MODERN DRUG TREATMENT AND PSYCHOTHERAPY[1]

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The use of sedatives along with psychotherapy has been a matter of controversy for the past fifty years, ever since the new methods of psychotherapy were developed. Some have held that the use of drugs might seriously interfere with psychotherapeutic procedures. Members of various contemporary schools of psychotherapy have thought that a patient, if given a sedative, might erroneously believe that the chemical by itself would lead him to recovery, which might interfere with the desired development of his own inner resources and initiative. Others, on the other hand, have held that if the patient were given adequate explanations, he would be able to anticipate and avoid such erroneous reactions. While the ideal goal, undoubtedly, is always to free the patient from the necessity of resorting to sedatives, their use has been accepted by many, provided it is planned as a temporary measure to help a patient over acute episodes in the beginning of treatment, or later on during an exacerbation of his condition.

Within the last few years new chemicals with decided advantages have been offered to the medical profession in the field of psychiatry. These differ from barbiturates, bromides, and other previously used sedatives in that they produce the desired results without inducing sleep. Thus the patient, while under medication, can continue to work and participate in his usual activities, and is approachable by psychotherapy.

Neuroses

The new chemicals used during treatment of neuroses differ from those used for psychoses. In neuroses, the meprobamates, widely known as miltown and equanil, hydroxyzine in the form of atarax, and many additional compounds are used. These help, in the main, by producing *relaxation from tension*, often with subsequent lessening of anxiety, as in the following case. A young woman applied for treatment because for the past few weeks she had suffered from such tension and anxiety that she had to stay away from a responsible job and was unable to face having to return to work. The psychodynamics in this case, namely, long-standing rivalry with a successful sister and lack of

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proper guidance by the parents, were evident, and the outcome of psychotherapy seemed promising. Much time and energy, however, would have been lost if the patient would have had to give up a desirable position for which she was well prepared. If it is evident that support through psychotherapy will not be adequate soon enough, as in this case, a temporary adjustment can now often be achieved comparatively easily with the help of one of the tranquilizing drugs. During the further course of psychotherapy, careful attention must be given to the reactions, physical and mental, of each individual patient so that adequate dosage, eventual increase, decrease, or cessation of drug therapy can be determined.

PSYCHOSES

In the psychoses, particularly in schizophrenia, the drugs most often used are, as is generally known, chlorpromazine in the form of thorazine, and the Rauwolfia derivatives.

General effects. The effect of these drugs is more than mere relaxation. It is often similar to that of psychosurgery, in particular frontal lobotomy, in that we usually find a *diminution of responses* to stimuli of destructive as well as constructive nature.

This results, on the one hand, often in a diminution or complete disappearance of hallucinations, delusions, hostility, and other forms of unrealistic thinking. This, in turn, may result in a more positive response to work, and an increased interest in human contact.

On the other hand, although schizophrenic patients are usually aware of these welcome changes, they are often even more impressed by certain drawbacks caused by drug therapy and, consequently, often show *dissatisfaction and unhappiness*. They suffer from their inertia, feel tired, and may complain of lack of interest in anything and of lack of sexual drive. This frequently causes intense depression. As after lobotomy, the patients lose the sense of purpose in life and often feel useless. Their newly acquired insight into their psychiatric disability often makes them ponder about whether they are or were psychotic, with resulting unhappiness. Before drug therapy, they had considered themselves sane and had often felt superior to and even contemptuous of their environment. Now, they realize that their feelings of superiority had been based on fantasy. They often comment that living in fantasy was more pleasant than realizing their shortcomings.

Since the introduction of modern drug treatment it has become even clearer than it was before that the schizophrenic, like any other

human being, may react favorably or unfavorably, respectively, to certain events. The type of aggravating event is often different from that which may profoundly shock a normal person. A schizophrenic on a long-term maintenance dosage of thorazine, which is always kept as low as possible, may, for instance, still react with panic and renewed formation of delusions when he is excluded from a social event involving his relatives or friends and, consequently, feels slighted. Such a situation occurs often because, even when greatly improved through the medication, schizophrenics are often not yet up to the standards of their former friends. On the other hand, actually catastrophic events which concern someone else, such as death of their closest relative or a critical illness in the family, may leave such patients unmoved.

Dreams and recollections. A further impressive observation is that under the influence of modern drugs, the quality and quantity of some other psychological manifestations change. This is, in particular, true of dreams and memories of the past. Before the schizophrenic patients undergo drug treatment, it is usually possible to interpret their dreams as an important manifestation of their conflicts, hopes, and frustrations. During drug treatment, however, the dreams have often the character of a toxic delirium and, so far, have sometimes proven difficult to understand in relation to the specific personality of the dreamer. Such patients often have dreams of violence and mutilation, perpetrated and suffered by people unknown to them, which frequently add little to previous knowledge of the personality of the patients. Could it be that this change in the character of the dreams is related to the *attenuation of purposeful thinking and planning* of the patient while he is tranquilized? We know that the urge to solve a certain problem is in general at the basis of dreams. This is evidently the reason why the mentally deficient, who are unable to plan, hardly ever dream. Reduction of purpose and planning seems to change the habitual character of the dreamer. At the same time hallucinatory components come to the fore which are more often observed under the influence of intoxications, as for instance during a fever delirium.

Memories of past events also change while the schizophrenic is under drug treatment, and, so far, we have no definite explanation of this phenomenon. Patients will suddenly remember vividly some details of their past. In my experience, these recollections do not date back to the first years of their life, to which commonly greatest importance is attributed when attempting to understand a patient. A

woman, for instance, who for many months had been functioning adequately with the help of thorazine, suddenly clearly remembered some clothing that she wore years ago on certain occasions. She kept wondering how such recollections came about. The fact that this woman is particularly clothes-conscious may be of significance here. Another patient suddenly remembered names of places, such as night clubs, which he had visited many years ago. Could it be that these recollections of formerly forgotten material which, because of their vividness and colorfulness, keep puzzling the patients, are more related to the pattern of hallucinations, although their content corresponds to reality? Further study will be necessary to find out more about the significance of this phenomenon.

Holistic treatment. The psychiatrist treating the schizophrenic with modern drugs has to be constantly on the alert to the reactions of his patient. He has to find out what can be achieved without the drugs; what psychiatric symptoms are eliminated through drug therapy; whether certain features, such as inertia, depression, blocking, and many others are caused by the underlying schizophrenic process or by the tranquilizers; and whether the patient's adjustment will be improved through an increase of dosage, or through a decrease of dosage. If the schizophrenic is well known to the psychiatrist, certain reactions can often be correctly anticipated and, if necessary, controlled with an adjustment of dosage. All this shows the necessity of a "holistic" approach, based on a thorough knowledge of the patient and his reactions, so that the dosage may be controlled correctly in order to produce the best possible results. The success of "psycho-pharmacotherapy," as this new type of treatment has been called, depends upon experience with and interest in the management of the whole personality of the patient.

In favorable cases the drug can finally be completely withdrawn and the schizophrenic patient may use his newly acquired knowledge and insight for a better adjustment. In other cases the drug is used over an indefinite period. Future years will tell about the final adjustment of patients under both these circumstances.

The recent advances in drug treatment of psychiatric conditions undoubtedly represent a promising and fascinating development, the importance of which for related fields of the natural sciences and psychology cannot be foreseen as yet. It has given new hope to many who long have been incapacitated and has offered new tools to those trying to help.