable them to select those aspects of reality that reflect their deeper needs. In this fashion, cognition attunes needs, healthy or maladaptive, to reality, serving as a guide or template to the future. An important synthesis was achieved in these personologic theories between the schemas of the unconscious posited by psychodynamicists and the cognitive expectations stressed by clinical psychologists.

Other cognitive style approaches gained favor in the 1950s and 1960s owing to the fact that they sought to bridge the gap between well-known "principles of learning" and the primary vehicle of most therapies, that of verbal interaction. Several semiformal systems were proposed along these lines (Breger & McGaugh, 1965; Kanfer & Saslow, 1965; J. Kelly, 1955; Miller, Galanter, & Pribam, 1960; Rotter, 1954). We cannot expand on these interesting proposals, given limitations in space.

Ellis's Confrontation-Directive Procedures

A major cognitive approach, what we term *confrontation-directive,* is in many ways opposite in style to that of *cognitive reframing* procedures, where the therapist takes a more

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neutral stance and where treatment gives the client the basis for deciding what course to take.

In the confrontation-directive group, the therapist assumes an authoritarian role; patients are, at least implicitly, considered to be inept, irresponsible, or sick, unable or unwilling to choose for themselves what their goals should be. Not only does the therapist take an active part in deciding the objectives of treatment, but he or she employs persuasive or commanding tactics to influence the patient to adopt a system of values that is deemed more or less universally appropriate. The major theorist of this procedure has been Albert Ellis.

Ellis (1958, 1962, 1967, 1979, 1980) considers the primary objective of therapy to be countering the patient's tendency to perpetuate difficulties through illogical and negative thinking. Patients, by reiterating these unrealistic and self-defeating beliefs in a self-dialogue, constantly reaffirm their irrationality and aggravate their distress. To overcome these implicit but pervasive attitudes, the therapist confronts the patient with them and induces him or her to think about them consciously and concertedly, as well as to "attack them" forcefully and unequivocally until they no longer influence behavior. By revealing and assailing these beliefs and by "commanding" the patient to engage in activities that run counter to them, their hold on the patient's life is broken and new directions become possible.

Based on the writings of Alfred Adler, Ellis's premise in *rational-emotive therapy* is that we are too harsh with ourselves, tending to blame and judge our actions more severely than is necessary. Underlying these destructive attitudes, according to Ellis, is the tendency of patients to blame themselves for their limitations and wrongdoings, that is, to subscribe to the false and self-defeating assumption that they are "no good and therefore deserve to suffer." The principal goal of therapy is to challenge and destroy this belief, to liberate patients, to free them from such irrational notions as shame and sin, and to live life to the fullest, despite social shortcomings or the disapproval of others.

At the core of Ellis's therapeutic approach is the assertion that thoughts and emotions are invariably intertwined. Phrasing the components of his assertion as the *ABC* model, he states that most forms of psychopathology (C) are determined by a person's irrational belief systems (B), which stem from misbegotten life events or experiences (A). His goal is not only to identify the irrational beliefs that lie at the root of the patient's disturbances, but to challenge and to expunge them. To maintain psychic balance, patients must constantly monitor and challenge these difficult-to-uproot belief systems.

Ellis (1970) outlined some twelve irrational beliefs that create unrealistic standards that patients typically live by. Among the most pernicious are: (a) it is essential that a person be loved or approved by virtually everyone; (b) one must be perfectly competent, adequate, and achieving to be considered worthwhile; (c) some people are wicked or villainous and therefore should be blamed and punished; (d) unhappiness is caused by outside circumstances and a person has no control over them; (e) it is easier to avoid certain difficulties and responsibilities than to face them; (f) a person should be dependent on others and should have someone stronger on whom to rely; and (g) there is always a right or perfect solution to every problem, and it must be found or the results will be catastrophic.

Although listed in the cognitive group owing to the central role given to distorting belief systems, Ellis employs a wide range of emotive and behavioral as well as

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cognitive techniques as therapeutic tools. Among them, Ellis selectively employs such methods as the self-monitoring of thoughts, role playing, modeling, imagery, relaxation techniques, operant conditioning, and skill training. In contrast to other directive cognitivists, Ellis's philosophical outlook clearly espouses self-acceptance, self-interest, and self-direction. Despite this primary focus, Ellis also seeks to help patients develop a tolerance for others, to acquire a commitment to social concerns, and to learn social flexibility and accept the uncertainties of life.

Beck's Cognitive-Reframing Methods

Therapists grouped in this category are neither directive nor nondirective insofar as treatment goals or style of therapeutic interaction is concerned. Rather, therapist and patient conjointly agree that the latter possesses attitudes that promote and perpetuate his or her difficulties in life.

Cognitive-reframing therapists are more active in the treatment process than those who follow the self-actualization philosophy, to be discussed in the next section; they encourage patients to alter self-defeating perceptions and cognitions instead of allowing them to work things out for themselves. In contrast to confrontation-directive therapists, however, they do not prejudge the patient's problem in accord with a fixed philosophy such as *integrity* or *rationality;* they have no particular "axe to grind," so to speak, no set of beliefs they seek to inculcate. Rather, they plan merely to reorient the patient's misguided attitudes, whatever these may be and toward whatever direction may prove constructive, given the patient's personal life circumstances.

Although subscribing to cognitive learning principles, these therapists differ from behavior-learning therapists in that treatment is focused not on overt symptoms or behaviors, but on those internal mediating processes (perceptions and attitudes) that give rise to and perpetuate behaviors. These more neutral cognitive approaches have recently begun to gain favor among many professionals because they bridge the gap between laboratory cognitive principles and the primary vehicle of most therapies, verbal discussion. Several formal cognitive theoretical models have been proposed along these lines (Breger & McGaugh, 1965; M. Hamilton, 1980; Kanfer & Saslow, 1965; J. Kelly, 1955; Lazarus, 1965; Miller et al., 1960; Neisser, 1967; Paivio, 1971; Phillips, 1956; Rotter, 1954, 1962).

A currently highly regarded cognitive approach has been developed by Beck and his associates (Beck, 1970, 1976, 1991; Beck & Freeman, 1990b). Central to Beck's approach is the concept of *schemata,* that is, specific rules that govern information processing and behavior. The concept of schemata derives originally from the writing of Kant. More recently it has been utilized by Piagetian psychologists and other cognitive network theorists to represent tacit internal structures that reflect abstractions about the stimulus world and their relationships. These schemata are stored in memory as generalizations or prototypes of specific life experiences; they serve as a template that provides an orientation, focus, and meaning for all sources of incoming information. Despite their unconscious character, they direct attention to aspects of ongoing experiences that are important for survival and adaptation. In effect, these broad-ranging schemata orient conscious cognitive processes such as attention, encoding, retrieval, and inference. Importantly, schemata incorporate not only cognitive but emotional and affective valences as well. No less significant, schemata relate to self. These *self-schematas* serve as a gauge for appraising and valuing aspects of self.

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Schemata may be classified in a variety of categories, such as personal, familial, cultural, and so on. They are inferred directly from behavior or from interviews and history taking. To Beck, the disentangling and clarification of these schemata lie at the heart of therapeutic work. They persist, despite their dysfunctional consequences, owing largely to the fact that they enable the patient to find ways to extract short-term benefits from them, thereby diverting him or her from pursuing more effective, long-term solutions. Beck recognizes that an important treatment consideration is recognizing that cognitive restructuring will inevitably evoke problematic anxieties, owing to the fact that patients are forced to reexamine or reframe their schemata.

Beck has been most fortunate in the number and quality of his disciples, many of whom have made significant contributions to the cognitive model on their own. Thus, Freeman and Reinecke (1995) provide a variety of classical distortions that patients utilize as maladaptive ways of processing information: (a) dichotomous thinking ("You are either with me or against me"); (b) emotional reasoning ("Because I feel inadequate, I am inadequate"); (c) personalization ("I know that comment was directed toward me"); (d) overgeneralization ("Everything I do turns out wrong"); and (e) catastrophizing ("I better not try because I might fail, and that would be awful").

Beck sets out a sequence of necessary steps in his cognitive therapy. Not only must one first conceptualize the core schemata that undergird the patient's pathological outlook, but the therapist must keep in mind the underlying goals for reframing them. As with other sophisticated therapists, Beck emphasizes the therapist-patient relationship as central to the therapeutic endeavor. As he notes further, considerable "artistry" is involved in unraveling the origins of the patient's beliefs and in exploring the meaning of significant past events. Toward this goal, therapists must examine "transference-like" reactions, but never be judgmental or pejorative in their responses. A list of 18 problems in establishing a good collaboration is described to illustrate issues that can undo this constructive process. Potentially problematic also are procedures for confronting schemata that repetitively distort the expectancies and assumptions of patients. A variety of *schematic restructuring* techniques are outlined to help build new schemata or to shore up defective ones. Role playing, imagery, and the reliving of childhood experiences are recommended by Beck as a means of schema modification and decision making. Important cognitive therapy developments have recently been introduced by Meichenbaum (1977), Mahoney (1974, 1977), Young (1990), and Wessler (1993), expanding the range of recommended procedures in this realm.

SELF-IMAGE MODALITIES

What is central to therapeutic success is not chemistry or unconscious resolutions, but treatment methods that foster and enhance each patient's self-esteem.

There are those who believe that personality can be understood only in terms of the intrinsic unity between biological functions and environmental stimulation. This view was fostered by the late-nineteenth-century writings of Hughlings Jackson and Theodor von Uexkuell. Its most convincing exposition in personality was made, however, in the brilliant work of Kurt Goldstein (1876–1965) and Kurt Lewin (1890–1947). Although both were influenced by the early Gestaltists, they extended the holistic idea along different lines. Goldstein, an eminent neurosurgeon, stressed

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the internal unity of biological functioning, whereas Lewin, a social psychologist, focused on the interdependencies of personality and environment.

To Goldstein, personality could not be understood by studying isolated behaviors or functions because the organism operated as a unit that could not be analyzed in terms of its parts. As evidence for his thesis, Goldstein illustrated numerous cases in which neurological damage to the individual led, not to a loss of the affected function, but to a reorganization of total functioning. This reorganization enabled individuals to keep their drives and goals intact, although more primitively. From this evidence, Goldstein suggested that individuals possess a sovereign motive, that of *self-actualization*. Through this concept, he proposed that our central motive is to realize our inherent potentials by whatever means and capacities available to us.

Kurt Lewin, following a similar philosophy, portrayed personality as a structure composed of interdependent and communicating regions interacting in a dynamic equilibrium with a psychological environment. Of particular note was Lewin's contention that events must be conceived in terms of how each individual consciously perceives them, rather than how they objectively exist; this phenomenological viewpoint has grown into the major cognitive orientation of contemporary psychotherapy.

Placed also among the holistic-personological theorists are other psychologists of the 1930s and 1940s, notably Henry Murray, who coined the term *personology* and whose contribution lies in the scope and depth of his writings. Drawing on a wide knowledge of neurological development, psychodynamic theory, academic psychology, and cultural anthropology, Murray formulated highly useful theories that represented the most sophisticated conceptions of personality integration of his day.

As touched on in books relating to developmental processes, the diffuse swirl of events that buffet the young child gives way over time to an increasing sense of order and continuity. The most significant configuration that imposes a measure of sameness on a previously more fluid environment is self-as-object, a distinct, ever-present, and identifiable "I" or "me." Self-identity, the image of who we are, provides a stable anchor to serve as a guidepost that creates continuity in an ever-changing world. Although few can articulate clearly the psychic elements that constitute this sense of self, it serves to color favorably or unfavorably the nature of one's continuing experiences. For some, the character and valuation of one's self image is a problematic one, an unhappy and dismaying self-reality, such as may be seen in the *avoidant's* feeling of being alienated, or the *depressive's* image of worthlessness, or the *negativist's* sense of self-discontent. On the other hand, there are those whose self-image is one of complacence, as is seen in the *schizoid,* or that of being gregarious among *histrionics,* or admirable among *narcissists.* Thus, self-image, despite the many particulars of its character, appears to be predominantly either of a positive or a negative quality. The self-actualizing techniques we describe next appear to fall into the same positive and negative division.

One group of therapists, labeled *self-actualization* types, assume that each person possesses an inherent wisdom for choosing a life course that is most suitable for him or her. Psychopathology arises because this capacity for self-fulfillment has been blocked or distorted by adverse circumstances. The task of therapy is to provide patients with a permissive and encouraging atmosphere that will facilitate the emergence of their potentials. By behaving in a nondirective and egalitarian manner, and by respecting patients' capacity to choose their own goals, the therapist encourages patients ultimately to discover ways to actualize the promise that inheres within them. We elaborate on these theorists, led by Carl Rogers.

Rogers's Client-Centered Therapy

The goal of self-actualization is most prominent in the *client-centered* therapeutic approach of Rogers's *self theory* (1942, 1959, 1961, 1967). This variant of the self-actualization therapies is based on the optimistic premise that we possess an innate drive for socially constructive behaviors; the task of therapy is to "unleash" these wholesome growth forces.

According to Rogers, patient *growth* is a product neither of special treatment procedures nor professional know-how; rather, it emerges from the quality and character of the therapeutic relationship. More specifically, it occurs as a consequence of certain attitudes of the therapist, notably *genuineness,* that is, therapists' ability to "be themselves" in therapy and to express their feelings and thoughts without pretensions or the cloak of professional authority; *unconditional positive regard,* that is, their capacity to feel respect for the patient as a worthy being, no matter how unappealing and destructive his or her behaviors may be; and *accurate empathic understanding,* that is, sensitivity to the patient's subjective world and the ability to communicate this awareness to the patient. In line with Rogers's therapeutic model, the patient assumes full responsibility for the subject and goals of therapeutic discussion; the therapist reflects rather than interprets the patient's thoughts and feelings and encourages, but does not recommend, efforts toward growth and individual expression. Experience appears to show that these techniques work best with patients who are already endowed with a positive sense of self-worth.

Kohut's Self-Analysis

It was Kohut (1971, 1977) who developed an influential variant of analytic theory; it furnished a special role for the self-construct as the major organizer of psychological development. To him, self-psychology was the proper next step following the earlier orientations of id-psychology and ego-psychology. Kohut's primary focus was on the development of self from its infantile state of fragility and fragmentation to that of a stable and cohesive adult structure. Disagreeing with classical analytic views concerning the role of conflicts as central to pathology, Kohut asserted that most disorders stemmed from deficits in the structure of the self. Owing to failures in empathic mothering, aspects of the self remain fragile and enfeebled, resulting in a variety of "narcissistically injured" personality disorders. Paying special attention to the importance of empathic responsiveness as a foundation for effective psychotherapy, Kohut added a new group of populations treatable by psychoanalytic methods. Unfortunately, Kohut was unable to continue his important contributions and, hence, may remain a less-than-significant figure in the development of psychoanalytic characterology.

Existential-Humanistic Therapy

Therapists of this persuasion are committed to the view that we must confront and accept the inevitable dilemmas of life if we are to achieve a measure of *authentic* self-realization. Themes such as these were first formulated in the philosophical writings of Kierkegaard, Nietzsche, Husserl, Heidegger, and, more recently, in those of Jaspers, Buber, Sartre, and Tillich. From these sources also may be traced the foundations of existential therapy, notably those advanced by Ludwig Binswanger (1942, 1947, 1956),

Medard Boss (1957, 1963), Viktor Frankl (1955, 1965), Rollo May (May et al., 1958, May & van Kaam, 1963), and Irvin Yalom (1980). Despite differences in terminology and philosophical emphasis, these existential variants are very similar insofar as their approach to therapy.

It may be useful, however, to illustrate differences between the European-engendered existential approach and that of the American-generated humanistic "third force" with reference to Yalom's (1980) incisive distinction:

> The existential tradition in Europe has always emphasized human limitations and the tragic dimensions of existence. Perhaps it has done so because Europeans have had a greater familiarity with geographic and ethnic confinement, with war, death and an uncertain existence. The United States (and the humanistic psychology it spawned) [is] bathed in a zeitgeist of expansiveness, optimism, limitless horizons, and pragmatism . . . the European focus is on limits, on facing and taking into one's self the anxiety of uncertainty and non-being. The Humanistic psychologists, on the other hand, speak less of limits and contingency than of developmental potential, less of acceptance than of awareness, less of anxiety than of peak experiences and oceanic oneness, less of life meaning than of self-realization. (p. 19)

Important to all existential therapists is the *being-together encounter* between patient and therapist. This encounter, characterized by mutual acceptance and self-revelation, enables patients to find an authentic meaning to their existence, despite the profound and inescapable contradictions that life presents.

Although the existential-humanistic approach consists essentially of a philosophical outlook, there are some clear-cut therapeutic goals and purposes. Most central is the desire to free individuals to relate *authentically* to others, to lead them to become more aware of their own potentials for choice and growth, and to realize that they can help redefine who they are and what their life course may be.

Glasser's Reality Therapy

The underlying assumption of client-centered, perhaps even rational-emotive therapy is that we are too harsh with ourselves, tending to blame and judge our actions more severely than is necessary. No more opposite a philosophy could be found than that espoused in Glasser's reality therapy (1961, 1965) or Mowrer's integrity therapy (1965, 1966). In effect, these men have claimed that patients are sick because they are irresponsible; they are *not* "oversocialized" victims of too rigid standards, but "undersocialized" victims of a failure to adhere to worthy social or moralistic standards. Anguish stems not from too much guilt and self-derogation but from an unwillingness to admit guilt and irresponsibility, such as may be found among *antisocials, sadists,* and *paranoids.* The task of therapy, according to this approach to altering self-image, is to confront patients with their misbehaviors and irresponsibilities and to make them "confess" their wrongdoings. The therapist does not accept patients' facile rationalizations or other efforts to find scapegoats for their misfortunes. Only by facing and admitting the "reality" of their deceit and guilt can patients regain self-integrity and learn to deal with the future truthfully and objectively. No longer needing to hide their sins, they can rectify past mistakes and find a more socially responsible style of life, without shame or the fear of being discovered. Therapists of this persuasion would not be suitable for dealing with a variety of personality disorders such as avoidants, dependents, and masochists. Moreover, where their philosophy may seem appropriate, such as noted

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above, there may be some difficulty in getting these patients to agree that they possess attitudes that promote and perpetuate their difficulties. Nevertheless, their methods may prove to be a useful entree into the self-image conceptions these troublesome patients possess.

Expanding on his original reality model, Glasser proposes a more general treatment framework in which one's behaviors are seen as purposeful in that their motivation stems from within the individual rather than from external forces; that is, causality is internal rather than environmentally determined. Addressing all syndromes and personality styles, Glasser states that people who wish to make the effort are able to change themselves and to live more adaptively. He speaks of patients, not as depressed, but as depressing; thus, rather than being angry, for example, they are angering themselves. Whatever form of behavior is manifest, it is a product of self-creation. People *choose* misery by developing a range of "misering" behaviors. From Glasser's point of view, depression, anxiety, and irresponsibility can be explained as an active, if unconscious, choice. The task of therapy is to help individuals become sensitive to their own inner strivings and wishes, and then to help them match their actions to these desires. However, when people take action that infringes on the freedom of others, their behavior is judged to be irresponsible.

Gestalt Therapy

What is known as Gestalt therapy may be credited to the ideas and methods of Friedrich (Fritz) Perls. Initially trained as a psychoanalyst, as well as a disciple of a number of Gestalt psychologists (Kohler, Wertheimer, Lewin), he was influenced significantly also by Wilhelm Reich and Kurt Goldstein during his early years as a psychiatric trainee in Germany. As with many innovative thinkers of his time, he left Berlin following the advent of Hitler, traveling in South Africa for several years and then on to the United States. For various reasons, Perls became anathema to his analytic colleagues, adopting as a result a number of Reich's more "radical" viewpoints. Notable at that time was his growing emphasis on affect, bodily experiences, the form rather than the content of therapeutic communication, and the use of confrontation as a treatment element.

Perls rejected the view that individuals' lives were controlled by either external or internal forces. Adopting a philosophy consistent with his own personal independence, Perls asserted that humans should be responsible for themselves and their lives. Implicit in this view was the belief that humans are free to change and to develop their own inherent potentials, a view shared by all self-actualizing theorists.

Perls contended that "neuroses" are an arrest or stagnation in growth. The goal of therapy, therefore, was to facilitate patients' control over their course of action and to actualize the "real self" rather than some fabricated "self-image." Moreover, Perls viewed psychopathology as a sign of immaturity and dependence; hence, therapy should be designed to foster maturation and independence, thereby facilitating the transition from external support to self-support.

Somewhat paradoxically, Perls and his associates did not view the therapist as a helper. In their view, "The very worst thing you can do for people is to help them." The function of the therapist is to frustrate the demands for help from patients so that they can learn that the resources for resolving problems are in themselves. In effect, patients are forced to find their own way, to discover their own potentials, and to learn that whatever they wish the therapist to do for them, they can do just as well by themselves.

Experiential Therapy

Viewing much of psychopathology to be a result of failing to experience or to dampen one's inner feelings, experiential therapists not only distrust intellectual exploration and analysis but seek to emphasize the spontaneous experience of life events. In this regard, they carry forward ideas first articulated by Aristotle in his examination of the cathartic value of drama and the powerful results that Breuer and Freud achieved in their method of abreactive treatment.

Experiential psychotherapy refers to a variety of techniques whose focus centers on the direct experience of emotions. Among current contributors to this perspective are Eugene Gendlin (1979), Alvin Mahrer (1996), and Leslie Greenberg, North, and Elliott (1993). Although their techniques differ, they seek to facilitate an inward focus on feeling experiences within the treatment context. It is their shared view that patients will not progress, much less actualize themselves, if they discuss their problems in a distanced, abstract, and intellectual way; similarly, little will be accomplished if they focus exclusively on the objective circumstances of their everyday or past lives.

Primary attention is directed to the felt or affective aspects of a patient's problematic experiences. Utilizing a technique called *focusing* (Gendlin, 1979), patients are asked to look inward and to "clear a space" so as to put aside all problems for the moment. Then, one by one, they are asked to focus on a single problem. Attention is directed to how the elements of that experience feel as a whole, to see whether certain words or themes emerge from the feeling generated by that problem. As a consequence, it is hoped that a "shift" may take place such that the character of the problem will take on a new quality by virtue of its associated feeling.

The role of the therapist is to utilize any of a variety of different methods to facilitate the task of eliciting the emotional tone of a problem situation. The therapist guides the patient through these different interventions, attempting to locate those methods that achieve the goal of enhancing a deep and sensitive exploration of feelings. As Greenberg (1993) noted, the therapist can use *evocative unfolding* to explore the emotional "edges" of a problematic experience. In this manner, patients are led to discover how they actually felt and construed a situation, and to better understand what really led to their response to that situation. No matter how dysfunctional that response may have been, it at least was "sensible" in that it reflected their real feelings about the matter. As a consequence of this discovery, new options presumably will open up for behavioral change. For experiential therapists, the process of treatment communication is one in which the topic stays in the moment, so to speak, that is, "in the flow" of what is being experienced within the session.

INTRAPSYCHIC RECONSTRUCTION MODALITIES

Behavioral expressions and conscious cognitions are but surface manifestations of more hidden and more central forces that reside in the unconscious.

The position that mental disorders are primarily caused by internal psychological conflicts is well-established in formal studies of psychopathology and psychotherapy. The patient's chemistry and nervous system function normally, according to this view, but inner thoughts and feelings are distorted and behavior is maladaptive. The major

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theory espousing this position is, of course, psychoanalysis, first formulated by Sigmund Freud (1856–1939). Few other schools of medicine have had so pervasive an influence on the traditions of their society.

Intrapsychic therapy had its formal beginning in the last decade of the nineteenth century. Most readers are acquainted with the history, rationale, and variants of intrapsychic theory; more will be said concerning this model of the mind in each of the clinical chapters later in the book. However, and despite inevitable controversies and divergencies in emphasis, often appearing more divisive on first than later examination, intrapsychic therapists do share certain beliefs and goals in common that are worthy of note and distinguish them from other modality orientations.

Intrapsychic therapists focus on *internal mediating* processes and structures that ostensibly underlie and give rise to overt behavior. In contrast to cognitivists, however, their attention is directed to those mediating events that operate at the *unconscious* rather than the conscious level. To them, overt behaviors and conscious reports are merely "surface" expressions of dynamically orchestrated but deeply repressed emotions and associated defensive strategies, all framed in a distinctive structural morphology. Because these unconscious processes and structures are essentially impervious to surface maneuvers, techniques of behavior modification are seen as mere palliatives, and methods of cognitive reorientation are thought to resolve only those difficulties that are so trivial or painless as to be tolerated consciously. "True" therapy occurs only when these deeply ingrained elements of the unconscious are fully unearthed and analyzed. The task of intrapsychic therapy, then, is to circumvent or pierce resistances that shield these insidious structures and processes, bring them into consciousness, and rework them into more constructive forms.

Intrapsychic therapists also see as their goal the *reconstruction* of the patient's personality, *not* the removal of a symptom or the reframing of an attitude. Disentangling the underlying structure of personality pathology, forged of many interlocking elements that build into a network of pervasive strategies and mechanisms, is the object of their therapy. To extinguish an isolated behavior or to redirect this or that belief or assumption is too limited an aim, one that touches but a mere fraction of a formidable pathological system whose very foundations must be reworked. Wolberg (1967) illustrated this philosophy in the following analogy:

> A leaky roof can expeditiously be repaired with tar paper and asphalt shingles. This will help not only to keep the rain out, but also ultimately to dry out and to eliminate some of the water damage to the entire house. We have a different set of conditions if we undertake to tear down the structure and to rebuild the dwelling. We will not only have a water-tight roof, but we will have a better house. . . . If our object is merely to keep the rain out of the house, we will do better with the short-term repair focused on the roof, and not bother with the more hazardous, albeit ultimately more substantial reconstruction. (p. 137)

Reconstruction, then, rather than repair is the option chosen by intrapsychic therapists. They set for themselves the laborious task of rebuilding those functions (regulatory mechanisms) and structures (morphologic organization) that constitute the substance of personality, not merely its "façade."

In brief, intrapsychic therapists contend that treatment approaches designed "merely" to modify behavioral conduct and cognitive complaints or distortions fail to

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deal with the root source of pathology and are bound therefore to be of short-lived efficacy. As they view it, therapy must reconstruct the "inner" structures and processes that underlie overt behaviors and beliefs. It does not sacrifice the goal of personality reconstruction for short-term behavioral or cognitive relief. Reworking the source of the problem rather than controlling its effects is what distinguishes intrapsychic therapy as a treatment procedure. Once the unconscious roots of the impairment are disclosed and dislodged, patients should no longer precipitate new difficulties for themselves and will be free to develop strategies that are consonant with their healthy potentials.

Freud's views on therapy followed logically from his theories of personality and its development: replace the unconscious with the conscious, eliminate conflicts generated during the infantile stages of psychosexual development, and redress imbalances between id and superego by strengthening the resources of the ego. Maladaptive behaviors were eliminated by eliciting memories and developing insights into the past through the techniques of free association and dream analysis; the major goal was the extinction of the patient's disposition to reactivate childhood difficulties in current life experiences. This was achieved by an analysis of the *transference phenomenon,* that is, patients' tendency to act toward the therapist with the same attitudes and feelings they developed in relation to their parents. Through this procedure, patients became aware of the roots and the persistence of their maladaptive behavior; with these insights, the ego could be reorganized into a more efficient and adaptive pattern.

Freud devoted his long and fruitful life to the development and elaboration of his theories and techniques. Unlike his German contemporary Kraepelin, who sought to classify broad groups of disorders with common symptoms, Freud stressed the personal experience and uniqueness of each patient. And unlike Janet, his French contemporary, who viewed conflicts as precipitants that activate an underlying constitutional deficiency, Freud traced the psychogenic and unconscious processes he perceived as fundamental to each disorder. It was not only the specifics of his findings that proved so epochal; his individualistic philosophy and his orientation toward psychodynamic causation served as the foundation for our twentieth-century understanding of human nature.

Classical Psychoanalysis

Psychoanalytic therapy had its formal beginning in the pioneering studies of Freud during the last decade of the nineteenth century. Despite inevitable controversies and divergences in emphasis, often appearing more divisive on first than later examination, intrapsychic therapists share certain beliefs and goals in common that distinguish them from other orientations; two were discussed in prior paragraphs.

Despite commonalities in data focus and reconstructive goals, psychoanalytic therapists part company on several matters, notably the extent to which they emphasize the developmental roots of pathology and the particular techniques they employ in conducting treatment. Let us briefly examine these differences.

First, a significant number of psychoanalytic therapists believe that successful treatment is contingent on the exploration and resolution of the infantile origins of adult psychopathology. This necessitates probing and uncovering the *conflicts* of early instinctual *psychosexual* development and the myriad *neurotic* defenses that the patient has devised to keep them from consciousness.

This emphasis on uprooting the past is not shared by all who follow the psychoanalytic persuasion. Rather than attending to childhood experiences, some therapists

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focus on current-day events and relationships. Efforts are directed toward the end of refashioning the patient's unconscious style of interpersonal behavior, rather than to tracing its origins in infantile development.

Second, therapists who seek to revive the infantile roots of pathology depend exclusively on treatment techniques that are employed only occasionally by those who concentrate on contemporary events. Those who focus on infantile conflicts maintain total passivity in the treatment relationship; the therapist becomes a "blank screen" upon which patients *transfer* the feelings and attitudes they acquired toward significant persons of their childhood. To further facilitate the reliving of the past, patients recline on a couch, face away from the therapist, become immersed in their own reveries, and are allowed to wander in their thoughts, undistracted by external promptings. Significant childhood memories and emotions are revived during these *free associations,* guided only by the therapist's occasional questions and carefully phrased interpretations; these comments are employed selectively to circumvent or pierce the patient's defensive resistances to the recall of repressed material.

The last major feature of what Freud termed his therapy of psychoanalysis followed from his observation that patients often expressed totally unwarranted attitudes toward the therapist. Freud noted that these seemingly irrational emotions and thoughts reflected hidden attitudes toward significant persons of the past. This transference phenomenon, which illuminated important aspects of the repressed unconscious, could be facilitated if the therapist remained a totally neutral object; by assuming this passive role, the therapist "forced" the patient to attribute traits to him or her drawn from earlier relationships with parents or other significant childhood figures.

To classical analysts, psychopathology represents the persistence of repressed instinctual drives that had generated severe conflicts during psychosexual development. Not only did the individual expend energies to control the resurgence of these memories, but because the conflicts they engendered remained unresolved, they persisted into adulthood and caused the individual to act as if he or she were living in the past. The task of therapy was to uproot the unconscious and to free potentially constructive energies that had been tied up in the task of keeping it repressed. To do this, classical analysts employed the procedures of free association, dream interpretation, and most important, the analysis of the *transference neurosis.*

Ego Analysis

These theorists believe that infants possess innate adaptive capacities which, if properly stimulated, enable them to develop in a healthy fashion. Although ego theorists accept Freud's *id* theory, which states that the seeds of pathology are the conflicts between libidinous instincts and the demands of society, they assert that an equal if not greater cause of pathology is the failure of adaptive potentials to develop adequately. Accordingly, ego therapy focuses not only on the resolution of the infantile neurosis, but also on the reconstruction of the patient's deficient adaptive capacities.

Although ego analysts pay less attention to infantile id conflicts than to infantile ego deficiencies, they retain the classical psychoanalyst's emphasis on the revivification and resolution of the past. To elicit early memories and provide patients with insights into the roots of their difficulties, ego analysts adhere closely to the classical techniques of free association, recumbent position, dream interpretation, and transference analysis. However, in addition to these procedures, they actively promote the

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strengthening and expansion of the patient's repertoire of adaptive behaviors. By various interpretive suggestions, they seek not only to eliminate the destructive and energy-consuming consequences of id conflicts, but also to build up the patient's deficient ego capacities. The manner in which this is done and how these active steps intermesh with the passive procedures required to foster transference have not been spelled out fully in the writings of the ego analysts.

Object-Relations Analysis

Significant experiences from the past, especially those involving important figures of childhood, leave an inner imprint, a structural residue composed of memories, attitudes, and affects that serve as a substrate of dispositions for anticipating, perceiving, and reacting to life's ongoing events, especially those related to significant persons in one's current world. The character and specifics of these internalized representations of others from the past remain as templates for interpreting and reacting to new relationships in the present. It is this inner template that shapes our perceptions of other persons that requires identification and analysis. These *object-representations* are, along with self-image, the major components and content of the mind. They bridge the division we have made between the cognitive and intrapsychic realms in that they are essentially unconscious images, assumptions, and emotions that persistently intrude in the patient's ongoing relationships. Moreover, they can be readily reactivated into consciousness and thereby be available for phenomenologic analysis and intervention.

Object-representations follow from Freud's observation that patients often expressed totally unwarranted beliefs and attitudes toward him. He noted that these seemingly irrational thoughts and assumptions reflected deeply embedded and usually hidden anticipations and feelings toward significant persons from the patient's past. This transference phenomenon, which illuminated important aspects of the repressed unconscious, could be facilitated if the therapist remained a totally neutral object; by assuming this passive role, the therapist "forced" the patient to attribute traits to him or her drawn from earlier relationships with parents or other significant childhood figures.

All modern intrapsychic therapists (Cashdan, 1988; J. Greenberg & Mitchell, 1983; Horner, 1990) recognize that patients project onto the therapist attitudes and emotions that derive from past relationships. Object-relations therapists consider these transference phenomena to represent the nucleus of the patient's infantile conflicts and pathological defenses. More than classical analytic therapists, however, they not only seek to foster the expression of transference materials and reveal their current manifestations, but center their attentions on making them conscious and to subject them to careful reworking in present life circumstances.

Although the uncovering of unconscious materials is a necessary phase in their work, object-relations therapists pay less heed to matters of the past than they do to the resolution of present difficulties. In another deviation from classical psychoanalytic doctrines, they assert that adult pathology is not simply a repetition of "nuclear" infantile neuroses. Early experiences are recognized as the basis for later difficulties, but intervening events are thought to modify their impact; problematic learnings and anticipations acquired early in life promote new difficulties, which, in turn, provoke new maladaptive strategies. By adulthood, then, an extensive series of events have occurred, making present behaviors and cognitions far removed from their initial childhood

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origins. Consequently, and in contrast to classical analysts, they consider it digressive, if not wasteful, to become enmeshed in the details of the roots of infantile neuroses. Instead, efforts can more fruitfully be expended in uncovering and resolving the patient's *current cognitive* schemata and strategies.

The therapist actively interprets the patient's object-relations distortions, not only in the treatment interaction, but as they are expressed in the patient's everyday relationships with others. The focus on the current ramifications of distorted phenomenologic assumptions, and the direct mode of attack on the vicious circles they engender, further distinguish the object-relations treatment approach from both other phenomenological methods and classical analysis.

BIOLOGIC REMEDIATION MODALITIES

Many biologically oriented therapists believe that all matters of a psychological nature (depression, anxiety) are epiphenomena, that is, superficial outcroppings of problematic neurochemical deficits and dysfunctions. As stated earlier, until that day in the distant future when practitioners can specify exactly which "pill" will dissolve the discomforts of psychopathology, patients will continue to be treated with drugs whose mode of action is only partially understood and whose effectiveness is limited. Unfortunately, this state of confusion and modest efficacy is paralleled among the equally perplexing and inefficacious psychological therapies.

Early Somatotherapies

From the early successes of surgery to the more recent advent of antibiotic medicines, the conviction has grown that treatment is most effective when directed at the root of a disorder and not its surface symptomatology. An assumption made in psychiatric somatic therapy is that the overt behaviors and feelings of the patient are expressions of an underlying biological affliction best treated at its source. The fact that few if any biological causes have been identified has not deterred the search for such therapies. Somatic treatments that have proved useful have resulted from *serendipity,* the art of accidental discovery. Perhaps the most striking fact about the history of somatotherapy is its progress through error and misconception. Speculative theories regarding new therapies were often far afield, and those who discovered effective treatment agents were usually blazing trails to other diseases. By good fortune and happy accident, alert clinical observers noted unanticipated effects that proved empirically useful for mental disorders.

Fortunately, new speculations regarding biological therapy are subject to the scrutiny of a sophisticated professional and scientific public today. The early history of somatotherapy, a curious mixture of humor and horror, did not have these needed controls.

Not all of the biological techniques used in former centuries should be considered forerunners of our present-day somatotherapy. Trephining was a religious and magical punishment to allow evil spirits to escape the possessed head of the patient, not to relieve a deficit in the brain. The medications of lizard's blood, crocodile dung and fly specs, prescribed by Egyptian physicians in 1500 B.C., were not disease cures, but magic potions.

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Hippocrates, despite his part in specifying the brain as the locus of mental disorder, offered no biological treatment for the disorders he observed. Although the rationale for treating the underlying disease was established in the Renaissance, medical reasoning was naïve. For example, the lungs of the fox were given to consumptives to eat because the fox was a long-winded animal, and the fat of a bear, a hairy animal, was prescribed as a cure for baldness. Paracelsus, in the sixteenth century, classified diseases according to the treatments that "cured" them, but the universal remedies of the day included powdered Egyptian mummy, unicorn's horn, bezoar stones, and theriac. Several of these contained more than 60 ingredients, all of which were worthless. As a passing note of humor, conferences were held complaining of flagrant tampering with these medications; to the physician of that early day, failures in treatment were best explained by the "pharmaceutical" adulteration of ingredients.

Not all physicians of past centuries were so naïve. Many astute observers recognized the crudeness of therapies. Maimonides, in the twelfth century, said rather facetiously, "I call him a perfect physician who judges it better to abstain from treatment rather than prescribe one which might perturb the course of the malady." And Oliver Wendell Holmes, the physician-father of the eminent judge, said as recently as 1860 that nearly all the drugs then in use "should be thrown in the sea where it would be the better for mankind, and all the worse for the fishes." Despite commentaries such as these, patients were subjected to fright, blistering, chloroform, castration, cupping, bleeding, ducking, and twirling well into the nineteenth century.

Somatic therapy for a disorder required that a disease first be identified. After syphilis had been established as the cause for general paresis, Julius Wagner-Jauregg, operating more on the basis of a hunch than scientific logic, inoculated paretic patients with malaria in 1917 and successfully cured them of their disease. His effort to extend this treatment technique to other psychotic disorders failed, and he concluded correctly that malarial action was specific to the underlying paretic infection and was not a general cure-all for mental disorders.

In 1922, Jacob Klaesi used barbiturates to produce continuous sleep treatment. Although this technique may be considered the precursor to modern "shock" therapy, it was designed to rest fatigued or irritated nerve cells. It was in the mid-1930s that the modern era of somatotherapies started with the almost simultaneous development of insulin coma therapy, convulsion treatment, and cerebral surgery.

Insulin coma therapy. Insulin was first administered to mental patients to increase their weight and inhibit their excitement. The step from this symptom-oriented approach to one based on "curing" the disease was made in the early 1930s by Manfred Sakel (1900–1957). He observed that unintentional comas induced by excessive insulin benefited patients. From this observation Sakel was led to the rather extreme hypothesis that psychotic behavior resulted from an overproduction of adrenaline, which caused cerebral nerve cells to become hyperactive. This excessive adrenaline made the patient oversensitive to everyday stimulation; insulin was effective because it neutralized adrenaline and restored normal functioning. Sakel's hypothesis was a simple one and easy to test. In a brief time, it was established that psychotic patients do not overproduce adrenaline. Furthermore, adrenaline is increased rather than decreased during insulin coma. Sakel realized the weakness of his theory and subsequently wrote, "The mistakes in theory should not be counted against the treatment itself, which seems to be accomplishing more than the theory behind it."

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The convulsion therapies. In 1934, Laszlo Joseph von Meduna (1896–1964) reported the successful treatment of schizophrenia by inducing convulsions with a camphor mixture, known in its synthetic form as metrazol. His rationale for its presumed effectiveness was quite different from the one proposed by Sakel. Meduna's (1935) thesis was derived from two observations that had been noted frequently in psychiatric literature: that epilepsy and schizophrenia rarely coexist, and that schizophrenic symptoms often disappear following spontaneous convulsions. This same observation had led Nyiro and Jablonsky in 1929 to administer blood transfusions from epileptics to schizophrenics, without therapeutic success. Nevertheless, Meduna was convinced that the biochemistry of these two disorders was antagonistic. Subsequent research has entirely disproved Meduna's thesis. First, epilepsy and schizophrenia are neither related nor opposed. Second, clinical experience has shown convulsive treatment to be useful primarily in depressive disorders and only rarely in schizophrenia.

Prior to the advent of pharmacologic agents in the mid-1950s, *electroconvulsive therapy* was the most widely used method of biological treatment in psychiatry. The technique of electrical convulsion, developed as early as 1900 by Leduc and Robinovitch with animals, was well-known to Ugo Cerletti (1877–1963) when he first used it with psychotic subjects in 1937. After his initial success, Cerletti formulated his own theory regarding its effectiveness; it was quite different from the ones proposed by Meduna and Sakel. He speculated that the convulsion brought the patient close to a state of death. This aroused extraordinary biological defenses, which led, in turn, to therapeutic recovery. Whether Cerletti's speculation regarding biological defensive action is correct remains unclear today. Other speculations proposed to account for the beneficial results of convulsive treatment are equally unverified.

Surgical therapies. One of the many hypotheses advanced to explain the successful effects of convulsive therapy served to spur the development of psychosurgery. This notion states that psychotic behavior derives from abnormally fixed arrangements in the organization of the brain. It was first proposed by Herman Boerhaave in the early eighteenth century when he devised a special twirling cage in which patients were spun to rearrange connections within the brain. This idea was approached surgically in 1890 when the Swiss psychiatrist G. Burkhardt removed portions of the brain cortex to rid patients of their fixed hallucinations.

Egas Moniz (1874–1955), unaware of Burkhardt's earlier work, reactivated this method of treatment in 1935 in what is known as the *prefrontal leucotomy.* This surgical separation of the frontal lobes (thought) from the thalamus (emotion) ostensibly minimized emotional preoccupations. Although the technique was used extensively in this country in the 1940s and 1950s, its effectiveness was always in doubt. Its use was sharply curtailed when pharmacologic approaches to somatotherapy emerged in the mid-1950s.

Pharmacological Therapies

The search for biological therapies was given a marked boost in 1952 when two entirely different drugs were discovered accidentally to have beneficial effects in tranquilizing anxious patients. In France, Delay and Deniker reported on the effectiveness of *chlorpromazine,* a drug originally synthesized for hypertensive and surgical patients. Almost simultaneously, another drug, *reserpine,* a product of the Rauwolfia snakeroot that had been used since the 1920s by Indian physicians, was found to calm hyperactive and

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assaultive patients. Interest in these drugs quickly swept the psychiatric world. Although they possessed undeniable chemical effects, much of their initial success in treating psychotic patients stemmed from *placebo* action—beneficial results arising from increased enthusiasm and high therapeutic expectations. After the early wave of excitement subsided, these agents, along with others since devised, have taken an impressive and useful place in the physician's kit.

The genuine beneficial effects of these agents encouraged a new wave of biochemical research. The action of many of the new drugs has been deciphered. More important, the search for natural biochemical dysfunctions has been intensified. The growing expectation that a scientific rationale for somatotherapy will be found accounts in large measure for the present strength of the biomedical tradition.

We need not be committed to the view that psychopathology is of biogenic origin to believe that biological therapies may be usefully employed; biological methods may prove efficacious in conditions in which the etiology is unequivocally psychogenic. For example, pharmacological anxiolytics may be fruitfully employed to ease "psychological" tension caused by the loss of a job or the death of a relative.

Biologically oriented procedures are only one of several sets of tools that make up the multitherapeutic armamentarium of an experienced and well-rounded therapist. They should not be employed to the exclusion of other therapeutic modalities and methods, as is too often the case. The practice of applying a single cherished treatment procedure, whether biological or psychological, to every form and variety of pathological condition is a sad commentary on the maturity of the profession, a sign of cognitive and behavioral rigidity most unbefitting to those who seek to aid others in achieving adaptive flexibility.

If the chief offense of psychodynamic theorists is the grandiloquence of their system and the tenuous connection between their concepts and the empirical world, the converse may be said for biologically oriented theorists. Medical scientists propose theories of limited scope and anchor their concepts closely to the observational world. Although these features are commendable, these theorists rarely propose hypotheses that go beyond established facts and thereby often fail to generate new knowledge.

At one time, biophysical treatment included only the use of electroconvulsive and psychosurgical procedures; these were never fully suitable for most syndromes and disorders and, with rare exceptions, are judged today to be technologies of the past. An early period of unjustified optimism in the 1950s and 1960s, characterized by the belief that pharmacologic "wonder drugs" would cure all mental illnesses and deplete the rolls of every state hospital, has also passed. Nevertheless, the field continues to be subjected to a flood of new products, each of which is preceded by massive and tantalizing advertisements that promise "a new life" for the mentally disordered patient. Despite this bewildering array of highly touted medications, we note that psychotherapists' offices, community clinics, and mental health hospitals are no less busy than before. Formerly agitated and assaultive patients are easier to handle, as are anxious and depressed syndromes less severe and of briefer duration, but there has been no sweeping change in the prevalence or variety of most psychopathological conditions. In short, these "wonder drugs" have assumed a solid scientific and commercially successful place as one of many tools in the broadly trained therapist's treatment kit.

The availability of efficacious medications in recent decades has signaled a major advance in the transformation of psychopharmacology from a hit-or-miss activity into one that has a scientific groundwork. Whereas there were only four or five general

groups of medications available for psychotherapy a decade or two ago, each of which had many side effects and diffuse main effects, more and more of the newer drug medications have been developed with few side effects and highly specific indications. In the past, the concurrent use of more than one class of medications often led to adverse effects; today, a wise choice of several agents often may be employed for optimal efficacy. Not that there are currently available pharmacologic treatments for all aspects of pathologic emotion, thought, and behavior; for example, there are no medications for the antisocial's conscience deficits, lying and stealing, but there appear to be useful drugs that may limit parallel symptoms such as irritability and impulsivity. Owing to these or other limitations of pharmacologic management, it is usually necessary to include one or another variant of psychotherapy to achieve optimal treatment outcomes. Specific symptoms may be satisfactorily controlled with medications, but the full range of most patients' psychosocial difficulties will call for a range of psychotherapeutic interventions. The specific goal of pharmacologic therapy is to eliminate focal symptoms such as dysfunctional behaviors and attitudes by modifying neurochemical balances and processes in the brain. The most relevant task in choosing a medication is to identify the primary and focal symptoms that the patient is manifesting.

When a pharmacological agent has been shown to exert an effect on a patient, questions arise as to the precise nature of its psychological consequences: whether it influences, singly or in combination, motor behavior, sensory processes, perception, discrimination, learning, memory, conceptual thinking, and so on; the specific biophysical mechanisms altered by the drug, for example, whether it activates or inhibits certain neurohormonal transmitter substances or has different kinds of effects on cortical regions, reticular pathways, limbic divisions, and so on; and the relationship between these psychological and biophysical changes and the "final" clinical effect.

Answers to the first question are largely obtained through animal laboratory studies, although certain functions, for example, higher cognitive processes, can be appraised only in human clinical trials. Answers to the second question involve the use of exceedingly complex technical procedures that specify the anatomical site of action and trace the precise character and sequence of the induced chemical changes; the task of unraveling the neurophysiological concomitants of drugs must disentangle effects throughout the awesomely intricate histological structure of the brain and the complicated network of interactions that operates among its diverse components. Attempts to answer the third question are even more difficult because the observed "final" clinical outcome reflects not only the action of interacting chemical and neurological pathways, but the individual's learning and adaptive history and the conditions prevailing in his or her current environment.

Because of the varied questions that can be posed regarding the nature of pharmacological action, and because of the complexity of the factors involved, theorists have had a relatively open field to speculate on why and how these drugs produce their effects. These formulations fall essentially into three categories: *neurohormonal defect theories,* which hypothesize that drugs overcome endogenous chemical dysfunctions in synaptic transmission; *neurophysiological imbalance theories,* which assume that these agents reestablish equilibrium among ill-matched functional systems; and *psychological reaction theories,* which posit that these substances result in energy and temperament changes that alter the patients' coping competencies and lead them to modify their self-image.

There are several ways in which drugs have been classified. For certain purposes, they are grouped according to their chemical structure (e.g., phenothiazines, SSRIs,

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tricyclics); for other purposes, they may be categorized according to their neurochemical mode of action (e.g., monoamines, oxidase inhibitors, neuroleptics); and in most cases, they are best classified according to their psychological mode of action (e.g., antipsychotics, antidepressants). It is this third, the most common basis for distinguishing and grouping pharmacological agents, that we utilize in the following sections.

Efforts to classify drugs in terms of "target" symptoms or broad clinical syndromes, however, tend to be misleading. Rarely is just one target symptom affected; rather, these drugs have a pervasive impact, influencing several clinical features simultaneously. In a different way, classifying drugs in terms of which clinical syndromes they influence implies incorrectly that the drug deals with all facets of that diagnostic group. Moreover, it implies that the drug does not produce meaningful effects with patients in other diagnostic categories; for various reasons, notably the heterogeneity and unreliability of diagnostic categories, such drug classifications are bound to be partially ill-conceived and often invalid.

More in line with clinical evidence is the view that some drugs tend to decrease activity and subdue mood, whereas others appear to increase activity and brighten mood. But even this gross differentiation fails to account for individual variations in reaction that are due to personality factors such as coping styles and a host of relevant socioenvironmental conditions.

Despite difficulties in establishing uniform criteria for classification, some schema must be employed for pedagogical purposes. We therefore turn briefly to the three principal drug types, antipsychotics, anxiolytics, and antidepressants, and review their distinguishing features and clinical indications. We mention only a few examples of each for illustrative purposes.

Antipsychotics. The discovery of the clinical utility of chlorpromazine and reserpine, reported in 1952, ushered in a new wave of optimism in psychiatric medicine. Many investigators, spurred by the impressive results of these two agents, began to manipulate their basic molecular structure in the hope of discovering variants that would be even more efficacious than the parent models. Modifications of these as well as other chemical substances have resulted in over 100 new psychopharmacological products in the past 45 years. Despite differences in structure, most of these agents affect essentially the same clinical behaviors as do chlorpromazine and reserpine, that is, they are antipsychotic *tranquilizers.*

Antipsychotics may be distinguished from a variety of compounds that have been used for over a century to moderate tension and agitation. In contrast to most of these medications, antipsychotics relieve anxiety and reduce hyperactivity without markedly dulling cognitive alertness and clarity; thus, they appear more selective in their dampening effects than sedatives, focusing on emotional and motor functions and operating modestly on cognitive functions. Let us briefly discuss the major subtypes of the tranquilizer group.

Chlorpromazine, chemically part of the dimethylamine series, was the first and is still thought to be among the most effective phenothiazines for handling markedly disturbed patients characterized by emotional tension, cognitive confusion, and motor hyperactivity. Numerous structural modifications of the basic chlorpromazine molecule have been made, producing drugs that differ from the parent model in both potency and side effects. In general, the greater the potency, the more severe and dangerous are the toxic consequences. For example, the addition of a piperazine ring

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to the basic molecule, as in prochlorperazine, results in a compound that is 5 to 10 times more potent than chlorpromazine, but increases the incidence of severe secondary complications. At the other end of the scale, in the piperidine series, significant alterations are made in the basic side chain and nucleus of chlorpromazine, decreasing both the potency of the compound and its associated side effects.

In the main, the various phenothiazine derivatives are alike in their clinical utility. Their primary indication is with the more severe reactions, disorders, and patterns in which a reduction in activity level and a dampening of heightened moods, such as anxiety and hostility, is desired.

Since the 1970s, a variety of new medications has been developed that parallels the effectiveness of the phenothiazines. For example, a major variant are the butyrophenones, generically known as haloperidol, or its trade name Haldol. Another relatively recent antipsychotic are the thioxanthenes; perhaps the best known variant is the piperazine group, among which is the prescriptive name Navane.

A more recent development, chemically somewhat atypical among the major antipsychotics, is the generic medication clozapine, given the trade name Clozaril. This medication appears to be especially useful if not superior to all previous antipsychotics; it has been successful especially in dealing with both positive and negative symptoms, and in the treatment of schizoaffective and complicated bipolar disorders. Particularly notable is its utility in combination with other antipsychotics and its minimal and low frequency of side effects.

Another recent antipsychotic derives from a combination of various neurohormones. It is judged a serotonin/dopamine antagonist; chemically termed risperidone, it is given the trade name Risperdal. A significant advantage appears to be its effectiveness in treating positive symptoms such as delusions and agitation; it also exhibits somewhat effective results for improving negative symptoms such as apathy and social withdrawal. There is a low incidence of extrapyramidal symptoms, as well as a low risk of inducing tardive dyskinesia. Care must be taken with both clozapine and risperidone not to abruptly terminate treatment, lest patients quickly relapse to their prior psychotic state.

A very recent chemical, termed olanzapine, possesses the prescriptive name Zyprexa, and has shown greater efficacy than certain antipsychotic forerunners (e.g., Haldol), as well as demonstrating fewer side effects. Quetiapine, another recent antipsychotic, known by the trade name Seroquel, likewise is proving useful in moderating both positive and negative symptoms of severe cognitive dysfunctions (e.g., schizophrenia). Another new agent, sertindole, labeled Serlect, is similar to olanzapine and may compare favorably to risperidone. Expected soon on the market is another antipsychotic, ziprasidone, to be prescribed as Zeldox; its efficacy is promising, but it has not been adequately evaluated as of this writing.

Each of these latter medications has proven to be useful in reducing psychotic thought and behavior. However, it should be noted that close observation is called for with several of these medications, notably their potential to produce syncope, orthostatic hypertension, and, most important, tardive dyskinesia.

Anxiolytics. For the most part, anxiolytic agents are both less potent and produce fewer troublesome side effects than the major antipsychotic derivatives. These drugs are of lesser utility than antipsychotics in treating markedly disturbed patients, but they do fulfill a function with moderately anxious and agitated patients. They

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appear to influence the same spectrum of symptoms as do the antipsychotics, but to a lesser degree.

These medications, once termed minor tranquilizers, grew in use during the 1960s and 1970s, especially with the introduction of the benzodiazepines. Perhaps the best known of these medications was chlordiazepoxide, better known as Librium, its trade name. Similarly popular was diazepam, known in the trade as Valium. Although preceded by the anxiolytic medication known as meprobamate (trade name Miltown), these benzodiazapines became highly popular treatments for run-of-the-mill emotionally distressed patients. Recently developed are anxiolytic agents of the buspirone chemical group, given the trade name Buspar. Each of these pharmaceuticals has achieved considerable support in the profession by virtue of their capacity to moderate minor levels of discomfort.

Antidepressants. An early report indicating that the antitubercular drug, isoniazid, produced a beneficial stimulant effect among psychiatric patients was lost in the vast sea of a growing medical literature on the "wonder drugs" (Flaherty, 1952). It was not until the late 1950s that the role of a similar drug, Iproniazid, was recognized as an agent that could produce "euphoric" behaviors. Evidence was gathered shortly thereafter that these drugs inhibit monoamine oxidase, an enzyme centrally involved in the metabolism of neurohormonal transmitter substances. This discovery in part gave impetus to the neurohormonal defect theories touched on previously.

Also in the late 1950s, several Swiss chemists synthesizing new variants of phenothiazine noted that one of their compounds, imipramine, produced an effect opposite to what they anticipated; it did not decrease tension or control hyperactivity, as was expected, but did appear to brighten the mood of depressed patients. New *antidepressant* compounds were quickly formulated on the basis of modifications of the iproniazid and imipramine molecular structures.

Antidepressants should be distinguished from compounds known as stimulants that have been employed for over a century to increase motor activity and mental alertness. In contrast to stimulants, the effects of antidepressants begin slowly and last appreciably beyond the termination of treatment. Also, and more important, antidepressants not only activate cognitive alertness and motor behavior, but favorably influence the mood of the patient; stimulants, in contrast, often aggravate negative moods. Let us outline the major categories of antidepressant drugs.

Iproniazid, the first widely used monoamine oxidase inhibitor (MAOI), produced dangerous side effects, notably liver toxicity; this led to its early removal from the prescription market. In the interim, several chemically similar substances were synthesized, of which several were hydrazine compounds, such as iproniazid (e.g., isocarboxazid and phenelzine) and other nonhydrazines (e.g., pargyline). The therapeutic effect of these agents on retarded depressive symptomatology appears to be well established. In general, tranylcypromine (Parnate) appears effective; its clinical efficacy, however, is somewhat dampened by discomfiting physical side effects. It should be noted also that MAO inhibitors frequently convert a retarded depression into an agitated one, and on occasion, patients may be precipitated into disorganized or hostile manic disorders.

Well established by now are the tricyclic antidepressants (TCAs). Among these apparently effective treatments are a number of tertiary amines; best known among them is amitriptyline (Elavil), imipramine (Tofranil), and doxepin (Sinequan). In a

somewhat different family of chemicals is bupropion, known by the brand name Wellbutrin. This latter antidepressant appears to be effective for patients who experience apathy, anhedonia, and decreased physical energy; similarly, it may be a good choice for depressed patients who also exhibit milder bipolar disorders such as hypomania and cyclothymia.

Especially impressive in the past decade or so are the selective serotonin reuptake inhibitors (SSRIs). These have achieved impressive results and appear to have become the treatment of choice of late among the antidepressants. Used perhaps more frequently than would be appropriate, the trade names Prozac (fluoxetine), Paxil (paroxetine), Zoloft (sertraline), and Effexor (venlafaxine) are well-known among psychiatrists, family physicians, and their patients.

Other pharmaceuticals. Brief mention should be made of a variety of sedatives that have been employed for over 70 years prior to the development of the recent anxiolytics. Among them are sodium and potassium bromides and the many barbiturates (e.g., phenobarbital).

Similarly, drugs have been introduced to control various manic states. Notable here are the lithiums (Eskalith), and the carbamazepines (Tegretol).

Not to be overlooked is the utilization of a variety of medications to counter panic states and minor phobias. Among them are the anxiolytic alprazolam (Xanax), the MAO inhibitor phenelzine (Nardil), and the tricyclic antidepressant, imipramine (Tofranil).

In Chapter 2 we turn to contemporary trends. Particularly significant are efforts to abbreviate the length of psychotherapy and movements to make treatment more relevant to the concerns of various minorities and genders, as well as to integrate in some systematic manner the many modalities discussed in this chapter.