TREATMENT OF THE NARCOTIC ADDICT

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2. OBSERVATIONS ON INSTITUTIONAL TREATMENT OF CHARACTER DISORDERS

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THIS paper is an attempt to describe the development of an institutional treatment program for patients suffering from character disorders, as well as a current cross-section of the treatment program.

The Fort Worth Hospital is one of two established by the United States Public Health Service for the treatment of narcotic addicts. The hospital was established in 1938, and for the first four years of its existence was devoted entirely to the treatment of narcotic addicts. During the war years, patients with more classical forms of psychiatric disorders, primarily psychoses, were admitted; and this policy has persisted. At the present time the hospital is populated by approximately 500 patients on the Neuropsychiatric Service, suffering primarily from psychotic reactions, and 360 patients on the Addict Service. The Addict Service treatment program has evolved slowly over a period of several years, and many basic contributions have been made by members of the staff temporarily assigned to this hospital.

Many factors have influenced the development of the Addict Service treatment program. Some of these which appear paramount to us include the development of a neuropsychiatric service with an active treatment program and strong ancillary services. The impact of the concomitant development of unusually strong departments of Social Service, Nursing Service, Vocational Rehabilitation, Education and Recreation cannot be overestimated. A second factor of major importance has been the active support and encouragement offered by the administration of the hospital. This does not mean that the administrative officers were always in agreement with the developing program. At times their function was one of limit setting for the staff. Another important result of administrative policies was the establishment of a climate of decision making by consensus. A third factor of importance has been the presence of consistent leadership over a period of five

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years. It appears to us that a prerequisite for the transition from a penal to a hospital setting is the stability of staff, particularly at the leader level. A fourth factor has been the utilization by the staff of a variety of reasonably new techniques such as group psychotherapy, group self-government, marginal interviews, group social work and the establishment of a permissive environment for group verbalization.

Although it is impossible to portray adequately all of the patients on the Addict Service we shall attempt to formulate some generalizations from several frames of reference. Two characteristics are common to all patients, namely, addiction to narcotics (or rarely only habituation to marihuana) and physical masculinity.

Ethnically a large number of our patients belong to two minority groups, Mexican-American and Negro. In a preliminary study, about one third of a random sample of admissions belong to these two groups with the Mexican-American group being larger; this is probably related to the fact that the hospital is close to areas where there is a large concentration of Mexican-American people. If considered from the basis of the average daily census the proportion of the patients belonging to these two groups would be higher since the fraction noted was based on admissions to the hospital. This is due to the fact that a large number of older, white patients are admitted to the hospital but leave against medical advice soon after their admission. Basically, the patients as a whole are a young group, approximately half being below the age of 30. Fifty-six per cent of the patients have been addicted to heroin, and approximately half started to use the drug prior to the age of 21. In 32 per cent of the patients, marihuana utilization preceded the advent of addiction to the opiates. Seventy-six per cent of the patients did not complete high school, and 69 per cent demonstrated a high degree of vocational instability in unskilled and semiskilled jobs. In one fifth of the sample admissions there was a history of alcoholism prior to drug addiction, and in most instances these patients were older white men.

Although approximately half of the patients admitted to the hospital were voluntary patients, the lack of any kind of legal machinery to detain them in the hospital results in the fact that by far the great bulk of patients remaining and participating in the treatment program are either Federal prisoners or are on Federal or State probation.

There is evidence that our patients' families lack psychological cohesiveness. The father frequently is absent or a weak, ineffectual individual, while the mother may be a dominant figure and at the same time an indulgent one. A surprisingly large number of our patients (40%) are the youngest of all siblings, and if not, frequently the youngest of all male siblings. The role of the "family baby" persists in many, as evidenced by the continuing use of names like "baby," "my little boy" and "baby brother." The mothers of

many of the patients use these terms, but they are also heard within the hospital.

Many of our patients manifested early evidence of disturbed behavior such as stealing or truancy, and 56 per cent of our sample had previous criminal records. Frequently all the other siblings were making personal adjustments of a socially acceptable kind. The overwhelming majority of patients turn to illegal activities to support their habit. These activities include stealing, a variety of confidence games, forgery, pimping, burglary and selling narcotics. Thirty-seven per cent of the patients have had some experience with the Armed Forces, but not infrequently this experience terminated other than honorably. Medically, many of the patients presented many complaints, but most of the patients were well physically. In only 8 per cent of a random sample of admissions was there a reasonable history of a medical onset of addiction, and an examination of these reveals that the medical illness played little role in the patient's addiction.[1]

From the psychiatric point of view most of our patients appear to be suffering from personality or character disorders. Of the 134 cases sampled, 3 were diagnosed as schizophrenic reactions, one case as depressive reaction, 80 as personality disorders, and in 50 cases no diagnosis was made because the patient was discharged from the hospital before an adequate evaluation could be completed. It must be kept in mind, however, that we can describe them only as they appear in a unique social setting; namely, a prison hospital with a basic authoritarian structure. It is our impression that their surface behavior may well assume different configurations in other social settings. Within the large group of personality disturbances, all varieties and mixtures are seen with perhaps the passive-aggressive group of personality disorders predominating. In our own thinking several descriptive terms seem especially applicable; namely, a primarily passive group, a primarily aggressive or acting-out group, and a narcissistic group.

The surface behavior of the primarily passive group is characterized by a marked lack of assertiveness, great dependency upon the staff or often upon more aggressive patients, and generally a high degree of conformity to institutional rules and traditions. Such patients are often referred to as being able to "do good time." Occasionally they become favorites of subprofessional clinical personnel because of their disinclination to be troublesome or threatening. We find that a great many of our Mexican-American patients fit this description, and suspect that their cultural inheritance may play a major role in what often is ascribed to their psychopathology. It has been our experience that this primarily passive group is the most difficult to engage in significant therapeutic processes. Frequently, participation would appear to be on the basis that the patient needs to conform to staff expectations.

[1] A. K. Berliner and J. M. Lewis, unpublished data.

The surface behavior of the primarily aggressive or acting-out group is characterized by repetitious rebellion against institutional policies. These patients seem to be overwhelmed with their impulsivity, and their lack of well-functioning internalized controls frequently leads them into situations which, in this social setting, are self-destructive. Their acting out necessitates staff interaction with them, and we feel that relatively more of these patients become involved in meaningful therapeutic situations. These patients are by and large the most threatening group to the ward psychiatric aides and vocational supervisors, and constant direct and indirect pressure is felt by the patient's therapist to "do something about the patient." If such patients do not become involved in the treatment program, their disturbed, aggressive surface behavior may eventuate in transfer to a penal type of institution.

The surface behavior of the narcissistic group is quite different from that of the other two groups, although considerable passivity as well as acting out is noted. This group of patients frequently includes musicians, artists and other professional people. Many such patients are devoted to progressive music. The group as a whole is relatively withdrawn from the social life of the institution, presents a bland, blasé demeanor and spends a large portion of the time intellectualizing. These patients participate in the therapeutic activities and read voluminous amounts of psychiatric and pseudo-psychiatric literature, but only with extreme difficulty are they able to work through some of their basic feelings and conflicts. Their defenses are apt to include typically neurotic mechanisms. They appear to threaten some staff members intellectually, but not physically or aggressively, and are reasonably well tolerated by the institution.

These terms are artificial and find their only value in the frame of reference of gross description. Considerable overlapping in transition occurs and "pure forms" are rare. In addition to the large number of our patients thus described, we do see a few patients who are either classically psychoneurotic or overtly psychotic. They do not form, however, a significant proportion of the total patient census.

As can be seen from the brief general description of our patients' families, these patients come from emotional climates known to result in a heightened prevalence of a wide variety of psychiatric disturbances. We do not feel that the precise factors leading to the development of the specific personality disturbances described here are known. This would appear to us to involve one of the major unanswered questions in the field of psychiatry; namely, the factors determining the choice of mechanisms of defense by the developing individual. What we have been able to see and try to understand in these patients insofar as genetics, dynamics and mechanisms are concerned, we also have observed in patients who, from the descriptive viewpoint,

represent classical schizophrenic, psychoneurotic and other syndromes.

In working with our patients we find abundant evidence of rejection and deprivation during the early phases of orality. Rejection by the maternal figure was for some patients overt, and for others, covert or poorly hidden behind the façade of indulgence. This lack of early oral gratification resulted in continuing urgent needs of an oral dependent nature, and at the same time an overwhelming hostility. This hostility is most frequently expressed in the form of acting out, but we have been impressed with its near total repression in many of our patients. We feel that these dynamics explain in many patients the underlying guilt and severe depression with accompanying feelings of worthlessness and inadequacy. At later stages the frequent physical or psychological absence of a stable father figure has many consequences. Resolution of oedipal conflicts is rare and the formulation of a comfortable masculine identification is infrequent. Many patients report previous homosexual experiences. A number of our patients indicate a preference for oral-genital sexual techniques with women, and we have the impression that heterosexual experiences frequently take the form of what other writers have referred to as "instrumental masturbation."

These underlying conflicts and feelings are expressed in a variety of defense mechanisms. Repression, denial, projection and regression are common. In addition to these so-called "basic" defense mechanisms, however, we have observed mechanisms of a different order in our patients. These mechanisms have some similarity to the recent description of overt-behaviorial defense mechanisms by Reid and Finesinger.[2] They differ, however, in that they appear to be basically unconscious. They are complex interpersonal interactions which appear to have the primary purpose of defending the individual against anxiety. We shall describe three such mechanisms: manipulation, corruption and wedging.

Manipulation involves a heightened perception to conflictive emotional areas in others coupled with the ability to capitalize on these for personal gain. Frequently, a successful manipulation of a staff member by a patient assists the patient in maintaining a defensive type of omnipotence. This in turn is related to underlying feelings of worthlessness and inadequacy. The goals of various manipulations are different, but one prominent goal is that of placing the patient in a dependent relationship to a staff member. The staff member may then give to the patient in a way which perpetuates a prior mother-child or wife-husband relationship and deprives the patient of the opportunity to experience a more mature independence. It may be extremely difficult for some staff members to accept the concept that giving can under any circumstances be injurious to a patient.

[2] J. R. Reid and J. E. Finesinger, *Defenses: Their Nature and Function*, Am. J. Psychiatry, 112: 1015–1020, 1956.

Corruption is a particular type of manipulation in interpersonal relationships. It involves the attempt by one individual to precipitate dishonest or amoral behavior in another. This type of mechanism is observed frequently in the patient population, and in particular in their dealings with staff members. It appears that integrity promotes anxiety in some patients which they attempt to counteract with this manipulation. We feel that one factor involved in this type of behavior is underlying, unconscious guilt concerning past experiences on the patient's part. In effect, this is superego bribery.

Wedging is an interpersonal mechanism involving the active attempt on the part of one individual to provoke disagreement between two others. We see this mechanism operative in the relationships of many of our patients to staff members. It would appear that consistency on the part of doctor and nurse or doctor and social worker causes anxiety to be felt by the patient, because such consistency highlights the interpersonal pathology of the patient. Furthermore, the majority of our patients come from families where parental inconsistencies were great, and they appear more comfortable in such a setting.

Despite the anxiety-alleviating goal of these interpersonal mechanisms, it has been our observation that confronting the patient with the mechanism in the course of psychotherapeutic interaction makes further movement possible. It should be pointed out also that the interpretation of such mechanisms to patients necessitates considerable staff awareness of their own possible participation in the patient's illness.

An attempt to describe the patients in the institution would not be complete without indicating that many have considerable charm and are quite appealing to many members of the staff. It has been a recurrent observation that many of these patients experience their greatest degree of detectable anxiety when their behavior does not elicit the usual cultural responses of rejection, hostility and punishment. This observation in many ways is incorporated as one of the basic themes in our treatment program.

Treatment Program

To a psychiatrist working in a prison hospital setting, the treatment program includes not only the formal contacts of the professional staff with the patient, but also the contacts that are made with many other members of the staff and other patients during "the other twenty-three hours of the day." From this point of view treatment includes the subtle effects of traditions in the hospital, the deterrent and beneficial effects of varying attitudes of personnel and, perhaps even more significant, the effect of one patient upon another. We can only suggest how this climate is in general significant, but it is possible to describe more accurately some of the formal aspects of the treatment program.

Ward meetings. Weekly ward meetings were held on each of the Addict Service wards and were attended by several members of the staff. These meetings often became significant situations in which patients verbalized or acted out their interpersonal difficulties. We shall describe a ward meeting.

The ward meeting involved in this particular anecdote occurred on a smaller ward of 25 to 30 patients that was known informally in the hospital setting as the "therapy ward." In the development of the Addict Service treatment program, the first patients involved in group psychotherapy lived together on this ward and in many ways it was differentiated from other larger wards. There was a tradition of minor privileges on the ward, and one of us was the ward's fourth psychiatrist.

The meeting reported here occurred during the week of a visit to the hospital by a group from headquarters in Washington. The visit interfered somewhat with the various staff-patient activities within the hospital and closely followed the Christmas holiday season, during which there had been a decrease in therapeutic activities.

The early phases of the ward meeting were concerned with a number of directly hostile comments in regard to decreased staff participation with the patients during the past several weeks. Specifically, these complaints were that the Chief of the Social Service Department had not met with the Patient Council, and that one of the authors had missed several group psychotherapy meetings and the other had missed the ward meeting. A great deal of affect was displayed by the patients during these verbalizations, and finally one patient indicated that he hated to keep bringing up the ward psychiatrist's predecessor's name, but that insofar as the ward was concerned the patients thought that they were better taken care of under his regime than under the current regime. There were comments that the present ward psychiatrist was the first psychiatrist to have as his responsibility, in addition to the therapy ward, a large general ward, and they wondered when some other member of the staff was going to be ready to assume the latter responsibility. There were verbalizations that there had been a great many rumors that now that the therapy program was generally accepted throughout the hospital, their usefulness was short-lived and that soon the therapy ward would be dissolved. The patients indicated that the psychiatrist's predecessor had clearly stated to them on a number of occasions that this was his ward and that no one was going to hurt it, and that the current ward psychiatrist did not seem to share the same feelings about the ward and had become institutionalized very rapidly.

At this time the ward psychiatrist stated quite directly that he felt his predecessor's warm care of them had been tremendously important when the ward was first forming, but that perhaps his feeling now was that the ward had progressed to the point where it could take more responsibility and not need the same degree of obvious care. He went on to draw the analogy of a child, stating that when the child was very young and ate his spinach his behavior was rewarded. However, when the child was older you no longer rewarded him for eating his spinach but might in fact punish him if he refused. This analogy led to a distinct reaction on the part of the ward characterized by scoffing, shouts of "no" and some laughter. It was obvious that the patients were quite uncomfortable, and the noise and uproar persisted until finally one of them said, "Well, maybe some of that is true. I don't know. But if you have been trying to wean us, you weaned us too damn fast."

The psychiatrist indicated that he felt that the patients on this ward in particular, since all were involved in some kind of psychotherapy, should be able to evaluate the part that their feelings and needs were playing in their present verbalizations. He pointed out that at this time the group seemed to need to be taken care of and to be "first" insofar as the staff was concerned.

After a period of silence the content of the ward meeting changed directly to food. The patients complained that recently the dietitians had been serving food which they in the past had specifically objected to through the Patient Council. Specifically, they mentioned chicken à la king and chop suey. Several of the patients stated that this dietitian seemed to be trying to "stir the patients up." The ward decided to invite the Chief Dietitian to be present at the next ward meeting so that they could discuss with her some of their feelings in regard to meal planning. They next discussed their feeling that several members of the Nursing Service had it in for them and were "out to get the ward." They pointed out that since the new ward psychiatrist had taken over the administration of the ward, they were being inspected by the Nursing Service, whereas under his predecessor's supervision no ward inspections were made. They also pointed out with a great display of feeling that this change in policy on the ward had been made without consulting them. This meeting continued in this way and extended approximately 45 minutes beyond the usual quitting time.

One aspect of this ward meeting which seemed pertinent was that the seven or eight patients most active in verbalizing their hostile feelings were mainly patients with whom the ward psychiatrist functioned as an administrative psychiatrist. Most of these patients participated in group or individual psychotherapy with other members of the Addict Service. One exception, however, was an outstandingly hostile verbalizer, a member of the ward psychiatrist's group. He was a young patient who was acting out negative transference feelings, both in group psychotherapy sessions and throughout the hospital.

Group therapy sessions. Participation in group psychotherapy became a significant part of the patients' therapeutic experience in that approximately half of the 360 patients participated in 11 different therapy groups. The groups met weekly for an hour and a half, and the patients participated in the groups throughout their hospital stay, which varied from a period of four months to two to three years. The therapists encouraged the relating of hospital experiences and attempted to deal with current conflictive situations. The seven group therapists, although psychoanalytically oriented, varied in their roles from relative inactivity and permissiveness to considerable activity with structuring of content and limit setting. Fairly characteristic of the group therapy sessions is the following account of two consecutive group meetings.

In the first meeting a Mexican-American patient who had been hospitalized for many months immediately raised the question of why the hospital had decided to check up on patients who were spending time in the tunnel. With some encouragement and support from other patients he went on to say that he thought this kind of interference was planned by the staff to harass the patients. When the therapist asked him if he included

the therapist with the rest of the staff, the patient readily stated that he did and that he wondered what was wrong with the therapist. He stated that he felt that the therapist gained a great deal of satisfaction in a sadistic way in keeping the patients upset, and mentioned other similar experiences in the hospital. Another patient in the group, a physician patient, immediately came to the defense of the therapist, stating that he knew him well and that this characterization of him as being a "sadistic creature" was not true. It might well be true about other individuals but not of the therapist. He wondered where the first patient had got his "ideas of persecution," and whether he had brought them in with him "from the outside." The first patient agreed that he had had these feelings for a considerable time and that he had felt this way in the past. He related a distorted picture of his relationship with the therapist early in his hospital experience when he had asked his therapist to support his desires to seek training in the garment shop. In actuality, the therapist had supported the patient's desires to seek the training. The patient was able to verbalize his hostility directly to the therapist, but without any detectable feelings of anxiety. He stated that had they met on the outside he would have beaten up the therapist. This was accepted by the therapist, who had seen the patient peripherally for a number of months, but it was anxiety provoking to a number of patients in the group. It was agreed that this would be discussed in the following group meeting.

In the next meeting the physician patient immediately went on with the previous discussion by asking if anyone else had feelings of persecution of a similar nature. A former Navy pilot who had had a very serious accident as a pilot, which led to his addiction and eventual hospitalization as a Federal prisoner, stated that he felt that the prosecution and incarceration of addicts was grossly unfair. He pointed out discrepancies in prosecution and sentencing, and there was some agreement with this on the part of the other patients. He related in detail his own experiences, which he obviously distorted and exaggerated. This was pointed out to him by other patients. For example, when he stated there were tons of opium coming into the West Coast harbors this was disputed openly by the group. The therapist, who had been seeing the patient individually, took up the statement that the patient had resented his mother, who had reported his addiction and actively participated in his being given a Federal sentence. With this encouragement, the patient verbalized a great deal of hostility toward his mother. The physician patient in the group immediately observed that he did have a problem with his mother and that he had always been quite close to her. The ex-pilot agreed, and stated that it was his mother who had bought him a car when no one else would and that he had always been very close to her, and not his father.

Another patient, who had a very severe problem of stuttering and who described himself as being the only delinquent of a fairly large, well-to-do, second generation immigrant family, became quite angry. He asked, "Well, what is wrong with having a mother on your team as an ace in the hole?" He stated that it was much better to have your mother taking care of you than to be pushed out on your own when you had no legs to stand on, and that it was much better to have your mother on your side than to have to take a gun and hold up somebody. At this point the Mexican-American patient, who had been quiet during the second group meeting, pointed out that the former pilot had never had an opportunity to really take care of himself. The pilot then described his experiences in the Navy after the war, including the "plush" circumstances and easy life. The group agreed with him that this was much like being taken care of by a mother. The pilot added that he had gone through a severe initiation in preflight training, and then described his injuries following the airplane accident. He did this in great detail, using medical terms. He was interrupted by questions as to whether or not he expected pity from the group. The group

answered their own questions and pointed out that they would not give him pity because of his accident. At this time the meeting broke up, and as the patients left the therapy group, the ex-pilot approached the therapist and stated that the physician patient had even suggested that they should take his veteran's disability compensation away from him. The therapist responded that he wondered if this might be helpful, and the patient replied that it certainly would because the compensation had taken away every incentive that he had to do something for himself.

It appeared to us that the patients in this group were examining critically their dependency needs and were able to recognize some of the self-destructive components of their dependency strivings.

Social casework. Since our patient group is isolated both psychologically and physically from relatives, the role of the social worker in encouraging the patient to discuss his home situation and relationships and in directly corresponding with the relatives and referring them to agencies has been of great value. The patient's proneness to "do time" implies to the staff that he is defending himself against these probable areas of emotional conflicts. Many patients characteristically describe their home situation as being ideal, and only with great reluctance will actually discuss it. We have often had the impression that they are quite oblivious to the emotional conflicts within the home. An anecdote which illustrates this is as follows:

A 21-year-old single white male was admitted to the hospital as a voluntary patient on state probation. When first admitted he was passive, withdrawn, suspicious, and most reluctant to discuss his family situation. After many months of work within a group and with individual sessions with his psychiatrist and social worker, he was finally able to write his father, whom he had characterized as very stern and distant. He had avoided writing this letter by a number of maneuvers, including his complaining bitterly about his social worker to his psychiatrist, who simply referred him back to the worker, stating that these feelings could be discussed with her. This pattern was repeated many times during the course of his hospitalization. Much to his surprise, after writing to his father he received a very warm letter from him, and stated that he never expected "anything like this." After receiving this letter, he was able for the first time to discuss the repeated arguments that occurred in his home and to discuss his "taking sides with the person who would do the most for me, who was usually my mother. I would side with her but I had a great deal to do with the arguments. It's like working with you and my social worker." In this sense then, not only did the patient have the opportunity to re-examine his family relationships, but a basis was laid for this through his working simultaneously with both the psychiatrist and the social worker.

A case history. We shall present in a necessarily abbreviated form a case history. The case is that of a young man who was seen peripherally in individual psychotherapy but who worked effectively with a number of members of the staff.

The patient, a 27-year-old single white merchant seaman, was admitted to the hospital as a Federal probationer. He was the youngest of a large group of siblings and was raised in a relatively small southern town. His parents were both middle-aged when he was born. His memories of his father are basically those of a remote, cold, obsessive

individual toward whom the patient felt considerable ambivalence. The patient pictured his mother as a warm, protective individual. Although this patient did not have any history of delinquency as a youngster, it was quite apparent that he was unhappy. He left school and joined the Navy at a young age and served successfully. However, following his discharge from the Navy and return home, he began to use alcohol excessively. He eventually joined the merchant marine. During his experience in the merchant marine he began to use drugs, and related this spontaneously to feelings of depression and inadequacy.

At the time of his admission to the hospital he was quite depressed, tearful, and showed considerable disorganization in his thinking. He was assigned to the sanitation detail, where he related positively to his immediate work supervisor, a warm, friendly individual. The patient participated in group psychotherapy, where for a long period of time he was passive and did not communicate verbally. After a number of months, however, he was able to verbalize effectively his feelings of a socially acceptable nature, which often were in opposition to those of the remainder of the group. He worked with his social worker on a weekly basis and discussed with her his difficulty in managing the usual social skills. He was also seen by his psychiatrist in peripheral interviews, where the focus was on his relationship to his father.

Throughout the ten months of this patient's hospitalization distinct changes in his behavior were noted. He became much more friendly with other patients and gradually his depression cleared. Approximately three months after his admission to the hospital he no longer manifested the extreme degree of disorganization. He formed a close relationship to one of the psychiatric aides on his home ward and was able to talk over with him some of his difficulties.

After approximately ten months the patient was discharged. Preceding this, however, the situation was structured that he would not be discharged until he had played a role in setting up postdischarge counseling plans with a member of a social agency in his home community. This was accomplished despite the fact that it delayed his discharge.

The patient has been out of the hospital for a year. We have continued to hear from him on alternate months, and have had a number of progress reports from the social worker with whom he is working in his home community. She indicates that after a great deal of ambivalence and suspiciousness he was able to work effectively with her, and in particular to discuss his feelings of inadequacy, difficulties in heterosexuality, church experiences, and his mother's excessive concern and indulgence regarding him. His social worker has felt that he has made progress and is working effectively in his home community.

In this particular patient we visualize the role of the many staff members who worked with him, and in particular his social worker, vocational supervisor and psychiatric aide, as having participated in the treatment process, the goal of which was the preparation for outpatient therapy. It was our feeling that without the hospital experience this patient would not have been able to utilize so effectively the therapeutic relationship with the social worker in his home community.

Results

We have no statistical evidence to support the point of view that the therapeutic program is a successful one. We can report a change, however, both in individual patients and in the institution as a whole.

The institutional changes have been numerous and have evolved slowly over a period of more than five years. It must be emphasized that the starting point of the evolutionary process was a rather typically rigid, authoritarian penal setting. The starting point then became an institutional tradition, and efforts to change it met with resistance in some areas. There remains a hard core of subprofessional staff members who under suitable circumstances openly verbalize a desire to "return to the good old days." We feel that such attitudes are motivated by a number of factors, one of which is that for many people rigidly controlling measures in dealing with hostile, provocative patients are the most comfortable measures.

Despite resistance, the program has grown and the tolerance of the institution for socially unacceptable symptoms has increased. One basic change noted by many is that as the hospital has become more permissive, particularly in regard to patients' hostile verbal communications, there has occurred a marked decrease in the amount and type of hostile surface behavior or acting out. The acceptance by the staff of such verbalizations at ward meetings, in group psychotherapy and in individual patient contacts appears to us to be the main outlet for such expressions. An additional factor, however, has been the general acceptance of verbalizations rather than acting out as the primary expressive mode by the patients in their own groupings. In informal groups the patients talk into the night frequently, and although some of the content remains in the realm of drugs, women and Cadillacs, more and more the emphasis is on some personal difficulties, a recent group meeting or a pressing ward problem.

This distinct trend is noted also in the changing pattern of disciplinary problems. Prior to the general acceptance of the program on the part of the patients, such issues as the illicit introduction of narcotics into the institution were a constant problem. This particular issue has been practically nonexistent during the past several years. Although many factors are probably involved, one primary factor is the lessened effort on the part of the patients to introduce such drugs into the institution. Similarly, the incidence of fights among patients has diminished dramatically. Recently the Chief Security Officer directly and spontaneously voiced to us his concern about the changing role of the security force within the institution as a result of the different types of problems his men were called upon to face. The most common reasons for a patient's appearance before the Adverse Behavior Clinic at this time are the possession of extra clothing, "cutting" the chow line, and failure to report to work on time.

Another noted change is the increasing number of patients now willing to discuss previously taboo subjects with their psychiatrist or social worker. Such subjects include homosexual experiences, prior selling of narcotics, prior informing to law officers, masturbatory conflicts, procuring and atypical sexual behavior.

A few years ago a staff psychiatrist's appearance on one of the wards frequently resulted in his being overwhelmed by demands, many of which involved covert manipulations for drugs. Currently the same situation produces invitations to play bridge or engage in a table tennis doubles match, and verbal demands usually involve a request for an office appointment.

Patients plan, prepare and enjoy ward parties to which staff members are invited. These affairs are characterized by informality and a sense of joint participation. On occasions when planning has been grandiose or cooperation ineffective, the feelings generated are frequently brought into the open and evaluated in group psychotherapy sessions or ward meetings. The staff has participated in the group athletic program, at times on patient teams and at other times as a distinct staff team. A staff softball team known as the "Nervous Nine" competed unsuccessfully in an evening softball league against ward teams. A large number of patients attended the games and found socially acceptable outlets for antiauthoritarian feelings in hooting and booing numerous staff miscues.

Perhaps one of the most impressive indications of the institutional growth is the participation of the patients in the program. Several years ago there was only a handful of patients in group psychotherapy and an even smaller number in individual psychotherapy. There were strong patient traditions against participation with the staff in such interactions. The few who braved the tide were branded by other patients as informers or homosexuals. Currently the situation is at the opposite pole. Over half of the patients are involved in group psychotherapy, and the three therapists are seeing a large number of patients in individual therapy. In addition, there are long waiting lists for individual psychotherapy. The same degree of acceptance of the over-all program is reflected in the large number of patients working with their social workers, focusing contentwise on family difficulties and discharge plans.

There is much more evidence of change which could be reported. Five years ago there was strong resistance on the part of both staff and patients to the use of the term "patient." "Inmate" was preferred. At the same time the idea that women personnel should actually go on the wards elicited a storm of protest. Now the frequent presence of nurses and women social workers in these areas is taken for granted. There have been no incidents. It is extremely rare for provocative or suggestive language to be used by patients in such contacts. One exception should be reported to demonstrate that when it does occur the participation of both patient and staff member must be evaluated.

A young student nurse, recently affiliated with the hospital, was cornered in a recreational area by a 17-year-old Puerto Rican patient with a long history of delinquency. As well as can be determined from both patient and student nurse, the verbal interchange was as follows:

Patient: How about it?
Student nurse: What do you mean?
Patient: You know.
The content of the student nurse's response to this situation suggests the presence of a conflictive area of her own and her possible participation in the interaction.
Student nurse: Oh, I can't. I'm married.
Patient: That makes no difference.

This anecdote demonstrates an inexperienced staff member's injudicious handling of the patient's behavior. The patient was evaluated by the Adverse Behavior Clinic and there was considerable pressure to transfer him to a penal type of institution. Of similar concern to the staff working with him, however, was the knowledge that within the patient population there was considerable feeling that the patients should employ some disciplinary devices themselves.

For the past 18 months we have been utilizing a form of follow-up service through the mail. Many discharged patients are given a packet of envelopes addressed to some member of the staff. Within the envelope is a form with the patient's name upon it, and space to describe not only his current situation but to indicate if he has remained off drugs. The forms are to be mailed monthly for 6 months, and then bimonthly. The patient understands that if the staff does not hear from him the interpretation will be that he has relapsed to the use of narcotics. The patients are selected only on the basis of a particular staff member's having sufficient interest in him and on the basis of the patient's indication of willingness to participate. During the first year of this procedure, 100 patients were discharged on the follow-up program. These men represented all varieties of patients, including voluntary patients, probationers and term patients. Some were discharged with medical consent and others against the staff's advice. Most had participated in the formal aspects of the treatment program but a few had not. At the end of the year the staff had responses from 45 of the men, 2 of whom indicated that they had returned to the use of drugs, leaving 43 who presumably had not. Of these 43, 20 had been out of the hospital three or more months, and the remainder a lesser period of time. Of the remaining 55 patients there was evidence that 5 had abstained from the use of drugs though they had not returned their follow-up forms. The staff heard directly or indirectly that 17 of the 55 had returned to the use of narcotics. The staff learned nothing about the remaining 33 patients who had not returned the forms.

Of the patients who continued to correspond with the hospital, a greater percentage were discharged into a situation where they were to report to a parole or probation officer than was true for the "no contact" group. While we do not feel that this form of follow-up program gives a valid picture of either abstinence or readdiction, we do feel that for many patients it may

be used as an index of their investment in the hospital treatment program. It has been helpful to the staff also in terms of team morale, and the returns thus far greatly exceed our anticipation.

Summary

We have attempted to describe the development and current status of a treatment program within an institutional-hospital setting for patients suffering from character disorders. The fact that our patients were addicted to narcotic drugs was in itself not felt to be of paramount importance since we feel that our observations have implications for the wide spectrum of character disorders, delinquency and criminality. Some of the inevitable difficulties in attempting to formulate such a treatment program have been enumerated. Our contention that in some ways the program has been successful lacks statistical validation. Indirect evidence, such as a recent statement by a member of the Federal Parole Board that our rate of parole violation is less than that of other Federal institutions despite a relatively high parole rate, is encouraging.

Discussion

Robert P. Cutler, M.D.:* My discussion is based upon viewpoints I gained at the Lexington hospital over a two-year period. Perhaps we should question my right to discuss this paper from the viewpoint of another hospital when immediately we must consider differences in policies, personnel, physical setup, numbers of patients, and differences in cultural background of patients. However, the differences are not too great between the Lexington and Fort Worth hospitals; in each the goal is the same: to try to enable each patient to live in society without resorting to the use of drugs.

I was interested in the description of the personality groups: the passive, the acting-out, and the narcissistic groups. Although working with many patients tempts us to generalize and to classify them as groups I question whether we should do this. We thus categorize patients according to surface behavior or behavioral states through which every patient can and often does fluctuate once anxiety is evoked. Furthermore, classifying patients by the *status quo* of the defenses, though not new and perhaps giving us some feeling of control or better understanding, is all too often misunderstood by nonprofessional personnel and is equally confusing to professional staff whose understanding is based upon different reference frames than ours.

I agree with the authors' findings relative to the father in the family history of most of their patients. At Lexington the finding of the absence of the father early in the patient's childhood was so common that some of the

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residents would ask their patients not "What can you tell me about your father?" but rather: "When did your father leave you?" or "What do you recall about your father before he left you?"

An abundance of oral fantasies and behavior is not always due to marked rejection and deprivation during the oral stage of development. Indeed I have found that our addict patients have usually been greatly attended by the mother during the early phase, that weaning was not altogether favored by the mother, and that regression to this phase occurred when the patient met overwhelming conflict, roughly between two and four years of age. He therefore commonly failed to reach a genital stage of development. His regressive, strong, oral demands are today met with frustration which evokes rage. The rage either meets with repression and the adoption of a reaction formation of passivity, or else tends to overwhelm the weakened ego, and the patient attempts to gain security by manipulating his environment and thus to achieve a certain sense of omnipotence.

Manipulation, corruption, and wedging are also commonly seen at Lexington and are defensive traits which appear to have the common goal of weakening external authority. This bribery is apparently motivated by many factors: the repetition of the corrupt parental situation is one reason for wedging; some hoped-for realistic gain often motivates manipulation. Corruption, wedging, and manipulation all seem to have for the patient one common purpose: the attainment of relief from his superego anxiety. These patients labor under the chronic impact of hostile introjections which make up the largest part of their superego. Because they are deprived in large part of an ego ideal, as well as a fair share of secondary narcissism, this hostile superego with its constant threat to ego integration would seem to be their chief heritage as well as the force behind their masochistic behavior. To bribe this internal agency as well as its external substitutes is the standard method of these patients to alleviate superego anxiety and thus achieve relief.

I recall an experiment by A. Wikler which proved that morphine significantly reduced anticipatory anxiety to a painful stimulus although it had little effect upon the pain response per se. In view of this I wonder if part of the relief afforded by the first few doses of morphine is in some cases due to the abolition of the chronic anticipation of danger originating from the addict patient's superego. If so, this chronic threat to the ego is perhaps later replaced by the dread of physiological abstinence symptoms.

I agree with the authors' assertion that the interpretation of the patient's various defense mechanisms necessitates considerable staff awareness of their own participation in the patient's illness. I regret that there was not more emphasis upon this aspect of treatment in the paper. Without question, careful supervision of—and interpretation to—the staff, especially the non-

professional staff, functions as the keystone of any good institutional treatment program.

Of the many aspects of this paper, the main theme of interest to me is that of instituting psychiatric treatment in such a setting, the difficulties involved in changing a prison to a psychiatric hospital—in essence, the rejection of the term "inmate" and the adoption of the term "patient." This, I can testify, is an exciting and rewarding experience.

At the Lexington hospital the personnel number about 500, and the addict patients about 1,000. Approximately two thirds of the latter are Negro, and the remainder white with a few Chinese, etc. About 225 addict patients are women. The majority of the patients are volunteers; the rest are Federal prisoners and probationers. The treatment program has for several years included psychoanalytically oriented group and individual therapy. This has been carried out by the professional psychiatric staff, which includes approximately 12 residents in training. At any given time there are about 8 to 12 group sessions of 8 or 10 patients each; usually about 5 per cent of the patient population are in individual intensive psychotherapy. Both types of therapy are closely supervised.

I understand that group therapy of patients comprising a ward was tried years ago and was abandoned when these patients incurred the enmity of those outside the ward, and justifiably were regarded as subject to privileges and special treatment denied the rest of the patients. Since that time patients composing the groups in therapy come from various wards. Because it was found that those patients in the different work areas showed far greater spirit, perhaps because of their joint endeavors in producing a product or a service, some success has rewarded our efforts to have regular group sessions at the site of their work. These sessions combine educational aspects of the industry—through movies and talks—with encouragement of the patients to ventilate their present feelings in a permissive atmosphere. Such sessions have caused several patients, who thus far had avoided therapy, to become interested and enter the regular group or intensive treatment program. The job supervisors present at such meetings have been able to face their anxiety evoked by the new atmosphere, and to overcome this anxiety in many instances through identification with the psychiatrist in charge of the sessions.

I feel quite familiar with the difficulties mentioned by the authors. Perhaps the major effort which brought us face to face with these difficulties was the initiation in 1955 of a therapeutic community, not only in the wards, but throughout the entire hospital and all of its personnel. Upon admission each patient is now assigned to his own psychiatrist, who works with the patient from the first two weeks on the orientation ward, sets up the treatment program, deals with all of the administrative problems of the patient during

hospitalization, and sees that the patient has proper posthospital planning before recommending discharge. Except in the case of an emergency, or of minor routine matters, no action can be taken regarding a patient without his physician's first being consulted.

As you can see, this brought the psychiatrist immediately, intimately, and daily into contact with the various areas of the hospital, and in time into direct contact with almost all the nonprofessional staff of the hospital. Though viewed at one time by occasional residents as a plot to tear them from their easy chairs behind the couch, it has brought to their awareness the importance of the repetitive nature of their patient's behavior, and the marked importance of knowing what are the needs, goals, anxieties and fixed prejudices of the personnel involved. Soon the residents detected the various strengths and weaknesses of the individual personnel, since they acted quite as the patients did in given situations. The importance of spending time with the personnel on individual milieu problems of patients became evident. Getting out of the "ivory tower" and working daily with personnel versus patient problems permitted a surprising amount of the psychiatric viewpoint to rub off on the personnel. It helped to allay their anxiety. The personnel felt part of a team which fostered a medical approach to the patient instead of a police approach.

By the very nature of this method, patients in groups who acted out found little solace as each member of the group was seen by his own psychiatrist and dealt with in terms of his own dynamics. Acting-out patients were of course first spotted on the orientation ward. They constituted approximately 10 per cent of each resident's caseload, or about 10 to 12 patients. Focusing the patient's transference on his physician rather than splitting it amongst many people was apparently beneficial. Before the initiation of this program the Adverse Behavior Clinic was meeting an average of three afternoons a week. The activity of this clinic diminished so greatly that during early 1956 the Adverse Behavior Clinic was completely abandoned. The patient's physician was directly empowered to recommend loss of statutory good time as well as to recommend transfer of the patient to a penal institution when necessary. Administrative alterations like any other changes always meet with resistance. I am sure the authors will agree with that statement. As Stanton and Schwartz expressed it in their book *The Mental Hospital:*

> Human beings are always difficult if one tries to fit them into a framework of some mechanical institution organized only to fulfill some explicit goal. The institution will function smoothly to the extent that it meets the needs of all the people who are a part of it. Failure to meet the needs of any people, be they patients, staff, or community, will lead to suppression, and resulting challenge of the institutional structure. The very existence of the institution depends upon the fact that to a large extent it meets the needs of all the people in it.

The reverberations of a program such as the authors undertook, or the Therapeutic Community program we undertook at Lexington, bring out anxiety in the staff at almost all levels. This is picked up by the patients, and at first all appears to be chaos. After this period the results of effective handling of the various problem situations begin to show up.

For example, the laundry has always been a place where no patient wanted to work during hot weather. Early in our program we were faced with groups of four to six patients who would refuse to work there. Prior to the program they would probably have been strongly disciplined. Under the new program, however, the two laundry supervisors called each patient's physician, who in turn got to the issues within the hour. One laundry supervisor at first was usually upset in these situations; he was frustrated because he no longer could automatically take direct action against the patients for their passive-aggressive behavior, and seemed convinced that the patients were going to riot and to be coddled by their physicians while they did so. It soon became clear that the patients had become able to carry out a wedging action between the two supervisors, thus provoking a chronic state of disagreement between them. When this state flared up openly, the patients reacted by a sullen refusal to work. After the supervisors as well as their chiefs were made aware of this, such acting out disappeared in the laundry. Later, after group sessions began in the laundry, some patients actually resisted changing from the laundry job to other work areas.

The authors emphasized that the request for treatment must come from the patient. With this I agree. However, motivation for treatment would often seem to be in direct proportion to the patient's anxiety. I am not clear about how the authors motivated their patients. Naturally, there are large numbers of patients with character disorders who simply never will be motivated for any type of psychiatric treatment. The lack of motivation for treatment amongst addict patients is a major problem. We tried various methods such as modification of the indefinite sentence without too much success. Fair success has been obtained when the patient's anxiety has been mobilized by the permissive atmosphere along with undermining defenses such as manipulation, wedging, and corruption.

The validation of success or failure of any treatment program depends of course upon follow-up studies. I don't feel we can put too much stock in the questionnaire method. Yet, since patients return to all parts of the country, this would seem to be the only feasible way to get the information. Here is another problem which badly needs solution.

The authors' anecdotes were of considerable interest to me. However, they raised certain questions in my mind. A large population of patients lends itself to group therapy. Is this because it is really useful for the patients or is it to satisfy our own need to "be doing something for the patient"? Although some patients definitely benefit from it while in the hospital setting, does the improvement last upon their leaving the group or hospital? I have been impressed with the transient improvement of some of those group therapy pa-

tients who returned. In a way their improvement struck me as comparable to the "transference cure" in psychoanalysis; fear of displeasing the group and need to please the group leader may be analogous to fear of rejection by the analyst and need to please the analyst. It is doubtless true that "corrective emotional experiences" occur in group therapy, but I feel uncertain about their depth and permanence.