Current Issues in Clinical Psychology

Volume 4

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Current Issues in Clinical Psychology

Volume 4

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Plenum Press • New York and London

The Library of Congress has cataloged the first volume of this title as follows:

Merseyside Course in Clinical Psychology.
Current issues in clinical psychology.—Vol. 1-—New York: Plenum, c1983-
v.: ill.; 26 cm.
Based on lectures presented at the Annual Merseyside Course in Clinical Psychology.
Editor: Eric Karas.
ISSN 0741-9724 = Current issues in clinical psychology.

1. Clinical psychology—Periodicals. 2. Psychology, Pathological—Periodicals. 3. Psychotherapy—Periodicals. I. Karas, Eric. II. Title.
[DNLM: 1. Psychology, Clinical—congresses. W3 ME56]
RC469.M45a 616.89'005—dc19 83-647976
AACR 2 MARC-S
Library of Congress [8503]

ISBN 978-1-4615-6777-6 ISBN 978-1-4615-6775-2 (eBook)
DOI 10.1007/978-1-4615-6775-2

Based on the proceedings of the Special Annual Merseyside Course in Clinical Psychology, held August 29-31, 1984, in Chester, England

A Division of Plenum Publishing Corporation
233 Spring Street, New York, N.Y. 10013

PREFACE

Since 1980, clinical psychologists and other professionals have gathered in Merseyside each year for the "Annual Merseyside Course in Clinical Psychology". The aim of this annual event is to offer post-qualification training and a forum for discussion in areas of current clinical interest. Over the years, the course has attracted national and international speakers and attenders of the highest calibre, plus up-to-the-minute reports on current research.

In August 1984, the course was held, for the first time, in the beautiful old city of Chester. As always, the papers were presented by leading clinicians and researchers in their respective fields; once again, this included several contributions from Merseyside psychologists.

Since 1981, the proceedings of this conference have been published as "Current Issues in Clinical Psychology". The present volume - Volume 4 - covers four major areas of current interest: The Child and Therapy; Rehabilitation Across the Specialties; New Directions for Psychology and the Law; and Addictive Behaviors. Each of these areas must be relevant to the work of almost all clinical psychologists, at various times.

The volume closely reflects the order and content of papers presented at the 1984 conference, although it also includes one paper (by Guliz Elal-Lawrence) written specially for this publication.

The 1984 conference was widely acknowledged to be another success - both academically and socially - and I hope that this volume fully conveys the interesting and stimulating ideas and information enjoyed by those who attended.

Gill Edwards

ACKNOWLEDGEMENTS

I should like to thank the other members of the Organizing Committee: Barrie Ashcroft, Nadine Eisenberg, Guliz Elal-Lawrence, Ann Fordham, Eric Ghadiali, David Glasgow, Sue Hingley, Barrie Jones, Robin Logie, Ray Miller, Jacqui Nevin, Glynn Owens, Sandy Reed, Austin Sinnott, Peter Slade - and our industrious Chairperson, Sheila Hamilton. Their hard work and dedication made the conference a success once again.

Many thanks to the twenty-six contributors to this volume, six of whom were also members of the Organizing Committee, for both their spoken and written papers.

The Committee is also grateful to those organizations who offered financial support to the course, thereby enabling us to offer an attractive registration fee.

Finally, my thanks are due to Maureen Parry and Marion Mott, who typed many letters in connection with this volume.

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A PERSONAL CONSTRUCT APPROACH TO THERAPY WITH CHILDREN

Peggy Dalton

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George Kelly's "The Psychology of Personal Constructs" started life twenty years before its publication in 1955 as a handbook of clinical procedures. But, as he says in the preface, the business of trying to tell people 'how' they might deal with clinical problems was continually interrupted by the need to explain 'why' these procedures were being proposed. The work therefore expanded until, by its completion, a large part of the first volume came to be devoted to an exposition of the theory behind the psychotherapeutic techniques described in Volume Two. It would be impossible to attempt anything like a comprehensive overview of the philosophy which gave rise to Kelly's approach to clinical work. But it does seem important to begin by looking at some of the more central ideas, in order to provide a context for the discussion which follows.

PERSONAL CONSTRUCT THERAPY

The theory is expressed in terms of the development of a system of personal constructs through which man, woman or child tries to make sense of themselves and their world. Since Kelly argues that we interpret events by noting similarities and differences, constructs are essentially bipolar. We understand 'gentle', for example, in contrast to 'harsh', or whatever our own particular opposite might be. A baby might construe the 'discomfort' of hunger as against the 'comfort' of being satisfied. It must be emphasized that constructs are by no means always verbalized, nor are they equivalent to thoughts. We may construe with touch, vision, hearing or sheer gut-reaction, without ever putting a name to our discriminations. And Kelly makes no distinction between these perceptual processes and action or behavior. In a paper on the psychotherapeutic relationship (Kelly 1965), he speaks of a child posing a behavioral question, construing by means of his or her actions:

> "A very young child meets a stranger. How shall he approach him? Being human and a child at that he can probably do no better than to construe the stranger as like one or other of his parents. But how right is he? This is a question which he can only pose through his own behavior. Thus, for the child, his behavior at this point is the posing of *a* question arising out of his construction of the stranger. The behavioral question he poses may be badly put and he may get an ambiguous or shocking answer.

But whatever answer the child gets, he will normally try some reconstruction of the situation - transferring from his past experience in somewhat different ways - and pose another behavioral question."

It should be clear from this example that constructs are not only interpretations made through many channels but they may be more or less directly available to us at the time they are brought into play. Kelly speaks of different levels of awareness, rather than using the conscious/unconscious dimension. He describes some constructs as 'preverbal', which can mean that they have been formed before the development of language or, though evolved later, have never been given verbal expression. He also refers to the 'suspension' of constructs, perhaps for many years, until an event stirs some feeling in us which is vaguely recognized. In addition, although there is always said to be a contrast pole, it may not be readily accessible to us. Perhaps the child he is describing has a very clear construct of 'mother' or 'motherness' when he meets a woman, but part of his difficulty in construing a female stranger is that he has not yet elaborated what a woman who is 'not mother' could be like. An older person may, as another example, have a strong sense of what it is to be 'vulnerable' but find it hard to grasp what the opposite experience might be. Any notion of invulnerability may be said to be 'submerged' as far as this person's construing is concerned.

I spoke earlier of the development of a 'system' of personal constructs. While we are always concerned with the content of an individual's construing - the meaning he or she attaches to events - we must also take into account the nature of construing processes, the structure of that system, if we are to comprehend the uniqueness of the individual more fully. Kelly sees this system as formed from inter-related networks of constructs developed around events of all kinds. And the more we know about this inter-relationship the better. We need to understand, for example, something of the hierarchical organization of constructs in particular contexts: what are the superordinate and what the less important notions governing our construction of an experience?

One person, for instance, may approach a meeting with others looking primarily for evidence of congeniality, with physical attractiveness being only a secondary or subordinate aspect of that attribution. For another, deeply concerned with her own weight problem, the fatness or thinness of these she meets may over-ride any other impressions and bring to her construing of them some ready-made expectations of what they will be like and how they will react to her.

This latter situation introduces a further feature of the structural aspects of construing. A construct may, as we have seen, be 'superordinate' or 'subordinate' to another in a specific context. It may also be said to be 'core' or 'peripheral' in nature. Core constructs are those closely related to the self - those which go to make up our identity or, in Kelly's words, "govern a person's maintenance processes." So for this woman (or man) with a weight problem, 'fatness...thinness' will be a core construct, while to someone for whom weight is not an issue, 'fat...thin' may be quite peripheral. Although children develop the sense of self gradually over time, many core constructs - and especially those related to problem areas - may begin to be formed very early and remain essentially unchanged into adulthood.

A striking example can be found in children with a speech difficulty such as stuttering. As Fransella (1972) points out, 'There is no reason to suppose that fluent children ever do establish a very elaborated sub-system to do with speech in the normal course of events; like other abilities such as walking, it develops without the child construing it in any detailed

way.' But she suggests how, in some cases, a sub-system related to speech might be developed through mother-child interaction. She describes how a caring mother might become anxious when her son stumbles, and draw his attention to his speech. He construes her constructions of him in his own way:

> "This is a young child, the majority of whose constructions will be at the pre-verbal level; he is more likely to be making behavioral than verbal discriminations. He begins to discriminate, say, the sounds he makes to his mother and the sounds he makes when by himself. His mother is making him construe his disfluencies but not his fluencies."

Fransella hypothesises that by starting him off on construing his disfluencies, she has laid the basis for the development of a construct sub-system that in time will have implications for him - linkages with superordinate constructs in the rest of the system.

Although Fransella emphasises that there is no experimental evidence to support such a countention, it has certainly been found in work with young stutterers of seven and eight years old that speech-related attributes do emerge in their construing of people in a way which is not typical of fluent children. By the time a stutterer reaches adulthood it is not uncommon for communication skills or lack of them to figure largely in any type of personality description they give. This may come out in conversation or in writing. It may also be highlighted in their rating on a repertory grid of significant figures in their lives in relation to what they see as important characteristics. (Grids and other means of exploring the dimensions a person uses in construing themselves and others will be discussed later).

Research using repertory grid technique (e.g. Button 1982) has shown that people often have a network of constructs around an area of difficulty which is very tightly knit, showing black and white pre-emption of the person's expectations with regard to their own and others' behavior in relation to their problem. This brings us to a third structural dimension central to Kelly's theory. He speaks of the normal cycle of 'tight' and 'loose' construing employed by most of us as we try to make sense of what is going on around us - 'the creativity cycle' in which an event may first be viewed from a variety of angles, then brought into sharper focus as its meaning is clarified. Although we should beware of labelling any person as a 'tight' or 'loose' construer, as if it were a set trait of character, there is no doubt that some do move more easily from tight to loose and back again. Others may tend to tighten prematurely, leaving less room for manoeuvre, or remain too loose on many issues for definition or action to follow effectively.

THE DEVELOPMENT OF CONSTRUING IN CHILDREN

Looking at the possible foundations for either tendency, Salmon (1970) suggests that the constructs of very young children are loosely organized, allowing them to change with relative ease with the widening of experience. As they develop, the organization of the expanding system needs to tighten sufficiently for them to make predictions about themselves and the world which are likely to be validated often enough to give them a sense of security in their understanding of things. Where this does not occur, Salmon described the individual as failing ever to come to grips with reality, and wandering through their adult years in childish non-comprehension. If, however, the system becomes over-organized, a child loses spontaneity of thought and feeling all too early in life, with constructions of interpersonal behavior which are entirely rule-bound.

Although Kelly himself has a good deal to say about children throughout his work, he makes no attempt to present a systematic theory of how construing might develop from the preverbal discriminations of babies onwards. In her paper already referred to, "The Pyschology of Personal Growth" (1970), Salmon presents a construct theory approach to personality development with its emphasis on change within the context of individual construing systems. She stresses that the terms in which a construct theorist would discuss change would be non-physicalistic, since a child's activities can be understood only in terms of the constructions he or she places on them. With this in mind, Salmon chooses as her main basis personal construct assumptions about commonality and sociality. She illustrates the growing importance of agreed interpretations and the child's ability to play a variety of social roles or, in Kelly's terms, to construe the construction processes of others.

Salmon suggests that in the early stages the mother, largely through non-verbal means, helps to define the relevancies of situational contexts for the child - offering, in effect, a construction by means of which the child can act towards a situation and, at the same time, relate to the mother's own construction. Later, through verbal communication, the child is explicitly taught constructs for appraising self and others and, for a while will incorporate them within his or her own construction system. As social experience widens, the child will need other interpretations from their peer group, older children and adults. And it is the degree to which these varying constructions are adopted as a basis for behavior and, in particular which poles of these constructs are applied to self and to other important people, which will represent, if you like the child's own definition of his or her personality.

Our understanding of the child's construing of self clearly will be of vital importance to our work with him or her in therapy. Salmon stresses the influence of reputation and the expectations, particularly of parents and teachers, in the child's developing sense of self. Bannister and Agnew (1976) place more emphasis on the child's own discriminations between self and others. They see children - like adults - as elaborating their construing of self by attempting to anticipate their own and other people's behavior and to formulate theories about it, which are modified as their anticipations are confirmed or negated. Both these authors and Salmon agree that in normal circumstances the construing of self, like other kinds of construing, will become more elaborated, less concrete and physicalistic, more effective with age. But Jackson and Bannister (1982) point out that such development is not automatic. It can go wrong. When a child, for example, is subjected to confusing experience such as inconsistent parental behavior, social isolation or rapid changes of subculture, he or she may become both mystified and mystifying to others. "Such a child" they say, "may be judged 'problematic' because he or she has been unable to develop reliable internalized guidelines for his or her own behavior in relation to others and thereby collides with educational, social, legal and medical agencies and comes to be labelled 'disturbed', 'maladjusted' or 'delinquent' and so forth."

PERSONAL CONSTRUCT THERAPY WITH CHILDREN

When a child is presented as having 'a problem' the therapist needs first of all to discover the nature of this collision between the young person's construing and the constructions of significant others. In order to do this she must try to put herself into the child's shoes - understand the meaning (to the child) of the stance he or she has taken and, at the same time, to explore with the parent or teacher, say, what constructions of theirs are being invalidated by the child's behavior. The ultimate aim

of this process is to enable the people concerned to construe each other more effectively or, in Kelly's terms, to establish a role relationship with one another where growth and development between them are possible.

In personal construct therapy there is no sharp distinction between 'assessment' and 'treatment'. The procedures used to explore an individual's view of things can provide means of clarification for that individual, raising questions as to the soundness of some of the theories which are governing their behavior. As they are asked to share their thoughts and feelings they begin to see something in a new light - which is the beginning of reconstruction or change. And this can apply as much to children, however inarticulate, as it may to older people.

Undoubtedly the most widely known exploratory procedure associated with construct theory is the repertory grid. Here, in its most frequently used form, constructs are usually elicited from triads of significant people or events in a person's life. They are asked to say some important way in which two of these are alike but different from the third. In this way they are not only free to choose personal themes which matter to them, rather than the investigator, but able to clarify the meaning as they specify the opposites. Thus one eight-year-old described two people as 'fighting a lot' and the third as 'getting on with people', while another used 'fights a lot' and 'is a cry-baby' as the contrast pole. This shows a similar preoccupation but very different notions as to what fighting implies.

Triadic elicitation of constructs may be used without difficulty with some children of this age but, for others and certainly for younger ones, this method may be too complicated. They may, instead, be asked to compare or contrast just two people or to say something special which strikes them when they think of one, then to describe what a very different sort of person might be like, to find the opposite. Constructs can be elicited from many different sources - conversations about the child's family and friends, about things that have happened, descriptions of pictures, telling stories and writing. These can then be put into a grid and the child asked to place the elements, the people or events we are interested in exploring, on a rating scale or in rank order. The results are then analyzed to discover the ways in which constructs are related and how the elements are perceived as alike or different overall. (See Fransella and Bannister 1977).

Again, the usual rating or ranking on a 7 or 9 point scale may be daunting for young children, so modification is needed. They may be asked to place the elements between 1 (for example 'the most kind') and 5 ('the most unkind') or even to put all those together who are 'kind' and all others together who are 'unkind', with anyone who does not fit either category in another group in the middle, thus using a 3 point scale. Salmon (1976) stresses that the younger the child, the more physical the elements to be rated should be. Moveable objects, models, pictures, will replace the numbered cards used by adults and older children. Her paper 'Grid measures with child subjects' (1976) presents some very inventive ideas and discusses in some detail the interpretation of results in relation to the development of construing in general. (See also Ravenette 1975).

One technique specially designed for exploring how children see themselves is Ravenette's Self Description Grid. They are asked to choose as elements significant people in their lives, such as parents, siblings, best-liked teacher, disliked teacher, best friend, worst friend and so on. Then we imagine that the therapist meets each of them in turn and, not knowing the child asks them to say 'three important things' they think

about the person. Eight or so of what the child considers to be the most meaningful attributes are chosen, their opposites agreed on and then, with self included, the child decides where each of the elements would place him or her on each of the constructs. Without using any computer analysis (but see Ravenette 1977), it is possible to obtain profiles of the way in which children believe they are seen by others. We can discover not only the dimensions they use for construing self, but also who they feel approves of them, who seek only their 'bad' side and, above all, where their own views seem to diverge from those of others. If we include an element 'how I would like to be' or 'how I will be in (say) 3 years time', we have some idea of where they stand in terms of current self-evaluation or anticipation of change.

This is just one example of how Kelly's original Rep Test has been adapted for specific use, and the possible variations are infinite. We are concerned here with the therapeutic function of this and other forms of dialogue which might help us to enter the child's world. And it must be emphasized that, in this context, a dialogue need not be in words. As young children interact with their environment, the therapist is trying to discover the meaning for them of their behavior towards the objects and people around them. As O'Reilly (1977) points out, it is not a question of interpreting according to our own frame of reference, but trying to infer that meaning from what we come to understand of theirs.

One striking example comes to mind of a five-year-old boy brought to the clinic because of his failure to relate to other children in school, his apparent inability to make any sense of the early stages of reading and number work and unaccountable fits of temper which seemed, to everyone else, to come out of the blue. On top of this, he very rarely communicated verbally, even with his mother, although there was clearly a warm attachment between them. No demands were made on him when he came. He could sit quietly with his mother looking at pictures or explore the room and its contents as he wished. The discriminations he was making became very clear. He obviously derived considerable satisfaction from the constant repetition of familiar activities which he was happy to share with others. When confronted with unfamiliar toys he either ignored them or backed away afraid. His mother's efforts to 'teach' him how they 'should' be used were met with intense anxiety and tears.

A picture was emerging of a child whose meaningful world was constricted to a very narrow range. Outside, apparently, lay chaos. And yet there was no perceptual or motor difficulty to explain this. We inferred a construct of himself as someone unable to risk the unknown - anything new threatened this notion. Somewhere along the line it looked as though curiosity and experiment had failed to thrive. We could not point to restrictive parental handling for the cause of this child's situations. He had been given the same opportunities, the same love as his adventurous elder brother. And it was here, as the mother compared the two children, that much of the problem seemed to lie. Within this family, by parents and grandparents, the two boys were construed virtually dichotomously. Where the older child was 'bold', 'clumsy', 'devil-may-care' and would 'talk to anyone', the younger was 'timid', 'careful', 'anxious to please' and 'frightened of strangers'. To seal him more firmly into this family construction, he was 'just like mother used to be' and his brother 'dad all over again'. But what were the temper tantrums about? A further hypothesis was that something within this boy's construing of self clashed with the pattern to which he was otherwise confirming. He was using, perhaps, a dimension of his own which did not belong to the family constellation.

It is not suggested that such powerful labeling was all that was implicated in this child's difficulty. But we did find that with a combin-

ation of encouraging the boy to take small experimental steps of his own within a familiar framework and helping the mother to construe him beyond the contrast with his brother, they both began to free themselves from the construction that had hardened around him.

This was a situation in which, for some time at least, therapist and child construed each other largely non-verbally. In many others, of course, conversation as well as action plays a large part in the process of psychological change. Ravenette (1965, 1977b, 1980), in a number of excellent papers, presents various ways of structuring dialogue with young people in order to elicit what has real meaning for them, rather than the answers they think we want to hear. Without this, it may be hard to understand what really troubles them or to find a basis on which effective change can take place. He points to a number of difficulties involved. Whereas adults, he says, may undertake psychological change on a base of reasonably stable expectations, children are in transition. Their representations of how they see and anticipate things are likely to be unstable and ephemeral. Their important constructs may defy easy verbalization and exist at a rather low level of awareness.

If we try to elicit constructs from children directly, he believes, they may find the whole thing an ordeal, irrelevant or just plain boring. You are probably asking them to do something they have never done before. Their experiences, thoughts and feelings may be relatively fluid and we are asking them to abstract. What we need to do is to ask questions which will help us to see how they are making sense of things. We may then have material out of which constructs can be fashioned. The child may be able to reflect back and abstract from this. We make inferential judgements about what those constructs are and have them validated or invalidated by the child.

We must not assume we know what children mean. They may think we do, but we must make sure. For example, if a girl is excited by something that happens we must find out what aspect of the event excites her, not go on what would have mattered to us. It can help to ask the child to describe the incident in detail, step by step. This may reveal something previously unspoken which she took for granted, and it may turn out to be the crucial issue.

Ravenette stresses the need for structured questioning. We must, he says, ask questions in a systematic way and enquire into areas in which the child feels relatively secure in their expertise: home, school, delinquency even. We can offer the child a number of possible answers from which to choose, if they have difficulty expressing themselves, 'Structure', Ravenette maintains, "can enable the verbally inhibited to talk and be used to constrain the garrulous."

In one particular paper, "An approach to the psychological investigation of children and young people" (1977b), Ravenette outlines a number of techniques of exploration. His "Perception of Troubles in School" is particularly interesting. He presents the child with a set of drawings of incidents in the class-room or play-ground, which the child is asked to interpret in his or her own way. They are loosely drawn in relation to detail but the themes - a fight in the play-ground, a girl called out in front of the class - are fairly clear. The young person is told that someone in the picture is troubled or upset and asked:

1. 'What do you think is happening?'
2. 'Who do you think is troubled or upset and why?'
3. 'How do you think this came about?'

Each child will produce his or her own perception of the situation and then the focus is turned onto how he or she would experience it:

4. 'If this child were you, what would you think? What would you feel? What would you do? What difference would it make to anyone? As a result of all this, would you feel good or bad? And why?'

These questions, Ravenette believes, put the individuals fairly and squarely into familiar situations and lead them to an awareness of their own thoughts, feelings and potential actions. 'Perhaps', he goes on, 'the most important of these questions is about the difference he makes to others since this issue is at the heart of a child's sense of potency in the world.' The final question, 'if the child were not you, what sort of a child would you say he or she was?' allows the child 'to entertain the possibility of alternative identities and therefore the possibility of change.'

This technique can be very helpful in revealing the typical ways in which young people are currently dealing with things. One boy gave as his solutions to a number of situations the single alternative of 'going away'. When asked what else he or someone else might do he became quite interested in other possibilities, such as stopping to explain, asking for help or even thumping the person who was giving him trouble. A girl of eight had obviously found crying her most meaningful way of coping but, when encouraged, could think of others and proved willing to experiment with them. Role-play, as in this case, can provide a useful bridge in therapy for setting up experiments to develop new modes of approach. It has the creative function of both loosening the person's perception of alternatives and tightening their ideas into action. Most children enjoy make-believe, which helps to reduce the threat of change.

Many techniques in therapy combine this process of tightening and loosening. Writing self-characterizations, which Jackson and Bannister (1982) show can be presented in modified form to children, allows a complete freedom of choice. When a child is asked to write 'what sort of boy or girl are you?' or 'what will you be like in three years time?', some use the experience to expand on a whole range of perceptions and possibilities. Others focus mainly on a few important issues for them.

Drawing is, of course, often used in therapy. And the personal construct notion of clarification by comparison and contrast can usefully be introduced here. By suggesting to a child that she draw situations in which she would be happy and others in which she might be unhappy, it is possible to find both themes of difficulty and resources of confidence which we can help her to bring together in order to function more effectively.

In presenting some ideas as to how a construct therapist might work, the focus has been mainly on the children themselves and how we might help them within their own frames of reference. Something must be said, however, about the importance of our taking the constructions of parents, teachers and other children into account when we attempt to help a young person in difficulty. The collision which may occur between the construing of our young clients and others in their environment was referred to earlier. And it is clearly as essential to understand the father's complaint or the teacher's confusion as it is to understand the child's position. This will involve exploring with them their constructions of how they expect the child to be. What important theory, perhaps, is being thrown into question by his or her failure to develop as anticipated? Is, in fact, some core construct of themselves as mother, teacher, elder sister being violated? Our purpose in this inquiry will be to help them recognize

where they may be imposing the constructions which are valid for them on a system which is developing in a different way. We would hope, too, to encourage them to put themselves into the child's shoes and thus be in a better position not only to facilitate the 'child's' personal growth but, possibly, through a renewed relationship to move on in their own.

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FAMILY THERAPY WITH CHILDREN: THE STRUCTURAL APPROACH

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Structural family therapy is an approach pioneered by Salvador Minuchin and his colleagues at the Philadelphia Child Guidance Clinic. However, it is important to say that despite its title my chapter is not just an account of the model, but how I interpret and apply it in the context of a Child Guidance Clinic. I should also hasten to add that I have consciously attempted to distance myself and my work from some of the problematic, normative and even chauvinist elements of the model which are reflected in the first two books published by Minuchin (Minuchin et al., 1976; Minuchin, 1974). In fairness to Minuchin, his more recent work including his latest book "Family Therapy Techniques" (Minuchin and Fishman, 1981), contains fewer normative assumptions about how families should function.

What precisely is the structural model and what are its advantages in working with families that present with child-focused problems? I can begin to answer the second of these two questions more easily, but in doing so I can really only provide a personal answer to the question. I became involved in family therapy for the first time when my own children were six years old and four years old respectively. At that time I was a relatively inexperienced parent and often I felt pretty lost in that role, but as a very inexperienced family therapist I felt even more lost. It was only when I came across Minuchin's work through attending one of his workshops and then reading his now classic book "Families and Family Therapy" (Munichin, 1974) that I felt some sense of security about how it would be possible to be effective as a parent or a therapist. I found the book very appealing and very comforting because it laid down some clear guidelines for undertaking therapy which made sense to me both as a parent and as a therapist. The more pragmatic (and strategic) work of Haley was also very stimulating, but less convincing to me, although I was instinctively drawn towards the more structural aspects of his work contained in such books as "Leaving Home" (Haley, 1980). (Whether Haley should be claimed as a direct contributor to the development of structural family therapy is debatable, but it is important to remember that Haley and Minuchin worked together for ten years. Haley himself argues that his 'structural' approach developed from work with young schizophrenics and their families while Minuchin and Montalvo's approach developed from work with choatic and psychosomatic families).

It is comforting to me that two of the most important contributors to the development of family therapy should arrive, somewhat independently, at similar ways of undertaking therapy, but it would be wrong to make too much of this issue. At times Haley seems to operate wholly as a structural worker, but at other times he seems to deviate from this position as he adopts techniques which derive from hypnotherapy and the work of Milton Erickson (Haley, 1973). It is this latter work that has led him to be labeled as a strategic family therapist (e.g. by Stanton 1981).

Obviously I want to avoid getting into a tiresome dispute concerning the difference between structural and strategic work, but it is worth noting that Stanton (1980) has made a useful contribution to circumventing this difficulty by pointing out that it is perfectly possible to combine structural and strategic work within a single, coherent way of undertaking therapy. He argues that it is best to proceed initially utilizing structural techniques, but to be prepared to use strategic techniques if and when the sessions become bogged down. When movement has been achieved it is then possible to return to structural ways of working*. This is the approach that I adopt, particularly in the later stages of therapy when the work has shifted typically from child-focused issues to marital issues. Interestingly, Minuchin has also acknowledged the value of strategic approaches by including a chapter on paradoxical techniques by Peggy Papp in his most recent book (Minuchin and Fishman, 1981).

But I am in grave danger of putting the cart before the horse - to summarize the essence of the structural approach in a short chapter like this is in fact difficult, because of the sophisticated nature of the model but the following checklist contains the main features. My summary of the model is based mainly on Minuchin's writings, but I have felt free to modify certain aspects of the model when I find I am in disagreement with him.

Definition of the Structural Model

Structural therapy is a body of theory and associated techniques which insists that the behavior of an individual cannot be understood in isolation. Individual behavior is largely incomprehensible unless the interactional context of the individual is fully explored and evaluated. If this assumption is accepted then therapy must necessarily undertake the task of changing the organization of the family and, when necessary, the organization of other systems (such as schools) which impinge upon the family (Aponte, 1976). Changes can obviously occur in an individual within a family, without major changes occuring within the family, but it is axiomatic to the approach to assume that sustained, irreversible behavior change in the individual requires transformation in the family as a whole.

The Goals of Therapy

Within this framework the goals of therapy will include helping the family to achieve a form of organization which will maximize the potential for growth of each member of the family. Interventions are primarily designed to change the interactional pattern of the family rather than being aimed at changing the behavior of the individual in isolation from other family members. There is a basic sequence through which the therapy passes:-

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* A particularly good example of this technique is demonstrated by Minuchin's videotape "Taming Monsters" which is available for hire from the Philadelphia Child Guidance Clinic, Philadelphia, Pennsylvania, USA.

1. Joining Phase - The family and the therapist are originally isolated from each other, but the therapist uses her skill so that she becomes absorbed into the family (through a process of accommodation). This process creates a new system - family and therapist. It may take several sessions to create the new system, but since it is essentially a transitory one the therapist must carefully monitor any signs that family members are going to drop out of therapy and hence disrupt the new system.
2. Middle Therapy Stage - This is the phase during which the major restructuring 'work' occurs. Restructuring interventions are made during sessions and consolidating homework tasks are set between sessions.
3. Termination Stage - This phase involves testing the family's ability to 'fire' the therapist and go it alone. The 'ghost' of the therapist is left behind by getting the family to simulate its ability to solve new problems and to deal with old problems if they recur.
4. Follow-up - A follow-up session after three months, six months or a year enables the therapist to evaluate the impact of therapy and test whether it has been successful in achieving second order change i.e. in enabling family rules and family functioning to change in such a way that the family generates effective solutions to the problems it is continually facing. If the family has merely played a game of musical chairs then first order change has probably occurred. This means that the family is either stuck in a groove recycling the problems it first brought to therapy or paralyzed by a new set of problems that have emerged in the meantime as the family is challenged by new stresses. In the latter case a new contract for therapy may well be negotiated if the therapist and the family think that a new initiative is likely to avoid a 'more of the same' solution.

The Essence of the Structural Approach

The structural emphasis on becoming an active and engaged part of the therapeutic system (therapist plus family) is not shared to the same extent by other models of therapy, although it is important to add that it is difficult to avoid being caught up in the family's accommodation process. I assume that all successful therapists have successful joining skills which enable a family to feel either relaxed or respected, or both, when they are with their therapist, but structural workers emphasize the process more markedly than most other schools of therapy because of the active, participatory role that the therapist plays, particularly in the middle phases of therapy. The therapist may create very intense situations for the family in order to engineer structural change. Needless to say, if such a therapist is neither respected nor liked by family members they vote with their feet. Strategically orientated workers create intensity differently, through the use of questioning techniques and more importantly through carefully designed messages which are devised by the therapist and her co-workers while taking 'time out' from the session itself. Such techniques can be used in structural family therapy especially when ending sessions, but there is always an emphasis on creating tangible change within the session itself by getting family members to interact with each other differently. In practice this means that a wide range of role play, psychodrama and even gestalt techniques can be utilized by structural family therapists.

Types of Family Structure

Family structure is determined by a set of rules that organize the way in which family members interact. A family is a system that operates through a series of repetitive transactional patterns. These transactional patterns are built up around the everyday events of family life such

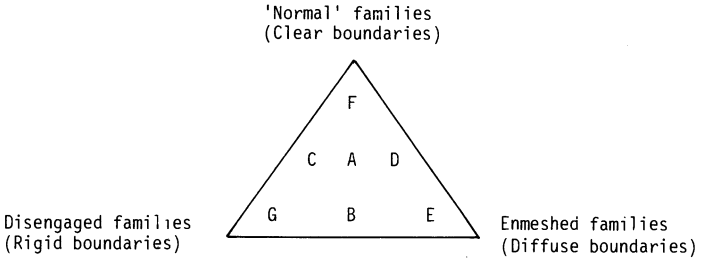
as getting children to bed or waking them up and preparing them for school. These necessarily repeated events are associated with repeated transactions that establish patterns of how, when and to whom family members are going to relate. These repeated patterns therefore underpin the system, but since they are unique to each family, they must be explored and evaluated if any attempt is to be made to understand the structure of the family.

Minuchin utilizes the concept of a boundary to enable him to discuss the different types of family system that he has encountered in the course of his work. Every family system has a set of sub-systems that contribute to its overall structure. These sub-systems are given various labels - parental, grandparental, spouse, sibling, parent-child, male-female, but the functioning of the sub-systems is crucially related to the nature of the boundary that demarcates them from other sub-systems. Minuchin uses the term 'clear boundary' to describe a boundary which allows unimpeded two-way communication to occur across it. A rigid boundary is one which involves blocked or non-existent communication while the term 'diffuse boundary' is applied to situations where two sub-systems in a sense coalesce, because the boundary between them has become so permeable that the boundary has more or less dissolved.

Minuchin assumes that all families can be located along a continuum which stretches from disengaged families (with rigid boundaries) at one end to enmeshed families (with diffuse boundaries) at the other (as the following diagram demonstrates).

Type of Boundary	Rigid	Clear	Diffuse
Type of Family	Disengaged	Normal Range	Enmeshed

This classification of families has some value, but it is commonplace to find families that have rigid, clear, and diffuse boundaries all within the same family structure. It is therefore useful for conceptual reasons to consider that families can exist in a kind of triangular space as the following diagram demonstrates.



A family located at point A would be one which contains all three types of boundary; the family at B contains predominantly rigid and diffuse boundaries; the family at C clear and rigid boundaries; D clear and enmeshed. But the families at E, F and G, are 'pure' types in which the boundaries are either diffuse or clear or rigid.

This method of conceptualizing the boundaries makes for greater flexibility in interpreting the complexity of family structures that are encountered in everyday practice. However, there is a major normative assumption implicit in Minuchin's approach. He assumes in a straightforward, no-nonsense way that clear boundaries make for effective family functioning. Clear boundaries are assumed by him to allow the overall family system to grow and for differentiation to occur within and between the sub-systems. Every family sub-system is assumed to have specific functions and to make specific demands on the members. However, the

development of interpersonal skills that can be achieved within these sub-systems is dependent on the sub-system's freedom from interference from other sub-systems. For example a parent who never allows his children (aged ten and twelve) out of the house unaccompanied by an adult will effectively deskill them and prevent them from growing up.

A structural family therapist working with such a family would attempt to deal with such a diffuse boundary by getting the parent and the children to negotiate new rules which would regulate, for example, how and when the children could visit friends or report back when they are delayed by activities at school. If the parent can be helped to achieve a new flexibility in relation to such issues then the children can also be helped to achieve a greater degree of responsibility in coping with activities outside the home.

Obviously there is a potential clash of value systems here - the parent may feel that he is showing the correct amount of caring as a parent in not letting the children out of his sight, whereas the therapist may feel he is inappropriately over-involved. In practice, if the therapist and the client share a common background and at least some common assumptions then the parent may well be able to shed his overinvolvement and indeed to acknowledge that he had a genuine problem in allowing his children more independence. Such a case appears insignificant when compared with more complex cases - if the therapist and the family with whom she is working are from different cultures or markedly different class backgrounds then the shared assumption that forms the bridge between them is either very shaky or non-existent. This means that the therapist must be very cautious in negotiating goals with the family. As Annie Lau has pointed out (Lau, 1984) this may mean that the therapist may have to spend some time getting the family to teach her which behaviors are appropriate or inappropriate for children, parents and other family members within that particular culture or sub-culture. The establishing of therapeutic goals will only be possible when this process is complete. Obviously ethical dilemmas arise from adopting this stance - is the therapist merely going to adopt the culturally prescribed position and proceed to 'fix' the child's behavior in accordance with that position or is she going to adopt a position which implicitly or explicitly acknowledges her own value system?

Ironically perhaps one of the sharpest ways of highlighting this dilemma is by considering the position of a feminist-influenced therapist from a middle or upper class background who is attempting to undertake therapy with a working class family which is dominated by male chauvinist ideas. It may well be that families from such a background have traditionally functioned in ways that have reflected the wider culture in which the families are embedded, but should the therapist therefore tacitly accept this value system and hence modify the way that she undertakes therapy? Structural family therapists were originally guided and influenced by Minuchin's position on such issues. He tended to take a traditionalist position, advising therapists to respect existing hierarchies and hence tend to work within them.

The work of Marianne Walters, and her colleagues within the family therapy movement (Walters, Carter, Papp and Silverstein, 1981) has, I am sure, contributed to Minuchin changing his position on these issues, but each therapist has to clarify his or her position in relation to such dilemmas. My own attitude to such issues hinges around the pragmatic consideration that it is often necessary to adopt tactics which may temporarily negate the achieving of a future goal. For instance, faced by a working class family which is currently influenced by the chauvinist stance of the father I might well have to adopt joining tactics which acknowledged the father's position of dominance within the family. But that would not,

by any means, be the whole story - at later stages in the therapy I would wish to tackle the issues of chauvinism which are clearly on a potential agenda for therapy given that the male and female members of the family relate to each other in destructively chauvinist ways. To 'fix' or attempt to 'fix' a child-focused problem within such a family without tackling these wider issues would be analogous, in my opinion, to a medical situation in which a doctor continually ignores treating a patient's broken back in favor of fixing a minor burn which the patient was also suffering from.

Minuchin's attempts to understand family functioning in terms of different types of boundaries is, I believe, valuable and unique, but many of the concepts he utilizes are shared by other theorists who draw on general systems therapy frameworks. For example his ideas about families' abilities to adopt and respond to stress are by no means unique. In general terms he accepts that families are subject to both inner pressure (deriving from the developmental changes in its own members who are all at differing points in their own developmental life cycle) and outer pressures (deriving from impact that significant social institutions have on family members). The family, whether it chooses to or not, is therefore caught up in a continuous process of change and adaptation to change. Stressful contacts with extra-familial) systems are continually occurring. These contacts often occur at transition points in the family life cycle. For example, a child approaching the age of five inevitably gets caught up in the culturally prescribed transition of going to school. The whole family must adapt to this transition by mobilizing alternative transactional patterns. Most families can indeed respond to such a challenge by producing new flexible patterns of behavior, but a minority get stuck at such a transition point through producing rigid, dysfunctional patterns which prevent the family from growing and developing. (Dare, 1979; Haley, 1973, especially pages 41-64). It is, of course, families of the latter type that in some shape or form typically become involved in therapy.

Structural Family Therapy

The techniques adopted by structural family therapists are very wide-ranging and it is, therefore, quite difficult to summarize them coherently. However, it is possible to provide a reasonably comprehensive inventory of techniques by considering the progress of the family as it moves through a series of family therapy sessions. Obviously the treatment package that a given family will receive is crucially dependent on the context in which the therapy is carried out (Treacher and Carpenter, 1984) but I believe that the following account provides a reasonably comprehensive summary of the techniques that a structural family therapist utilizes in her day to day practice.

1. Forming the Therapy Team

Before therapy commences in any shape or form it is essential that the would-be therapists get their act together. Family therapists have tended to work together in pairs using various models of co-therapy with or without a one-way screen. Since one-way screens are still a comparative rarity even in the allegedly 'elitist' setting of child guidance clinics it is probably most useful to base my discussion on the live consultancy model advocated by Smith and Kingston (1980). This model involves one member of the partnership (the therapist) being actively involved with the family while the other partner (the consultant) sits back, away from the action, yet able to be involved by talking directly to the therapist (but not the family except on rare occasions when it is appropriate to deliver a message to both the therapist 'and' the family).

This model is very flexible and is essentially a poor woman's version of the one-way screen. An imaginary screen can be visualized as being placed between the therapist and the consultant so that the family is effectively prevented from having direct access to the consultant. This means that the consultant can stay 'meta' to the interaction between the therapist and the family and hence be able to help the therapist from getting stuck as she is drawn into the family system. Obviously I have insufficient space to really explore the potential of this way of working in a short chapter like this, but interested readers should consult a chapter on this topic by John Carpenter in our recent book (Treacher and Carpenter, 1984) and a follow-up report on the use of the method by Kingston and Smith (1984).

2. Pre-Therapy Stage

Once a referral has been allocated to a therapist/consultant team then the process of beginning therapy can begin, but it is important to stress that there is always an important 'pre-therapy' stage before therapy can begin in earnest. I use this rather clumsy term to describe the work that has to be undertaken before the family attend the first family therapy session. Families attending Child Guidance Clinics are generally referred by GPs, schools, health visitors or some other professional worker - they rarely contact the clinic directly. This means that the situation is already quite complex - the would-be therapist must therefore be prepared to mobilize a series of 'brain storming', convening and engagement skills which are sadly written about very little in the major textbooks. I have no space to explore these skills in this chapter, but a recent article by my colleague John Carpenter and myself has attempted to fill a rather yawning gap in the literature (Carpenter and Treacher, 1983). However, to cut a long story short, the essence of our argument is that the therapist needs to:-

1. Clarify the 'customerhood' of the family she is seeking to engage in therapy.
2. Establish how 'clear' the referral is.
3. Establish (on theoretical and practical grounds) who shall be invited to the first session.

If the referral letter is detailed and well formulated these three tasks can normally be accomplished without contacting the referrer, but often the best tactic is to go back to the referrer asking for clarification. Needless to say it is essential for the therapist to develop a strong working relationship with her referrers, otherwise there is a danger that, on some occasions, a troublesome triangle will be formed between the family, the referrer and the therapist. Some families are adept at playing the two professionals off against each other, particularly when the family therapist begins to raise the stakes during family therapy sessions in order to try and achieve changes in family transactions. On the other hand some referrers are notoriously 'gluey' and seek to maintain their current relationship with the family they have referred. In practice this may mean that they prevent the family from changing - clearly if this is so, then the therapist will have to eventually find a way of getting the referrer to shift his or her position.

Convening family members to attend sessions is a complicated art, but ingenuity and creativity in solving convening problems bring their own rewards because a well-convened first family session enables the therapy to start in the most productive way. Structural workers tend to stress the importance of adequate convening; incomplete convening (which often in practice means that fathers do not attend) can bedevil therapy, so I personally make every attempt to get all family members to attend the first session (Treacher and Carpenter, 1983).

First Family Interview

The importance of the first interview with a family is difficult to underestimate and first sessions have duly received a great deal of attention (e.g. Haley, 1976). However, it is important to stress the particular significance of first interviews as carried out by structural family therapists. Crudely put, the primary task of the first interview (at least in the majority of cases) is to ensure that the family is able to attend subsequent interviews. The therapist's task is, therefore, to 'join' the family in such a way that she is accepted by the family as somebody who is likeable and resourceful enough to help them crack the problems that they present. The process of joining with a family is complicated and Minuchin has recently elaborated his idea about how different families require different joining techniques (Minuchin and Fishman, 1981) but in practice this is normally achieved by having a long social phase in the first interview which involves the therapist getting to know 'the family as a family first' before exploring the nature of the problems that bring them to therapy. (Many strategic therapists shun this approach - they mobilize their joining skills around discussing the problem with the family - but I personally find this approach inelegant as it surely meta-communicates to the family that the therapist's interest in them hinges solely around the fact that they have a problem).

Of course the first interview has other tasks too - the therapist wishes to hear about the family's problems, what they have attempted to do to fix these problems and what they expect the therapist to do to help them. However, structural family therapists attempt to gather such information not from a stance of 'pathology hunting', but from a stance which effectively says "yes, all families have problems at some time or another, I hear you are having problems right now, but I want to hear about the strengths that you have too." Structural family therapists explicitly attempt to build on the competences that families have because of the particular stance that they take on the essence of therapy, i.e. for structural workers the essence of therapy lies in the ability of the therapist to mobilize families' abilities to crack their own problems. In the case of child-focused problems this means that the therapist concentrates most of her attention on mobilizing the resources of the parents to deal directly with the problem that their children are experiencing. This is not to say that the therapy is just parent-training - it is much more complex than that - but it does mean that the thrust of the therapy is to attempt to mobilize and develop the skills of the parents while at the same time unleasing the very real healing resources that children also bring to family therapy sessions (Carpenter and Treacher, 1982).

This philosophy means that first interviews devised by structural family therapists are not 'assessment' interviews in the classical sense of the word. An assessment is made in the course of the interview, but it is the family's structure and resources that are being assessed. The only facet of the family's structure that is immediately available to the therapist is usually the dysfunctional one that the family mobilizes in relation to the 'problem' which is its entry ticket to therapy. The therapist's task is to probe this facet of the family structure in order to locate areas of possible flexibility and potential for change. If the probing is carried out successfully then the therapist's input effectively highlights facets of the family structure that have been submerged. It is these facets of the family structure that need to be brought to the center of the stage in order to replace the overutilized, dysfunctional circuits centering around the problem that have dominated the everyday activities of the family. The probing inputs of the therapist during the first session necessarily need to be tentative and exploratory since intense probing may cause the family to feel threatened and hence retreat from therapy. The

therapist, therefore, needs to concentrate on creating a mood of hope that change can be achieved while at the same time being aware that the family may well have all sorts of misgivings about achieving change. It is usual to negotiate a contract with the family towards the end of the interview in order to formalize the relationship between the family and the therapist, but it is essential to be flexible about such contracts.

For instance, some families are apparently very phobic of change and hence feel very threatened by the prospect of being in therapy. One of the best tactics that can be adopted with such a family is to negotiate what I call a 'puzzle' contract e.g. a therapist might say to a family, "I'd like to propose that you attend two or three more sessions with me so that I can puzzle out whether I can offer any ideas about how best to help you. Right now I am very confused and I do not want to make any hurried suggestions which may be unhelpful. I should also say that it is possible that at the end of these two or three sessions I may still not be in a position to help you."

Such a message often helps a doubtful family overcome their anxieties so that the therapist is then able to use her joining skills in subsequent sessions to cement her relationship with them. By adopting a slow and gentle pace the therapist will then be able to be in a suitably manoeuverable position to start therapy in earnest. In some cases the therapist may, of course, be none the wiser at the end of the two or three further sessions so the possibility of referral on to another agency or termination is automatically placed on the agenda.

Obviously, more straightforward 'problem-fixing' contracts are normally negotiated as a result of the first interview, but it is important to stress that structural family therapists have a particular attitude to contract negotiating and 'problem-fixing'. Often structural family therapists wish to avoid the task of fixing a particular problem, 'urgently and right now' because it is part of the trap of working with families that they often demand the impossible. Skilful contract negotiating often enables the therapist to place a broad range of problems on the agenda and hence avoid being restricted to just one relatively big item. A caricatured example of this would be - "fix my daughter's behavior once and for all or else I'll go down to the Social Services and have her put into care." Obviously it would be ridiculous not to work on items related to this problem, but a structural family therapist might well want to place other items on the agenda too, e.g. the therapist might have noticed that a younger sibling was getting his own way by throwing tantrums and yet the parents had overlooked this problem because they were currently mesmerized by the acting-out behavior of their elder daughter.

Second Session

Generally, a second session will follow directly from the first. A key problem area in the family's life is selected for exploration, but usually the therapist gets the family to role-play the problem. Minuchin uses the term 'enactment' to describe this technique. Eddy Street and myself have discussed some guidelines for enactment (Street and Treacher, 1980) but it is essentially very straightforward. A successful enactment involves the family constructing a 'slice-of-life' scenario which contains all the sequences relating to the problem behavior. It is essential for the therapist (and, of course, the consultant) to adopt a very low profile during the enactment so that it is 'for real' and is not 'contaminated' by intervention from the therapist. Once the enactment has been completed then the therapist needs to (1) establish (through questioning the family) whether it was accurate; (2) discover whether the enacted sequences were

complete i.e. often there are undisclosed first or last steps in the sequence which are not usually seen as important by the family.

When the feedback has been completed then the therapist is usually in a good position to design interventions which can begin to change the problem sequence. Usually this involves re-enacting the sequence with new patterns of behavior being introduced. The therapist is usually more active at this stage in the session - she may suggest new seating arrangements, slow the action at times, speed it up at others, 'double' for a family member who has become momentarily blocked and tongue-tied etc. Structural family therapists, unlike strategic therapists, are thus very active during the sessions - they create movement through moving family members and they use the symbolism of their own movements to affirm and confirm family members and can form fleeting alliances with one family member as opposed to another. At times they will openly confront a family member who is sabotaging the session.

Often what happens in a session is crucially dependent on what is triggered off in family members by the probing of the therapist. But through the use of the consultation process the spontaneity of the session is channelled and re-channelled in order to construct new patterns of behavior. The information derived from enactments is utilized to create possibilities for re-enactment. Homework tasks are also devised in order to consolidate changes that have occurred in the session or to create probes which will generate information about hitherto unexplored facets of family life.

Middle Therapy

After the completion of the first two or three seminars, therapy generally enters a middle phase in which the family, now well joined with the therapist, is open to major restructuring interventions. The nature of these interventions differs since each family is unique and therefore requires custom-built interventions which suit the family's style and pace of interacting. The therapist must become increasingly sensitive to the constructs and language that the family utilizes in its day-to-day life.

Often restructuring can be achieved through straight forward techniques involving re-enactment. However, it is important to stress that families differ in their ability to respond to action-based techniques. Some families are extremely laid back and unresponsive to each other so that they may find action techniques in the session very difficult. However, if they do respond to these techniques then, from a process point of view, an important victory has been won - their behavior repertoire may well have been expanded so that they now can open up new possibilities for themselves. If a family remains unresponsive then the therapist is caught in a dilemma - she can either use intensification techniques in the course of the session to achieve change, or she can rely on the use of strategic interventions backed up by the use of homework tasks (both of which involve the use of paradoxical injunctions).

Minuchin himself is very skilled at creating intensity in sessions, particularly through the use of unbalancing techniques. Intensity is created by the therapist supporting the stance of one family member against the others. The technique is essentially a shock technique since the therapist is most often in the referrer's position supporting all family members. A temporary switch to back one family member creates a new situation which often disrupts the perpetually stuck ways of responding to each other that family members are normally caught up in. Obviously unbalancing is a tactic which a therapist adopts on a temporary basis - if the tactic is successful then the therapist can regain her flexibility by

returning to her more normal facilitative-cum-supportive role. Many other techniques can be mobilized to achieve structural change - the interested reader should consult "Family Therapy Techniques" (Minuchin and Fishman, 1981) to gain some idea of the range of possible techniques.

Termination

If the therapist's restructuring techniques prove successful then she responds to the family's success by spacing out sessions so weekly sessions become fortnightly, and fortnightly, monthly. Termination is now automatically placed on the agenda particularly if the family is responsive and continually 'using' the work undertaken during sessions. Structural family therapy is not necessarily brief in terms of time exposure to the families involved, but it is usually brief in the sense that relatively few sessions are undertaken within a given contract with a family. Typically, if the restructuring of the family has resulted in effective executive parental functioning being established (or re-established) then the therapist will be thinking of discharging the family from therapy. However, it is usual to find that there are some adult-to-adult relationship or marital difficulties which remain unresolved despite progress on other fronts. Structural workers are usually prepared to open a new contract with the parents (or parent) involved rather than assuming that the cleaning up of the child-focused problems will have inevitable 'knock-on effects' in helping other problems.

The actual process of terminating with a family is relatively straightforward, but Minuchin gives the process an elegant twist by leaving the 'ghost' behind. In practice he explores whether a family is ready to terminate by asking them what they would do if a new problem surfaces at some future date. A family which has been able to utilize the structural approach will usually report that they will attempt to crack the problem by consciously recapitulating the techniques they have learnt in the course of therapy e.g. holding a parents' conference to establish whether they are in agreement about how they could fix the problem, devising tactics and applying them in order to see whether they work and so on. If they give the therapist a convincing account then clearly there are good grounds for immediate termination.

Follow-up

A three month or six month follow-up is usually advisable since it is obviously important for the therapist to establish whether the therapy has created any important changes. The follow-up session can be used in a number of ways - sometimes it turns into a 'booster' therapy session with another follow-up session being agreed to but obviously the therapist must beware of her dependency-inducing capabilities. Often the family reports that it is now having 'difficulties' (that it can handle, rather than 'problems' which it can't). If this is so then the therapist can in effect give the family a quick MOT and then discharge them completely, albeit with the proviso that if they encounter difficulties which become problems then the door is open for further work to be undertaken. A minority of families do, in fact, return to therapy on this basis, but usually the number of sessions involved is very limited because the family retain the strengths that it has gained from previous work with the therapist.

CONCLUSION

Given its heritage as a method of therapy that was devised to deal with child-focused problems (Minuchin et al, 1976) it is not surprising that structural family therapy is popular in many Child Guidance Clinics.

It is a well-structured approach which provides practitioners with a battery of tried and tested ways of achieving change within families. Some of the rigidities of the framework have been overcome and I would personally stress the ability of the framework to absorb ideas and techniques derived from other schools of therapy. Obviously there are dangers in absorbing techniques derived from other approaches, but the structural emphasis on setting clear goals for structural change within the family is usually sufficient to prevent the structural practitioner from losing her way. Families are complex and confusing to work with, but the body of knowledge and techniques[1] generated by Minuchin and his colleagues is a comforting source of inspiration and guidance which enables practitioners to retain their sense of direction and efficacy*.

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* The overall efficacy of structural family therapy (like so many forms of family therapy) is still open to question, but the interested reader should consult the important review article by Aponte and VacDeusen (1981).

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PSYCHODYNAMIC THERAPY WITH CHILDREN

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Recognition of the importance of childhood in Western culture was late in developing. Until the 17th Century, children were regarded merely as little adults, no different to their larger counterparts other than in what they lacked. Children were not seen to have special needs and in the main childish activity, including play, was frowned upon. In its place there was encouragement of the social niceties amongst the rich and of physical work amongst the poor. Towards the end of the 17th Century came more enlightened views in the form of the Liberalist ideas of John Locke and the child-centered educational principles of Rousseau, and a century later Pestalozzi, Froebel and Itard who, with a progressive leap, founded institutions for abnormal and backward children.

The specialness of childhood thus came to be recognized. However, apart from within the circles of eccentric modernists, practice was far behind philosophical theory. Children were now seen as primitive beings who needed to be protected, not only from external harm, but from their own creativity. This led to an era of suppression as constricting to developing emotions as physical toil had been.

After a peak of such insult in Victorian times came the social change which allowed for the development of a knowledge of childhood, which is continuing to the present day.

Arguably, one of those who was in part responsible for the breakdown of social taboos in the so-called civilized world was Sigmund Freud, who initially caused outrage by the public exposition of his views on childhood sexuality in 1898, and who later provided a coherent model of child development taken from the primary perspective of the inner world.

It is with Sigmund Freud that the history of psychotherapy with children begins, with his publication in 1909 of the case of Little Hans. Interestingly, it was in this very same year that the first child guidance clinic was set up by William Healey and Augusta Bonner in Chicago, USA, and only three years later Cyril Burt was to be appointed the first Educational Psychologist in Britain. It was also within four years of the publication by Binet of his first work on the mental measurement of children (Binet, 1905).

Little Hans was five years old when his analysis took place. He suffered from a phobia, a fear of horses. More specifically he feared that his fingers would be bitten off by a horse (the Oedipal symbolism of which is hardly subtle!). Hans was known to Freud before this time and he mentions him in two previous works - in 1907, when he refers to him as 'Little Herbert' and less directly again in 1908. Hans was not directly analyzed by Freud but by his father, who met for regular discussions with Freud. The whole analysis lasted only five months, but its significance to Freud is exemplified by his continued reference to this definitive case up to fifteen years later (Freud 1912-12, 1916-17, 1918, 1926).

Truly though, the originator of child analysis was not Freud, but Hermine von Hug Hellmuth who devised and, around 1915, introduced the use of drawing and play as methods of expression and communication in the treatment of young children. Her work was published in 1921 and she died in Vienna three years later, murdered by the illegitimate son of her sister to whom she had been as a mother. Her death was not, however, in time to save her from feelings of jealousy towards Anna Freud, Sigmund's youngest and favorite daughter, who had quickly risen to local fame as the pioneer of child analysis. It was the publication of her work in 1926 that signified child analysis as a distinct discipline.

Meanwhile, in Berlin and London, Melanie Klein was developing her own techniques of analyzing children based more closely on play than those of Anna Freud, and along with these, a complete theoretical treatise on the emotional development of infants, the starting point of which was her observation that the Oedipus complex was in evidence in children far younger than allowed by Freud's theory of psychosexual development. (See Klein, 1928).

The history of child analysis from this point until the 1940's surrounds these two innovatory figures, Anna Freud and Melanie Klein, the development of their theories later leading to an almost irrevocable split within the British Psycho-analytic movement between the followers of the Object Relations Theory of Melanie Klein and those of Anna Freud's classical Ego Psychology. The conflict began at the Innsbruck congress in 1927, where both gave papers on their own perspectives on child analysis, but became truly public only in 1943. The final battle resulted in the resignation from the Society of its temporary war time president, Edward Glover, who had fought for the expulsion of the Kleinians, and re-established the credibility of Ernest Jones, whose only deviance from loyalty to Freud had been his support for the psycho-analytic respectability of Melanie Klein. Jones' presidency of the British Psycho-analytic Society only continued until 1944 however, when a heart attack put him into semi-retirement.

There is not space here to do justice to the divergent theories and techniques of Anna Freud and Melanie Klein, but in brief, Anna Freud made it clear in her 1926 work that it was neither desirable nor, under normal circumstances, possible to attain a true transference relationship with a child (that is, where emotions attached to an earlier relationship are projected on to the person of the therapist, a crucial concept in dynamic psychotherapy). One of the reasons for this, she states, is that one of the therapist's roles is to act as an educator, as an external superego more benevolent than the child's own, rather than as the 'blank screen' able to take on whatever facade the patient unconsciously desires. Also, in the case of many children, the real and powerful influence of the parent will overwhelm the phantasy* that it might become the transference. Indeed, the therapeutic work is often carried out alongside the parents, using them as a source of information and as agents of change outside the therapy room. Anna Freud also warned against using play as an equivalent

of the 'free association' of adults because of what she described as the 'many levels of symbolism' which may lead to uncertain or arbitrary interpretation. Anna Freud saw the therapist as having two opposed main functions: first to allow free expression and to help make that which is unconscious, conscious; and second, to control id gratification. She argued that play is primarily about instantaneous gratification and that there is a risk of fixation if free play is encouraged. She therefore advocated the use of verbal interchange to the greatest level that the ability of the child allows.

Melanie Klein followed more closely the techniques of Hug Hellmuth, (though not her theory, which was largely educational in its principles). Klein saw play 'in the analyst's presence' as being based on issues other than the Pleasure Principle and held that this was able to come about through the interpretive role of the therapist. The motive which allows continuity and development derives from the release of anxiety through the effects of accurate interpretation. Melanie Klein believed that it is possible for a child to build up a transference, and she argued this through her ideas of very early object and part-object relationships. Indeed, she stated that the very earliest ego functions are those of splitting and of projection and introjection which enable the transference, and that the most effective means of expression of phantasy in children is through the medium of play. Klein had little interest in the child's outside life, attributing primacy to the inner world of phantasy.

Incidentally, Anna Freud later changed her views on the transference. In 1966 she accepted that a transference neurosis (that is, the shift of the original neurosis on to the relationship with the therapist) could occur with a child, albeit in a different form to that which occurs with an adult.

There have of course been many other influential authors in the field of child analysis during and since this time, and these are well documented in the many books and journals available.

So much then for this brief background, which you will have noted has been of child psycho-analysis rather than child psychotherapy. What is the difference? Traditionally one associates psycho-analysis with a frequency of four or five sessions per week, and a duration of many years. However, in 1914 Freud said in relation to the concepts of transference and resistance, 'Any line of investigation, no matter what its direction, which recognizes these two facts and takes them as the starting point of its work may call itself psycho-analysis'.

A further blurring of the edges between psycho-analysis and psychotherapy, has come about from the interest shown by psycho-analysis in Short-Term Psychodynamic Psychotherapy. Though this interest originated in the 1920's with Ferenczi's 'Active Therapy' (Ferenczi and Rank, 1926), short term interventions only achieved respectability with Alexander and French in 1946, and became widely used following the researches of Malan in Britain, Sifneos in the U.S.A. and Davanloo in Canada, all within the last twenty-five years. (For recent reviews see Bauer and Kabos 1984; Davanloo 1980; Marmor 1979; Sifneos 1979; Wolberg 1980).

Winnicott (1977) described as psycho-analytic treatment, the case of a young child whom he saw 'on demand' only sixteen times over a period of

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* The word 'phantasy' is used to denote an unconscious mental representation of instinct, while 'fantasy' is used to convey its conscious, imaginative counterpart.

thirty-three months and pointed out that the important issue is what is done with the unconscious and not the formal arrangements. However, earlier in 1958 he said, on the question of the difference between psycho-analysis and psychotherapy, 'for me the question is; has the therapist had Analytic training or not?'

In summary, psychodynamic philosophy is a way of construing the world of relationships, both internal and external, that is based on the existence of a dynamic unconscious. One of the practical applications of this philosophy is, through technique, to aid people in a process of change. If these techniques are imparted by people qualified to hold the title of psycho-analyst, and if the therapeutic contract and technique allow for a coherent restructuring of the personality, then the treatment would generally be agreed to be psycho-analysis. If either or both of the above conditions are not met then the treatment might be called dynamic psychotherapy, and this might be qualified by a further descriptor such as psycho-analytically oriented psychotherapy or humanistic psychotherapy, or even more precisely by Gestalt psychotherapy or primal psychotherapy etc.

A more important point of definition for our purposes here does arise however, and that is to correct what I believe is a commonly held misconception that working dynamically is necessarily synonymous with carrying out individual or group psychotherapy. I would like to make the distinction between what I will call dynamic psychotherapy on the one hand, and psychodynamic therapy on the other.

In common with proponents of most psychological therapies with their different orientations, I would suggest that all problems of human relationships can be formulated in psychodynamic terms. Whether individual or group psychotherapy is the treatment of choice however is another question. Only a proportion of my heavy case load in a busy city Psychology Department are what I would describe as psychotherapy, but all my work is psychodynamic.

Psychodynamic theory can be applied to work with families, with groups, with marital couples, it can be used as a basis for counselling... and so on. The question of selection for individual psychotherapy, for me, is one of exclusion. Winnicott (1962) has said 'Analysis for analysis' sake has no meaning for me. I do analysis because that is what the patient needs to have done, and have done with. If the patient does not need analysis then I do something else. In analysis one asks: How much can one be allowed to do? And by contrast, in my clinic the motto is - How little need be done'.

In a busy NHS department the same question needs constantly to be asked. Where possible I prefer to work towards the mobilization of the dynamic strengths of the family or to try to help provide an environment where the child's natural urge towards maturity can thrive. Thus in my work I spend much time working with parents, singly or together, or with whole families. I sometimes conduct an intensive intervention followed by regular but infrequent follow-ups. When individual psychotherapy is indicated following the referral of a child, it is often with the parent rather than the child. On what basis then is the decision to take a child into psychotherapy made?

Basic to psychodynamic psychology is the person's use of defence mechanisms. These are normal and adaptive means that the ego adopts to avoid anxiety. However, under certain past and present circumstances these mechanisms may become rigid and cause secondary and neurotic anxiety of greater magnitude than the original conflict would produce.

Paul was a 7 year old, referred for being over-sensitive and socially withdrawn, a potential school refuser. Through assessment it became clear that his mother was very dependent on him for the satisfaction of her own needs, becoming quite panicky (her own neurotic defences in action) when he was out of her sight. Projective testing showed that Paul experienced guilt but also powerful hostile feelings towards his mother. Consciously he could only describe being worried about her health. This scenario is one which will be well recognized both by workers in the child field and by therapists working with the recollections of their adult clients. On this occasion the results of an extensive assessment led me to feel that Paul's problem was not pathologically ingrained, but that his symptoms were a means to protect himself from the guilt of his unconscious desire to abandon his mother, and also a way to protect the conflicting mutually dependent relationship that existed between them.

In object relations terms, his mother had projected the libidinal (or need-exciting) part of her ego on to Paul, causing him to experience, and thus feel the need to respond to her demands for nurturance. Simultaneously, because Paul was realistically unable to meet these needs he experienced feelings of guilt and inadequacy causing him to withdraw from all relationships apart from that with his mother, to whom he in his turn looked for strength and nurturance.

In this instance, therapy was offered to and accepted by Paul's mother, whose problems, though overtly similar to Paul's were historically and not situationally determined. In her case it was only through psychotherapy that she would be able to re-experience and resolve the early conflicts that arose from her own less than adequate parenting. Paul, on the other hand, had quite adaptively adopted strategies for coping with current conflict and also for gaining the maximum from his mother's limited nurturing resources. Assessment had suggested that in other senses Paul was not fixated at an earlier stage of development, and indeed with a little support he was able to make appropriate changes in his life and continue the developmental process of separation, as soon as his mother had transferred her needs on to her therapist.

Psychotherapy for Paul, then, was not indicated. His symptoms, and the failure of the natural tendency to develop emotionally, were a response to current and external issues and not due to stagnant intrapsychic conflict. Incidentally, if Paul's mother had not been willing or able to work towards change herself, then it might have proved helpful to Paul to enter into therapy, with the aim of increasing his ability to cope with his difficult life circumstances. In this case the priority in therapy might have been towards the substitution of a more benevolent superego, to reduce the guilt he experienced from being unable to satisfy his mother's neurotic needs, and hence to allow his emotional resources to be channelled into personal maturation.

There are obviously many other quite different examples that might be given of circumstances where individual psychotherapy is not the treatment of choice, and there are also particular children for whom dynamic psychotherapy is not an appropriate medium for change. For example, Settlage (1966) points out the need for object constancy (necessary for an enduring relationship) and ego autonomy and superego structure (so that conflict can be internalized). Outcome research is of obvious help in delineating selection criteria for any clinical technique. Though publications are readily available on this issue in the field of the dynamic therapies (see for example A. Freud, 1970), I have already described how dynamic psychotherapy is by no means a unified field, and thus very few incontrovertible guidelines are available. That is not to say, however, that each therapist will not have a body of knowledge available to them that has emanated from

writers in their own tradition, on which basis they can make assessments of suitability depending on the facilities they have available to them and on their own training and experience.

The next part of this paper will describe the therapy of a child for whom individual psychotherapy was the treatment of choice.

In order to carry out an effective therapy with a child, a thorough knowledge of developmental psychology is necessary. Children are not a homogeneous group and obviously what is normal in, say, a four year old may be pathological in a child in latency. Techniques will also differ between age groups, and it is up to the therapist to search for a suitable language, either verbal or non-verbal with which to communicate with the young client. The case is however somewhat complicated by the regression phenomenon, where a child may temporarily move backwards along the developmental process during the course of therapy.

Emma was aged eleven at the time of her therapy, that is at the upper end of her latency period. Middle childhood is largely concerned with the consolidation of the ego based upon the completion of the tasks of psychosexual development, which culminate in the resolution of Oedipal issues. This period is characterized by planning, by convention and by activities which have material outcomes. Methods are conformist and symbols are often collective. In Erikson's (1950) words, it is the 'age of industry', where the 'fundamentals of technology' are developed.

Expression of imaginative activity is always externally influenced, but during latency phantasy is at its least apparent. First, the child's understanding of its world is undergoing critical change due to the assimilation of knowledge of the external world and its confirmed realities and second, at this time phantasy is actively regressed in an attempt to escape the pain of self-punishing emotions resulting from the skeleton of Oedipal desires of possession and annihilation, which through experience can now be seen in the light of their real life consequences. Failing at this stage can result in a state of inadequacy or in Erikson's (1950) term, inferiority. It is in this sense also that repression has a function.

Latency children are often observably embarrassed by, even contemptuous of, expressions of love or tenderness and intense feelings fend to be displaced away from parents and on to comic book characters, sport heroes or other more distant objects. The power of the repressed feelings can however sometimes be recognized through the force of the obsession with the accepted love object, be it a pop star or a childhood 'gang'. Although intense, displaced latency love (and hatred) is also fickle, and this can be understood by the observation of its malleability under the pressures of peer-group conformity.

An understanding of these issues is particularly crucial in non-intensive therapy with latency children, intensive therapy allowing greater scope for regression, thereby enabling children to transcend some of the emotional boundaries that their age inflicts upon them.

The therapeutic environment must be such that children can allow themselves to reach their inner world in a way that is congruent with their developmental stage. In latency the choice of activity within the playroom is usually seen to have an emphasis on structure. This might be achieved, for example, by devising a reality-based 'play' using the available materials, by making a model of a real or of a familiar object or scenario, or by engaging the therapist in a game. Games are the most common form of post-Oedipal play and game playing can have many functions. It can combat superego activity by the compensatory fantasy of shared responsibility, it

allows for strict and even rigid adherence to external rules or, conversely, for the opportunity to break those rules. It allows for new beginnings if the outcome is unsatisfactory and for experimentation with different strategies. Outcomes can be interpreted by the child as his or her own responsibility, or as the responsibility of the other player, or as a vagary of chance. The player can distance him or herself to the point of being an active observer, or identify with the opponent.

Games of latency are characterized by their hidden agenda. They provide acceptable displacements for libidinous drives which might, in their true incarnation, reach frightening and uncontrollable fruition.

In the case to be described, the therapeutic attitude conforms to an object relations perspective, but being non-intensive, outside issues were taken into account in the understanding of Emma's play.

Much of the important work was done through the medium of a draughts board, as one of Emma's main symptoms was that she was virtually electively mute. The letter of referral stated '... she has been treated as a more or less retarded child, but I am sure there is a heavy psychological element here and she seems to be in a considerable state of depression'.

Emma had a history of enuresis, sleep-walking, picking up imaginary objects, staring into space, and hardly speaking except when alone at home with her mother. The family history included a dead father, a deaf and 'maladjusted' older brother and an epileptic mother who was a shift worker. On the occasion of our first meeting Emma said not one word and showed no interest in play or in drawing material though she did engage in some games of 'Noughts and Crosses'. She was a drab, slim, round-shouldered girl who emitted an aura of sadness and whose eyes only raised above floor level in response to reflections of this sadness and to make her pencil and paper gesture towards interaction. She was reluctant to leave at the end of the session. Emma was able to write, though badly, and so on the occasion of her next visit she was asked to undertake a 'sentence completion' task. She willingly did this, and the results emphasized her silent call for help (see Table 1).

It was partly on the basis of these responses and other non-verbal communications such as her eye movements and reluctance to leave at the end of sessions that she was offered individual psychotherapy.

She was introduced to the playroom and a contract was drawn up with her, and separately with her caring and worried mother by another therapist. Emma was to attend for one hour weekly for an undetermined period of time. The initial sessions consisted of Emma spending most of time seated on a chair, occasionally looking around the room, and more often at me, apparently when she thought that my eyes were averted. She made one or two uncertain overtures towards play equipment, mainly the sand-tray, but generally her energies seemed to be directed at an understanding of me. In view of her affect and virtual immobility (and tentatively bearing in mind the death of her father and her fear of her grown up brother, who was the only significant male figure in her present life), I made several interventions about her fear of the consequences of her actions. In the third session I noted her recurrent interest in a pile of games. The important point about these was that they all required two players. Following further reflections and interpretations, Emma was able to pick up a game of draughts and place it on the central table. I pulled up my chair, and Emma, still silently, began to set up the pieces.

Typically, early sessions of psychotherapy with children involve a testing of the boundaries both of the setting and of the therapist. The

Table 1. Sentence Completions

1	I'd like to	shop girl
2	I am best when	swep (sweep) the carpet
3	I wish my family would	Be good
4	When I take my report home	I dont liek (like) it
5	My father	Dayd (dead)
6	Some day I will	go to the swiming
7	I worry	when my mummy gos out
8	A good mother always	liek you
9	I hope I'll never	hurt my self
10	I secretly	Mek me glad Meak my flegs (things) secretly
11	I feel bad when	when I go out
12	Children would be better off if	Tha wood get hep (help)
13	When I was little	I farted on My gradas (grandads) nie (knee)
14	I don't know why	My Big Bruther is deif (deaf)
15	If no one helps me	I will day (die)
16	Some teachers	are Bad
17	A sister	is Bad
18	It makes me cross when	I dont get woching the tella (telly)
19	I am happy when	I haf frent (friends) to go a bowt wif My pals
20	Some brothers	are Bad and good
21	If my mother only would	Be well el (all) The Tiem
22	At school	I am happy

main agenda of these initial sessions had been the establishing of a sufficiently secure relationship to help the task of exploration. Emma had allowed me to understand her primitive fear, that through me she might cause destruction, suggesting that she had very basic difficulties in understanding the relationship between herself and others and between her own actions and theirs, her ego boundaries being weak. These phantasies caused her to enter an almost schizoid retreat.

It seemed to me that the game of draughts could be used to modify and challenge Emma's phantasies about her own power and destructive qualities, and in view of this, I decided that my moves in the game would have to be completely consistent. I therefore adopted a strategy which was direct and unsophisticated but which was genuine in its aim to win the game. The games that followed within this session allowed an agreement of the basic rules. However, I won each of them.

Over the next series of sessions a pattern established itself. During the first part of each session, Emma would adopt her fearful position, tentatively toying with odd items of equipment. Next, she would bring the draught board to the central table and begin to set up the pieces. Each time I would win the games with Emma making unnecessary sacrifices if her position was looking strong. I began to reflect this to her and her response changed in time from puzzlement to annoyance and finally to a coy smile as realization and acceptance came to her. At each meeting my policy was to give five minutes warning before the end of the session and significantly Emma overcame her fear of retaliation sufficiently to win her first game after this reminder in the sixth session.

The basic therapeutic strategy in this early phase was to attenuate the effects of negative transference which might have slowed down or even halted the progress of treatment. To a lesser extent at this stage I aimed

to uncover the unconscious content of the play by pointing out the meta-communication inherent in it and tentatively interpreting the nature of her projections and introjections. By this means her anxieties about destructiveness were able to emerge and thus be interpreted and, in winning her first game, Emma showed her ability to work with that anxiety in an overt (though still symbolic) way.

Over the next series of sessions Emma would win the occasional game and after each victory her attitude would be the same (yet different to her manner after defeat). She would pause and look at me for a response. My response sometimes took the form of an interpretation of her fear, sometimes an intervention pointing out that I had remained unharmed through my defeat, and sometimes noting that she herself was unharmed even though she was experiencing anxiety. Later it was possible to make links with early traumas, of family violence and of separation and loss using both prior knowledge and an increased understanding of her phantasies.

After several more sessions Emma seemed able to win or lose at draughts without anxiety and the time involved with other play materials gradually squeezed the draughts out of the therapeutic hour.

During the sessions so far, I had learnt much from Emma about the nature of her inner conflicts and fears. Very important was guilt related to Oedipal issues, which through the untimely death of her father, had achieved the proportions of self-hate. In simple terms, in her phantasies, not only did she carry the burden of her father's death but also she was responsible for her brother's violent behavior and the consequent suffering of herself and her mother. The important current link here was her rivalrous relationship with her mother for her brother's favors (which in practice were in the forms of non-violence) and her equally rivalrous relationship with her demanding brother for her mother's love and forgiveness (in the form of attention and care). In practice, when she obtained the attention of her mother, she was 'punished' by her brother, one effect of this being to confirm her guilt. Thus Emma was in an impossible dilemma rendering the resolution of internal conflicts, through the experience of real life, impossible.

It must be remembered that Emma was communicating this to me via the medium of her non-verbal play. Outside information allowed me to make sense of this material in relation to her real life situation and the actual characters involved. But this knowledge was not important for the process of therapy which was largely via interpretation of the transference relationship centered on the draught board and to a lesser extent on drawings and sand play.

Over a series of months Emma worked with these issues and gradually became able to use more and more verbal utterances in conjunction with her play (prior to this I had commented on her silence and its defensive function in terms of her fears both of her own power to damage or destroy and of resultant retaliation). As she passed through the middle phase of therapy, she used many items of play equipment, notably the sand-tray, where a recurrent theme was of an isolated figure, often on a hill or island, fighting off or occasionally allowing in other figures. In this way Emma was able to communicate her need to form relationships and her associated fear of them, negative transference feelings, which again could be interpreted in the light of a substantial knowledge of her phantasies.

The next phase of therapy was marked by a spontaneous return to the draught board and this time Emma's strategy was very different. Within the first session of this phase, Emma began to play aggressively, and within a few sessions she would cheat if her position looked weak. The cheating was

not subtle and not intended to deceive. It had the positive quality of communicating her new ability to acknowledge part of herself that she had previously been unable to accept. Through repeated struggles within her relationship with me, Emma had been able to understand how her phantasies had distorted reality causing a strangling of her abilities to interact with others or to express negative or angry feelings.

Feedback from her mother's therapist suggested that during the course of therapy Emma had invested many of her primitive fears in the transference relationship, and things had improved in her relationships outside, notably at school and, interestingly, she was reported to be interacting verbally somewhat more normally at school, while in therapy it was still unusual for her to make more than single word or phrase utterances, though these were now more frequent.

Generally the activity in the playroom that followed her aggressive phase suggested to me that Emma had reached the final phase of her treatment. There was evidence from imaginary play that phantasy was less inhibited and broader in scope and that Emma had, to a large extent, relinquished her bi-polar vision. The draughts games seemed to have an open quality with appropriate affect and for the first time Emma's sense of humor emerged. She began to speak in sentences soon after the issue of termination was broached and though her speech was marked by a poverty of content the final phase of therapy was conducted on a much more verbal level.

I'd like to end this paper by acknowledging that psychodynamic treatment for children and their families is just one of a variety of ways of providing help. The choice of working model will always be a personal one. I use a psychodynamic model because I understand my own life and relationships in terms of the workings of my own inner world, and so it feels appropriate to apply those principles to my work with others. Within the department in which I work, I have colleagues who work in different ways. We run an open waiting list, and together consider that, with the clients' consent, any of us can deal with the majority of problems which arise. There are occasions when we cross refer. In my case this might be when my young clients (or, more usually, their parents) and I cannot reach a basic agreement on the nature or origins of their difficulties, or when I consider that a dynamic approach of any kind is less appropriate than, for example a behavioral or a systems approach might be. Psychodynamic therapies are not universal panaceas, but neither need they be any more restricted or time-consuming in the long-term than other modes of psychological interventions.

I have sought in this paper to introduce some of the background to, and in a limited fashion, ways of working within, a psychodynamic framework. Initial professional training in clinical psychology and in the other helping professions can never hope to provide its recipients with a fulfilling experience of a full range of treatment methods. Similarly, working clinicians can find that the setting of their work does not provide them with the opportunity to experience models with which they feel less than expert. I believe that the dynamic tradition has suffered more than most in this respect. There are no easy ways to become a proficient psychotherapist, no 'cook-books' to follow. In many parts of the country, training and supervision are hard to come by and personal therapy for training purposes can be both scarce and expensive. The literature too can be awe-inspiring and even seem mystical. People may react to this by dismissing the approach as unscientific, as uneconomic or as over-selective. I hope that if this paper has achieved anything, it may have served to put a perspective on these fears by showing that there can be a flexibility within the psychodynamic model. It is not necessary to carry out

regular psychotherapy in order to make use of the vast body of knowledge that has emanated from the psychodynamic culture, and while not advocating an eclectic philosophy, it is, I believe, for each individual to accommodate into their own psychological model whatever has personal validity for them.

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GROUP THERAPY WITH CHILDREN:

A GROUP ANALYTIC PERSPECTIVE

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INTRODUCTION

In a recent overview of child group psychotherapy Irvin Kraft (1983) stated that group psychotherapy with children "sets up goals of education and control of emotions which the children accomplish in various ways. These accomplishments are centered on the acceptance of both feelings and specific types of behavior that are pertinent to the child's developmental progress." These words could apply equally well to the work of primary school teachers, especially to those teachers who recognize that education has an affective component as well as the more obvious cognitive and psycho-motor dimensions. Herein lies the difficulty when discussing group therapy with children up to the age of puberty. What are the features of the situation that require a psychotherapist and not a teacher?

The relevance of this question increases when one reads about psychotherapists having problems over the management of groups, especially with regard to the setting of limits both within and outside the group (viz. Speers and Lansing, 1965; Slavson and Schiffer, 1975). Farrell (1984) provides a very lucid description of the problem relating to limits, in a British setting: "painting on the walls, throwing and dumping sand far and wide all over the room and at other people, fighting, climbing in and out of windows (a semi-basement room), turning lights on and off, banging things incessantly (making verbal communication impossible), running around the building, running down the street, throwing things into a brook (when the group was taken outdoors), and hammering holes in walls." It is a matter of some wonderment as to what "goals of education and control of emotions" can be achieved in these circumstances. Such a description of group management problems could rarely be rivalled by even the most progressive of educators.

If some therapists who practice group psychotherapy with children experience grave problems of management and limits, then it becomes appropriate to enquire whether the therapeutic mode is appropriate, whether the appropriate conditions are being treated, whether the physical situation is appropriate, and whether the therapists have achieved an adequate therapeutic alliance with their clients.

James Anthony (1971) has identified six special characteristics of group psychotherapy: 1) It should be impartable by the ordinary routines

of training and not depend upon trust or faith; 2) it should provide a therapeutic model that helps to explain both the process of therapy and the process of change; 3) its theory and technique should be open to growth and development; 4) its therapeutic appropriateness should be clearly understood; 5) its theoretical framework should be compatible with psychological knowledge, especially group dynamics; 6) finally, its efficacy should be amenable to research evaluation. If therapy is defined as the setting up of "goals of education and control of emotions," as Kraft (1983) has done, then Anthony's special characteristics do not exclude the work of teachers.

Where teachers and psychotherapists differ appears to lie within the characteristics of their client group. Traditionally teachers require their clients to possess an adequate attention span and the ability to voluntarily focus their attention where it is required; to have the ability to comprehend verbal utterances, grasp relationships between things and their symbolic representation, inhibit large muscle activity while engaging in covert 'mental' activity, repeat instructions to oneself, and persist in a task until a self-determined standard is attained (Jensen, 1972). When their clients do not possess some or all of these criteria, teachers have initiated referrals to psychologists, psychiatrists or psychotherapists. If group psychotherapy with children is defined in terms of the characteristics of the client group, then the aetiology of such characteristics becomes of crucial importance, and it is theories about aetiology which distinguish and color the work of psychotherapists. However, when the child group psychotherapist attempts to put his or her theoretical orientation into practice, the difference between the work of teachers and the work of therapists starts to fade.

Much of what is stated above can be exemplified by an examination of psychoanalytic approaches to group therapy. Here we have a theoretical model of the aetiology of behavior which, though there are differences in emphasis, has produced three principal schools of technique in group psychotherapy: psychoanalysis in the group, psychoanalysis of the group, and psychoanalysis by the group.

Psychoanalysis in the Group

Samuel Slavson (1947, 1950) is a representative of the approach which can be described as "psychoanalysis in the group." In essence this is a classical Freudian approach which perceives group psychotherapy as a means of permitting the acting out of instinctual drives, accelerated by the catalytic effect of the other group members. Because the members find support in one another and the fear of self-revelation is strikingly reduced, there is less caution and greater abandon in a group. As a result, patients reveal their problems more easily, since defences are diminished through the permissiveness of the total environment and the example set by others; accordingly therapy is speeded up. However, it is an error to speak of 'the group' as an entity in therapy. It is always the individual and not the group as such, that remains the center of the therapist's attention. The group is merely a means for activating individuals and supplying the kind of experience that helps modify feelings and attitudes. To consider the group as a treatment focus instead of as a treatment tool is to confuse the aim and means of therapy.

The application of Slavson's theoretical position to technique in the field of child group psychotherapy has resulted in Play-group therapy, Activity group therapy and Activity-Interview group therapy.

Play-group therapy is structured by the therapist along play therapy lines, and is intended for children between 3 and 7 years. Emphasis rests on the interactional qualities of the children with each other and with the

therapist in the permissive playroom setting. The children use toys (e.g. water, plasticine, doll's house, toy guns etc.) to act out aggressive impulses and to relive with the group members and with the therapist their home difficulties. The therapist interprets a child to the group in the context of the transference to her (Slavson recommended that the therapist should be a woman) and to other group members. Play-group therapy is believed to effect basic changes in the child's intraphysic equilibrium through relationship, catharsis, insight, reality testing and sublimation. The mechanism of identification affords the child major opportunities for therapeutic gain as he or she identifies himself or herself with the other group members and with the therapist.

Anthony (1963) has provided a useful description of play-group therapy in his account of the 'small table' technique. This involved a small round table sufficiently high to allow the group members to kneel or squat and sufficiently large to be divided into five sectors, each separated from the others by a low, removable wall. The walls radiated to the center of the table where there was a trough containing water, which was common property. The small table technique produced two stages of group development; in the first, where play was individually centered, there was little reference to the activities of other children, territories tended to be respected with each child cultivating his or her own areas and all group interaction tended to be therapist-centered; the second saw the crossing of boundaries, the linking of play themes until play interactions produced both 'collective fantasies' (e.g. new baby, parents, mess-making, aggressive siblings etc.) and collective monologue.

Though client behavior is broadly comparable in the play-groups described by Slavson and Anthony, the interpretative behavior of therapists is different. In a Slavson group the therapist interprets a child to the group in the context of the transference to her and to other group members.

In the 'Small Table' technique, on the other hand, the therapist interprets only in terms of the 'collective fantasy' so that the interpretation is directed towards the activity of the group as a whole.

Much of what is done in play-group therapy with children under six years of age finds an echo in the work of Suzan Issacs at the Malting House School in the mid 1920's (viz. Gardner, 1969). This was a progressive educational establishment catering mostly for children between the ages of three and seven.

The school gave equal place to affective, cognitive and psychomotor development; there was no nipping in the bud of every hostile act, every sexual interest, every bit of dirtiness or rebellion. There was plenty of space, material equipment was abundant and suitable, and the child was free to use it in ways that appealed to him or her. The curriculum was not fixed and the children did what appealed to them at the moment. The teachers refrained from teaching but let the children find out all they could for themselves, answering their own questions with the teachers helping them to discover where the answers could be found. Discipline was very free with no punishment and little admonition.

Play-group therapy imposes active restraint when the children undergo excessive tension and resort to physical aggression. A similar rule operated at the Malting House School though verbal aggression was not checked. However, the policy on verbal aggression changed after a visit from Melanie Klein. Both Susan Issacs and Melanie Klein agreed that verbal aggression could be too painful to be tolerated by the victim and could produce guilt over the aggression. Young children need order and stability, and adult support for their loving and constructive impulses against the impulses of

hate and aggression. This Kleinian observation highlights a potentially counter-therapeutic factor in play-group therapy where more vulnerable children are involved, i.e. unrestricted catharsis in a permissive environment.

Most applications of group psychotherapy for latency-age and pubertal children follow some modification of the two basic designs formulated by Slavson, namely Activity-group therapy and Activity-Interview group therapy.

Activity-group therapy assumes that poor and divergent experiences have led to deficits in appropriate personality development and that corrective experiences in a therapeutically conditioned environment will modify them. The group is conceived as offering its members a substitute family or peer group in which the passive, neutral therapist becomes the surrogate for the parents. The therapist assumes different roles, mostly in a nonverbal manner, as each child interacts with him or her and with other group members. The setting is highly permissive which encourages freedom of expression of pent-up feelings along with regression. Identification (with therapist, other group members and with the group as family), reinforcement and the development of insight (direct, indirect or derivative) are the main therapeutic agents. Activities involve games, structured activities and projects that have to be planned and executed, but the overall scheme allows variation for different syndrome types. For children with neurotic-type difficulties equipment is minimal in order to reduce the potential for frustration and failure and the expression of feelings about others. On the other hand limits are set only to protect personal safety and to prevent property damage. Anxiety is allowed to develop and the therapist works to help the group cope with it. Ego-impaired children are presented with highly structured sessions in which anxiety is reduced to a minimum, until such times as their frustration tolerance rises when freeing of the structure can take place. Impaired children experience active discouragement of all forms of destructive behavior.

Activity-group therapy is not considered suitable for children with strong neurotic traits (e.g. fears, high anxiety levels, guilt etc.) and a more verbal form of group therapy, Activity-interview group therapy, has been adopted. This format employs interview technique, verbal explanations of fantasies, group play, work etc. Children verbalize in a problem orientated manner, becoming aware of the problem which brought them together. Dreams, fantasies, daydreams, traumatic and unpleasant experiences as well as their group behavior undergo open discussion. With the absence of toys, real objects become the subjects of transference.

Pasmau et al. (1976) describe Activity group therapy as the provision of a neutral area in which the youngster can freely act out impulses; where sublimative activity, gratifying experiences, group status, recognition of achievement, unconditional love and acceptance from an adult can all be achieved. The therapeutic aspects of this activity progress through three identifiable phases. The initial phase involves regression, the testing of limits, exploration and relaxation. Growing interaction and cohesion, and transferences on to the therapist and other group members mark a middle phase. Finally, there is an increase in frustration tolerance, an improvement in self-image, a dilution in transference, and identification becoming reality-oriented.

Is freedom to act out impulses necessary for therapy at latency? Dannefer et al. (1975) argue that attempts at treating the impulse-ridden youngster through the medium of Activity-group therapy often fail because such therapy offers a permissive atmosphere to children who need clearly

defined structure. Their experience of frustration in attempting to service the acting-out child through the medium of Activity group therapy has eventuated in the designing of a program of verbal therapy. This involves short discussion periods during the activities sessions.

Anthony (1963), in what he described as his "early technique" with latency children, adopted a similar approach. In each session a discussion phase which allowed for dramatization and 'acting out' of communications was followed by an activity phase. Anthony records that there was general relief when the discussion phase drew to a close; the clamor for activity would begin and spontaneous activity would increase. The group would often combine against the therapist as if he were the restraining factor on their more spontaneous behavior. The 'later technique' was more verbal, analytic and interpretative, with a focus on the positive and negative aspects of the group but not on the individual relationship with the therapist. Activity periods were done away with altogether in favor of a single-phase group session in which any activity occurred spontaneously and then became a matter for group discussion. The members were confronted with their own tensions, anxieties and silences and liberal use was made of interpretation, which was directed at the here-and-now of the therapeutic situation. From this evolved the 'Small Room' technique which, through the physical restraints of space, prevented scattering, fragmented group activities and subgroup formation. Members had no alternative to being in close therapeutic contact with the therapist and the only explicit rule was 'no exit'.

That conversational group therapy can be employed with latency-age children has been described by Barcai and Robinson (1969). Sitting around a table, the group met weekly to talk together about problems they had in school or at home, with the assurance of confidentiality. The main difficulty Barcai and Robinson experienced with such groups arose over the handling of aggressive behavior. Their solution was to keep the number of aggressive children small, to mobilize the opposition of the quiet members and to establish limits. Those who threatened to disrupt the group were offered the alternative of leaving the group or of conforming to group rules.

If conversational group therapy is possible at latency why has Activity-group therapy had such an influence? Slavson developed the technique and he played an important role in the group movement as a founder of the American Group Psychotherapy Association in 1948 (Sadock and Kaplan, 1983). In psychoanalytic terms Slavson could be described as a classical Freudian who emphasized the specific importance of the sexual drives and the instinct of aggression. 'Acting out' which is a characteristic of Activity-group analysis (ie. carrying into action impulses stirred up in the course of treatment), was regarded by Slavson (1950) as the equivalent of verbal communication and insight in adolescent and adult groups. Indeed, Slavson saw great therapeutic merit in acting out; it served to "detense the total organism, with a consequent equilibrating effect;" and it was of great advantage for eliciting catharsis and establishing a positive transference. Pines (1979) has suggested that the model of the mental apparatus as a mechanism fuelled by instinctual drives is not appropriate to group phenomena. Rather, the appropriate model is one of internalized object relationships in the form of the super-ego and ego ideal projected onto the central group figure, the therapist. This shift in models for the group reflects the shift in general psychoanalytic models to that of a psychodynamic system maintained in a state of dynamic equilibrium by complex ongoing processes of communication and relationships.

Another reason for the enthusiasm for Activity-group therapy may stem from adult-therapist perceptions of child-patients (viz. Anthony, 1965).

If children are perceived as immature beings whose major problems have to do with being insufficiently adult then it is easy to conceive that the 'un-grown-up' individual is an uncommunicative, often unintelligible creature whose actions tend to speak louder than words and is preferably better seen than heard. So conceived, inactivity in such a being would represent a state of resistance, in direct contrast to the situation with adults where action is decried as resistance, and the therapeutic aim is to immobilize the adult and compel him to express himself in words rather than deeds. But why should motility mean something basically different in the case of adults as compared with children? It is certainly not the assumption upon which primary schooling is based (viz. Jensen, 1972), nor is it the experience of those who work regularly and intensively with children (e.g. teachers). Children, adjusted or mal-adjusted, respond to the situation with which they are presented. If objects (e.g. toys) and space are available they will seek to make use of each. If therapists support their patients by allying themselves with their patients' impulses (id) as against their super-ego in a permissive atmosphere with few limits, then children will push to discover where these limits lie and resent restriction within such limits.

The second and third schools of psychoanalytic technique applied to groups, namely, "Psychoanalysis of the group" and "Psychoanalysis by the group," employ strictly conversational approaches; their differences lie in their theoretical concepts and in what they regard as the therapeutic process.

Psychoanalysis of the Group

"Psychoanalysis of the group" is an approach to group therapy associated with the Tavistock School and the name of Bion. Bion (1961), a Kleinian psychoanalyst, tried to approach his experiences in groups free from the prejudices of individual analysis. He conceived the group as if it were one individual having a separate mental life, with its own dynamics and hidden structure, and locked into a transference battle with the omnipotent parent figure of the therapist.

The hidden structure of groups refers to what Bion called the "basic assumptions," of which there are three. They are primitive states of mind which are generated automatically when people combine in a group. These states are inevitable because of the dilemma created by dual pulls of human individuality and groupishness. The first basic assumption is that group members are looking for a leader upon whom they can depend for spiritual sustenance and protection; the 'dependent' assumption. In institutional terms this assumption would be represented by the Church reflecting dependence upon a deity. The second basic assumption is the eventual recognition by the group members that such a leader does not exist except in fantasy, that the need for an omnipotent and ominscient figure is irrational, and that they must look to themselves for salvation and survival; in so doing, they form the so-called pairing group and act out the 'pairing' assumption. Institutionally, this assumption is represented by the Aristocracy; the coupling of individuals which could lead to the birth of a person or an idea that would provide salvation and ensure the next generation of superior leaders. Finally, the group members realize that there may be no one in their midst to fulfil a role that, to their dismay, they realize cannot be filled in any case. They have met for a purpose but have become annoyed and disappointed. Some may choose to stay and fight amongst themselves or with the leader as to their motives; others may choose to leave and flee from a situation they find unendurable. At this stage, the third basic assumption, has been realized. The Army is the institutional representation of the 'fight-flight' assumption.

Bion did not see the basic assumption as separate phases in the life of a particular group. All may be operative at the same time, and in varying degrees. The fantasies and emotional drives associated with these basic assumptions unconsciously dominate a group's behavior in a way that is apt to interfere with its explicit work task and so prevent creative change and development.

Each basic assumption can be identified with a particular fantasy system; thus the 'dependence' assumption relates to 'oral-dependence', 'fight and flight' to 'separation and individuation', and 'pairing' to the 'Oedipal' situation. The basic assumptions can be traced then to defences against anxieties. If the reality of belonging to a group does involve facing up to jealousy, envy and the frustration of dyadic dependency, it is not surprising that early phantasies and anxieties of this type are stirred up in an analytic group.

Brown (1979) notes that a group dominated by a 'basic assumption' is one which avoids reality testing of those elements in it which embody creative strength and self-reliance, as well as of those involving hatred and despair. In the 'dependence' group strength resides in the leader; there is no chance for integration of the group's own strengths because of 'depressive anxiety'. In the 'fight-flight' group badness resides in the outside enemy; this 'paranoid position' avoids testing out the essential ambivalence of relationships. Finally, in the 'pairing' group despair is kept at bay only by a hopeful illusion; assertive feelings cannot be mobilized in a way that makes the defeat of despair less dependent upon hopeful illusion.

What is missing from Bion's conceptual approach is reference to the group's ego function and its work task and where and how it is achieved.

Such a conceptual scheme has implications for technique. Brown (op.cit.) questions what work a Bion-type group should do. This is reflected in the style of therapist leadership which ignores the individual and concentrates upon the group. The description of group sessions which Bion (1961) provides under the heading of "The Experience of Taking a Group" makes one ask if Bion's approach fosters "basic assumptions." Anxiety and regression are stimulated quickly.

The de-emphasis of work and the heightening of anxiety may not make Bion's technique appropriate for latency-age children. It is true that some teachers ignore individuals and attend only to the group (the class) but there is emphasis on ego function, secondary thinking and reality testing. This emphasis relates to the development needs of the latency child (viz. Erikson, 1963). Where there is poor ego development already, this need requires even greater attention.

Psychoanalysis by the Group

Psychoanalysis by the group or Group Analytic psychotherapy was developed by Foulkes (1948 and 1964) and at the Institute of Group Analysis (London). It represents a synthesis of elements drawn from psychoanalysis (both classical and object-relations), social and gestalt psychology and general systems therapy. It places emphasis upon both the individual and the group with the treatment of the individual through the group processes. Thus Foulkesian group analysis occupies an intermediate position between the approach of Slavson and that of Bion with its respect both for the dynamics of the group as a whole and for the individual as a legitimate focus of therapy.

The conceptual framework of Foulkesian group analysis can be described under seven headings. Firstly, the essence of the individual is social, as people develop only in a social context and are defined as a person by this context; a person is a nodal point in the social network. The individual and the group are two aspects of the same entity, two sides of the same coin. To emphasize one to the exclusion of the other would be to create a distortion. Secondly, neuroses and psychological disturbances in general have their origin in disturbed social relationships. Neuroses are based on conflict and this conflict is essentially one between the individual's instinctive impulse and his or her group's cultural taboos, transmitted to the child through his or her parents. The neurotic person is both more isolated from society that he or she can tolerate and more fixated to a group (i.e. the family group) than normal people. Thirdly, since the neurotic position is the result of an incompatibility between the individual and their original group and is, at the same time, an expression of destructive and aggressive tendencies, then the resolution of the individual's conflict is possible in a social network - either that of the group in which the disturbances arose (e.g. the family) or in a therapeutic (proxy, stranger) group. Fourthly, the symptom or disturbance will be reactivated in the group. It will be located in the communicative processes and in relationship patterns and will appear as a characteristic disturbance of these. The symptoms will be translatable into communicational processes, since the person's inner world is actualized in the group context. Therapy in Foulkesian terms is a widening and deepening of communication through at least four identifiable levels: the level of current relationships (the 'working alliance'); the level of individual transference relationships; the level of projected and shared feelings and fantasies, often from early pre-verbal stages of development prior to separation and individuation from symbiotic merging (viz. Bion's "basic assumptions"); finally a primordial level of archetypal images (innate reaction patterns and releasing mechanisms). In addition, the healing properties of the group situation lie in the uncovering of the interpersonal disturbances and their resolution in the relationships context of the group. The Foulkesian group is essentially a transference group in the sense that members can use each other and the therapist as transference figures, so that each can become the super-ego, ego and id in relation to each other. At the manifest level the basic problem reflects relationships to other people in contemporary reality; at the latent (unconscious) level the basic problem has to do with relationships to parental authority and past infantile experiences. Also, the group heals because all its members reinforce each other's normal reactions and wear down and correct each other's neurotic reactions (i.e. collectively they constitute the very norm from which, individually, they develop). This relates to the second and third headings. The neuroses of group members stem from disturbed relationships but, since the individual comes to the group as a nodal point representing many social relationships, the common pool of all members' social relationships has enough healthy material to ensure that the community norm is present in the group. Thus neurotic behavior tends to diminish in the group while normal behavior tends to be supported. Finally, the therapist's role is predominantly to be of service to the group as a whole. The therapist identifies processes which obstruct free communication and fuller understanding between its members. He or she creates a situation where tolerance, acceptance, and relative freedom are self-understood. Foulkes (1971) has drawn attention to a vicarious learning aspect of group therapy, namely the submission of group members to the therapist's conscious and unconscious opinions; group members continuously tell and do what their therapists ultimately expect and want to hear. This is a very important factor in social education which can result in permanent change through such mechanisms as cognitive dissonance (viz. Wicklund and Brehm, 1976).

As a therapy for children at the latency stage, Foulkesian group analysis has much to offer. It emphasizes verbal communication, and latency children are willing and ready talkers; it emphasizes the role of disturbed social relationships in the aetiology of neurosis, and children at this stage are experiencing the expansion of their social relationships away from the primary group. Evidence has already been cited that latency children can make use of conversational group therapy techniques. Finally, the role of the therapist in freeing obstructed communication and facilitating fuller social understanding is not a strange one for children who have experienced two or more years of full-time schooling.

CONCLUSION

If conversational group therapy is suitable for latency children why is there a reluctance to adopt it on the part of some practitioners? There are at least two possible answers. Firstly, how familiar and confident are therapists in dealing with children? My experience has been that many therapists have not sufficiently orientated themselves towards their child clients. Anthony (1965) came to a similar conclusion. To carry out any sort of therapy with children involves a capacity to talk to them, and talking to children requires effort and practice. This necessitates a complete change of attitude and behavior on the part of the therapist. He or she must become interested in what the child has to say; there must be reciprocal communication which is simple, brief, direct and concrete and without a 'data gathering' emphasis. There is also the nature of the counter-transference to consider. Since they are other people's children the barriers and taboos are weaker, and there will be more conflictual feeling around aggressive and erotic impulses. These positive and negative feelings may, at times, occasion guilt and shame in the therapist and which may inadvertently discharge itself onto the children. When recognized and suppressed, the same feelings may find their way out in excessive tiredness, boredom, irritability, permissiveness, strictness, forgetfulness of names, slips of the tongue, cancellation of sessions etc.

Secondly, does the treatment fit the client? Overtly aggressive and hyperactive children do not seem suitable for conversational group therapy. Nor do those with late pregenital fixation - that is, marked compulsive and hysteroid personalities or suffering from disabling neuroses (viz. Skynner, 1976). As with adults, there is a tendency in some treatment centers to offer some form of group therapy to all their child clients. With such random forms of selection it is not surprising that conversational therapies become early casualties.

Finally, how should group sessions be organized? Patients should be well prepared for group psychotherapy, and this could mean offering each potential child client a number of individual sessions prior to joining the group. They allow the child to become familiar with the therapist and lay the basis for achieving reciprocal communication. There is considerable merit in having male and female co-therapists; children at latency have not yet begun the movement away from parents, and the activation of transference and relational problems can thereby be facilitated. The groups should be of mixed sex since, apart from modelling the usual family situation, the verbalization ability of the girls can greatly help the boys to verbalize rather than act out. No materials should be provided save chairs to sit on. Most latency children associate tables with some activity whether at home (eating, playing and so on) or at school (writing, handwork and so on) and their presence in the therapy situation raises unwarranted expectations. Lastly, thought should be given to the length of sessions, their frequency and duration. It is no accident that schools latched upon the forty minute period. Children need variety in their daily activities and

half the length of the normal adult session is probably a reasonable expectation to be demanded of children. Though group therapy with adult outpatients tends to be once weekly, there is a strong argument for the greater continuity provided by twice-weekly sessions. As children tend to perceive their lives as much more fragmented than adults, twice-weekly sessions probably represents the minimum frequency. Since children have a smaller network of social relationships, and since they are much closer to their primary group there is every reason to believe that the eighty session notional minimum for adults could be reduced for children - though as with adults, therapeutic progress will be the determining element.

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BEHAVIORAL THERAPY OF PROBLEM CHILDREN

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INTRODUCTION

I would like to begin with an acknowledgment or admission. There are undoubted limitations to behavioral theory and epistemology! But behavioral therapy does offer the practitioner quite clear guidelines as to how to approach a range of children's problems (see Herbert, 1981) with some hope of amelioration. Of particular note are the home- and school-based approaches based on theories of learning, and variously called behavior therapy, behavior modification and behavioral psychotherapy. These highly systematized theories and methods are growing in influence.

The importance of genetic predispositions and biological differences is recognized in the genesis of human problems, but the focus is particularly (although not exclusively) on learned behavior. It is based on the concept of a functional relationship with the environment in which changes in individual behavior produce changes in the environmental and vice versa. Attempts to identify and modify environmental conditions which control problem behavior are very much in line with the renewed emphasis, in community psychology and social work, on social and environmental (rather than individual intrapsychic) change.

The behavior of persons tends to be relatively (and in children highly) specific to the persons, places and situations in which they find themselves involved (Mischel, 1968). Behaviorists, by recognizing the crucial mediating function of interior cognitive events seem to be losing some of their previous rigidity. Thus contemporary behavior modification belatedly makes room for such concepts as self-control, self-observation, self-respect and observational learning.

A HISTORICAL NOTE

The behavioral treatment of children with psychological problems can trace its origins to some innovative (but strangely isolated) work carried out by Mary Cover Jones in the early 1920's. When Little Hans with his fear of horses became the much quoted hero of the psychoanalytic paradigm, Little Peter (aged 2 years 10 months at the beginning of his treatment for a fear of rabbits) became the hero of the behavioral paradigm (see Jones, 1924). In this he was to join Little Albert, victim of a distasteful

experiment - the deliberate engineering of an experimental neurosis in the hapless infant - by John Watson and Rosalie Rayner (see Watson and Rayner, 1920). By the application of conditioning methods, they converted his fondness for white rats into phobic anxiety; and by stimulus generalization, they engendered milder aversive reactions to a fur coat, a dog and a Santa Claus mask. No wonder behavior modification has had to live down a bad name.

Little Peter, who is often mistaken for Little Albert because of the similarity of his fears (and perhaps because of a compassionate wish that a wrong might be put right) was treated by Mary Cover Jones by methods which foreshadowed contemporary in vivo desensitization (exposure training) and also modelling and habitation.

Apart from some isolated studies, this experimental work (based upon learning therapy) seemed to be forgotten; its humane potential certainly did not catch on within mainstream child therapy - which was mainly psychodynamic and very often play therapy (Axline, 1947).

It is worth mentioning the studies of Holmes who conducted a survey of children's fears and the most effective ways they were dealt with by parents and the sufferers themselves. She advocated encouraging the child to cope actively with the feared situation, following the attempt with a reward (see Holmes, 1936). In effect, she was putting forward an operant conditioning paradigm.

The really dramatic developments in the behavioral approach have taken place in the last twenty or so years (see Kazdin, 1978). The 1980's saw a revival of interest in behavioral therapy; it derived its impetus from operant work ('behavior modification') with handicapped (including autistic) children, and respondent work ('behavior therapy') with phobic children (Kardin, op.cit.). The terms behavior modification and behavior therapy nowadays tend to be used synonymously (except by some purists) and they are applied to a wide variety of specific problems generated by the interaction of children's social environments with their particular organismic disabilities, such as mental and physical handicap, autism and psychosis. Many of the problems represent exaggerations or deficits of behaviors common to all youngsters, which arise in the course of day-to-day coping with growing up.

The generic term 'childhood problems' refers to a large and heterogeneous collection of disorders ranging from depression, anxiety, inhibition and shyness to non-compliance, destructiveness, stealing and aggression. There is a remarkable consensus among clinical and statistical studies for a meaningful distinction between those disorders which primarily lead to emotional disturbance or distress for children themselves (e.g. anxiety, shyness, depression, feelings of inferiority and timidity) and those which involve mainly the kinds of antisocial behavior (e.g. destructiveness, aggression, lying, stealing and disobedience) which disrupt the well-being of others, notably those in frequent contact with the child (Achenbach, 1972). The former category, the so-called 'emotional disorders', are manifested by about 2½% of pre-adolescent children; their prevalence increases somewhat by adolescence.

For most children these kinds of problem manifest themselves briefly at certain periods and then become minimal or disappear completely (MacFarlane, Allen and Horzik, 1954). We know as a result of longitudinal studies that, for the most part, children who suffer from emotional disorders become reasonably well adjusted adults; they are almost as likely to grow up 'normal' as children drawn at random from the general population. In a sense these difficulties are the emotional equivalent of 'growing

pains'. These problems lend themselves to clinic-based treatment, and behavioral methods (such as systematic desensitization, exposure training, social skills training, cognitive problem-solving) have proved encouragingly successful (Herbert, 1981).

There is another category of difficulties which declines at a rather later stage, and at a slower rate than most others; for example, overactivity, destructiveness and tempers. In their severe forms these and other types of aggressive, antisocial behavior constitute a constellation of problems referred to as 'conduct disorders'. They involve physical and verbal aggressiveness, disruptiveness, irresponsibility, non-compliance and poor personal relationships; delinquent activities, early drug and alcohol use and substance abuse may also feature as part of the syndrome. This behavior pattern is notable for the fundamental inability or unwillingness on the part of the youth to adhere to the rules and codes of conduct prescribed by society at its various levels: family, school, and indeed the community at large.

THERAPY IN THE NATURAL ENVIRONMENT

The parents may be the only people who can make the necessary changes in adverse conditions controlling the conduct problem.

The time span for change is necessarily - in the case of conduct problems - a long one, given the slowly evolving, complex psychological attributes (e.g. internalization of rules, resistance to temptation, empathy, self-control) we are dealing with. The goal of behavioral work in home settings is to change not only the target child, but also parental and sometimes sibling behavior (see Herbert and Iwaniec, 1981). Rather than tinkering with the child's problems in the rather detached setting of the clinic or office on a once-a-week basis, we attempt to involve the significant persons in the child's environment in the process of change. Help is directed to the modification of that environment rather than withdrawing the child from it.

All parents are informal learning theorists and all are in the business of behavior modification (i.e. changing behavior). They use various techniques to train, influence and change the child in their care. Among those used are material and psychological rewards, praise and encouragement, giving or withholding love, reproof, corporal and psychological punishment, approval and disapproval, as well as direct instruction, setting an example and providing explanation of rules.

The basic principles of behavior modification are clear and relatively easily communicated to parents and other care-givers and to professionals and para-professionals (Herbert, 1981). The characteristics of behavior modification make it particularly amenable to employing individuals in a client's everyday surroundings as treatment intermediaries. Far from adopting an authoritative posture (as an esoteric cult) behavioral modification is willing and able to rally the support of people in the community in the task. Many of the factors which contribute to the instigation of problem behavior (and interactions) need to be influenced directly and immediately, and the psychologist may not be well placed to do this.

CAUSATION

Many of the 'why' questions in traditional psychotherapy and casework assessments are formulated in terms of an historical analysis of the client's life. Such a retrospective look at past events is often of

interest (and certainly of value), but essentially there is nothing that can be done to change history. An exclusive or obsessive preoccupation, in assessment, with the client's history can have the effect of 'distancing' the problem (keeping it in soft rather than sharp focus), keeping it vague because it remains at arm's length. The crucial 'what' question - the painstaking specification and measurement of the parameters of the client's problems in their various settings, are only too often skimped. A predominant historicism also alienates clients who are struggling with current problems. Parents are well aware that contingencies in the here and now (inter alia) affect their children's behavior.

Sadly, a careful examination of the developmental and clinical literature (Herbert, 1974) shows us that our knowledge of capability in behavior development is modest, and therefore our conjectures about the outcome of conditions far removed in time from present manifestations of dysfunctional behavior - combinations of parental attitudes, home and school circumstances, reinforcement contingencies, genetic influences, temperamental and other intrinsic factors - are tenuous at best.

BEHAVIORAL ASSESSMENT

Behaviorally orientated psychologists will lose little sleep over the doubts and uncertainties about early precursors of childhood problems. Their gaze is firmly fixed on the 'here-and-now', on the immediate antecedents and consequences of problematic episodes, which for them are the controlling contingencies of note. And they work on the assumption that it is necessary to have highly detailed and specific information (based on specially designed 'sharp focus' interviews and direct observation) about the child's behavior in various life situations (see Herbert, 1981).

The behavior of any child tends to be highly specific to circumstances as was stated before. Assessment techniques designed to identify and gauge generalized attributes (e.g. personality traits) in a child, have poor predictive value (Mischel, 1968), and thus find little favor with behavior therapists. The behavior therapist works from the premise that prediction is best from behavior in one situation to behavior in similar situations (Bandura, 1969).

IDENTIFICATION AND SPECIFICATION OF THE PROBLEM

Thus the first step is to obtain information about all aspects of a child's behavior which are considered to be problematic by the parents, any other persons (e.g. teachers), agencies (e.g. medical or educational), or the child him/herself. The process of labelling behavior as 'deviant' occurs in a social context; in any group, be it a school or a family, each member will have different perceptions of the 'real problem' in that system. Social learning theorists attempt to conceptualize the problem not as an encapsulated entity but as a process. A longitudinal perspective is adopted which views the client and the behaviors of the client as part of a complex network of interacting social and learning systems, any aspect of which may have a bearing on present troubles. Thus, in attempting to reach some kind of assessment and plan a program of treatment, the unit of attention is broadly conceived; the focus of help is no longer simply on the child brought for assessment. Rather, attention is on the whole human being within a fluid, 'real-life' situation. The analysis is functional, in that it provides a description of the child-in-situation and the relationship between the child and his/her setting.

THE TRIADIC MODEL (BEHAVIOR MODIFICATION)

As behavior is seen as a function of the total learning environment, behavior modification is not only about changing the undesirable behavior of 'problem children' but also about altering the behavior of the persons - parents, teachers and others - who form a significant part of the child's social world. The parents become the real agents of change in what may be a long-haul operation (in the case of the conduct disorders), thus contributing to the problem of extending positive changes over time. This family-orientated approach (in contrast to the clinic-based intervention) seeks to utilize the ongoing and intensive influence of those in closest everyday contact with the client in attempting to alter problematic behavior and teach new strategies; the Triadic Model, as it is called, gets around the problem of generalizing change from clinic-based sessions; after all, the parents are 'on the spot' most of the time to consolidate change.

Parents are likely to facilitate therapy because of their emotional significance to the child and the sheer commitment they have to him or her. (The opposite might also be the case, especially with some of the conduct disorders - a consideration requiring assessment and perhaps casework in its own right).

TECHNIQUES/METHODS

There is a wide range of empirically based therapeutic procedures from which to choose in planning an intervention. Among the more optimistic developments in recent years has been the application of behavioral treatments to the alleviation of emotional disorders and, indeed, even the intractable conduct disorders; methods such as differential reinforcement, time out from positive reinforcement, response-cost and over-correction procedures, have been applied to good effect. Incentive systems (token economies) are negotiated and contracted between parents and children, and some are linked to behavior at school.

In the case of older children and adolescents, therapists tend to use more cognitively orientated methods (see Herbert, 1981) including self-control training (assertion and relaxation training, desensitization of anger, role-play, behavior rehearsal); problem-solving skill-training and social skills training. A technique which has proved to be invaluable with hyperactive, impulsive children is self-instruction training - the development of children's skills in guiding their own performance by the use of self-suggestion, comments, praise and other directives.

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INPATIENT TREATMENT OF CHILDREN:

A PSYCHIATRIC PERSPECTIVE

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The treatment of children in psychiatric units is by now well established. There has been a steady development in this area since the first units were started some 40 years ago, and inpatient intervention has become part of the standard psychiatric treatment, for a small minority of children with psychiatric disorders.

Inpatient treatment is probably child psychiatry at its most complex. In addition to knowledge about psychiatric conditions, good powers of observation are required from the staff working in these units, as is the ability to tolerate and control severly disturbed behavior in an accepting therapeutic environment. The expertise comes from different areas of knowledge in what is essentially a hospital based multi-disciplinary approach. Doctors and nurses work in close conjunction with other disciplines, teachers, occupational therapists, psychologists, and social workers to deal with problems with multi-functional etiology and handicaps.

The paper describes the development of psychiatric units, indications for inpatient treatments and its outcome. This is illustrated by a survey of recent admissions to one unit.

THE DEVELOPMENT OF INPATIENT UNITS IN CHILD PSYCHOLOGY

Both the Maudsley Hospital and the Tavistock Unit in London started to treat children in specialized psychiatric units in the 1930s. At the Maudsley Hospital this was followed about a decade later by the setting up (on an inpatient unit) an adolescent unit; and in 1970, an additional unit was created for the treatment of mentally handicapped children. The number of inpatient units grew throughout the country and, from 1964 to 1976, they did in fact double. In 1972 there were 742 places and 502 for adolescents in inpatient units for a child population (under 16 years of age) of 13 million. A survey of these units in 1974 showed that most were functioning with high bed occupancy and the average waiting time for admission was 6 weeks. About half the units reported that inpatient facilities were adequate to meet the service needs of pre-adolescence, but this was less so for school age adolescents and for adolescents above school age (Court Report, 1976).

The need for inpatient services is of course to some extent dependent on the quality of other services available such as outpatient services, day units and residential special schools. But it is estimated that 20 beds will be required for every 250,000 children in the population.

The Court Report indicated that expansion was needed in some areas. There was generally a need for more adolescent inpatient units and long stay hospital units for severely disturbed children with chronic psychiatric conditions, for example psychosis or widespread brain damage. It is recommended that inpatient units should be properly integrated with community and outpatient services, and that all permanent nursing staff should have had adequate specialist training in child and adolescent psychiatric nursing with an overall ratio of at least one appropriately trained nurse per child patient. The need for day hospital services is established as 20-30 places per 250,000 total population or 20-30 places per 60,000 child population.

INDICATIONS FOR TREATMENT

The indications for inpatient treatment vary with the age of the child and to a degree also with the therapeutic orientation of the unit. For a unit with a broadly based therapeutic orientation and taking school age children under 13 or 14 years, the following will be common reasons for admission:

(1) Severe disorders unlikely to benefit from other types of treatment because of marked risk and/or difficulties in managing the child's condition (e.g. psychotic states and bizarre behavior, anorexia nervosa, suicidal risk).
(2) Separation from home is needed as part of managing outpatient treatment; for example to achieve school return in a child with school phobia and excessive emotional involvement with his parents; or when there is environmental encouragement for a child to maintain an attitude of invalidism or abnormal illness behavior following physical illness or injury.
(3) Diagnosis when the child presents with an ambiguous clinical picture.
(4) Treatment admission as for monitoring a course of drug treatment or a behavioral program (as in endogenous depression or encopresis respectively).
(5) Acute psychiatric states such as confusional states or in certain anxiety states.
(6) Neuropsychiatric admissions for investigations and monitoring of treatment; as in epilepsy with conduct or emotional disorders.

Within these broad categories, the setting in which the unit is based will determine the types of problems seen more frequently. In an inpatient unit within a pediatric or psychiatric setting, pediatric-psychiatric conditions (hysterical symptoms, abnormal illness behavior, anorexia nervosa, encopresis), and severe psychiatric disorders (psychoses, anxiety states, obsessional illness) are likely to be present. In other units, different clinical features may be more prominent. A recent paper outlines the main problems seen in a community inpatient service and will be summarized in some detail here.

Kashani and Cantwell (1983) compare 100 children aged between 7 and 12 years admitted to the inpatient service of a community mental health center in Missouri, with a matched control group of 100 children from the outpatient department of the same mental health center. There were differences in the reasons for referral between the two groups. Symptoms disturbing to the environment (frequent fighting, stealing, fire-setting), or

considered dangerous to the child, or to others were much more likely to lead to inpatient care. The major symptoms that distinguished the inpatients were temper tantrums, hyperactivity, running away, school refusal and suicidal behavior. Those children had had psychiatric assessments at a younger age, so that problems were probably more longstanding, as suggested also by the fact that they had more mental retardation and specific developmental disorders, as well as more physical illness (e.g. epilepsy) thought to be important in either the etiology or the management of the psychiatric disorder. The outpatients had more symptoms indicating transient maladjustment problems in response to stress, more academic problems and fewer parents with psychopathology.

THE RESULTS OF TREATMENT

It is not possible to summarize the results of inpatient treatment in a satisfactory way. Treatment is tailored to the individual child, so that a variety of different techniques are used to treat conditions with a considerable range of symptomatology and natural course. The parameters with which to measure improvement are necessarily different in a child with chronic schizophrenia, where treatment can alleviate, contain, and promote development within very altered personality functioning to a child with an acute affective state, where treatment may be restorative and life-saving.

Partly because of the risk for the child or others in some cases requiring impatient admission, it is not easy to set up controlled studies on the effects of hospitalization, but they have been attempted. Winsberg et al. (1978) randomly allocated 49 children with severe behavioral problems admitted to a psychiatric unit in New York, to either a community or a hospital based treatment program. All the children had been initially assessed, for between 1-3 weeks, with prolonged interviews and observations as inpatients. Few differences emerged between the two groups during the experimental treatment period. However there were basic methodological difficulties due to biases in the assessments of change made by different staff members. And the prolonged impatient observations of children prior to the treatment trial make this a test, not of the value of hospitalization, but of ongoing inpatient treatment as against intensive community work with "continuous availability, persistent advocacy and treatment flexibility." It is nevertheless intersting to note the beneficial effects that resulted from the subsequent outpatient treatment of children with disorders severe enough to have required initial hospitalization.

Other reports on the outcome of children admitted to inpatient units say more about the conditions themselves than about treatment. For example, in the long-term follow-up (8 to 23 years) of 100 children psychiatric admissions to the Menninger Clinic, a third were leading ordinary lives, a fourth had made a marginal adjustment, and the rest had a poor outcome with unusual behaviors or chronic handicaps often involving further psychiatric hospitalizations. But there were diagnostic differences and the subjects with psychotic diagnoses did worse (Levy, 1969). Similarly, in the follow-up study by Warren (1965) of patients admitted to the adolescent unit at Bethlem Royal Hospital, there was an association between initial diagnosis and outcome.

DESCRIPTION OF INPATIENT TREATMENT AND PATIENTS IN ONE UNIT

As an illustration of the types of problems treated in an inpatient unit, 22 patients will be described. They have been admitted under the care of the author at Booth Hall Children's Hospital over the last two years.

Booth Hall is a teaching pediatric hospital based in North Manchester with some 200 beds. There are units taking general pediatric cases and several specialized units treating children from a wide geographical area. The Child Psychiatric Unit has an active outpatient department with links with local child guidance services and an attached inpatient unit with 20 beds run by 3 consultant psychiatrists. Doctors and nurses work in conjunction with psychiatric social workers, psychologists and occupational therapists. There is a hospital school which the children attend from 9.15 am to 3.15 pm daily. The unit also takes day patients.

There are regular inter-disciplinary ward rounds and ward staff meetings. New cases are discussed at 'referral meetings' and these are followed by pre-admission home visits by nurses.

On the ward, children are divided into three small groups, each with its own inter-disciplinary team. There are general ward activities for all children throughout the year, including evening activities in the hospital school and local community center, swimming in the local baths, cinema and sometimes day trips or camping holidays. Children are encouraged into appropriate social interventions and responsible behavior. The ward provides the children with a variety of human relationships plus opportunities for new learning experiences, for understanding the reasons for their difficulties and for gaining more adaptive behavior and increased self-confidence.

In addition, every child has his or her own individually tailored treatment program. This may include special nursing, drug treatment, individual psychotherapy, a behavioral program, educational help and family therapy sessions. The overall progress and treatment are discussed and monitored in weekly ward rounds.

The 22 cases to be described here (13 girls and 9 boys) were all treated as inpatients. The mean age of the children was 10 years with a range of 4 to 15 years. The mean length of stay was 3 months with a range of under 1 month to 7 months. Most of the referrals came from other child psychiatrists who had seen the children as outpatients and had referred them on for inpatient admission, but almost as many children were referred by pediatricians, and a minority by general practitioners, or via the outpatient department of the hospital (Table 1).

Table 1 shows the reasons for admission, with abnormal illness behavior or hysteria being the most common problem, followed by a suspected psychotic condition or anorexia nervosa. Other problems included obsessional neuroses, anxiety states and school phobia, encopresis, attachment failure and possible child abuse.

Table 2 gives basic features of each of the 22 cases (age, sex, diagnosis, length of stay and outcome).

In addition to psychiatric nursing and teaching in the hospital school, in a number of children treatment involved psychotherapeutic sessions with doctors, occupational therapy, individually or in groups and behavioral progress. Medication was an important part of treatment in about a third. Some children were admitted primarily for observation and this did not always lead to ongoing inpatient treatment.

CASE VIGNETTES

Tracy was a 12 year old girl living with her parents and younger sister. She was referred by another child psychiatrist with a one and a

Table 1. Summary of Inpatients

Reasons for Admission	
Abnormal illness behavior	5
Possible psychosis	4
Anorexia nervosa	4
Obsessional neurosis	2
Anxiety neurosis and school phobia	2
Possible child abuse and conduct disorder	2
Encopresis	2
Fostering failure with emotional disorder	1
TOTAL	22

Referral Agent	
Other Psychiatrist	9
Pediatrician	8
General practitioner	3
Psychiatric outpatients	2

half year history of severe and incapacitating abdominal pain. This had led to several pediatric admissions, multiple physical investigations and absence from school of about a year. No behavioral, emotional, educational or family problems were reported, but it was noted that the family had marked difficulties in discussing emotional issues and that Tracy exercised a considerable degree of control through her symptoms.

While in hospital, Tracy and her parents were encouraged to communicate at an emotional level. This was done in individual psychotherapeutic sessions with Tracy and in conjoint family sessions. On the ward, the emphasis was on ignoring her pain, expecting normal behavior and school attendance. Her pain was not denied to her, but it was explained that she would improve through learning to live with it. She responded well to this approach and was discharged after 4 months (free from pain, more relaxed and able to enjoy life) to a less academic school than the one she had been attending.

Andrew was a 12 year old only child living with his divorced mother. He was referred (by another child psychiatrist) with a 6 month history of obsessional rituals, mood changes and uncooperative behavior. His mother had become unable to control him. His obsessional symptoms decreased considerably after admission but they recurred after weekend stays at home and his behavior on the ward deteriorated. There was a marked improvement on anti-depressant medications and he was discharged recovered after 5 months. At a 9 month follow-up he had maintained his improvement at home and he was coping adequately at school.

Jane was a 6 year old girl, the only child of elderly parents. She was referred from the pediatric ward where she had been admitted with a history of refusal to eat and weight loss, of about 1 month duration. This had coincided with a deterioration in her parents' paranoid schizophrenia and 'folie a deux'. There were suggestions that Jane might be sharing her parents' delusions about contaminated food, and she presented as anxious and preoccupied. Assessment on the ward established that Jane's condition was not psychotic. She became much more relaxed after admission and, although she remained faddy, she responded to encouragement to eat. Her

Table 2. Description on Inpatients

Patient	Age	Sex	Diagnosis	Months in hospital	Outcome
1	12	F	Psychalgia - school phobia	4	Much improved
2	10	F	Anorexia nervosa and depression	5	Much improved
3	13	F	Epilepsy and hysteria	4	Much improved
4	11	F	Depression and hysteria	1	Much improved
5	6	M	Encopresis	1	Much improved
6	12	M	School phobia	4	Much improved
7	13	M	Neurodegenerative disorder and hysteria	7	Died
8	12	M	Obsessional neurosis	5	Much improved
9	11	M	Mental handicap	1	Unchanged
10	13	M	Encopresis	3	Much improved
11	10	F	Anorexia nervosa	1	Much improved
12	6	F	Eating disorder	2	Much improved
13	4	M	Emotional disorder	4	Much improved
14	15	F	Anorexia nervosa	3	Much improved
15	6	F	Conduct disorder and abuse	2	Much improved
16	12	M	Mixed conduct/emotional disorder and hallucinations	6	Much improved
17	14	F	Psychalgia	2	Much improved
18	8	M	Early onset psychoses and mental handicap	3	Improved
19	9	F	Anxiety neurosis	1	Much improved
20	7	F	Eating disorder	1	Unchanged
21	10	F	Anorexia nervosa	-	-
22	11	F	Obsessional neuroses	-	-

parents were in the meantime treated by the local adult psychiatric services and the staff there attended our ward rounds regularly. Her parents were given advice as to how to manage her mealtimes, and supported in not sharing their delusions with Jane. She was closely followed up after discharge and she maintained her improvement.

COMMENT

These Vignettes illustrate some aspects of treatment in one particular unit. In units taking preschool children, different skills and organization are needed, as for example with use of mother and baby units. There is an increasing interest in the use of day patient facilities, involvement

of families in conjoint family therapy sessions during the child's admission, and in broadening the training and role of nurses with more community involvement and home visits in connection with the admission. These developments are likely to increase the scope of inpatient treatment in the future.

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REHABILITATION ACROSS THE SPECIALTIES:
A CROSS-FERTILIZATION

INTRODUCTION: ISSUES AND CONCEPTS IN REHABILITATION

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The aim of this symposium is to provide the opportunity for ideas to be exchanged and developed by looking at a common process of intervention as carried out in different areas of work.

Rehabilitation tends not to be responded to with great enthusiasm by those not working in the field. However, it is possibly unique in its ability to illustrate principles of our general clinical practice. In this introduction I hope to provide a structure within which each of the speciality papers may be placed and viewed in relation to the others. In a general sense rehabilitation can be seen as the treatment process instigated in response to circumstances which have resulted in an individual losing functional abilities - socially, cognitively or physically - such losses being the result of psychological or physical trauma and/or deprivation.

Geoff Shepard, in his recent book 'Institutional Care and Rehabilitation' (Shepard, 1984) quotes the definition of rehabilitation given by Bennett in 1978 as "the process of helping a physically or psychiatrically disabled person to make the best use of his residual disabilities in order to function at an optimum level in as normal a social context as possible."

Wing and Morris (1981) in their "Handbook of Psychiatric Rehabilitation Practice," recognizing the interaction of multiple causes in losses of social functioning, provide the following broad definition of rehabilitation in the psychiatric context: "Rehabilitation is the process of identifying and preventing or minimizing these causes while, at the same time, helping the individual to develop and use his or her talents, and thus to acquire confidence and self-esteem through success in social rules."

These definitions can lead us to the major aims of rehabilitation, which are: firstly, the prevention of any further losses of function; secondly, the maintenance and optimization of remaining abilities; and finally, the restoration of function. Any intervention program in rehabilitation can be examined in terms of these levels of intervention, as far as the aims of intervention are concerned. The levels overlap: for example, a program aimed at re-training a specific skill automatically encompasses preventive and maintenance functions. Every example of the rehabilitation process must be addressed at preventing further losses of

function or the recurrence of such losses, and the maintenance of remaining and regained abilities.

In facilitating exchanges of ideas between specialties it might be helpful here to clarify some relationships between their different terminologies. In the terms of general medicine, rehabilitation is classified as tertiary intervention, the optimizing of remaining abilities and restoration of function. The preventive aspects of medical care and rehabilitation are encompassed under primary and secondary intervention. (Primary intervention means primary prevention, i.e. health education and purely preventive measures in the absence of illness; this level of intervention is generally little involved with rehabilitation. The preventive aspects of rehabilitation fail under the term secondary intervention - that is prevention of recurrence or secondary prevention).

Often of crucial importance in rehabilitation is the choice made regarding the most appropriate level of the social system selected as a focus of intervention. In the traditional social and domestic skills training programs of psychiatric rehabilitation aimed at restoring lost abilities to long-stay institutionalized patients, the individual was the common, and quite appropriate focus of intervention. Currently, as Mark O'Callagham discusses in his paper, the situation is quite different for the 'revolving door' and 'new long stay' patients, who are generally young and can experience multiple social and emotional problems. Thus, rehabilitation now needs to consider more fully interventions at different levels of social structure, in particular the family and the hospital sub-systems.

To provide a sense of structure to the various possible interactions between levels of intervention in rehabilitation it might be useful to look at them graphically, with the two types of levels, 'aim of intervention' and 'social focus of intervention', being represented by two axes, generating something of a construct system. The social focus of intervention ranges from the individual through family, hospital ward, institution to community (Figure 1).

Work in the different specialities will illustrate and highlight different combinations of levels of intervention. For example, general medicine will particularly illustrate the preventive aspects of rehabilitation, and, as already mentioned, psychiatric rehabilitation will illustrate the significance and value of selecting the most appropriate level of the social system at which to work.

Specific interventions in all three specialties can be plotted in this system, according to their main aim and focus. Five examples are plotted in Figure 1:

Point 1 A skills training program focussed on the individual, such as a domestic skills program in psychiatric rehabilitation or mnemonic strategy training in cognitive rehabilitation, both aimed at the restoration of function.

Point 2 Family therapy in psychiatric rehabilitation with the aim of maintaining the more independent functioning of a family member.

Point 3 The development of community facilities to maintain the social functioning of rehabilitated psychiatric patients.

Point 4 An individually based behavioral intervention to increase positive health care behavior in cardiac rehabilitation, aimed at preventing a heart attack.

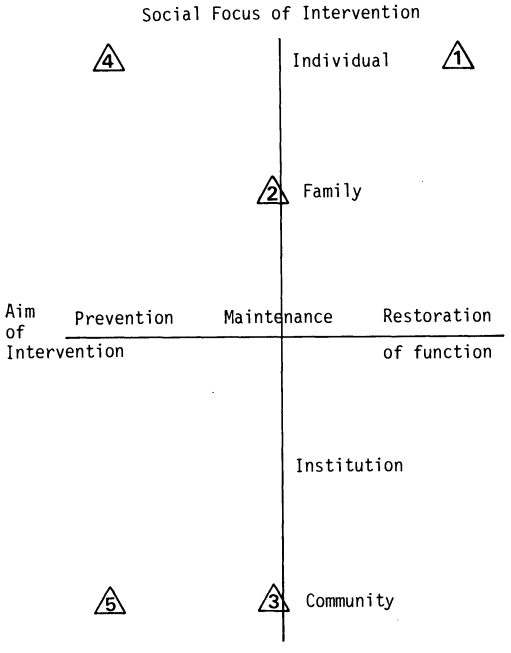

Fig. 1. Levels of intervention in rehabilitation.

Point 5 An educative program at the community level of intervention in psychiatric rehabilitation, aimed at preventing the recurrence of psychiatric problems by facilitating the integration and acceptance of discharged psychiatric patients.

The process of rehabilitation in response to the individual client in any specialty typically includes assessment, the development of an intervention plan specific to the needs of the individual, and the implementation and monitoring of the intervention. Assessment includes direct observation of functional abilities in a range of situations judged as relevant to the presenting problems, and intervention in response to the resulting formulation of the situation is often organized along the lines of goal planning, with the setting of major and sub-goals according to clients' needs and utilizing the strengths of their current situation. (The same principles can apply in interventions at all other levels of social system, but will obviously vary in practical details).

The definitions of rehabilitation above emphasized the importance of the social context of the individual, and the common goal in all areas of rehabilitation to achieve the best quality of life for the client. As for all of us this comes largely from satisfaction and success in our social existence. Hence another aspect of clinical intervention in general which is particularly salient to and illustrated by the process of rehabilitation, is the interaction of the individual with the environment, both social and physical.

Psychiatric rehabilitation is particularly concerned with the social environment, with the importance of the physical environment largely lying in its mediating capacity between the individual and his or her expression of and acquisition of practical and social skills. Rehabilitation in both general medicine and neuropsychology could be seen as illustrating a more direct concern with the interactions between clients and their physical environments as well as their social contexts.

It seems appropriate now to consider the role of the clinical psychologist in rehabilitation. Since it is inherently such an interactive and multidisciplinary undertaking, the situation often highlights the problems which normally face us (but which can often be more easily resolved) as to which level and in what capacity we choose to work. The choices are the common ones: between the individual and larger social units; between direct clinical involvement with the client and staff training, guidance and supervision; between direct clinical or training involvement and working largely in a consultative capacity.

We typically become involved in the development and facilitation of a process such as rehabilitation, and make major contributions to areas that are our particular preserve, such as assessment and planning intervention programs. Arguments prevail as to the most appropriate roles psychologists should undertake in rehabilitation, especially regarding work in psychiatry, and our understandings of these are extended by the other three contributions which make up this symposium.

Finally we come to the difficulties psychologits, and others, face in working in rehabilitation, and the problems encountered in achieving and maintaining rehabilitative change. These difficulties are likely to vary between the specialties, but will have aspects in common. In many areas of work rehabilitation involves the need to change the system or institution, and is hampered by various, possibly inevitable, resistances to change. Further difficulties in achieving an efficient and effective process are those involved in the functioning of multidisciplinary teams, and the problems of effective communication, decision making and cooperation between disciplines of potentially disparate backgrounds and philosophies. Relevant staff training may often be lacking and can result in inappropriate and unhelpful attitudes prevailing amongst the staff.

In individual instances, and in general, effective work may be inhibited through lack of access to the appropriate level of the system for intervention.

The three papers on rehabilitation which follow were prepared by authors who are specialists in their areas of work. Dr. Ed Miller's paper discusses the limitations of the gains to be made through cognitive rehabilitation after severe head injury; Mark O'Callaghan reviews the intricacies involved in approaching psychiatric rehabilitation with full recognition of the importance of the level of intervention, and Dr. Louise Wallace provides us with a clear understanding of the various ways in which psychological factors are involved in the treatment and rehabilitation of cardiac patients.

Together the three speakers provide a broad look at the rehabilitative process and the vital role psychologists can play within its various areas of application.

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REHABILITATION IN NEUROPSYCHOLOGY

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Neuropsychology is a broad field concerned with the psychological consequences of a very wide range of conditions that can damage the brain or disturb its functioning. Some of these conditions are relatively minor and cause only small and transient impairments in functioning. Others, such as some forms of brain tumor, can result in death within a fairly short period of time.

Rehabilitation for the neuropsychologist is mainly centered around conditions that are fairly static (i.e. not involving progressive pathology like most tumors or the degenerative diseases of the nervous system), that result in significant handicap, and where the expected length of survival in relatively long (i.e. years rather than months). Within this group severe head injury provides a very good example. It is encountered reasonably frequently in clinical practice, its psychological consequences can be very disabling, and since it occurs predominantly in young adult males there is a long life expectancy (at least in those who survive the immediate post-injury period).

This paper will use severe head injury as the major example because it provides a good illustration of a number of important features. The general principles will naturally apply to the rehabilitation of people with neuropsychological handicaps produced by other causes. However, there will be different emphasis when dealing with other conditions. For example, lasting and significant dysphasia is not a common problem after head injury (e.g. Hailman et al., 1971), whereas it is often of major concern in those with left hemisphere lesions of vascular origin.

In considering the rehabilitation of those with neuropsychological impairments a number of basic points or features need to be kept in mind and these will be briefly outlined.

1. Handicaps are typically multiple. In contrast to much of the published scientific work in neuropsychology with its emphasis on subjects whose picture is dominated by a single, relatively isolated impairment (e.g. patients with the Korsakoff syndrome), the reality of work in rehabilitation is that handicaps are almost always multiple. After severe head injury some degree of cognitive impairment is almost always encountered. These cognitive impairments have recently been reviewed by Brooks (1984) and van Zomeron et al. (1984) but may include such things as dis-

orders of memory, visuospatial ability and attention. It is worth noting that marked impairments in specific functions such as these can persist despite the return of IQ to what would appear to be pre-injury levels.

In addition to the cognitive impairments is a range of changes that can occur in other aspects of functioning. These are not always easy to pin down and describe but involve such aspects as emotional response, personality and the maintenance of social relationships. Post head injury patients can be generally apathetic and withdrawn, yet irritable and unpredictable on occasions. They may lack persistence and behave in socially inappropriate ways. In many ways they exhibit the kinds of personality changes associated with those who have suffered focal lesions to the frontal lobes.

Not surprisingly these changes have an impact on the victim's family as well as his social relationships in general (and here the male pronoun is used quite deliberately because the severely head injured patient is very much more likely to be 'he' than 'she'). An interesting Israeli study by Rosenbaum and Najenson (1976) studied the wives of patients who had suffered either a head injury or paraplegia whilst undergoing military services. Despite the greater physical handicap in the paraplegic group it was the wives of the head injured patients who suffered most. These wives reported more extensive life changes, they tended to be lonely and isolated, they experienced depression, and they had to assume their husband's role in the family. The wives of the head injured group saw their husband's as being changed and not the same person that they had married. This extended so far that the wives did not like to have any form of physical contact with their husbands. This picture is very like that picked up from discussions with relatives in routine clinical practices. Relatives find the personality change very difficult to cope with and the constant refrain is "He's just not the man that I married" or "He's just not the same son that we had before."

Finally, it has to be remembered that many people with neuropsychological impairments will have physical impairments as well. These often include such things as epilepsy, hexiplegia and sensory impairments. Whilst the physical aspects are not the major concern of the psychologist they do set important limits on what can be achieved and must be taken into account in planning rehabilitation programs. Nevertheless, it is generally accepted by most people working in the field of neurological rehabilitation regardless of disciplinary affiliation that the psychological problems produce more difficulties than the physical handicaps. This is particularly so in the case of head injury where it is the personality changes that are often the most handicapping feature (e.g. Bond, 1975).

2. Direct reduction of impairment is usually not possible. Although neuropsychological impairments typically show some spontaneous recovery (see Miller, 1984) it is difficult to influence recovery directly by psychological means. To take memory impairment as an example, where memory capacity is reduced psychological knowledge does not really suggest interactions that might lead to an improvement in memory capacity per se. In other words, psychological interventions do not lead to removing the basic deficit. This is not to say that psychological interventions will be of no value but that their mechanism of effect will be indirect.

Probably the only way of directly improving an impaired function that stands any chance of success given the present state of knowledge is by pharmacological means. This would be by affecting the basic biochemical mechanisms that underlie memory. So far the track record of pharmacological interventions in this field is not at all impressive. There are also reasons for believing that if any drug were to be reliably established as being of some value then its effects would be very limited (Miller, 1984).

3. The goal of rehabilitation is largely amelioration. If it is not possible to cause direct improvements in impaired functions then intervention has to be directed at amelioration or reducing the impact of impairments. The aim is therefore to assist the patient to achieve the same ends by other means and to live as normal and independent a life as possible despite the handicaps. In general terms this can be achieved in two ways; either by getting the afflicted individual to use his remaining functional capacities in the most efficient way possible or by altering the environmental circumstances so that they put less demand on the individual.

WHAT CAN BE DONE?

Neuropsychological intervention is still rather new and it is probably a fair comment to state that most effort so far has gone into devising methods of intervention and establishing their feasibility. The necessary work of testing out and establishing the clinical worth of these techniques has yet to come. The field is currently at a stage where there are many interesting suggestions and hints but it is difficult to provide hard evidence that the techniques provide real benefits for handicapped people. In this writer's opinion such evidence should start to emerge in the future, but further refinement and development of techniques may be required before this evidence really starts to emerge.

In general, most of the work that has been done so far has been concerned with cognitive deficits. The personality changes that are so troublesome after severe head injuries (and after other forms of brain pathology) have received scant attention. This is possibly because they are less easy to define and it is far more difficult to think of potentially useful interventions. They have not been completely neglected and both Craine (1982) and Powell (1981) have described attempts to deal with personality changes; but these attempts are not entirely convincing and no evidence is presented as to their success.

Miller (1984) and Powell (1981) have provided descriptions of the kinds of interventions that have been described in relation to a wide range of neuropsychological impairments. These include techniques to deal with such problems as memory disorders, dysphasia, dyscalculia and visuospatial neglect. Space does not permit a worthwhile discussion of all the different problem areas. This presentation will just concentrate on one example.

The Amelioration of Memory Impairments

The most common approach to the amelioration of memory impairments has been to look at manipulations known to affect normal learning and memory of verbal material. Knight and Wooles (1980) have outlined a number of these and they include such things as lengthening rehearsal time, improving rehearsal efficiency, ensuring the organization of stimulus material, supplying verbal labels for non-verbal material and a great many more. Most of these manipulations have yet to be tried with memory impaired subjects.

The manipulation that has attracted attention is the use of imagery. The role imagery in normal memory has been extensively studied following Paivio's work (Paivio, 1969, 1971) and it seems to be the case that imagery can improve the learning retention of verbal material by normal subjects under laboratory conditions.

Although there were earlier clinical reports, Jones (1974) was the first to test the possible role of imagery with brain damaged subjects in an experimental manner. Her main group consisted of patients who had

undergone left temporal lobectomy for the relief of epilepsy. Such subjects are well recognized as having verbal memory impairments. Subjects learned lists of paired associates with delayed recall two hours later. Those with left temperol lobectomy performed consistently worse on the recall test than normal controls regardless of the condition. Getting subjects to use imagery to form associations between stimulus and response items enhanced recall for both the experimental group and controls, at least for lists where the words had high imagery potential. The relative gain produced by the use of imagery was the same for the temporal lobectomy group as it was for the controls.

As it stands, this experiment gives encouraging results for the potential clinical use of imagery but, as Lewinsohn et al. (1977) point out, it does have limitations. The beneficial effects of imagery were not very large and this could have been because Jones used quite short lists, thus enabling some subjects to get near perfect recall and so producing a ceiling effect. In addition the retention period used was quite small, and remembering paired associates is not a task that relates very directly to real-life situations.

In their investigation Lewinsohn et al. (1977) used two tasks. One was learning paired associates of the conventional kind and the other was to link names to photographs of faces. (Head injured subjects often complain that they cannot remember people's names). Half the subjects in both experimental and control groups had attentive training in the use of imagery and all subjects learned lists of paired associates and face-name pairs to criterion. Recall was tested both 30 minutes and 1 week after initial learning. The experimental group were 'brain injured' but were otherwise very inadequately described; most probably they had suffered head injuries.

An effect of imagery was found for both experimental and control groups, but the potential value of the effect was vitiated by two things. Firstly, the benefit of imagery was manifest after 30 minutes delay but had been washed out at one week. This loss of effect with time was not due to the overall level of recall being so low that a beneficial effect would be lost (i.e. a floor effect). Secondly, the effect of imagery was less marked on the test with greater 'face validity', that is the face-name test.

There is also now quite an array of reports of investigations that have shown that imagery can enhance retention in memory-impaired subjects using laboratory-type verbal learning tasks (e.g. Binder and Schreiber, 1980; Gianutsos, 1981; Gianutsos and Gianutsos, 1979). It is possible that imagery might work by having a 'placebo' or non-specific effect, however, the one study that has looked at this issue has suggested that this is not the case (Gasparrini and Satz, 1979).

The crucial test for the clinician interested in rehabilitation is whether the use of imagery can have an effect on the kind of problems that patients encounter in their everyday lives. There is no really convincing test of this kind. Glasgow et al. (1977) report a single case study with a male student who had apparently suffered a head injury. This student specifically complained of an inability to remember the names of people that he encountered frequently. Having established that this subject could recognize faces and that the problem truly was in associating the name with the face the authors embarked on a training program. This involved teaching the subject the technique advocated by Lorayne and Lucas (1974) which is based on developing images linking facial features to their owners' names. The subject found this procedure difficult at least partially because it took him an exceedingly long time to think up suitable images

for each face-name pair. There was also no demonstrable benefit of training on the subject's ability to recall the names of people whom he actually encountered outside the training situation.

Given this situation, Glasgow et al. (1977) switched to a much simpler strategy. The subject was simply asked to write down the name of anyone he encountered on a record card when he had difficulty in spontaneously recalling the name. He had to take three cards out of his pocket three times each day and try to visualize the person as he read the name. Introduction of this procedure did have an effect, as measured by the subject's daily record listing the number of times he had encountered a person whose name he felt that he should have been able to recall but could not within a set time period. Such occasions dropped from about four per day to less than one per day. Although this study is not completely sound methodologically, it at least offers something positive obtained within a clinical setting, even if imagery itself was not of much value.

As it happens, the report of Glasgow et al. (1977) very much mirrors my own clinical experience. Head injured subjects do seem to find it very difficult to think up suitable images. Even where beneficial effects can be demonstrated by test runs using photographs linked to artificial names within the clinical setting, this is very time consuming both in terms of the amount of training required and the time taken for the patient to derive each image even when trained. Patients then report that this difficulty makes the system unworkable in everyday settings. Crovitz et al. (1979) have also commented upon this problem and describe a 'memory retraining practice set' which is a procedure for teaching people to derive images. This technique is inadequately described and no evidence as to its effectiveness is offered.

The work on imagery has thus not yet demonstrated real clinical effectiveness. Possibly this is because we have not yet learned how to use imagery effectively, or it could be that imagery is not an appropriate technique for clinical use. In fact some recent work has started to explore other techniques (e.g. the use of cueing), but so far these have not been an extensively explored as imagery.

GENERAL COMMENT

In many ways, the work on memory that has been outlined above gives a reasonable impression of the general level of development of work in this field. The fact that the amount of work invested in using imagery as a possible means of ameliorating memory impairments has not produced much in the way of a pay-off (in terms of a technique of proven clinical value) could be taken as a cause for pessimism. This would be unfortunate for at least two reasons. One is that good progress is being made in other areas, such as the amelioration of unilateral spatial neglect in those who have suffered right hemisphere strokes (e.g. Weinberg et al., 1979). The second reason for not being pessimistic is that this is a very complex field presenting a number of severe problems. To imagine that the earliest forays into the field, such as the use of imagery with memory impairments, would quickly hit the jackpot is a little naive. The important point is that psychologists are now trying to work at the problems and, with reasonable luck, their efforts should pay off eventually. There is a very large seam of potential techniques to be developed, and this is only at the very earliest stages of being mined.

Having said this there are a number of other points that should be made in conclusion:

1. The work so far has been almost entirely directed at cognitive impairments. These are the most obvious and easy to tackle, but the marked emotional and personality problems that can occur in brain damaged populations need more attention.

2. To date, interventions have been largely directed at the afflicted individual. As already indicated, the families of those who have suffered brain damage can find it very difficult to adapt to their handicapped family member. There is therefore considerable scope for interventions directed at helping families to cope with the situation of having a member who no longer behaves in the usual way, and who may be permanently unable to resume his former roles.

3. Within the concern of trying to ameliorate cognitive impairments in the victims of brain damage, the fact that presently available interventions are of limited power and require a considerable commitment of time and effort means that the selection of suitable cases for intervention may be crucial. On a priori grounds it seems reasonable to concentrate interventions on situations where a small improvement of functioning in a given area may have substantial effects on the individual's circumstances. For example, the milkman with mild dyscalculia who can almost cope with the requirements of working out a household's milk bill for the week and giving change will be a more appropriate target for therapeutic endeavor than the accountant with more severe dyscalculia in whom a much larger improvement would be necessary in order to get back to something approximating to previous occupational level.

4. There is a tendency in this field, as in many others, to overemphasize the extent of generalization. It may be necessary to direct interventions at specific circumstances rather than more general principles. Thus the use of imagery by Glasgow et al. (1977) may have had a much bigger impact for their subject if they had directed it towards the particular people and names that their subject needed to remember, as opposed to teaching a general principle for learning names and expecting the subject to apply it. Similarly, analyzing the aphasic patient's actual communication needs, and teaching the particular words and phrases required to meet these needs, is likely to be of greater benefit than trying to teach general strategies for word finding or sentence construction.

As a final comment, the rehabilitation of people with neuropsychological impairments is a new, exciting and potentially rewarding field. As with other pioneering situations, the excitement and stimulus is also accompanied by the uncertainties of treading on untested ground. I hope that this paper has illustrated both of these aspects.

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PSYCHIATRIC REHABILITATION: PUTTING PRACTICE INTO THEORY

(The Role of a Clinical Psychologist in Rehabilitation)

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McCue (1978) in an article entitled "From Enthusiasm to Nonchalance" identified five stages in the career of clinical psychologists:

1. Open-eyed enthusiasm
2. The 'revolutionary' phase
3. The phase of incipient cynicism
4. The phase of consolidated cynicism
5. Nonchalant nihilism

These five stages were intended to reflect the growing disillusionment of clinical psychologists with their career. According to McCue (1978), the final phase ('nonchalant nihilism') was one in which, "cups of tea, lunch, and going home are the high points of the working day" (p.36). Clearly, if amongst other motivations clinical psychologists enter the profession in order to better people's lives then it appears that appropriate reinforcement is not being gained from the work carried out. In other words, there is a basic lack of job satisfaction because, as the article itself suggests, patients/clients do not appear to be improving due to factors which the psychologist is unable to influence. In the field of psychiatric rehabilitation four reasons may be identified as to why clinical psychologists might fail to be effective and thus become disillusioned:

1. Their knowledge of rehabilitation may be out of date
2. The techniques they use in the field may be inappropriate
3. They need to broaden their area of work
4. They can't deal with difficulties/set-backs appropriately

THEIR KNOWLEDGE OF REHABILITATION MAY BE OUT OF DATE

Until recently, psychiatric rehabilitation appeared to be regarded as an activity which occurred in the 1960s and 1970s, especially in the United States. In clinical psychology courses, therefore, it was 'covered' in an almost historical perspective with the suggestion that it bore little relevance to the present apart from some 'back-wards' of a few particularly backward hospitals. Thus, newly qualified clinical psychologists coming into this field have had to revise their expectations of psychiatric rehabilitation which has changed in two ways:-

The Population Served by Psychiatric Rehabilitation has Changed

The emphasis in psychiatric rehabilitation in the 1960s and 1970s was on 'getting the long-stay out'. For example, in our own hospital (as in many others), whilst rehabilitation still assists 'long-stay' patients who have been in hospital over three years, over the last 25 years there has been a drop of about 50 per cent in inpatient numbers. However, the assumption by some that there would not be any new long-stay patients has not been borne out. Rehabilitation's second area of focus is presently often aimed at these so-called 'new chronics' who have about a ninety per cent chance of remaining in hospital if they have spent longer than nine months on the admission ward. In these cases, therefore, rehabilitation acts to reduce or even prevent 'institutionalization' rather than acting after the latter has exacted its toil. Further, whilst there has been a reduction in inpatient numbers, admissions have also increased; up by about fifty per cent in our own hospital. Many of those who might have been long-stay inpatients in the past now 'revolve' in and out of hospital with multiple admissions in a brief space of time - called 'revolving-door' patients - the third area of focus. In our own service these patients make up a sizeable proportion of our clientele. The fourth population served by rehabilitation are those who, instead of being admitted as inpatients as they would have in the past, are now in long (over a year) and regular contact with psychiatric services - the so-called 'high contact' group. In our own system many of these live in lodgings and attend as day-patients. Finally, with the emphasis on "Care in the Community" there is the need to deal with the more social aspects of psychological disturbance, a sizeable proportion of psychiatric hospital admissions. The term '(re-) habilitation' rather than 'rehabilitation' might be a more appropriate term in recognition that as well as restoring the 'old-chronics' to a previously higher level of functioning we may also be developing independence skills in some people who may never have possessed them.

The Needs of the New Rehabilitees have Changed

In the past patients regarded as suitable for rehabilitation often received the somewhat pejorative label of 'burnt-out chronic schizos'. It was thus suggested that their active symptoms had reduced or 'burnt-out' and that those remaining were mainly 'negative' ones which included social withdrawal, apathy and emotional blunting. These patients were also seen as somewhat passive with occasionally mild to moderate problem behaviors, mainly regarded as resulting from 'institutionalization'. Nowadays, rehabilitation helps people at different stages of the 'patient career'. Thus, rehabilitees may now have more acute/active psychiatric disorders than previously was the case. Further, one may sometimes be dealing with very severe but very infrequent problem behaviors, many of which may not be purely 'psychiatric' in nature (e.g. problem drinking, aggressive behavior, self-harm). The majority of people coming to rehabilitation would still attract the diagnosis of 'schizophrenia' although its proportion has reduced. It must be noted that at present about fifteen per cent of psychiatric hospital admissions receive this diagnosis, whereas between one third to one half the beds at any one time are occupied by patients diagnosed as 'schizophrenic'.

THE TECHNIQUES THEY USE IN THE FIELD MAY BE INAPPROPRIATE

The implications of the new needs/problem areas outlined above are that different ways of working are required in terms of the methods of training/treatment in rehabilitation as well as in the ways in which rehabilitation is evaluated.

More Appropriate Training/Treatment Methods Must be Used

'Old' rehabilitation was carried out after medication had 'done its work', prior to discharge into the community and finished at the hospital door. It dealt mainly with training up work and self-care/domestic skills (e.g. personal hygiene, cooking and cleaning) as well as with problem behaviors seen as a result of 'institutionalization'. Nowadays, we must also use a variety of methods available in the general 'mental health field', including anxiety management techniques, 'voice-control' treatment for auditory hallucinations as well as ways of dealing with severe but infrequent problem behaviors, such as those mentioned previously. Further, our general approach to rehabilitation may have to be different as well. The new candidates are often not a 'captive' population as in the past. Once one may have had a ward of long-stay patients upon whom one could 'impose', say, a Token Economy system. Nowadays, with a functionally more critical and intelligent 'consumer', one must persuade what are often regarded as 'recalcitrant' individuals to accept rehabilitation. This in particular applies to those 'revolving-door' patients who come into hospital for short spells and then leave without their real difficulties ever being adequately tackled. It also means that there is often only a short time span on which to work and therefore the 'luxury' of long assessment periods may not be available. One's perspective of rehabilitation needs to be widened to include the period before they enter the unit and after they leave. Indeed, for some clients one must have some formulation about how to help them (e.g. for those carrying out arson) before they arrive in the (non-flame resistant) rehabilitation unit! Further, with those who 'revolve' around the hospital system one must carry out careful follow-up rather than just let the individual leave the hospital and hope that they do not come back, as in the past when people were discharged to Group Homes with little or no follow-up or support.

The Need to Use More Appropriate Methods of Evaluating Rehabilitation

Allied to the changes in methods of training/treatment is the issue of the need for different ways of evaluating rehabilitation. Previously, increase in levels of self-care/domestic skills, decline in problems behaviors and high discharge rates were taken as indicators of success. Given the changes in population discussed above one must look for other outcome measures including maintaining some longer-stay patients at their present level of functioning or at least slowing deterioration in them. Further, an outcome for some people living in the community may be amount of support needed. For others it may be the prevention or even just reduction of (repeated) inpatient hospitalization.

Four other issues must be considered in the evaluation of rehabilitation.

a. We should be interested in qualitative as well as in the quantitative aspects of rehabilitation mentioned above. Thus we should no longer just be interested in how many people we discharge into the community but also in the type of life they will have once they leave.

b. We must consider efficiency as well as effectiveness of rehabilitation. This means that we must not just count how many people are discharged but also assess how the rehabilitation system is organized to get the maximum benefit from the resources available.

c. In the past evaluation has usually been carried out by a series of one-off projects which do not appear to have been used in the betterment of the service under review but rather to 'prove' the efficiency of the particular approach under study. For example, studies of staff-patient

interaction do not appear to have been used to improve the therapeutic environment of rehabilitation units but rather to show that the interaction at present is high.

d. Rather than just evaluate our own small part of the system, we must recognize what effect the hospital rehabilitation service may have on the community. In some cases the 'community' has reacted adversely to "Care in the Community" or rather the discharge of psychiatric hospital patients into the neighborhood. There is also the danger that the burden of care may shift to those who are least able (and in some cases least suited) to bear it. In particular, families now have to bear a large responsibility for caring for more incapacitated relatives, very often with little support. In time these members too may require assistance when the burden becomes intolerable and they fall under its weight. Staff in Social Services hostels who are often un- (or minimally) trained may also be in a similar situation. Evaluation therefore must occur across agencies into the community rather than concentrating upon one small section of the system.

THE NEED TO BROADEN THE HORIZON OF OUR WORK

This need to work across agencies and in particular across the divide between hospital and community services is an important and ideal opportunity for clinical psychologists, given the recent trend of a shift of emphasis of psychiatric care from hosptial to the community (both social and Voluntary Services). We belong to a relatively new profession and are therefore less likely to be firmly entrenched in either the Health or Social Services camp. There is much ignorance amongst others about what we do anyway, but we may at least be seen as not being too closely identified with medicine nor with social work. At best we may also be regarded as having an overlap of approach with both 'sides'. Thus, we may be able to pass more easily across the barriers between the hospital and community services and so encourage cooperation between the services which will assist in the transition of psychiatric care from the institutions into the community. We also have an advantage in our relative ability/freedom to work at different levels of the system. For example, we can work with social workers and nurses alike as well as with their direct managers and in turn their seniors, and can therefore influence the different levels of the system appropriately. Finally, our 'scientific' approach (reflected in our 'three R.s' - our ability to read and critically assess relevant literature, to write proposals and reports and to gather and analyze statistics) is useful in an area crying out for proper proposals with overall aims and objectives being set and evaluated. Recent discussions on 'performance indicators' are of relevance here. Joint financing arrangements are, according to the British Psychological Society Professional Affairs Board (1983) Working Party on Psychological Services in Social Services Departments "an increasingly popular method of financing innovative programs which span the responsibilities of more than one section of the public service" (p.25), especially in a time of financial stringency elsewhere. However we must be careful not to succumb to the temptation just to work in the 'community' with, say, Social Services and thereby abandon the 'long-stay' wards - we must work across the various agencies rather than in one section of the system.

This need to work across agencies is matched by the need to work at the different levels of the system, a task clinical psychologists are ideally situated to do as previously mentioned. This is the latest phase in the development of clinical psychology.

Alongside a comparatively dramatic expansion in members since the Second World War (about eight fold from the 153 whole time equivalents in 1957), the profession of clinical psychology has witnessed a shift of emphasis in the work carried out, with four overlapping phases of this development being discernible. At first they spent most of their time carrying out assessments "such as intelligence testing, providing in effect an ancillary service to psychiatrists and other medical staff," as the Department of Health and Social Security's (1975) document Better Services for the Mentally Ill noted (p.76).

In the 1960s psychologists began to get more involved in treatment. Castell (1982) has noted that in 1966 a psychologist could be expected to spend some forty per cent of his/her time on assessment alone with an equal amount of time spent on treatment and assessment combined. He reported that the figure in 1982 for the former activity was just five per cent and sixty per cent for the latter. Towards the latter end of this second phase of the development of the role of clinical psychologists, there was also an increase in the amount of time psychologists spent working through members of other professions, in particular the nursing profession. This activity of "handing over of skills," as Castell called it, was boosted by the publication of such papers as that of Ayllon and Michael (1959) entitled "The Psychiatric Nurse as a Behavioral Engineer." Despite the controversy amongst some clinical psychologists caused by this activity (Dabbs, 1982) McPherson, 1983) Castell reckoned that in 1982 some twenty per cent of a psychologist's time was spent in 'handing over of skills', compared to only two per cent in 1966. Regarding the future, Castell, as reported by Cole (1982), suggested a fourth phase which would include "continuing to demonstrate our utility in existing settings and also broadening the scope of our contribution, for example, working at different levels within Social Services and with special need groups such as the elderly and the violent" (p.31).

There has been an unfortunate tendency in clinical psychology to develop into areas of interest rather than relative need, as analysis of vacancies in clinical psychology posts serving mentally handicapped/ intellectually impaired people reveals. However, two recent interesting developments give some cause for hope. Firstly, there has been the emphasis by Plymouth Clinical Psychology Course to concentrate on special need areas such as the Elderly and Mentally Handicapped/Impaired people. Secondly, this need to work with special need groups has been recognized by the development of "Special Interest Groups" in a number of fields including the Elderly, Psychiatric Rehabilitation and Mentally Handicapped/Impaired people.

This fourth phase of the development of clinical psychology, namely working at different levels, has been advocated by other clinical psychologists, particularly those already working in Social Services (Bender, 1976, 1979; Brown 1983). Bender (1976) defined these levels as:

1. working with clients, either individually or in groups
2. working with staff in helping larger groups of clients
3. working with managers in monitoring, policy and planning

Levels one and two clearly corresponds with the first three phases of the development of clinical psychology mentioned above and which, as Castell showed, was the mainstay of the work of clinical psychologists in 1982. Clinical psychologists must now extend their work to this third level, as Bender (1979) pointed out; "If the primary responsibility of psychologists is to influence the quality of life of the client groups they relate to, they must work effectively at all these levels" (p.6, italics in original).

If psychologists wish to do this most effectively then as well as helping to train clients and assist staff involved in the training process psychologists must also help plan, develop and monitor the appropriate training environments (see Grierson, Wallace, O'Callaghan and Neil, 1984; O'Callaghan, 1982; O'Callaghan, 1983; O'Callaghan, Wallace, Davidson, Grierson, Raychaudhuri and Chaparala, 1984 for an example of a joint health, social and voluntary services rehabilitation system) consisting of six levels (see Table 1).

If psychologists do not have some influence at the 'higher levels' then their work at 'lower levels' might be (and often has been) wasted. The italics in that quotation from Bender are appropriate for there is the danger that Basic Grade psychologists may only work at the first two levels, Seniors level three and possibly four, with Principals (and Top Grades) working at the 'highest levels'. McCue (1978) noted that there was a tendency to overcome 'nonchalant nihilism' by avoiding direct contact with patients by moving up levels of the treatment system. It is important that those who have greater direct contact with patients are also involved in the planning process so that it becomes 'user orientated'. Clearly, planning and management require people with skill and experience hence the more senior grades of the profession. Thus, instead of Basic Grades being thrown into the 'deep end' of rehabilitation alone they should either specialize in this field after appropriate further experience/training or assist a more senior psychologist already working in this field.

DEALING WITH DIFFICULTIES/SET-BACKS APPROPRIATELY

One of the reasons for the growing disillusionment in the career of many clinical psychologists is their failure to deal effectively with difficulties. Unfortunately, the way courses teach clinical psychology may even compound the problem in two ways.

A. Often courses present information about rehabilitation projects mounted a long time ago in the USA, usually involving highly staffed

Table 1. Levels of Working of a Psychologist in Rehabilitation

Level	Focus		Work undertaken
I	INDIVIDUAL		Assessment
II	INDIVIDUAL		Training/treatment
III	STAFF		Overall programs
		(	(Buildings
		(Facilities	(Equipment
		(	(Fittings
		(	(Selection
IV	UNIT	(Staff	(Training/experience
		(	(Overall approach
		(	(Timetabling
		(Running	(Process
			(Resource allocation
			(Techniques
		(Evaluation	
V	SYSTEM	(Coordination	
	'SUPRA-	(Health	(Joint evaluation
VI	SYSTEM'	(Social	(Joint planning
		(Voluntary	(Coordination/cooperation

projects. Such a practice occurs throughout the teaching. Indeed, much of clinical psychology training relies on the presentation of successful cases where problems are ignored. Thus, courses do not prepare students for the possibility of failure. A 'mastery' rather than a 'coping' model is used in training. Given that adult mental health is only one of the three placements in clinical psychology, trainees are unlikely to have any experience of rehabilitation and therefore little opportunity to watch and learn from a trained practitioner coping with problems in the field. A further difficulty is that at present training concentrates more on techniques rather than looking at the more practical aspects of working in rehabilitation. Thus, for example, whilst trainees may be taught about the effectiveness and workings of a Token Economy System, little is offered in the way of helping the individual establish one. The new psychologist somehow assumes that merely to present the effectiveness of a program should be sufficient to persuade staff to implement it. Unfortunately, he/she may fail to recognize other considerations which may be equally if not more important for them. Further, as Woods and Cullen (1983) have pointed out, even when an innovation is implemented much work needs to be done to seek out ways of maintaining it. Levels Four, Five and Six require knowledge of strategies of change of institutions or systems rather than just concentrating on techniques for modifying individuals. Otherwise "organizations such as schools and hospitals will, like dragons, eat hero-innovators for breakfast." (p.212), as Georgiades and Phillimore (1975) pointed out in an much cited article on "The Myth of the Hero-innovator." Milne (1984) has provided a thoughtful review of a number of papers presenting strategies for change needed by the 'realistic hero-innovator'.

It may rightly be argued that such strategies might be more appropriate for psychologists later on in their career. Future training in rehabilitation may therefore have to be in two parts; firstly an overview and some practice at working at levels one, two and a little even on three under supervision; later there is a need to receive a training package which teaches the other levels as well. In the absence of further training, where can one get recent information about rehabilitation?

1. Published Literature

Papers on psychiatric rehabilitation can be found through Psychological Abstracts of Index Medicus. Unfortunately, in the Division of Clinical Psychology Reference List nothing is given on this topic. However, one on rehabilitation and related topics has been produced by The Kings Fund/MIND.

A number of books which provide a more practical guide than is usually the case have recently appeared. These include:

Morgan R., and Cheadle C., 1981, "Psychiatric Rehabilitation," National Schizophrenia Fellowship, Surrey.

Shepered, G., 1984, "Institutional Care Rehabilitation," Longman, London.

Simpson, S., Higson, P., Holland, R., McBrien, J., Williams, J., and Henneman, L., 1984, "Facing the Challenge," British Association for Behavioral Psychotherapy, Lancaster.

Watts, F.N., and Bennett, D.H. eds., 1983, "Theory and Practice in Psychiatric Rehabilitation," Wiley, Chichester.

Wing, J.K., and Morris, B., 1981, "Handbook of Psychiatric Rehabilitation Practice," Oxford University Press, Oxford.

2. Unpublished Literature

As the Psychologists' Specialist Interest Group in Rehabilitation Register shows (O'Callaghan, 1983) much of the literature in psychiatric

rehabilitation is unpublished and only available from the authors themselves. These papers appear to be in the main working documents and therefore offer more practical information than is obtainable in published papers.

3. From Other Colleagues in the Field

About once a year the Psychologists' Specialist Interest Group in Rehabilitation meet to discuss various issues of interest in the field of rehabilitation. The register mentioned previously also contains a variety of topics in which different psychologists in the field are working.

4. From National Demonstration Centers For Psychiatric Rehabilitation

At present there are five National Demonstration Centers for Psychiatric Rehabilitation in England. These have been designated as such by the Secretary of State for Health and Social Services to provide a model for others wishing to develop their rehabilitation services. They are:

1. Coppice (Mapperley) Hospital, Nottingham
2. Hollymoor Hosptial/Middlewood House, Birmingham/Solihull
3. Maudsley Hosptial and 'District Service Centre', London
4. Netherne Hospital, Coulsdon, Surrey
5. St. Crispin Hospital, Duston, Northampton.

5. By 'Borrowing' from Other Fields

One of the riches of psychiatric rehabilitation is the ability to 'borrow' from other fields. Thus, the experience gained from others can be put to good use here. These 'borrowings' include:

a. Mental handicapped/intellectually impaired people: 'core and cluster' - 'normalization' - assessment - goal planning - independence training
b. Elderly people: family support - crisis/relief stay - staff/careers training and support - warden controlled/minimal supported accommodation
c. Children: family therapy - 'at risk' concept - key workers - adult fostering
d. Social psychology: community surveys of 'current needs' - prevention - community attitudes - social support networks
e. Organizational psychology: systems - design and use of facilities - change.

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PSYCHOLOGICAL CONSIDERATIONS OF REHABILITATION AFTER MYOCARDIAL INFARCTION

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INTRODUCTION

General Consideration of Rehabilitation in Medicine

Psychology as applied to medicine is a growth area of research and clinical practice. However, experience in a variety of medical settings has exposed some of the many differences in the medical management of different problems, as well as the differences in perspective between psychologists and the medical profession. This paper explores and highlights the limits of the medical model as applied to heart attack patients, and points to areas where psychological models may more fruitfully interface with, although not displace, the medical model.

The principle of psychological rehabilitation as outlined in the papers by Hingley, Miller and O'Callaghan (this volume) are useful to the psychologist in medical areas. However, understanding the biomedical model and its limitations is a necessary prerequisite to the effective use of psychological skills in these areas. The medical system is concerned with dysfunction of organ systems, and the aberration in structure or function is prevented or treated. Rehabilitation, making the best use of available function, represents a failure. The medical system may cure this disease, but too often the patient 'fails' his/her treatment; for example, a plastic surgeon may heroically cure and ameliorate a patient's disfiguring facial cancer, but the patient may become self-destructive in his/her grief and unable to face making use of this new 'masterpiece'. The pitfalls of the biomedical model are similar across specialities. These include a failure to work towards psychosocial as well as physical goals, and a focus on non-compliance and psychological disturbance as products of inadequacies of the patient rather than perhaps the iatrogenic effects of 'cure'. It is argued that recent work in other areas of rehabilitation, and social-psychological research which examines the patient's role, beliefs about illness and treatment and motivation towards self-health care, will provide bridges between the biomedical and psychosocial models.

An Overview

It is impossible to do justice to the complexity of the medical and psychological literature relating to rehabilitation of MI (myocardial infarction) within the scope of this paper. However, a brief description

of the medical model of MI and the effectiveness of medical treatments and rehabilitation procedures will be provided. The contribution of psychological research to the amelioration of psychological distress and the application of psychological techniques to improve the efficacy of medical treatment and rehabilitation procedures is described. A brief critique of the inadequacies of the medical model, and of existing psychological research is given, and some suggestions regarding the possible development of psychological research and clinical intervention based on psychosocial learning principles is provided.

THE BIOMEDICAL MODEL OF CORONARY HEART DISEASE

What is Coronary Heart Disease and Myocardial Infarction?

Myocardial infarction represents the acute crisis of an underlying coronary heart disease. Like a stroke, it is, therefore, not only a life-threatening acute crisis, but it represents the acute phase of an underlying chronic disease.

There appear to be two basic pathological processes involved in coronary heart disease. The first is atherosclerotic changes in the walls of the arteries supplying the heart muscle, and the second is occlusion of the resulting narrowed artery by a thrombus (clot). The deposition of atheroma in various arteries of the body starts in early adult life and is the fundamental degenerative disorder. But it is only when the supply of oxygenated blood through the coronary arteries is insufficient to meet the demands of the heart muscle, that the symptoms of coronary heart disease are apparent. The clinical picture, therefore, is best described as a continuum ranging from a symptom free adult with objective signs of and evidence of arterial changes, through to one experiencing pain on exercise (angina) to a sudden and unexpected MI. Heart attack may occur when there is sudden occlusion of a coronary artery resulting in death of the heart muscle supplied by that artery which causes acute and severe pain in the chest. However, occlusion of the main coronary artery may occur without any symptoms at all, provided that there is sufficient circulation to the heart through other colateral vessels. By contrast, MI can occur without total occlusion of an artery due to electrical changes in the pumping mechanism of the heart.

Britain, and in particular Scotand, has one of the highest rates of coronary heart disease in the world. In Britain, approximately 94,000 men die each year from the disease and in Scotland the figure is approximately 10,000. The death rate from coronary heart disease has been rising in Britain, despite the fact that many European countries, and the United States have shown significant decreases in coronary heart disease. Coronary heart disease is the most important single cause of death representing nearly one quarter of all deaths. Furthermore, even when patients survive an acute crisis such as MI, 90% of deaths in the first year, and 80% of deaths for the subsequent year are a result of coronary heart disease. For every 100 middle-aged men who have an MI, 20% die suddenly, another 20% die in hospital in the first few weeks of the illness and of those who recover, another 20% die within the next five years. The social cost of coronary disease is perhaps impossbile to measure. Approximately 15,000,000 working days per year are lost on account of the disease (Finlayson & McEwan, 1977).

Levels of Intervention in the Disease Process

Traditionally, interventions have been designed to fit a medical model of the disease process. That is, an infectious agent, trauma or patho-

logical process causes a decline in function or aberration of structure of the organ system. Interventions are then designed to prevent the occurrences of the disease (primary intervention), treat the manifestations of the disease and prevent recurrence (secondary intervention) and ameliorate the effects of the disease (tertiary intervention or rehabilitation). The disease model therefore dictates the timing of intervention and the end points.

Criticisms of the Biomedical Model

Cardiology, the medical specialism concerned with heart function, is a highly technical and glamorous medical specialty. Not only does it involve dealing with life-threatening disease, but the scope for effective intervention is great.

However, even some of the most renowned experts in the field have begun to recognize some of the inadequacies in the medical model as applied to people with coronary heart disease, (Marriot, 1983; Nixon, 1983). In calling for a society to be set up entitled "International Society for Humanism in Cardiology" they drew attention to the excessive and indiscriminant use of medical technology, reductionism in scientific theory, the cost implications of highly technical cardiological care, the possibility of iatrogenic disease, and the importance of complementary and alternative medicine.

The causes of coronary heart disease are multiple. This has lead to the identification of 'risk factors' which predispose a person to coronary heart disease. Some risk factors are the immutable biological factors of sex (maleness), increasing age, family history of coronary heart disease, and concurrent diseases such as diabetes and renal failure. Others are changeable and include hypercholesterolemia (high blood lipids), hypertension, smoking, and possibly also sedentary lifestyle, chronic stress, type A behavior and excessive weight.

It can be seen that the foci of intervention are regarded as signs of the disease process. Traditionally, psychosocial goals have not been regarded as appropriate foci of intervention. This is in contrast to psychiatric rehabilitation where the schizophrenic patient's psychosocial well-being is generally considered of greater importance than the biochemical status of his brain function. This is even more apparent in the areas of mental handicap where functional psychosocial goals are paramount. As will be discussed below, the failure to include psychosocial goals at each level of intervention is a major weakness of the medical model.

However, there is evidence that the entirety of known risk factors do not reliably predict even half the occurrence of coronary heart disease. While in the well known Framingham studies the heart disease rate for people with one major risk factor is double that of those with no such risk factors, and it is six times the rate if three major risk factors are present, however, 86% of those with three risk factors were healthy 10 years later. Rosenman argues that the concept of risk factors has not clarified the pathogenic mechanisms of coronary heart disease. Furthermore, subsequent biochemical research has led to a host of repetitive studies and to extraordinary efforts for their modification for prevention in high risk subjects and even the public at large. Other problems of prediction and therefore of prevention have led to a wide range of strategies varying from mass intervention on a population level or high intensity interventions with higher risk populations (Rosenman, 1983). This area is highly controversial, but many have argued that these programs are costly and largely ineffective on medical criteria, that is, delay of coronary heart disease death (Oliver, 1984).

At the level of rehabilitation, despite changes in medical care which have led to reductions in hospitalization time from several weeks to under a fortnight, and increasing technicalization of care demonstrated by the introduction of computerized coronary care units (CCU's), the patients consistently report failing to reach their functional capacity, and this seems to be largely for psychological reasons (e.g. Wynn, 1967).

Also at the level of rehabilitation, patients show apparently unnecessary restriction in other activities such as sexual behavior (leading to the so-called 'coital coronary' or 'death in the saddle'); or, more exasperating to the physician, apparently reckless non-compliance with self-care recommendations such as taking medication, increasing exercise, special diets, and smoking cessation. It is as if the doctor, who has heroically snatched the patient from the jaws of death, is left unrewarded by the patient who fails to make good use of their newly overhauled heart.

Psychologists have published a large research literature on the application of behavioral psychology to medicine. The application of behavioral psychology to coronary heart disease is the best known text book example. The concept of Type A behavior as an independent risk factor has put psychologists on a footing with cardiologists, and the success of the Stanford Program of Type A behavior modification after MI on 'hard' cardiological outcomes such as recurrence of MI and death rates, provides access for psychologists to the lucrative acute medical care system. It is argued below that psychologists are essentially following a medical model, which dictates that the appropriate end points are the patient's physical state, morbidity and mortality which are only indirectly susceptible to psychological intervention. Psychosocial frameworks provide for concepts such as the patient's career and the sick role, the influence of social systems and social networks, models of health beliefs and patient's understanding of their illness and treatment, which can contribute to a greater understanding of the problems of rehabilitation across a number of specialities, and which also point to fertile areas for research and the development of potent interventions.

SECONDARY INTERVENTION IN THE TREATMENT OF MI

Medical Management of MI

Technicalized medicine is enshrined in the development of intensive care environments such as the Coronary Care Unit (CCU). The major advance has been in getting established methods of diagnosis and treatment to the patient faster (Hackett, et al., 1973). There are no 'hard signs' that are available in the early stages of a heart attack to allow differential diagnosis before admission, so the sole criteria for admission to a CCU are the patient's clinical history and presenting symptoms. Only after admission can judgement be made on the 'hard findings' of serum enzyme values, ECG changes, or radionucleied angiography. Potentially lethal arrhythmias are most likely to occur within a few hours of the onset of chest pain, and may occur without evidence of myocardial necrosis. The presenting symptoms for MI are given in Table 1.

CCU Procedures

The patient is put into a bed and kept lying down for 24 hours and may not move beyond the bed to a commode in the first 24 to 48 hours. During this time the patient is wired up for continuous ECG monitoring, a chest x-ray is taken to exclude cardiopulmonary causes of chest pain, and blood tests are taken to detect elevations in cardiac enzymes caused by the infarction or damage to the heart. Treatment is initially palliative to

Table 1. Presenting Symptoms of Myocardial Infarction

Wenger (1980)	
1.	Pain descriptions: Tight, squeezing, choking, heavy
2.	Location: Substernal, radiating down left or both arms, shoulders, arms, neck, throat, jaws
3.	Duration: 20-30 minutes, increasing over time, nor subside with rest, nor GTN medication for angina
4.	Additional symptoms: Sweating in non-axillary areas, nausea, vomiting, dyspnoea, fear, weakness, diarrhoea or urge to defecate
5.	It can also be painless - particularly in elderly, diabetic, or patients with pulmonary oedema

decrease chest pain by medication, and diet is regulated to control excess sodium which can affect the heart rate. The CCU is a specialized and technical environment in which the patient is expected to be immobilized and to have little control over their behavior, which can add additional stress to an already frightened patient. The possible influence of the patient's anxiety on specific arrhythmias gave emphasis to the endeavors of staff to minimize psychological distress.

However, the majority of early studies were largely anecdotal and psychiatric in orientation. Using psychiatric criteria, the consultation liaison staff reported that 80% of patients are anxious, 58% depressed, 22% hostile, and 16% are agitated (Hackett, et al., 1968). In a further study more than half the patients had psychiatrically equivalent levels of anxiety or depression on the CCU (Hackett, et al., 1973). However, the transient nature of the anxiety response was also noted, and they believe that less than one third of the patients required psychiatric treatment. In a follow-up of patients seven days after admission, Lloyd and Crawley (1978), believed that 35% of patients warranted psychiatric referral.

More systematic psychological studies by the Edinburgh group have been carried out despite the obvious difficulties of applying psychological assessments to acutely ill patients in a technical and public environment. They confirm that at least one third of patients have detectable psychological problems soon after admission to a CCU (Vetter et al., 1977). Furthermore, there are periods of particular vulnerability such as transfer from the CCU to the PCCU (Post-Coronary Care Unit) (Klein et al., 1968). However, 88% of patients are reassured by the CCU and transfer from the Unit is only stressful to patients who do not have a confirmed diagnosis (Cay et al., 1972; Dellipiani et al., 1976; Philip et al., 1979).

However, all the studies suffer from the problem that psychological measures of anxiety state and depression are often contaminated by physical symptoms such as fatigue or weight loss which can be physical rather than psychological in origin.

Intervention to reduce patients' anxiety is largely focused either on the application of minor tranquilizers, or on the relationship between the nurse and patient. Studies carried out in the Dudley CCU show that although coronary care nurses are aware that many patients are anxious on admission to the ward, they are inaccurate in identifying which patients

are anxious, and also the specific concerns that an individual patient has. It is, therefore, unsurprising that many patients report that they are dissatisfied with the information available in hospital, even though they are often very impressed with the technical and life-saving aspects of their care (Wallace et al., 1984; Wallace and Joshi, 1984) (Table 2).

A few studies have been carried out to verify whether changes in nurse-patient communication can influence patients' psychological adjustment to the CCU.

Doer and Jones (1979) report that preparing visitors to visit their relative on the CCU resulted in lower anxiety levels in the patient. Silva (1979) reported a similar effect for surgical patients. Preparing patients for transfer from the CCU can also reduce patients' anxiety levels (Shipley-Miller, 1981) and preparing patients for stressful medical procedures such as cardiac catheterization (Finesilver, 1980) and cardiac pacing (Wallace and Joshi, 1984) can also be effective. In addition, on the Dudley CCU the psychologist has helped to develop role-play demonstration tapes so that nurses can learn from skilled members of staff how to incorporate counseling skills along-side their more technical interventions (Wallace and Joshi, 1984).

Criticisms of the Biomedical Approach to Acute Coronary Care

The biomedical approach to acute coronary care ideally requires a patient who can:

1. Discriminate cardiac from non-cardiac symptoms.
2. Can give a coherent clinical history and presenting symptoms to enable someone to admit him to a CCU.

Table 2. Nurse estimates of ten patients' worries compared with patients' report of their worries while on the CCU (N=10)

Worries	Nurses	Patients
Environment		
1. Admission to the CCU	3	4
2. Night-time fears	2	2
3. Monitoring equipment	5	2
4. Computer alarms	1	1
5. Length of stay in CCU	1	5
6. Transfer to post-coronary ward	4	1
7. Serious illness episodes of other patients	6	3
8. Lack of privacy	5	3
Illness		
1. Being in pain	5	6
2. Information given about the illness by doctors	3	3
3. Being seriously ill	5	1
Personal problems		
1. Illness limiting social life	4	3
2. Illness limiting sex life	2	2
3. Returning to work	6	2
4. Financial worries	5	1
5. Family worries	4	3
6. Other worries	0	4

3. Can get attention from trained staff within the first one to two hours of symptom onset.
4. Will not get anxious during admission and the early infarction stage and will be able to attract the attention of nursing staff to answer any queries they may have.

As patients do not reliably behave in these ways, not all patients are well served by coronary care services, and yet there is evidence that patients welcome an active role in that they welcome information about their treatment and care.

Medical Treatment in Post Coronary Care

The PCCU period is designed to start to return the patient to normal activities, without over-stressing the healing heart. Ideally the patient is monitored during exercise and is stress tested to sub-maximal levels to detect the patient's safe limits of exercise. Observation is also necessary to ensure that any other complications such as angina are appropriately medicated, typically with nitrate therapy (GTN).

The secondary prevention and rehabilitation regime may require the patient to:

1. Take regular and possibly life-long prophylactic medication with side-effects (anticoagulant, antihypertensive or antiarrhythmic medication), and medicate appropriately if anginal symptoms occur.
2. Anticipate being away from employment or home activities for two to three months, and abstain from sex for two to four weeks after a heart attack.
3. Be prepared to take regulated walking activity as prescribed and supervised in hospital, and then take supervised exercise for the next three months.
4. Eat a low calorie, low fat and low salt diet.
5. Moderate alcohol if this is in excess.
6. Reduce physically demanding work within the first three months and change jobs if the work is of a heavy manual type or involves heavy goods vehicles.
7. Any patient who smokes will be strongly advised to give up smoking.
8. In addition to these medical aspects of rehabilitation, more psychologically oriented physicians may advise the patient to take up less stressful activities, become less stress-prone in their attitudes, and less competitive.

It is perhaps unsurprising that many patients do not adhere to the advice they are given, and may show adverse psychological reactions after their heart attack.

Secondary Prevention (Risk Factor Modification) after Myocardial Infarction

Secondary prevention after MI is defined as the reduction of morbidity and mortality achieved by special measures. As cardiovascular diseases are the direct cause of death in 90% of cases during two year follow-up (Shepherd, 1979) much interest has been focused on the modification of primary risk factors, and most interest has been devoted to the three major risk factors of tobacco smoking, hypertension and hypercholesterolemia. The major risk factors of obesity, physical inactivity and stress-prone behavior are also relevant. Discussion of just two areas is given to illustrate the state of knowledge of how well patients respond to risk factor modification.

Smoking

Unlike other risk factors such as hypercholesterolemia, there is no question of who will benefit from smoking cessation. There is a direct linear relationship between smoking cessation and reduction of incidence of reinfarction. For example, a 35 year old who smokes 40 cigarettes per day is estimated to die 8.9 years before his non-smoking age peer, and to have double the risk of non-fatal cardiovascular complications (USPHS, 1979). The potential benefits of smoking cessation for the average patient with few other risk factors far out-weigh other medical interventions.

An excellent review is provided by Burling et al. (1984) which supports the clinical 'lore' that a large number of patients do successfully cease smoking after a heart attack. The studies vary in the quality and length of follow-up, but rates of 30% - 65% cessation are reported. This is more than double that expected of healthy patients who quit spontaneously. Interestingly, the non-compliance curve parallels that of exercise therapy, that is, most recidivism occurs in the early period which in the case of smoking starts when the patient may still be hospitalized.

Interestingly, the studies where simple strong advice was given by the doctor to the patient show double the compliance rate of studies where no advice was given; see Figure 1. The implications for cost-effective service changes are obvious. The general smoking literature indicates that smoking cessation is particularly difficult during crises and where social support is lacking. These two experiences are typical for the post MI patient.

Further, investigation of the relationship between professional advice, social support and patients' beliefs about the efficacy of treatment may help us to further understand the surprisingly high rates of smoking cessation after heart attack.

Type A Behavior and Stress Management Training

The major thrust of psychological research in coronary heart disease has been to establish the Type A Behavior profile as an independent risk

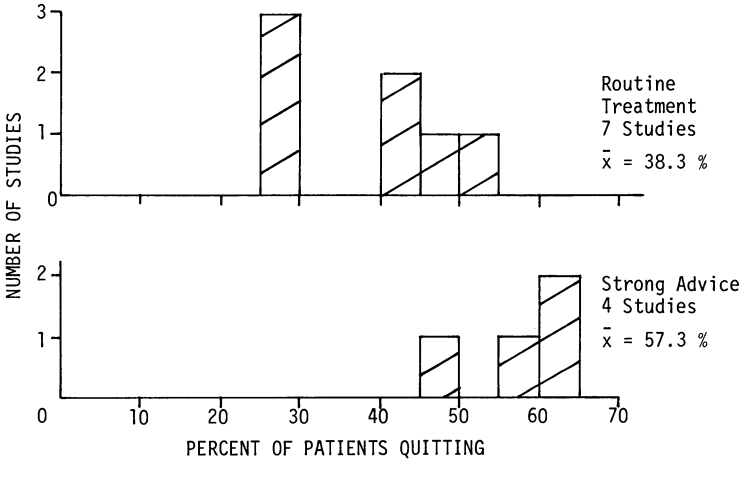

Fig. 1. Rates of post-MI cessation reported in published studies reviewed by Burling et al. (1984), as a function of the type of advice to quit which was given by the doctor.

factor for primary coronary heart disease (Rosenman et al., 1975; Jenkins, 1976). The typical characteristics include strong achievement orientation, aggression and time urgency, which are supposed to be typical of a coronary prone individual.

The Recurrent Coronary Prevention Project is worthy of description because of its explicit theoretical basis in social learning theory and careful attention to medical and psychological aspects of clinical trial design. Thoresen et al. (1982) report on the first three years of a proposed five year project. There were 1,035 patients allocated to three groups. Section one includes cardiological health education; section two is run parallel to section one and consists of a group approach to the modification of Type A. Section three contains patients receiving routine care, and section four are section one and two drop-outs.

The major findings are impressive:

1. The cumulative recurrence rate of MI favors section two (Type A modification) in comparison to section one (cardiological education). See Figure 2.
2. The non-fatal recurrence rate at the end of one year was lowest in section two, and both treatment groups have lower fatal recurrence rates than controls (Table 3).
3. There is evidence of a differential impact of Type A behavior modification on a range of Type A behavioral assessments in comparison to patients receiving other treatments (Figure 3).

There are major problems in generalizing these findings to the UK, one of which is that the measurement and validity of the Type A concept to the UK's populations has not been established. Whether extensive stress management packages are relevant to all or to a sub-set of MI patients who report high degrees of stress at the time of MI is currently being investigated in Dudley.

Since the modification of Type A behavior, by definition, involves moving patients away from their usual activities, modification of Type A is generally seen as secondary preventive rather than a rehabilitative goal. Studies in the UK have not reported compliance rates, but studies by

Table 3. The Recurrent Coronary Prevention Profect: Fatal and Non-fatal MI's

	n	Non-fatal recurrence	Fatal recurrence
Section I (Cardiologist group)	213	7 (3.3%)	2 (0.9%)
Section II (Behavior change group)	514	6 (1.1%)*	9 (1.8%)*
Section III (Controls)	124	5 (4.0%)	6 (4.8%)
Dropouts (Sections I and II)	124	5 (4.0%)	3 (2.4%)

* $p < 0.05$

Key: Section I - Cardiological Health Education. Section II - Stress Management/Type A Behavior Change. Section III - Routine Care Only. Section IV - Section I, II, dropouts. From Thoresen et al. (1982).

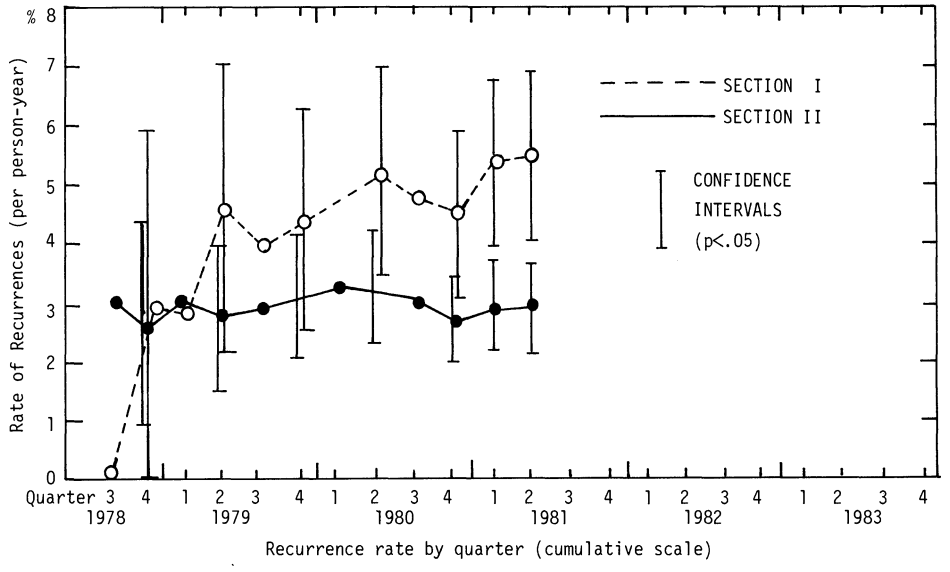

Fig. 2. The recurrent coronary prevention project: recurrence of MI. Key: Section I - Cardiological Health Education. Section II - Stress Management/Type A Behavior Change. Section III - Routine Care Only. Section IV - Section I, II, dropouts. From Thoresen et al. (1982).

Fielding in Bolton (Fielding, 1980) indicates that one major difficulty in attempting to introduce stress management training for any group of post MI patients is that of non-compliance. Little attention is given to whether Type A's have qualitatively better psychosocial outcomes as a result of changes in Type A behavior. It is argued below that patients themselves may not respond to interventions designed only to influence quantity of life, and that more immediate gains are necessary to ensure compliance. Failure to integrate the rehabilitative and medical treatment goals of Type A modification programs may explain some of the problems in achieving long term modification of life-style.

Patient Education and Secondary Prevention

Patient education has been advocated as a possible remedy to the high rates of non-compliance with secondary preventive interventions. Improvements in patients' knowledge are shown in studies by Woodward and Gauthier (1972); Gregor (1981) and Wallace et al. (1984c). Wallace and co-workers compared the efficacy of a British Heart Foundation booklet and a specially prepared booklet containing information of direct relevance to the rehabilitation program in Dudley. Significant increases in patient comprehension were shown favoring the specially prepared booklet, both while the patients were in hospital and at a four week follow-up. However, no changes were shown in patients' well-being or recovery at this stage. In one impressive study which included long term follow-ups after patients had received a fortnightly program over 12 weeks, patients showed an increase in knowledge up to 18 months after MI, but not three to four years later (Rahe et al., 1979).

Patient education has been shown to influence cardiological status in a number of studies (Woodward and Gauthier, 1972; Rahe et al., 1979), and a combination of individual psychotherapy and education on a daily inpatient basis during convalescence was also associated with fewer occurrences of

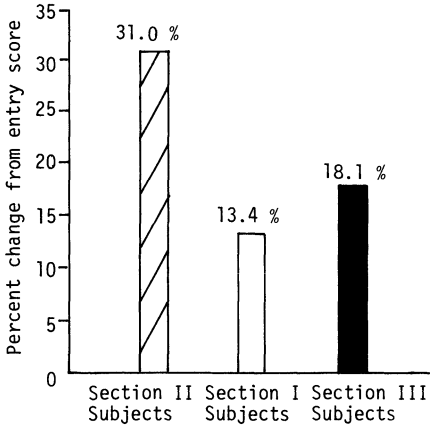

Fig. 3. The recurrent coronary prevention project: change in type A behavior (as measured by VSI) in Sections I, II and III (From entry to end of third year). Key: Section I - Cardiological Health Education. Section II - Stress Management/Type A Behavior Change. Section III - Routine Care Only. Section IV - Section I, II, dropouts. From Thoresen et al. (1982).

cardiac complications in hospital (Gruen, 1975). However, a three to four session out-patient intervention with a psychiatrist in comparison to exercise training for controls was not effective in influencing cardiological symptoms in a study carried out in Oxford (Mayou et al., 1981). However, modification of risk factors was not impressive in these studies. Possibly, therefore, the improvements in cardiological status cannot be attributed to risk factor modification alone, a finding which of course calls into question the usefulness of the concept of risk factors (Rosenman, 1983). Possibly these results were achieved through the improvements in patients' well-being and reduction of stress which are generally regarded as rehabilitative rather than secondary preventive effects of patient education.

In conclusion, the evidence for the effectiveness of modification of secondary risk factors on cardiological status is quite optimistic, but this effectiveness is marred by non-compliance in some areas, and yet surprisingly high compliance in others. It is possible that patients are confused by the dual goals of secondary prevention which aims to achieve supranormality, and the rehabilitative goals which aim to return the patient to normal activities, which may have more tangible short term benefits. However, it is argued below that too often rehabilitation also fails because the goal is to return the patient to a level of activity which is optimal rather than normal for that patient in his or her community. As such, focus on the motivation of patients to promote health in the short term, based on an understanding of how they may perceive their illness and their health goals, may be more effective.

REHABILITATION AFTER MI

Rehabilitation is traditionally concerned with the restitution of the patient to maximum functioning. In cardiological studies, this is generally defined in terms of cardiological functioning, and return to work. As would be expected, the numbers of patients who return to work will vary considerably across studies because of differences in the time of follow-up, the severity of patients' physical problems, and available employment.

Figures vary from 69% return to work by four months (Dellapiani, et al., 1976) 77% at six months (Finlayson and McEwan, 1977) and 86% at eight months (Byrne et al., 1981) and 83% at one year (Stern et al., 1976). This is confounded by the fact that some patients go back to work but give up subsequently, and the majority of patients go back to work slightly less onerous than before, or for shorter hours.

Studies that have examined those patients who apparently fail the medical system by failing to return to work have found high associations between psychosocial and emotional problems and vocational disability (Wynn, 1967; Nagle et al., 1971). But psychological reasons are not the sole reason, as Wenger et al. (1980) found that only 13% did not return to work by one year and for only 3½% of this sample was this due to psychological reasons. Interestingly, the severity of the original myocardial infarction is only found to be a predictor of vocational disability at the highest extreme of severity (Stern et al., 1976). Further, acceptance of the sick role in hospital is a strong predictor of not returning to work subsequently (Byrne et al., 1981); possibly patient education and post-discharge counseling would influence this outcome.

Returns to leisure activities have seldom been evaluated, but again these show moderate reductions even after the recovery period is complete. Mayou et al. (1979) found that 41% of the sample had reduced their physical activities and 37% had reduced their social activities at six months after MI. Several researchers find that more than half the sample report a lower frequency of or abstinence from sex after heart attack e.g. Hellerstein and Friedman (1970), and Stern et al. (1976) report that only 69% of their sample returned to normal sex after one year. Once more, patients appear to be functioning at lower than their rehabilitive potential, largely because of the lack of information and guidance available to patients on this subject (Wenger et al., 1980; Croog and Levene, 1977).

Psychological Adjustment

The degree of psychological disturbance in patients during the rehabilitation phase varies from 43% at one year (Mayou et al., 1979) to 17% - 22% for anxiety and 10% - 13% for depression at one year (Stern et al., 1976). As indicated above, the meaning of these figures is unclear as comparison to patients in the community are not provided. Pre-MI levels of psychological disturbance are not useful predictors of long-term psychological adjustment, although psychological disturbance in the first six weeks after discharge does not appear to be transient and is therefore predictive. Seventy-eight per cent of those patients who are anxious or depressed at six weeks were similarly disturbed at three months and 67% of those patients were disturbed at one year (Stern et al., 1976).

Rehabilitation Interventions

Of all interventions, exercise training has received the most study and support as a rehabilitative measure, although the problems of non-compliance are a major draw-back. Compliance rates vary from 13% at one year (Kentala, 1972) to 81% at two years by Kavanagh, et al. (1973). The rate of compliance with primary preventive interventions with healthy subjects are not a great deal better with rates varying from 50% at 18 months and 30% at four months (Oldridge, 1977) to 86% at 18 months (Oja et al., 1977). MI patients generally have lower compliance, perhaps because the reasons for exercising may initially be to promote recovery from heart attack, but once the patient has returned to normal activity by six months or so, the idea of long-term secondary prevention or of achieving rehabilitative potential beyond their pre-MI status may not be attractive.

Several studies have shown that drop-outs can be identified on the basis of psychosocial variables including the cost of attending sessions, family support and patients' beliefs in the efficacy of exercise training, (Andrew et al., 1981). As the perceived efficacy of treatment is a major fact which is also related to patients' knowledge of coronary heart disease and treatments (Tirrell and Hart, 1980), the application of patient education and cognitive behavioral methods to enhance the saliency of benefits could be employed. Exercise testing and feedback of information to patients on their cardiological functioning has been shown to influence perceived self-efficacy to carry out activities at home as was elegantly demonstrated by Ewart et al. (1980). The efficacy of behavioral and cognitive behavioral methods has been evaluated for patients with chronic obstructive pulmonary disease (Atkins, in press) and shows promise in this area.

Interestingly, relatively few parallels have been drawn with the rehabilitation of other patients. Carmody et al. (1980) have noted the downward sloping negatively accelerated drop-out curve reported in previous studies of cardiac patients, which resembles the group relapse curve described by Hunt and Matarazzo (1973) for smoking, alcohol, and heroin addiction. The literature on back-sliding shows how the determinants of dropping out early differ from the determinants of patients who drop-out later. Studies of the changing patterns of perceived costs of benefits of exercise on post-MI patients are therefore indicated before effective intervention can be designed and matched to the needs of individual patients.

Patient Education in Rehabilitation

A plea for patient education to begin in the CCU is made by Shipley-Miller (1981) on the basis of a small study of five patients who have had lower state anxiety when given structured information prior to their transfer from the CCU in comparison to five patients given routine information only. The efficacy of in-hospital information has been shown in reducing the length of stay of patients in ITU's and in hospital (Gruen, 1975); Rahe et al. (1979) also reported that patients who received information returned to work earlier at three months, six months and one year afterwards and Naismith et al. (1979) also reported that patient education was associated with patients returning to work 2.4 weeks earlier than patients who did not receive such information.

Patient education can be useful in shortening hospital stay, and even in influencing cardiological status in some studies, and in facilitating return to normal activities. But there is relatively little influence of patient education on patients' psychological adjustment. Also patient education, unless it is specifically designed to influence the determinants of non-compliance, is unlikely to be a sufficient intervention to modify risk factors.

In addition to examining the influence of patient education and cognitive behavioral methods of enhancing compliance, it is suggested that attention is given to the role of social support, since lack of social support has been implicated not only in failures of patients to achieve rehabilitation goals, but also in higher rates of non-compliance with secondary preventive interventions. Interventions designed to include the family also show promise, as the family often experience considerable psychological distress as a result of caring for the heart attack victim, and so are also potential change agents available to help the patient make a number of often radical changes in their life-style (see Finlayson and McEwan, 1977; Gentry and Haney, 1978; Tjoe and Luria, 1972).

TOWARDS A PSYCHOLOGICAL MODEL OF HEART ATTACK

Criticisms of the biomedical model discussed above have included the failure of existing risk factor models to account for the occurrence and recurrence of heart disease. Secondly, coronary care itself fails to reach more than half of its clients, and creates a number of iatrogenic problems through the over-technicalization of care. In addition, the emphasis on the passive patient role during the early stages of coronary care is at variance with the later expectation that patients should take an active role in their rehabilitation. It is also paradoxical that patients are expected not only to return to their normal activities after a heart attack, but many interventions, particularly secondary preventive interventions, are designed to return the patient to a supra-normal level of functioning. The introduction of secondary preventive interventions during the early phases of recovery and rehabilitation may pose additional demands upon the patient. Where patients lack adequate knowledge about the purpose of specific interventions, it is unlikely they will comply with medical advice.

Attempts to provide psychological interface to the biomedical model have constrained the impact of psychological intervention, and this is reflected in the number of studies which merely catalogue and attempt to predict those patients who have adverse psychological outcomes after heart attack. It is suggested that attention to the wider principles of rehabilitation as demonstrated in other areas of applied psychology could increase the efficacy of psychology in coronary care. Furthermore, it should be noted that most psychologists report working at the level of direct client referral for assessment and therapy, as discussed by O'Callaghan (this volume) precisely because they are accepting and perhaps bolstering a biomedical model of coronary care. However, it is argued that intervention at the level of service development and delivery is a prerequisite for effective intervention. The studies discussed by Wallace (1982); Wallace et al. (1984, a,b,c) demonstrate that an acknowledgement of the importance of the biomedical approach to coronary care does not necessarily confine the psychologist to dealing with the psychological sequelae of heart attack and its medical management. Further, intervention at the community and political level to influence the policy of employers towards heart attack victims, and towards the community and relevant industries at large such as the food, tobacco and drug industries are also possible foci of a psychosocially oriented model of heart disease (see Leventhal and Cleary, 1979).

A plea for a psychosocial model in addition to the biomedical model has been made, although we are only at the stage of providing strands of evidence towards such a model, rather than providing comprehensive new theories. Examples of development in psychology of relevance to coronary rehabilitation include the areas of social support and health beliefs as discussed above. Also of relevance are the social cognitive information processing models of Leventhal and Everhardt (1979); Skelton and Pennebaker (1982). The essence of these models is that the individual is an active information processor. People analyze, experience and integrate information about their illness and treatment to make schema or representations of actual and potential harm. People also make action plans, and monitor the effects of actions against criteria which are set to assess the success of coping efforts. It is therefore a self-regulatory model.

The basis for hypothesis development of the causes of chest pain may be past personal experience (e.g. previous chest pain) and experience of other people with apparently similar symptoms, or information gained from professionals. However, people may not hold the same schema as their physicians, and may not understand and therefore follow medical advice. A

study by Rudy (1980), shows that the majority of patients attribute heart attack to stress, but they regard this as an immutable cause. A post-MI patient who is told to take exercise may not comply because she/he believes the heart is damaged and should not be put under strain. Further, many patients appear to believe that heart attack is an acute illness, resulting in a temporary weak link in the heart machinery, and that therefore repair by medication or surgery should be sufficient. The patient who has such an acute illness model representation of heart disease may only feel it is necessary to cater for each occurrence of chest pain, for example, by taking GTN pills, rather than to change other health behaviors such as smoking and exercise which are life-long habits and appear irrelevant to acute crises. Further, one third of MI patients admitted to a CUU did not believe that they had had a heart attack (Tjoe and Luria, 1972). Investigation of cognitive representations of heart disease is an area of useful further research.

As indicated above, many patients do not use the medical system efficiently, with over half the patients not reaching hospital before a fatal MI occurs. The literature suggests this may be because the most relevant schema for the cause of chest pain and other symptoms is not called to mind. Symptoms of chest pain can be ambiguous in that they are intermittent and they may not occur over the supposed site of dysfunction. Many patients do not understand the concept of referred pain. Similarly, it may be difficult for the hypertensive patient who is asymptomatic to believe they have a chronic and life-threatening illness (Nerenz et al., 1982).

The patient may not only interpret information concerning their health in line with an acute schema, they may be differentially sensitive to information that fits this schema. Hackett and Cassem (1969) report that MI patients may fatally delay seeking help for chest pain, misperceiving their symptoms as caused by indigestion. As much as 68% of this delay is attributable to patients' uncertainty in the face of symptoms. Patients may seek information to support or confirm this hypothesis, by recalling what they ate, palpating the stomach or taking anti-acid medication. However, people tend to find verifying information rather than discomfirming evidence (Snyder, 1979). Hypothesis testing based on recalled experience or comparison with others is using inaccurate data on which to test a hypothesis. Further, the social psychological research shows that individuals are resistant to changing hypotheses; that is, they perseverate (Ross et al., 1975). Simple information given to people in the community and to heart patients about the meaning of symptoms may therefore be ignored if it does not fit with the patient's schema.

Psychological research into how patients understand their illness and treatment, how they develop and test hypotheses and encode new information about treatment, their understanding of the importance of self-care and life-long change in habits may well be prerequisite to the design of effective psychological interventions. Investigation along these lines is likely to build the bridge between biomedical and psychosocial principles of rehabilitation.

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NEW DIRECTIONS FOR PSYCHOLOGY AND THE LAW

NEW DEVELOPMENTS IN PSYCHOLOGY AND THE LAW

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At first glance the inclusion of a symposium on forensic issues in the present conference program might seem a trifle anomalous. On the one hand it may be seen as a somewhat specialist, almost exotic branch of psychology, with little in the way of general interest. Even if a certain breadth of appeal were acknowledged, to hold such a symposium within three years of one on 'Forensic Issues in Psychology' might seem a trifle premature. Overall, then, the convening of the present symposium might seem open to criticism on the grounds of specialism and prematurity.

Ten years ago such a criticism would, perhaps, have had a certain justification. The present picture is rather different. Other symposia in the conference concern such issues as rehabilitation, work with children, and addictive behaviors. Each of these, and other areas not included, may involve some forensic element. Addictive behaviors have long been associated with legal issues; a substantial proportion of crime is committed by juveniles; and of course much rehabilitation involves ensuring that an individual will not in future fall foul of the law. In addition to such links, however, which have existed as long as the specialities themselves, recent years have seen an increased relevance of legal issues to the broader fields of psychology.

In appreciating this it is perhaps helpful to consider the present situation in terms of its historical development. The life of the historian is a difficult one, even for the professionals. An account of historical development by an amateur can be little more than speculative, particularly in a field where, as I shall argue, recent change has been rapid. Nevertheless, in the absence of any account by professional historians, I intend to identify three phases in the growth of criminological and legal psychology. These consist of a formative stage, with the first involvement of psychologists, an establishment stage, with the formalization of such involvement, and a recent stage of growth and diffusion, paradoxically characterized by almost every psychologist becoming at least to a slight extent, a forensic psychologist. Such stages merit closer examination.

FORMATIVE STAGE

For a long time the law managed quite well without the benefit of professional psychologists. It had little choice; in this country psy-

chologists have been around for a hundred years or so, the law since before the Norman Conquest. Perhaps the single most significant 'admission ticket' to the legal process for the psychologist has been the psychometric tests, and in particular the intelligence test. Once the issue of mental health's general relevance to the legal process had been established, the way was paved for psychologists to contribute, by the use of standardized test, to such questions as the issue of diminished responsibility, the role of intellectual impairment and so on. Moreover the early days of Clinical Psychology inevitably brought practitioners into contact with individuals who had clashed with the law. Coupled with the specific research skills of the psychologist, of political value in the assessment of attempts at reform etc., the combination of clinician/researcher enabled psychology, it could be argued, to put not one foot but two in the door of criminology.

It is important to remember, however, that in these early days the role of the psychologist might be to perform statistical analysis on figures for recidivism, or conduct a psychometric assessment on a remanded prisoner. The interpretation of the results of such procedures would typically be by a non-psychologist. Civil servants, administrators and politicians would decide on policy, retaining the right to ignore or even totally misunderstand the results of research. The results of psychometric assessment would usually be passed to a psychiatrist who would decide on interpretation and their presentation (or otherwise) in judicial proceedings. The notion of the psychologist as a responsible independent professional had yet to obtain any material substance. Yet despite such problems psychology had gained its foothold; its next task was the consolidation of its position.

ESTABLISHMENT STAGE

Once psychologists had become involved in legal issues it was perhaps inevitable that they would demand, and earn, a more substantial and independent role. The establishment of forensic psychology was characterized by many events, but perhaps most obviously by the emergence of the forensic specialist; psychologists began to be employed in a number of settings directly concerned with the law. Perhaps the most obvious, and certainly amongst the most significant, was the increased employment of psychologists by the Prison Department and the Special Hospitals. A couple of example may illustrate this kind of growth. Moss Side Hospital, in Liverpool, had in 1973 an establishment of one Principal Clinical Psychologist, filled at the time by a psychologist of Senior Grade. Ten years later the same department boasts an establishment of six Senior, one Principal, and one Top Grade Clinical Psychologist , together with a support staff of graduate psychology technicians and a departmental staff nurse. Similar growth has been apparent within the Prison Department. The first Prison Psychologist was appointed in 1946. Twenty years later there were over forty psychologists in the Prison Department, a figure which itself doubled over the following ten years (although it should be noted that many of these were not clinically qualified). Besides the obvious areas of Prison and Special Hospital psychology, psychologists were also increasing their involvements in such settings as criminological institutes, centers for legal studies and the like. Concurrently many workers in other fields were turning to psychology as a subject of study; one of my own recent students was a Detective Inspector in the Police force. Psychologists even found themselves constructing theoretical models to account for criminal behavior, though it is fair to say that no general model of criminality has had notable success, and that many workers in the field now consider such broad theorizing to be misguided in principle.

Of course such growth has led to an identifiable 'professionalizing' of the field, the most striking feature of which was probably the foundation, in 1977, of the Division of Criminological and Legal Psychology of the British Psychological Society. Whilst the profession still lacks a formal qualification for forensic psychologists, the criteria for Divisional membership imply the need for a certain degree of expertise. Professionalism has been paralleled by a marked extension of the activities of the forensic psychologist. Whilst still involved in such fields as assessment and evaluation, the psychologist is now much more likely to be recognized as the only person qualified to interpret the results obtained. Thus in settings such as the courtroom the psychologist is now much more likely to be the one who interprets information and gives opinions - the appearance of the psychologist as the 'expert witness'. Such a role, incidentally, is increasingly being extended to the civil courts, with psychologists giving opinions on such issues as the effects of brain damage where claims for compensation are being made.

Psychologists, now, are clearly established as an important part of most forensic institutions. The development of the Regional Secure Units, for example, has involved not only the employment of psychologists but, in some cases at least, the involvement of psychologists from the early stages of planning and determination of operational policy. As far as the forensic field is concerned, the psychologist seems to be here to stay.

It is possible, at this point, to be a little more speculative, and to suggest that not only are we at, or at least near the stage of Establishment of forensic psychology, but that we may indeed be entering a third stage - that of integration. Despite the hazards involved in futurology, it is perhaps worth considering briefly what is happening now in the forensic field, with implications for the future.

INTEGRATION STAGE

An interesting possibility for forensic psychology goes beyond the notion of 'another speciality' to the observation that forensic psychology, at least to some extent, may become an integral part of clinical psychology generally. The extended role of the forensic psychologist has paradoxically brought us to the position where many 'non-forensic' clinicians may find themselves involved in legal issues. Psychologists in many fields may be called upon to act as expert witnesses. The role of the neuropsychologist has already been alluded to, and those working with children or parents may find themselves giving opinions in court on such matters as child custody in divorce cases and the like. Recently the Mersey Region has seen at least two criminal cases where the defendant has been required to see a clinical psychologist as a condition of probation; in neither case was the psychologist concerned working primarily in a forensic setting.

A further role for the psychologist has resulted from the formation of the Mental Health Commission, described by the DHSS as including '... lawyers, nurses, psychologists, social workers and laymen in roughly equal numbers'. The psychologists appointed to the Commission have not necessarily been those working primarily within a forensic setting, and once again we see a forensic role extending to the 'non-forensic' psychologist.

In the light of these developments it is valuable for clinical psychologists in general to be kept informed of activity in the forensic field. The speakers in the present symposium do much to provide such information. To be able to obtain information at this early stage regarding developments such as the Regional Secure Units and the Mental Health Commission is particularly fortunate, and likely to be of value to many

clinicians. The developing role of the psychologist as an expert witness is one which has, as yet, been little researched or discussed in the literature. Fortunately Dr. Jones' research is as close to an up-to-date account as could be required or expected, and promises to be of value to psychologists in many specialities.

Finally it is important in an area like psychology to beware of becoming too parochial. Whilst the prize concern of the present symposium is with forensic psychology in the United Kingdom, there is an obvious - value in comparing this viewpoint with one from overseas. The Dutch legal system has earned the admiration of many, not least because of its acknowledgment of the need to understand psychological factors in crime. Professor Beyaert's paper permits an insight into some of the issues involved in considering a particular type of offence, besides giving a wealth of information on the operation of the law in Holland. Psychologists concerned with the law in the United Kingdom may learn much from a society where the law operates, in many ways, dramatically differently.

Overall the four papers presented in the symposium provide a coverage of major issues in psychology and the law. The next few years, revealing how these develop, may well be of interest to us all.

REGIONAL SECURE UNITS[+]: THE EMERGING PICTURE*

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Up to about the 1950's, National Health Service (NHS) psychiatric hospitals in England and Wales had secure locked wards with staff experienced in dealing with difficult, moderately dangerous or disruptive patients. The conditions in these wards were often unsatisfactory and the pattern of care became progressively less acceptable with the spread of open-door policies, effective new psychotropic drugs and the enlightened forms of rehabilitation and community care which came to be reflected in the 1959 Mental Health Act.

One consequence was increasing pressure on the prisons and the high security special hospitals administered directly by the Department of Health and Social Security (DHSS). Courts often had to award prison sentences when hospital disposals would have been appropriate. The special hospitals became progressively overcrowded owing to the increased referrals and difficulty in transferring their own improved and no longer dangerous patients for further treatment and rehabilitation in NHS hospitals.

In 1961 a Ministry of Health Working Party recommended:

1. That a proportion of psychiatric hospitals should retain secure facilities with 'to and from' transfer arrangements within each region.

2. That a number of centrally financed special diagnostic centers, functionally intermediate between NHS and special hospitals, should be established for the assessment and treatment of patients presenting particularly difficult problems, and for research in this field.

Only one center, dealing with adolescents, was in fact established in response to this report.

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* The research upon which this paper is based is supported by the Department of Health and Social Security. Any opinions expressed are the authors' own.

+ This paper refers only to secure units for the treatment of adult mentally ill patients. Similar units have been established to care for mentally handicapped and adolescent patients.

Two, more effective, official reports were published in 1974. The committee on Mentally Abnormal Offenders, chaired by Lord Butler, issued an interim report (Home Office and DHSS, 1974) to recommend the urgent establishment of regional secure units (RSU's) within the N.H.S. to provide an initial 2,000 places. A DHSS working party, chaired by Dr. Clancy, had already suggested (DHSS, 1974) that 1,000 places would be required to deal with referrals from hospitals.

In response to these reports, the DHSS provided revenue allocations from 1976/7 and set aside appropriate capital sums for the provision by regional health authorities (RHA's) of an initial 1,000 places by adapting old buildings or constructing new.

The proposed units were intended to be integrated into the psychiatric services of a region to provide a medium security element in a range of facilities from intensive care wards to the high security of the special hospitals. The major characteristics were to be:

1. Acceptance of referrals from all sources including prisons and the courts.
2. Security achieved largely through intensive treatment and high staffing ratios within good physical perimeter security.
3. Admission restricted to patients whose condition is likely to respond to treatment within 18 months to 2 years, at least to a degree which allows transfer to a less secure setting. This criterion was thought to exclude most psychopaths.
4. Admission criteria primarily behavioral not diagnostic.
5. A multi-disciplinary approach to treatment and care.

The Royal College of Psychiatrists (1980) published a comprehensive policy document on secure units. This report emphasizes that the size of the problem is very difficult to judge and existing estimates of the need for places are very crude. Also that it is equally difficult to define precisely the types of patients requiring these places. They would not be persistently dangerous but would be unpredictably and periodically uncooperative in ways which were dangerous or threatening to themselves or others and to a degree beyond the management capabilities of ordinary psychiatric units. Many would not be offenders and some would be suffering an acute psychiatric disorder requiring short-term treatment. Probably more than the 15% estimated in the Clancy Report would be women, and this should be catered for in planning facilities. Stress is laid on the principle that it is behavior not diagnosis which should determine admission, but that potential treatability is an essential criterion. This would not exclude those of psychopathic personality who, as pointed out in the Butler Report, may well benefit from appropriate treatment.

An important aspect of the Royal College Report is the comprehensive policy which it advocates. The main features of this are:

1. That secure facilities should be planned at inter-linked regional, sub-regional and individual hospital levels.

2. Sub-regional units of about 15-20 beds, to cater for care at a security level less than that at RSU level, might be based on existing interim facilities when replaced by regional units.

3. The essential professional services are considered to be: a) forensic psychiatry b) nursing - provided by staff adequately trained for this specialist role c) clinical psychology d) social work e) occupational therapy.

4. It is considered vital that a secure unit operates in close liaison with, in addition to other psychiatric services, social and community services, probation services, prisons including the prison medical service, and the special hospitals. Admission must be fully justified on security grounds and only for a limited period. Any patients who present long-term management problems which prove non-susceptible to active treatment will need to be transferred to a long-stay psychiatric hospital or a special hospital.

5. Finally, research and evaluation should be one important function of appropriate unit staff, and there is also a great need for broader operational and epidemiological research in this area.

Despite strong Departmental encouragement and the provision of financial resources, the response of RHA's has been slow, in some instances very slow. Among the factors affecting progress have been staff and trade union difficulties, resistance by local residents and competing clinical priorities. Even where units have been established, there are considerable staff recruitment difficulties.

According to recent government statements, there is still a commitment to provide 1,000 RSU places and 6 such units are operational, 4 in the course of construction and a further 4 planned. Several interim secure units (ISU's) have also been established in converted accommodation, but most of these are likely to be discontinued when the new units are completed. Nevertheless at present there are few more than 100 beds staffed and available for use in permanent units. By the end of 1986 about 500 beds are hoped to be available. Meanwhile, some 200 beds are available in interim units.

At this stage of development it is important that research be carried out to examine the functioning of the earlier established units, to seek answers to the following broad questions:

1. How does the RSU/ISU run?
2. What are the characteristics of the patients admitted?
3. What are the characteristics of the patients refused admission?
4. What happens to the patients during their stay?
5. What happens to the patients on discharge or transfer?
6. How does the unit relate with outside bodies such as psychiatric hospitals, police, probation services, social services, etc?
7. What are the roles of all the types of staff?
8. How do the patients spend their day?

The answers to these questions are necessary to arrive at answers to various policy questions:

1. Are RSU's an appropriate solution to the problem they were set up to solve?
2. Do all regions require RSU's?
3. What are the implications and effects of the units on regional forensic services, regional mental health services, regional local authority services and regional prison services?
4. Is there need for Butler's proposed second thousand beds?

This, then, was the need to which our own research is a partial response. It has to be an essentially descriptive project, descriptive of an expanding and evolving picture, from which it is hoped to extract some findings of clinical and scientific interest as well as those with policy implications.

The main constraints and practical difficulties are:

1. The limitations of a 3-year study staffed by one half-time director, one research fellow and one secretary.
2. Owing to the state of flux in all regions, changes of circumstances, policy and practice are inevitable during the course of the study.
3. As it is desirable to include all the patients entering the systems examined during the period of active study, referral and admission data will become available for all but mid-treatment data will be incomplete, and discharge data more so.

The study which went into the field on the 31st March, 1983 and is now at a half-way stage, is based on a sample of 7 of the 14 English RHA's: Yorkshire, North Western, Merseyside, West Midlands, South East Thames, Wessex and South Western. These represent a wide range of geographical, economic and socio-cultural variation as well as varying forms of secure provision.

Within these regions there have, so far, been 10 active ISU's ranging from a 6-bed, single sex unit to a 25-bed, mixed unit, and 2 permanent RSU's, neither of which is yet fully operational; 10 of 30 beds were available at Butler Clinic, Dawlish and 30 of 50 at the Scott Clinic at Rainhill. Two other RSU's will open shortly.

Five hundred or so patients have so far been encountered. During the course of the study it has been found necessary to greatly expand and modify our data sheets. For example, the bald statement of a conviction is usually a very poor reflection of an offender's actual behavior during the relevant incident as, say, when very bizarre violent behavior may be simply recorded in criminal records as assault. On the other hand, that behavior and the patient's subjective experience may become the subject of intensive clinical investigation in a unit where its relevance to treatment may be greater than the psychiatric diagnosis.

Full analysis of the data must await the end of the field-work as the relevant computer programs demand that the entry for each patient is complete. The majority of the patients have yet to be discharged and, among those who have been, gaps often remain to be filled, for example concerning criminal records.

Nevertheless, a preliminary simple analysis of the data concerning the first hundred discharged patients in now in progress. This can be misleading as this hundred does not represent a sample of the whole 1,000 or more ultimately to be included. For example, durations of stay will, inevitably, be unrepresentatively short for early leavers and the growing number of patients referred for assessment are likely to be over-represented. Numbers are also too small for unit differences to emerge.

What we propose to present in this paper is a number of qualitative and approximate quantitative statements with comments based on all the data accumulated so far, most of which have yet to be formally analyzed. These will best represent what we see as the emerging picture.

The ages of patients at the time of admission range from around 16 to nearly 70 with a mean around 32. The distribution appears to approximate to a normal curve with the lower end sliced off at about 17, as would be expected.

About 30% of admissions are of females, which confirms the Royal College of Psychiatry prediction that more female places would be required than the 15% originally predicted in the Clancy Report.

Although some 80% of the patients are white, native-born British, almost all the remainder are black or of mixed racial stock with West Indian associations. A substantial number of these were born in Britain but a common pattern is for the pre-adolescent years to have been spent in the care of grandparents in the West Indies before joining parents already in Britain. These patients are mainly seen in those units serving certain inner-city areas. These may then have to take particular cultural factors such as Rastafarianism into account. Problems deriving from such cultural differences are less evident in areas such as Merseyside where there has been a large black population for many generations.

Unit differences will also probably emerge in relation to the sources of referral but it is too early as yet for these profiles to emerge. Overall it seems that 4 types of referral source account, almost equally, for some 90% of the patients.

On the basis of the data at present available the special hospitals account for nearly 20%, but this may be underestimated as many special hospital patients come with long-term restriction orders and their discharge may be delayed by Home Office reluctance to consent.

Around a quarter come from prisons and related institutions and over 20% are referred by Courts, remand centers or defence solicitors. Both of these general areas of referral may figure large where the unit psychiatrist also has a strong external forensic practice and close relationships with one or more prisons. Courts already send patients for assessment while on bail. This type of referral is likely to increase from October 1984 when further sections of the 1983 Mental Health Act are implemented.

General psychiatric hospitals and units constitute the fourth main source and account for about 20% of admissions.

The remaining approximately 10% of patients are referred from a variety of sources mainly of a community nature involving social workers, general practitioners or the police. A few are transferred from other secure units, usually within the same region.

Consistent with this distribution of referral sources, some 50% of the main reasons for security referral are of a forensic nature, either Court Orders of one sort or another or the transfer of 'mentally ill' convicted or remand prisoners. The substantial number of special hospital patients, often rather institutionalized, require a period of graduated rehabilitation into the community or before transfer to an open psychiatric hospital ward. The other main reason (which may be additional to a Court Order) is current behavior which is dangerous to the patients or to others. Several of the transfers from psychiatric hospitals result from attacks on hospital staff or other patients. There are a variety of other less frequent reasons including the self-referral of patients who have had previous contact with a unit and fail to cope with life in the community.

Owing to the intimate nature of the community within a unit, referred patients must be acceptable to the staff as a whole, especially nurses, before admission is granted. Therefore, except in case of emergency, although a unit psychiatrist has probably interviewed the patient at an earlier stage, a multidisciplinary assessment team usually makes a follow-up visit.

The main criteria which appear to actually determine acceptance are:

1. Whether or not the patient could be nursed in an ordinary psychiatric ward.

2. The need for specialized in-patient forensic psychiatric assessment.

3. The seriousness of behavioral problems such as threats of violence, disruptiveness or fire-raising. However, a significant proportion of patients would not pose a threat to the community if at large and can be granted early parole even when there is a high risk of absconding.

4. The likely duration of treatment.

5. The willingness of the patient to accept and cooperate in unit treatment. This may not apply, for example, to some otherwise appropriate 'mentally ill' prisoners.

Data concerning rejected patients are being collected but it is not possible as yet to generalize concerning the reasons for rejection. Many referrals are quite inappropriate, displaying a misunderstanding of the nature and purpose of units. It is also difficult to assess how many acceptable patients cannot be accommodated owing to lack of available beds.

As would be expected few patients in secure units have informal (voluntary) status, except those, about 10%, being treated as a condition of bail or probation. About 45% of admissions have been subject to relevant Court Hospital Orders under Part III of the Mental Health Act (Section 60 of 1959 Act, Section 37 of 1983 Act). Of these over half are subject to restriction orders (Section 65, 1959; Section 41, 1983). A further 10% are likely to represent transfer from penal institutions (Section 71 and 72, 1959; Section 47 and 48, 1983). Few of these are subject to orders placing restrictions on their discharge after the expiry of their prison sentence (Sections 73 and 74, 1959; 46 and 49, 1983). The largest group of non-forensic patients, approaching 20% of the total, are subject to Part II compulsory treatment orders (26, 1959; 3, 1983). Orders under other Sections of the M.H. Acts are comparatively rare as are those under other acts such as the Criminal Procedure (Insanity) Act, 1964.

Over half the patients are diagnosed as suffering from schizophrenia, almost always of the paranoid type and often experiencing delusions which are directly related to the behavior which brings them into a more secure unit. A few are more aptly described as paranoid than as paranoid schizophrenic. Over 15% have affective disorders, usually depressive and often very severe. Again delusions are likely to be relevant to the behavioral disorder. Depression is also often a secondary feature. The units under study are not intended for the treatment of the mentally impaired but, nevertheless, several patients have minor degrees of mental handicap and for a very small number of patients this is the major diagnosis. Approximately 15% - 20% of patients have a primary diagnosis of psychopathy or behavior disorder, but for about one third of these there is also an important secondary disorder such as schizophrenia, mental or neurological impairment or some form of sexual disorder. Conversely, some form of personality disorder commonly occurs in association with schizophrenia. Clearly, not all psychopaths are considered untreatable by forensic psychiatrists. Alcohol or drug abuse is a complicating factor in about 5% to 10% of cases.

In terms of the formal categories of the Mental Health Acts, approaching 70% of unit patients are classified as suffering from 'mental illness', around 15% as psychopathic, about 5% are as mentally impaired or placed in dual categories involving mental impairment. The so-called mentally impaired are usually special hospital transferees and, often formal intellectual testing is inconsistent with the label.

The vast majority of patients have a previous psychiatric history. For only about 15% does the unit represent a first hospital admission. An equal proportion have eight or more pre-admissions with the remainder fairly evenly spread from one to seven pre-admissions.

The pattern of treatment and care is very similar in all units. The vast majority of patients receive psychotropic medication which, at later stages of rehabilitation, becomes of the depot variety. All, so far as they are able, join in a general ward program and, following an assessment of their behavioral problems and social and educational deficits, more specific individual programs with multi-disciplinary staff participation. Concurrently, most patients also pass through a graduated sequence of escorted and unescorted parole within and away from the hospital grounds and trial leave before discharge. Discussion groups figure prominently in the program as do social skills training and various forms of occupational and industrial therapy. Formal individual behavior modification programs are applied but far less frequently than we expected. The same is true of remedial education which is often highly desirable. One would expect many management problems deriving from the behavioral history of unit patients. Outbursts of aggressive or self-mutilation behavior do occur as do other forms of disruptive behavior. Nevertheless, the unit staff, presumably owing to their specific training and the good staffing ratios seem to have better forestalling and coping techniques than elsewhere. For example, seclusion of patients is less frequent and for shorter periods than is common in many general psychiatric hospital wards.

The social and family histories of these patients are typically very unfortunate. Early childhood has been subject to some form of disturbance for some 50%. One West Indian pattern has already been mentioned. Others include the death of a parent or parents, desertion and family violence. Many patients have spent part of their early life in care, remedial or penal institutions. Consistent with these disadvantages there is a typical educational and occupational history of minimal schooling, lack of qualifications and skills and unstable employment.

Given these histories, it is not surprising that some 50% of patients have criminal records apart from a particular criminal incident which may have led to their referral to a secure unit. Neither in this respect nor in respect of the other characteristics we have described is there a clear distinction between those referred via forensic and those via non-forensic channels. The unit population is essentially homogeneous and there appears to be no validity in a 'Butler/Clancy' differentiation.

As would be expected violence is predominant among the index offences or incidents, accounting for about 50%. Next come various forms of criminal damage, amounting to about 20%, of which nearly half are arson, a crime which, even when comparatively trivial, carries a high probability of a Court Hospital Order. Crimes involving financial gain are less frequent and usually secondary to other types of offence. Only about 5% are sexual offences and we have the impression that sexual offenders, particularly when also violent, are likely to enter a special hospital and are then less likely to be transferred than most other offenders.

About half the victims of violent index offences are known to the patient with family members and sexual partners being in the majority. Fellow psychiatric patients and authority figures may also be vulnerable.

In respect of discharge data our comments can only be based on the relatively small number of patients already discharged and are therefore less representative for reasons already given. Quite unrepresentative is the fact that, although the range of duration of stay in a unit was from

one month to nearly 6 years, the mean duration was only 10.3 months and there was no delay in the discharge of 71 and 100 patients. Many, particularly those subject to restriction orders, still in units, but ready for discharge by the judgement of unit staff, are subject to often long periods of morale-sapping delay. Reasons for these delays include lack of Home Office agreement, unwillingness to accept the patient by a psychiatric hospital and difficulties in arranging social supervision or residential accommodation.

Of those already discharged about half moved into some form of private residence, approximately a third to psychiatric hospital placements, a number to social or voluntary service hostels and three to special hospitals. Two of the latter returned to the referring special hospital, one after a period of trial leave in the unit, a practice which is tending to grow and which has several advantages for the patient and the unit. The other, whom the unit failed to rehabilitate, had not previously been in a special hospital.

A surprising number, 16 of a hundred discharged patients, went to live with their parents while only 4 returned to a spouse or other long-term sexual partner. Nineteen of the others in private residences set up on their own in a house or lodgings.

All the discharged patients had improved greatly in their clinical state but the majority of those who had been admitted with psychotic conditions required periodic depot medication. Failure to maintain this medication is likely to cause relapse.

Hence follow-up is important and, for those patients discharged to the community, units are, to an extent not initially expected, carrying out their own community nursing and social work, and often the patient attends out-patient clinics, and sometimes, even program sessions, at the unit. Patients subject to restriction orders are legally subject to specific psychiatric and social supervision with periodical reports to the Home Office. Frequently the unit psychiatrist is the psychiatric supervisor with a probation officer being responsible for the social supervision.

This, then, is the emerging picture. Does it answer the questions posed earlier?

1. We do believe that we are beginning to have an accurate profile of patient characteristics, except that this profile will change, for example, with more admissions for assessment.

2. We do not yet have an equivalent profile of rejected patients.

3. We can describe what happens to patients during their stay but this may also change to some extent.

4. Discharge data are still very thin and, even at the end of the study, there will not be adequate follow-up-data.

5. The role of nurses is fairly uniform but there is considerable variation in the roles of members of other disciplines between the different units. At a later stage it is hoped to establish a tentative unit typology.

6. Units also differ in their relationships with other services and these differences will contribute to that typology.

As for the policy questions:

1. It does seem that the secure units do serve a useful or even necessary function and that all regions should establish RSU's.

2. However, it is impressive how effectively quite small ISU's function and develop a network of appropriate outside relationships within a catchment area. It may well be that plans such as those of the West Midlands Region to establish a single 100-bedded RSU to serve this very large region, are unwise. We are inclined to agree with Baroness Robson, an ex-RHA chairman, who in a recent House of Lords debate said that she had become convinced that the RSU itself must not be too large and suggested that the creation of one large regional secure unit in virtual isolation from the rest of the psychiatric service in the region could run the risk of labelling the patients as 'impossible' and might create a special group of forensic patients in mini-special hospitals, not too different from Broadmoor in the minds of most people.

3. The need for Butler's proposed second thousand beds is doubtful. The present need has not yet been met and it is difficult to predict growth in that need but we are still well short of the first thousand beds.

One great difficulty in assessing need is estimating the potential demand from the prison service. In the House of Lords debate already mentioned, Lord Windlesham, Chairman of, the Parole Board, claimed that 'just how many men and women in prison are mentally disordered, whether or not their state constitutes actually mental illness, nobody knows'. We believe that claim to be true.

Finally, as these proceedings are concerned with the practice of clinical psychology, we should like to enlarge a little on the role of psychologists in the units. We have mentioned the three aspects of the patients' treatment - medication, a common ward program of activities and individual remedial therapeutic and behavior modification programs. Psychologists have a very important role in both programs. As a member of the multidisciplinary team with a great deal of relevant specialized knowledge, she or he should have considerable influence on the ward program, which sometimes seems to leave too much time for rather aimless television watching, playing of snooker and listening to 'pop' records.

But it is in relation to the individual program that the clinical psychologist's expertise is really vital both in assessment and program planning. Formal assessment is often inadequate, and individual programs, be they behavioral, cognitive or psychodynamic in nature, often sketchily devised and implemented by other staff members who do not fully appreciate the principles upon which they are based. It is clear from our study that secure units provide a challenging but stimulating and satisfying environment for the practice of clinical psychology.

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(Editor's note: Sadly, Professor Gwynne Jones died while this volume was in press.)

TESTING TIME FOR PSYCHOLOGISTS: THE PSYCHOLOGIST AS AN EXPERT WITNESS

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A variety of legal and quasi-legal tribunals use psychologists as expert witnesses, giving evidence on issues ranging from whether the siting of a nuclear power station may be damaging to the psychological health of the local community, to how sexual harassment at work might affect a woman's work performance - an issue recently raised by a psychologist called in an Industrial Tribunal considering an unfair dismissal. More familiarly perhaps, psychologists find themselves asked to provide assessments for the civil and criminal courts, most commonly where personal injury litigation is involved or a client seen in practice has become a defendant or victim in a criminal case. More routinely still, changes in the Mental Health Act have meant frequent involvement in Mental Health Tribunals. Thus the psychologist has become increasingly caught up in legal or semi-legal procedures be that in the Magistrates Court, Crown and County Court, or the Appeal Courts, as well as within a wide range of other legalistic fora. It is with the psychologist's role as courtroom witness however, that this paper is primarily concerned.

Much of the psychologist's role is till tied to giving evidence on perception - for example, in Admiralty Courts, a psychologist may be called upon to discuss perception of ships' lights allowing a collision of vessels; in Patent Courts, she/he may be called upon to comment on similarity or difference between labels on cans of food and so on. Criminal cases may call for perception evidence on eye-witness accounts, speed of travel in motor-vehicle cases and so on. Personal injury cases will commonly require a psychological assessment and some statement of future expectation, chance of recovery and rehabilitation etc., which all go to fix compensation for injuries. Criminal cases likewise may call for assessment evidence and this has become increasingly controversial in cases where confessions have allegedly been made under duress or through suggestibility. A final example of court work may be found in a recent Scottish case where the sentence in a murder trial depended upon whether, in the lawyers' terms, the accused had 'a disease of the mind' or 'a personality disorder' - depending on which were found to be true, the accused would either be consigned to the State Special Hospital or to an out-patient clinic: and if neither were thought appropriate she/he would face a custodial sentence in prison.

Thus, the importance of the psychologist's evidence may vary depending upon the seriousness of the case and the likelihood of a custodial sen-

tence; where the latter is likely, a plea in mitigation may well call for a psychologist's report.

PRE-TRIAL

Evidence in Court is, however, only the tip of the psychologist's role in legal cases. Most of the work takes place out of court, in examination and report writing, and in conference with lawyers - literally in draughty corridors or smoky witness rooms in down-at-heel court buildings where the loo is miles away from the court. Since, in civil cases, there is a 90 per cent chance that the case will settle, psychologists involved in civil work will go to court less often than their colleagues engaged in criminal proceedings. Reports in civil proceedings are most often used by lawyers to effect such a pre-trial settlement.

Moreover, since psychological evidence is all too frequently submitted as part of the psychiatric evidence, it may not be the psychologist, but the psychiatrist who sets foot in the witness box. We will touch on this again later. Unless one becomes what is known as a "professional expert witness" i.e. someone who regularly does court work for the money and becomes good at being a witness, one's experience of courts will be limited by these considerations. Most psychologists perhaps go to court only once or twice in their careers; others may go once or twice a week and still others, once or twice a day! It is partly a matter of one's own choice, partly a product of one's reputation: once a lawyer knows a psychologist she/he will come back again.

INDUCTION INTO LEGALISM: THE GOOD EXPERT WITNESS

It is from the experience of the 'court regulars', the 'repeat players', the professional expert witnesses who have learnt what lawyers look for in a witness, that any advice offered here is gleamed. Beware, however, of accepting too readily textbook advice which is what the lawyer wants from the psychologist. Inevitably, symposia on expert evidence have been legalistic in tone, but it is perhaps time that experts made lawyers more aware of what they want from the legal system.

SPECIAL WITNESSES

Experts are, then special sorts of witnesses because legally, they can give opinion evidence: ordinary witnesses can only speak to fact. (How the legal system effects such a nice distinction between fact and opinion is another issue). But they are special witnesses too because they are often repeat players who have the chance to put their case more effectively than the ordinary witness. For the first-time expert, however, or the court irregular, the difference between him/herself and the ordinary witness may seem less marked: both are intimidated by the confusion of who is who, who sits where, when to stand up and sit down, what can be said in evidence, and so on. The experience has been outlined in sociological studies but perhaps is most strikingly compared to that of Kafka's trial. Often witnesses emerge from their experience bemused by the procedure: 'It's all a game', or 'It's all a piece of theatre' are phrases commonly heard in the corridors of the court.

Unless one can overcome these intimidatory forces and counteract the forceful tactics of trial lawyers, one is likely to fall easy prey to those more experienced in the art of advocacy or the technique of persuasion - and here we may include not only the lawyers, but the skilled psychological witness for the other side.

PSYCHOLOGIST AS WITNESS

I am not going to outline here the procedure and stages at which psychologists are used - much of this can be found elsewhere. What I am going to concentrate on is the witness role, since although it forms a relatively small part of the psychologist's overall legal involvement, it assumes a far bigger significance because of its problematic nature and its public dimension.

The first thing to remember is that the lawyer has called the psychologist to court because his/her evidence will assist in the legal task of putting "the best possible case" for the client. In an adversarial system, the lawyer is out to win that case, and the psychologist is a means to that end: in this respect, the psychologist's reports and his/her evidence in court are tools of advocacy - subject to adversarial influences. Both pre-trial and in court, one may be asked not only to give evidence but to frame questions for the cross-examination of the other side's psychologist: one is part of a legal team but within this team one is a subsidiary or secondary player. Lawyers want and need psychologists but they want them "on tap - not on top". It will be no part of the psychologist's job to take control of the evidence but it may be part of that job to suggest questions and lines of attack. Moreover, in the witness box itself, one may be asked to answer questions in a limited fashion and may be stopped from saying more than the lawyer wants. Thus if one attempts to "give away" more information than the questions required, one may find one's own lawyer saying "Please don't lecture the court, Dr. so and So', or "Just answer the question, yes or no". Adversarial contests are largely about managing information - concealing some, highlighting some, playing down some. In the business of producing information in court, it is the lawyer who is in charge and any expert who over-reaches his/her role will possibly be severely reprimanded. Moreover, it is always wise to avoid over-reaching oneself when temptingly invited to do so by a friendly lawyer. In holding forth on a matter outside one's own area of expertise one may wax lyrical. The lawyer may then ask the fatal question "And what exactly are your qualifications in this field"? By such means, experts do the lawyer's job for them.

'MAN/WOMAN OF SCIENCE' vs. 'MAN/WOMAN OF LAW'

In some respects then, the psychologist is in a better position than the ordinary witness by virtue of being involved with the legal team. But this involvement makes his/her position worse than that of the ordinary witness. As a member of the legal team, the psychologist may find him/herself asked actively to participate in this management of the evidence - reports are sometimes sent back with a request to redraft in order to omit a damaging piece of information and so on. Similarly in the witness box, psychologists may be required to keep their mouths shut on crucial issues just as often as they are required to hold forth. The conflicts which inevitably arise from the witness role are difficult to work out because unless one does play the game and play it well, the lawyer may never use one as an expert witness again. Yet, one is aware that to play this advocatory role, one might be asked to forego any allegiance to professional ethos and surrender one's professional integrity - and certainly, others in the profession may look askance when and if they hear evidence which is clearly incomplete or has been slanted in some way. This is the conflict between being a 'man or woman of science' (and hence non-partisan) and being a 'man or woman of law' (and being a good expert witness).

Moreover, it is suggested here that the stereotypes of good and bad experts are themselves largely legal constructs, ideal types, drawn up on the basis of the expert's skill in advocacy. The 'good' expert is not only skilled in his field, but also a 'good' witness. He - it is usually a 'he' - knows what the lawyer requires and does it with few explicit instructions; he 'picks up' what makes and breaks a legal case, absorbs the legal implications of technical and scientific issues; he conceals damaging information from the 'other side'; he protects the legal team's version of events from the witness box, and compiles his report so that it will assist the legal dynamics of settlement and/or contest. He does not try to include that which the lawyer wants omitted and indeed, has no ultimate power to do so even where he wants to. He is a tool of advocacy and accepts his subsidiary position as assistant to the legal team. He does not compete with the lawyer for control of the case nor question the lawyer's position as overall master of its design. He is usually white, middle aged, male and a member of the professional classes.

The bad expert, by comparison, fails to appreciate that the lawyer is in control of the case and questions the legal parameters set upon his work. He is unhappy in the legal harness and may try to get out of it by putting his head together with the expert from the other side in an attempt to reach a 'more rational' or 'more scientific' conclusion. He also fails to omit damaging information from his report, or where he has done this, fails to paper over the cracks so that no-one will notice the omission. He fails to put out useful information in a covering letter, thus forcing solicitors to exchange information they would rather keep concealed until legal strategy provides an opportunity for profitable usage. He may refuse to alter or structure his report to omit certain information, and may argue over how to present his testimony. Indeed he may fail altogether to listen to what advice the lawyer gives about testimony. He further fails to repair damage done by cross examination. He is 'wooly headed' in the witness box, 'too academic', wanders off into areas he knows nothing about only to get caught out by counsel. He drifts or lectures, rubs the judge up the wrong way by giving his evidence too fast or in too technical a fashion. He may come across as dogmatic or partisan if he argues too much or is too insistent in his testimony. A bad expert is one who mumbles indistinctly in the witness box, whose command of the English language is imperfect, and whose appearance and demeanour raise doubts about his professional status and witness credibility.

So there may be conflicts to the psychologist in this 'man/woman of law' vs. 'man/woman of science' dilemma. On a theoretical level, it is also reflected in conflicts between lawyers and psychologists in their understanding of terms, and between law as a body of knowledge and psychology as a body of knowledge. These conflicts are made worse by the position of the psychologist as a secondary player in the legal process, required to accept the legal way of world-making even where this clashes with his/her own professional ethos. What one sees in court is partly the playing out of a clash in theories - the law seeks to establish guilt and responsibility according to a 'free will' model which psychologists find simplistic. But the problems do not stop there. Psychology and psychologists are not merely subsidiary and secondary to law but often they are below psychiatrists in the hierachy of witness-ship. This partly stems from the division within the health service itself where psychologists may be seen as being prescribed by psychiatrists. The law courts will continue to accept this division until and unless psychology itself challenges the premise upon which it is based, i.e. the medical model of mental health. The upshot of the division is that the psychologist may not only defer control of his/her evidence to the lawyer, but also to the psychiatrist. To set at rest the minds of those worried by recent legal teaching that psychologists cannot qualify as expert witnesses on state of mind because

not medically qualified, I would emphasize here that legal rules are more honored in the breach than in the observance. For every psychologist whose evidence upon such issues is questioned there will be ten who every day comment upon them without ever being challenged. Legal history makes it plain that the law is still making up its mind about psychology and that it is up to the profession to educate lawyers about what it can offer the law courts. Indeed, despite the present position of psychiatry, psychology may find itself overtaking it in the law's favor, particularly since probabilistic and statistical evidence appeals to the law's highly positivist image of what real science is about. In order to effect this change, however, psychologists might have to insist that they appear in court themselves to give their evidence, rather than permitting psychiatrists to present it on their behalf. In any event, it is perhaps true that psychologists have a better understanding of psychiatry than psychiatrists of psychology!

Another conflict enters the court room arena of the psychologists. We have looked at lawyer/expert conflict and expert/expert conflict but a final problem is that of cross cutting loyalties - to the legal team, to the professional colleague, the latter particularly so when the issue is one of professional negligence. Lawyers want certainty and will push for it. One of the certain things they may want is a condensation of another psychologist's view or action. Courts of law attempt to render things into black and white terms, forgetting the context in which psychologists take decisions - the setting for everyday decision-making in the health service is lost in the lawyer's filtering of the issues into "legal issues". One question raised by the sight of two psychologists disagreeing in court may be: how damaging is this to the public's image of the profession at large? On a more immediate level most psychologists will be reluctant publicly to say "I think that line of thought is wrong", because she/he is aware both of the legitimacy of alternative views within the discipline and of the professional consequences for any psychologist publicly discredited - i.e. career repercussions. For those seeking escape from the lawyer's question, "In your view, was that a reasonable decision to make"? one possible get-out clause may be to reply that reasonable people sometimes do unreasonable things, or simply to say that one is aware of that view, that whilst it is widely held, it is not one subscribed to by oneself. In this way one retains one's own aura of reasonableness, without discrediting the views of one's colleagues also in court and expressing different views. If the public is ever to be weaned off positivism and the medical model, and if courts are to follow suit, pluralism of views must be seen as legitimate within science.

CONCLUSION

There are then, a number of conflicts inherent in the psychologist's witness role. How does a psychologist manage them? What are the consequences of trying to be "a good witness"?

Management of the role is a question of balance - of being authoritative but also differential. Judges do not like to feel redundant and may, when threatened, be heard to mutter "we do not in this country have trial by expert". In looking at what lawyers require of a "good witness" the psychologist must decide whether or not she/he wishes to accept it and if so, what that means.

One thing it can mean is the possibility of being hoist with one's own petard. By attempting to be a good witness, the psychologist may be asked and/or tempted to 'firm up' the evidence, to leave out some things, tidy up ambiguities and so on. Indeed, the yes/no questioning technique is designed to do this. But what if, at the end of the day, one's work is

subject to intense public scrutiny and found to be less than 'the whole truth'? It will not then matter that it is at the lawyer's behest that evidence is less than complete - it will be the psychologist who bears the brunt of any criticism. One does not, moreover, need to be a 'bent' expert to fall foul of this trap. In trying to be a good witness and in trying to live up to the law's unrealistic expectation of scientists as people who are wholly impartial, who always agree and who have a hot line to certainty, the psychologist may make a rod for his/her own back. Any expert who fails at some point to live up to these images may be publicly censured.

There are ways to survive in the witness box which enable psychologists better to present their evidence effectively while at the same time promoting their profession. The first step is to become aware that what the law wants of psychology may not be what psychology should give or can provide. Awareness of the legalistic tenor of advice to the expert witness is an initial move towards altering the law's image of psychology. Beyond this, it is up to practitioners to challenge the legal framework and the law's discourse whenever it clashes fundamentally with psychological treatment of behavior.

To learn how to be an 'expert witness' and use this skill to promote the interests of the profession is to learn behavioral skills. Psychologists may see this as akin to sending coal to Newcastle, but in the light of psychology's past experience in the law courts, it is perhaps time to explore the conflicts, explode a few cherished myths about science, and set fire to the traditional legal theories of responsibility. Conflicts within the witness role supplement conflicts between law and psychology to render psychology all but impotent in many legal proceedings. By learning how to be a 'good expert witness' psychologists can, if they so wish, contribute to the lawyer's definition of their role and further the profession's public image. The alternative is to accept the law's harness.

THE MENTAL HEALTH ACT COMMISSION:

THE FIRST YEAR'S EXPERIENCE

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The 1983 Mental Health Act has been hailed as a progressive breakthrough in civil rights terms. But like many British Acts of Parliament it represents essentially a typically British compromise. What I would like to do in this paper is discuss some of the implications of the compromises that were made, go on to mention the role of the psychologist in it all, review some of the work of the Commission itself and finish by offering some assessment of what the new Act and the Commission might mean in terms of the longer term effect on patient care.

The Mental Health as a Compromise

A proper analysis of the inception of the 1983 Act, the discussion that took place around it, various Interest Groups (I am tempted to say vested Interest Groups) involved and the many compromises that were made by those groups would be quite interesting but would take more time than is presently available. I am not, therefore, proposing to enter into such an analysis in this paper. Personally, I was involved only peripherally in the pre-publication discussions that went on and would certainly not have any detailed knowledge of those machinations. The main point I would like to make in this report is that the Act does represent a compromise and a very successful compromise between the various interest groups within the Mental Health field.

Two major, non-orthogonal, factors within these interests are:- Firstly that of the Civil Liberty of the subject "versus" clinical treatment, I would like to leave a discussion of this until later except to say at this stage that the "versus" is in inverted commas and very much so. The phrase "patients dying with their civil liberties intact", with the implication that the two are diametrically opposed seems to me to completely misunderstand the dilemma. The second dimension along which compromise was made was that of the powerful professions (psychiatry and to some extent nursing) and the less politically powerful (clinical psychology, social work and the para-medical professions). It seems that it is largely out of the second of these compromise dimensions that the Commission emerged.

As a result of the unwillingness of the psychiatric establishment to allow any significant constitutionally enshrined multi-disciplinary basis for decisions relating to the compulsory detention and treatment of psychi-

atric patients, the compromise emerged of providing for a constitutionally multi-disciplinary special Health Authority to oversee certain aspects of the new Act - hence the birth of the Commission.

The Balance of Forces on the Commission

The balance of the different interests on the Commission is well arranged as representing the realities of power and influence as they presently exist but perhaps recognizing the possibility of change and the need for developments in this area to take place.

Thus, the representation for psychiatry is double that of the other professions. Within that representation there is a plurality of views so that 'Royal College Plants' as they are becoming known are easily identifiable, as are their arguably more liberal, less professionally opinioned colleagues (which incidentally leads to some quite interesting debates).

The two other professions having defined roles within Mental Health legislation - namely social work and nursing - are also represented. I think I detect a similar dimension of establishment versus rebel within nursing members but this is much less clear. To my perception anyway, such a dimension is absent in the social work members.

Bringing up the rear, as it were, is one Health Service profession having no defined role under the new legislation - namely clinical psychology. It is by no means obvious why this profession was chosen for inclusion as against occupational therapy for instance (which is, I believe represented only by one "specialist" member of the Commission). It seems that our inclusion was due to some fairly skilful lobbying during the passage of the Bill. When one considers that we have the same representation as social work, the successful outcome of that lobbying can be better appreciated.

The two groups so far not mentioned are, in my view, the most important ones. The legal profession is represented by members who are almost universally at the "progressive" end of the spectrum and represent the most coherent group in terms of "Civil Liberties" interests. The "lay" group is large and important with, again, a plurality of interests and views. Although referred to as "lay" members, most are associated with the Health Service or similar bodies (e.g. retired Health Service Administrators, Health Authority Chairman and at least one teacher of the Mentally Handicapped). My working model of what the Commission ought to be about is that of the various professional groups advising the lay members, who ought to have a much greater influence over policy than appears to be the case now.

The Pluralism of the Commission

One thing the Commission is not is democratically representative in any real sense. Thus, there are no members of the Asian and Black communities on the Commission although we know that these groups of patients represent specific problems within Mental Health (in terms of language problems and, for example, the fundamental cultural problem raised by the treatment of some Rastafarian patients). Women, particularly within the professional groups, seem to be underrepresented even though women have specific problems in relation to Mental Health and a high proportion of detained patients are women. Similarly, there are very few members of the Commission who could be described as in any real sense "working class" although we suspect in the UK, and know within a USA context, that social class is a major variable in predicting how patients will be treated - in terms of the likelihood of being compulsory detained, of being treated with ECT or major tranquilizers, of receiving psychotherapy etc. The pro-

fessionals represent very much the higher "management" echelons of those professions (so that, for instance, there are very few "clinical" nurses in the sense of nurses having direct patient contact).

Thus the Commission is unusual, if not unique, in being a genuinely pluralistic and multi-disciplinary, though not representative, statutory body with considerable influence and power. Such an arrangement sounds like a recipe for a battleground but, in fact, provides a creative forum where, by and large, debate is conducted very reasonably but where real and difficult issues are ventilated.

Certainly, in the sense of being a model of multidisciplinary teamwork, it has already proved a success. Credit for this lies with the members themselves, with whoever chose them, but more particularly with the Chairman both Regionally and Nationally. (For those of you who have already worked out my political views, proof has just been given that the Commission can change your life - I have just praised a Tory hereditary Peer).

The Structure of the Commission

The structure of the Commission is reasonably simple. The most powerful body is the Central Committee which, to dissociate itself from any Stalinist connotations is actually called the Central Policy Committee, or CPC. It is a Statutory body within the Commission and its members were appointed to it by the Secretary of State, but in addition it has six members elected to it from the three Regional Groups. These Regional bodies cover vast areas. Our "Liverpool" Regional Group in fact covers the whole of the Mersey and North Western Health Service Regions in addition to North Wales and parts of the Midlands. In addition there are meetings, on a quite infrequent basis, of the National Professional Group - each Group consisting simply of all Commissioners of that profession plus a number of lay members. Because of the need to prepare the Code of Practice there are also Working Parties set up, presumably on a short-lived basis, to deal with separate aspects of that Code.

Again, the system seems to work quite well; there seems to be a reasonable balance between the Center and the Regions and the professional groupings tie in very well with the Commission as a whole.

The Functions of the Commission

There are three or four major functions of the Commission.

1. The investigation of complaints

The Commission has the statutory obligation to investigate any complaint received from, or on behalf of, individual detained patients. Note that it is only formally detained patients who have this right - although it does extend to patients who have at some time in the past been detained and who may now be informal patients or not patients at all. It is perhaps too early to predict how effective this will be as a safeguard. Most of the complaints I have been involved in investigating have either been relatively trivial or virtually impossible to adequately investigate, but my experience may be by no means typical. There is one very serious complaint presently "in the pipeline" which could well prove the touchstone of how much of a protection the Commissioners' investigation of complaints is likely to be. The allegation in the complaint is that a young detained female patient was kept naked in "seclusion" (of a nature which amounted to solitary confinement) for some ten consecutive days during part of which time she was, for example, not provided with any sanitary protection whilst

menstruating. This case could be extremely important in showing whether the Commission can establish its credibility in effectively dealing with, and preventing, such alleged brutalization of patients.

There is strong pressure within the Commission to extend this role of investigating complaints to some subsets of complaints from informal patients - particularly those that are "de facto" detained. Such an extension of our role could be made on recommendation of the Commission to the Secretary of State; Parliament need not be involved.

Of some importance for those of us working within psychiatric hospitals is the fact that complaints can be made on behalf of patients either by outside friends or relatives or internally by staff. It may be more likely that a complaint from a member of staff will be listened to, and adequately investigated, than if that complaint emanates from a possibly inarticulate, deluded patient. There has been much discussion within the Commission as to whether we can take complaints from patients before they have been investigated by the hospital, but the balance of opinion seems to be that we can.

2. Hospital visits

In our MHAC Region we have determined to visit each hospital (containing detained patients) annually (and Special Hospitals more frequently) - quite a time-consuming commitment. I have been surprised, frankly, by the usefulness of these visits (although one disappointment has been the relative lack of comments from clinical psychologists at the hospitals). The effect of these visits ranged from the mundane (having leaking ceilings seen to) through the practical (effecting the "Seclusion policy" of hospitals) to the highly theoretical (taking up for discussion within the Commission the "problem" of aggressive questioning of consultant psychiatrists by solicitors). Hospital visits, more than any other aspect of our work, have convinced me that the Commission could be a very significant force in ameliorating the conditions in which patients are detained; although the Commission has very few formal powers, most hospitals visited have seemed to react very positively to suggestions made as a result of our visits.

3. Code of Practice

The third major function of the MHAC is the preparation of a Code of Practice. This code, which does not need to be limited to detained patients, could be of crucial importance. It is being prepared via some seventeen working groups looking at separate aspects of what might be in the code.

4. Second Opinion Visits

The Commission also has the responsibility to provide, either from its own members or from a panel chosen by the Commission, psychiatrists authorized to give a 'second opinion' under Section 58 of the Act and non-psychiatrists similarly authorized under Section 57.

Wider Issues Raised by the Work of the Commission

The main positive effect of the Act seems to me to be the greater clarity of role given to the various personnel involved (in addition, of course to the increase in "rights" given to detained patients). Thus psychiatrists now know that they can forcibly treat patients if certain conditions are met - previously this was by no means certain and there was very little case law about whether compulsory detention implied compulsory

treatment - now it clearly does. Similarly, nurses now know that, under Section 5(4) they are legally able to detain a psychiatric in-patient for up to six hours - previously this was often done but with doubtful legality. Social workers, now as "approved Social Workers", have clarified powers of detention (and of refusing to agree to detention). The lawyers are in a clearer and more "powerful" position in knowing that, for instance the client they are representing at Tribunals is allowed legal aid to be so represented. Even the "other professionals" like ourselves have a few defined roles under the Act.

Most important of all, the detained patient is in a much clearer position - each will, or should, have had issued to him/her leaflets plus verbal reinforcement and elaboration explaining their Rights under the Act. They have gained greatly in terms of the rights of appeal against detention and in the fundamental issue of being able to apply for legal aid for those appeals - there is in this context the interesting departure in the new Act that some patients are forced to go before a Tribunal even if they don't want to - or are in no position to appeal on their own behalf.

In fact the only people who seem not to have gained anything in terms of clarity of position, or in power or rights are the informal patients. They are not issued with any leaflets explaining their rights, they appear to have no rights of appeal against ECT or chemotherapy - other than by discharging themselves from treatment altogether, if allowed to by the nurse who may detain him/her under Section 5(4) or by the doctor who may detain them under other Sections. None of this is necessarily explained to the informal patient. Nor does the Act seem to offer any clarification about the "de facto" and, I would argue often mystifying, detention of the form "You are informal and free to leave until you do try to leave in which case we will section you". This form of detention is that of which Szasz has gone on at length in relation (one suspects) to his middle class, articulate clients. The main groups where, in my view, considerations such as this are more important are the elderly mentally infirm and the mentally handicapped patients in hospital. Very few of these will be legally detained but many will be detained in the way outlined here - and their Rights are very unclear. For example a behaviorally disturbed mentally handicapped patient might be treated by long term medication - clearly quite reasonable alternative forms of treatment are possible and potentially more efficacious. But who will, or can, look after that patient's right to refuse the preferred treatment and be offered instead the arguably more appropriate treatment?

Considerations such as these have led to pressure within the Commission for the status of the informal patient to be clarified. As a result, one of the Working Parties set up to prepare the Code of Practice had as its remit the status of informal patients. Two unanimous recommendations of that Working Party are that all informal patients should have the right of access to the Commission if they are complaining about the restrictive nature of their hospitalization (for example, being kept in "night clothes", being kept in seclusion, being kept on locked wards), and that informal patients who are deemed not able to form a valid opinion about conditions of their detention should have available to them some form of "advocacy" on their behalf. It remains to be seen whether these and other recommendations are accepted by the Commission as a whole.

A major issue raised whenever one is concerned with the civil rights of patients is that of Civil Rights "at the expense of" care. In some ways this is the crunch issue as far as professions within the Health Service are concerned. How do we balance the ability of patients to protest and complain about being detained (and about the various things happening to them in detention) with the perceived need, as the professional sees it, to

defend patients against themselves, against the patients' own wishes which are harmful to her/him? The phrase of "dying with his Civil Liberties intact" mentioned above is perhaps the ultimate expression of this dilemma. We may be quite certain as professional psychologists acting in good faith that a patient needs a particular behavioral program - how do we balance this against the wishes of the patient who may not want to be placed on such a program. This is arguably not such a problem for us as compared to psychiatrists for two reasons - we are not normally in such a position of power with respect to patients except perhaps as a member of a multi-disciplinary team, and many of the techniques we would tend to use are difficult if not impossible to apply without the active co-operation of the patient, anyway. But the first of these reasons depends very much on the context in which we work and the second is probably not true if, for example, we consider work with mentally handicapped patients.

This is perhaps the major dilemma of professionals which has led many to embrace to a greater or lesser extent a "deprofessionalizing" approach to their work. The dilemma can be expressed in different ways but I would isolate just three implicit professional attitudes in the dilemma:-

Firstly, the professional always knows better than their client what is good for them. This is the attitude that tends towards more-or-less subtly coercive rather than persuasive patterns of interaction with patients. Whilst not wishing to attempt a formal definition of the difference, persuasion emphasises the ability of the patient to disagree with the professional view and for that dissent to be reported. Subtle coercion emphasises the authoritative position that the professional is in so that to disagree is silly. (Unsubtle coercion applies an authoritarian attitude to virtually force compliance - perhaps with veiled or open threats).

Secondly, the professional never takes risks with their clients. In terms of risk, a greater degree of containment is almost always safer. In terms of all patients, the greater the degree of containment the more can the therapeutic environment be controlled. In terms of the "anti-social" patient, less risk is run of damage being done to others and less risk is run of the professional being pilloried for having taken a decision to lessen the containment.

Thirdly, the professional never says "I don't know". An authoritative attitude must be bolstered by omniscience, real or imagined. Uncertainty can exist only in the patient. Thus the patient is invalidated in the sense that their uncertainty or lack of knowledge is a result of being a patient - not of being a human (non-professional).

Clearly, in many interactions we need a professional in the above terms. But how relevant is such a form of relationship within the Mental Health field? Often, if not always, patients are struggling in one way or another to deal with issues of autonomy, of self-validation, of self-worth, which a "professional" relationship goes half way to smashing out of existence by denying them as issues.

It is easy in discussing the concept of professionalization in Mental Health to lapse into somewhat crude "anti-psychiatrism" - for they (the psychologists) are the ones with the professional power, they are the ones who more than any other depend on paternalism and Authority to justify the non-voluntary aspects of their interaction with patients. But this I suggest, is unfair and probably based more on professional jealousy than anything else. If we had that power would we exercise it in any more "progressive" a way than the majority of psychiatrists? The issue is not psychiatry per se, but professionalism.

I am conscious that I have only skirted around this very important and crucial issue. In more concrete terms within the Commission, the debate is represented by the sort of attitude that all we need to protect patients is a proper professional attitude on the part of staff, less interference with their clinical freedom etc. opposed by the viewpoint that more protection than that is needed.

The Role of Psychologists

There is very little in the way of a specified role for clinical psychologists under the Act:-

The clinical psychologist may be involved as one of the possible non-medical, non-nursing, professionals to be consulted, but only consulted, about 'second opinion' with respect to ECT and extended drug treatments. (These are the treatments subsumed under Section 58 of the Act, requiring the consent of the patient or the agreement of a 'second opinion' doctor nominated by the MHAC for that purpose). Such a doctor must consult a nurse and one other person (not a nurse) who has been professionally concerned with the patient's treatment. Under this section, if we are consulted, we might be able to give professional advice that, for instance, there are alternative treatments which have not been tried and that, as a result, ECT or major tranquilizer treatment is not appropriate. We might also be able, I hope, to give some sort of opinion on whether there exist sufficient grounds to overrule the patient's lack of consent. (This latter consideration is as important as the judgement as to whether the proposed treatment is appropriate and necessary).

The 'second opinion' doctor may, or of course may not, agree with us and as a result may or may not authorize the treatment be carried out. It is quite interesting, incidentally, that in the first nine months the Act was in force, there were 1759 'second opinions' under this Section. Of these in considerably less than one per cent was the outcome to refuse to authorize treatment, which is quite remarkable given the general unreliability of psychiatric diagnosis and the fact that the decision in these cases is, or should, be quite a complex one - not just that the treatment is the appropriate one but that also there exist good grounds for overruling the lack of consent on the part of the patient. It is interesting to speculate what this concordance rate means - an initial suspicion might be that conscious or unconscious collusion is taking place - the medics looking after their own. But what might be happening is that because of the need to seek a second opinion, ECT or extended drug treatment of formally detained patients is only being insisted on in cases where it is clearly necessary - hence the high measure of concordance. The first suspicion is to some extent reinforced by the way the list of authorized, non-Commissioner, 'second opinion' doctors was chosen. It was effectively a "black-balling" procedure whereby any Commissioner could nominate names but if any name was unacceptable to even one Commissioner it was excluded. As one of the voices raised from within the Commission was that all the nominated doctors should be acceptable to "the Profession" and any known to be "anti-ECT" excluded one can perhaps see the problem. A further difficulty in analyzing the significance of such a high concordance rate is that 'second opinion' doctors may, with good reason, try to reach a compromise agreement with the RMO rather than record a formal "failure to agree". Similarly, it may be that in some cases, after consultation with the 'second opinion' doctor, the patient agrees to the treatment. Clearly research is needed into why there is such a high concordance rate and what this means in protecting the limited rights patients have to refuse particular forms of treatment.

A psychologist might similarly be involved as one of the members of the Commission involved in 'second opinion' for psychosurgery or normal implants (that is, treatments subsumed under Section 57 of the Act requiring the consent of the patient and three people, two being non-medical, appointed by the Commission - presently this means members of the Commission). One of the interesting points here, in Civil Rights terms, is that the 'second opinion' can remove the Right of the patient to receive the treatment of his or her choice even when the patient's doctor agrees with the patient. Another issue, raised formally within the Commission by the Psychologists' Group is whether it is possible to gain valid consent when so little evidence is available of the balance between therapeutic and deleterious side-effects of such treatments (particularly with respect to psychosurgery).

More important, perhaps, than these formal roles under the Act is the role we might have, or might expropriate for ourselves, in terms of clarifying some of the conceptual issues involved in this area. An example might be to help in the defining of valid (and I would add, by implication, informed) consent. The Act lumps together all withholding of consent - but there are clearly different "kinds" of withheld consent. For example:-

(i) Where the patient is unable either to give or withhold comment by reason of his or her mental or emotional state - for instance during a "depressive stupor" when the patient might, literally, seem unable to say "Yes" (or "No").

(ii) Where the patient is allegedly mistaken about the situation due to a presumed disease process or disease symptom - for instance "I do not want ECT because the doctors are all agents of the Conservative Party who are trying to destroy my brain so I won't vote Labor next time" (delusion). But what about "I don't want ECT because it will destroy my brain" or even "I don't want ECT because there is a fair chance that a number of neurones in my head will be destroyed"?

(iii) Where the patient is quite clear about the situation but still refuses consent for "ideological" reasons - for instance, "I understand that I am depressed and ECT might help to lift my depression but I prefer to try and understand what is making me depressed and work through the feelings associated with it". But what about "because God is punishing me by making me depressed"?

(iv) Where the patient is quite clear about the situation and withholds consent for "empirical" reasons - e.g. "I know I am depressed but I am concerned about the evidence concerning ECT and its side-effects - I prefer to be depressed a bit longer and be treated by drugs and/or Cognitive Therapy".

It might be argued that the above examples are unrealistic and unlikely to occur in practice, and certainly some would only apply to extremely articulate patients. But they illustrate the theoretical point, and even inarticulate patients have articulate friends/relatives on occasion (and also there are "pressure groups" which might enable an articulation to take place).

Another aspect of the concept of valid consent is presented by the question "How much information is required before the consent, or lack of it, is valid?". Different views have been espoused in the (mainly medical) literature. I tend to the view that the answer is "However much the patient feels they need". It has been argued that this is unreasonable and one position adopted is "However much a reasonable man would ask for". Another view, which according to recent case law appears to be the legal

position in Britain is that sufficient information is that which a reasonable doctor would consider sufficient.

I hope that the issues I have raised here are not seen as purely theoretical - for they are not. An analysis such as the above is necessary (though not sufficient) before anybody can express an informal opinion, in terms of "second opinion" consultation, on whether a patient's lack of consent should be overruled. (And yet if I can take our profession to task over this, a recent letter to me (in the Bulletin of the British Psychological Society) asking for informal discussion about consent elicited just one reply). A much more fundamental question is raised if we go on to question what exactly "consent" means anyway - when does persuasion become coercion, does "consent" refer to an internal state which even in principle cannot be adequately operationally defined and so on.

What I would like to suggest is that as a profession, or perhaps more accurately as a group of informed intelligent people experienced in mental health, we have a responsibility to attempt to help the conceptual analysis such as the above in an attempt, perhaps, to influence future legal amendments, and if not that, at least to have an effect on "Good Practice" guidelines. I would also like to suggest that more perhaps than any other profession within the Health Service, clinical psychology has traditionally been less authoritarian, more attunded to civil rights issues in treatment and containment, and therefore has a major role and responsibility to rebalance the "civil rights versus need to treat" dimension in favor of the former. It is disappointing that in many of the hospitals visited the clinical psychologists do not seem to perceive themselves in this way at all - seeming to be more concerned about their roles vis-a-vis other professions than their role in protecting and defending patients from some of the excesses of the system they find themselves contained within.

A Review of the First Year of the Commission

The situation, as I perceive it, is that the Commission has already established for itself a degree of credibility and a role for itself in protecting the Rights of formally detained psychiatric patients. There was a degree of scepticism around when the idea of a Commission was first mooted as to whether it would become anything more than yet another talking shop having little effect on patient care. I hope we have started to remove some of that scepticism.

But the sceptics may yet be proved correct. There are simple resource problems with maintaining credibility, especially with those who matter, the patients, in that the administrative infra-structure available for the Commissioners is inadequate, but it seems unlikely that this is going to be improved. One simple reason why this affects our credibility with patients is that quite often it leads to their having to wait inordinate lengths of time for a reply to the complaint they are making. I always thought, and still do, that one real test would be how we dealt with the first real "biggy" complaint about ill-treatment. This is with us now and presumably fairly soon we should know what the outcome of that complaint is going to be.

One rather worrying apparent trend militating against our credibility was the behavior of some 'second opinion' psychiatrists who were seen by some staff and patients to be less than one hundred per cent committed to the 'second opinion' process as a serious protection for patients. It was claimed that consultation with the patient and other staff was sometimes cursory (and that on one occasion, in respect of the former, was absent). The significance for the Commission is that patients rarely differentiate between 'second opinion' doctors sent by the Commission and Commissioners

themselves. This trend seems to have been reversed with the CPC stipulating that the absolute maximum number of 'second opinions' which can be done in one day is eight (at slightly more than forty six pounds a time). I understand that on one occasion before this stipulation , seventeen second opinions were done by one doctor in one day - which is an extremely creditable level of productivity given that each case requires consultation with three different professionals plus, presumably, the patient.

Whether we can maintain and consolidate our credibility remains to be seen. We have established our internal credibility insofaras the Commission is functioning reasonably well, with a growing identification of "Commissioners" rather than of particular professions within the Commission. Whether we can continue to significantly affect patient care depends very much on the collective will of the Commission but would be very much facilitated by a more active involvement in Civil Rights issues of care by mental health professionals such as ourselves.

FORENSIC ASSESSMENT AND THE KILLING OF PARTNERS:

A CRIME PASSIONEL?

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In more than one sense the penal law system in Holland is different from other countries and as a consequence the position and the role of the forensic psychiatrist is a different one. In Holland there is the system of the one and impartial forensic expert. In other words we do not have the expert for the defence or the expert for the prosecution. Although the possibility of a 'second opinion' exists, the so-called "battle of experts" in court is avoided (Beyaert, 1982).

In this system, the judge of instruction can ask the probation officer for information and advice, and he can request a pre-sentence forensic assessment from:

- a psychiatrist or psychologist, working as an individual or together;
- a civil psychiatric hospital in an observation period of six weeks;
- a specific observation clinic of the ministry of justice, called the Pieter Baan Center.

The judge of instruction, sometimes advised by the public prosecutor, the lawyer for the defence or the probation officer, decides which form of assessment is the most appropriate in each case. Guidelines for this decision are: gravity of the crime, the expected severity of the verdict of the court and the personality of the suspect. The most drastic intervention (the clinical observation) will as a rule be reserved for persons suspected of a serious crime. Sometimes young suspects are clinically observed, in the hope that some device might be found to divert a threatening criminal career.

The judge of instruction has two formal questions for the expert, as a consequence of the penal law act of 1928. The first one is to obtain the conclusion from the expert (psychiatrist) on the lack of, or degree of diminished responsibility of a suspect. In Dutch law the offender's lack of, or degree of diminished responsibility has nothing to do with legal culpability nor does it affect the question of whether or not the suspect is "fit for trial". A psychiatric conclusion of diminished responsibility may consequently affect the sentence, and will shorten the term of imprisonment. The question whether a suspect is "fit for trial" is hardly ever posed by the judge of instruction; every suspect stands trial. The second question asks whether the suspect is capable of repeating the serious crime, because of "defective development or pathological disturbance". In

fact this is the question of dangerousness and whether or not the measure of the TBR (detention at the government's pleasure) should be ruled. The diminished or lack of responsibility is therefore a necessary but not sufficient condition for the measure of the TBR. The predicted dangerousness is the second necessary condition.

The measure of the TBR may be combined with a prison sentence for, as they say "the responsible part" of the individual. The TBR is feared by all suspects, because of the undetermined duration; although the TBR is ruled for two years, every two years the court can rule for another one or two years. Statistically the average duration of the measure of the TBR is 3-4 years, with large ranges, so some people have been detained in the TBR for a very long time. (In Holland a prison sentence of six months is officially considered by the government as a long sentence; or perhaps I should say "was considered": things are rapidly changing in the last few years, as everywhere in Europe). The TBR is also feared for the stigmatization it implies, and because of the fear of psychiatry and psychology and the implicitly-given order to change the behavior to become less dangerous. Of course, no-one wants to change himself or herself. An order to change under penalty of undetermined detention is even worse, and therefore difficult to accept. For psychohygienic reasons most judges of instruction will ask for clinical observation when the measure of the TBR is to be expected. This advice to the court to rule the measure of the TBR is then at least given after a lengthy and thorough examination by a multidisciplinary team, and for that reason is more acceptable to the suspect.

During even the first two year period of the TBR, however, the seven clinics especially designed for this measure are authorized under the supervision and responsibility of the ministry of justice to allow conditional and unconditional leaves as well as discharge. Successful treatment, in the sense of becoming "less dangerous" to others, can thus lead to a short detention in the TBR On the other hand, the court sessions every two years can and do muzzle the possible therapeutic fervour of the TBR institute, questioning and controlling the legal position of the TBR/detainee. The measure of the TBR does not authorize enforced treatment; it simply authorizes enforced nursing. Every kind of treatment - medication, psychotherapy or systems therapy - can be refused by the inmate, unless there is real danger to the inmate's or other people's lives. Refusing every treatment, however, can postpone the behavioral change in the direction of becoming "less dangerous" and therefore lengthen the duration of the TBR The coercion is friendly, but nevertheless powerful. The seven TBR institutes are well equipped with staff and facilities - better-equipped than the normal psychiatric hospitals in Holland - and they offer a large pallet of therapeutic possibilities.

It is necessary to outline the above since the penal systems in the world are so fundamentally different, that one must elaborate the framework within which the forensic expert is working.

There is another point worth mentioning. Last year the Dutch psychiatric-juridical association celebrated its 50th anniversary. In Holland there is a tradition of aiming for mutual understanding between lawyers and psychiatrists; for example, in Holland four out of five professors in forensic psychiatry are nominated by the faculties of law. Perhaps the mutual influence of lawyers and psychiatrists has something to do with the progress of forensic psychiatry in Holland, which follows closely the new theories in psychiatry and psychology. When one compares the oldest assessments made by the Pieter Baan Center more than thirty years ago with those from ten years ago and those from the last few years, one can follow the evolution in psychiatry. More remarkable, however, is the fact that

the courts have followed this historical development. Years ago they were expecting Kraepelinian diagnoses. Nowadays they are expecting subtle descriptions of the relating capacity of the subject, a verified personal history, the past and present family circumstances, and clarification of these findings from a variety of viewpoints. Biological facts such as minimal brain damage, for instance, as a starting point for a disturbed mother-child relationship and also the psychodynamically understandable results of such a disturbance, and (for instance) the scapegoating - mechanisms in the family that could hamper the development of such a child still more, can be explained to the magistrates. They will accept the conclusion of a certain degree of diminished responsibility for the person who had such a childhood and finally came to robbery.

The courts would probably not accept an assessment of a rapist without reflections on his relations with his mother, assuming some degree of 'transference' in psychoanalytical terminology. They would likewise ask themselves whether a battering parent has been a battered child, and whether the incestuous parent had been a victim of incest. On the other hand, forensic experts understand that no one could be and should be prosecuted who is not the real suspect of a crime. For instance, if group dynamic processes are (for the forensic expert) the 'cause' of a crime committed by one of the groups members, or if the scapegoating family is the root of the criminality by the scapegoat, it could never be the group or the family that is prosecuted. If penal laws and penal law procedures have been constructed for the defence of the individual against the power of governments, which I believe is the case, there is very good reason to restrict the government's power over individuals to those (and only, those) who have been proved guilty of a specific crime (Bayaert 1980).

However, there are problems in the legal system. Some laws, especially those concerning the family, have been made with the intention of protecting "hearth and home" against offences from the outside. But we now realize - and this is confirmed by research - that much violence in the family is coming from inside the family. They say that, with the exception of the police and the military, the family is the most violent social group, and the home is the most violent social setting, in our society (Gilles and Straus, 1979). While one out of every four girls in the United States will be sexually abused before she reaches the age of 18, in 75% of the cases the victim knows her assailant and in 34% of the cases the molestations took place in her own home (Webber, 1977). More than three out of every hundred children (3.6 per cent) are at risk of serious injury from their parents each year (Gilles and Straus, 1977).

The laws made in order to protect members of a family against aggressive or sexual abuse from the outside failed for the great part. Even the reverse is true: when we create the opportunity to disclose some form of child abuse without imminent consequences of penal law, the number of notifications by the participants rises remarkably (Webber 1977; Koers 1979).

Another penal law construction is the relative lenience with the "crime passionel". Men as well as women are more or less excused in several penal law systems when they kill an intruder, if they find them 'in flagrante delicto' with their partners in their own homes. Again the protection of 'hearth and home' was the aim of the legislation, while trapping the adulterous partner outside the house and killing the third party was not considered so excusable. Feminists could say that these laws were made to privilege men by male legislators and to oppress women. I think, however, that the first aim of the legislation was to protect "health and home", and the final result of these laws was disadvantageous for women, because they were not considered to be outside the home.

However, whatever the intention of the legislators, the reality of what happens is different. It is not the intruder, the third party, who is killed in most of such cases, but the partner, the second party. To illustrate my point I will sketch two short case histories:-

Mrs B. killed the man to whom she had been married for twenty five years. She had divorced him after this time "for the sake of the children". During the next five years he returned to her, and at times they lived together for several months. He was a heavy drinker, and the noise of their quarrels at night during these periods often led to police intervention. At such times he was thrown out of the house and was refused further admission. However, she allowed her ex-husband to live in her house again and again "out of compassion".

When she came to know that he was living with another woman, she found out the address (which he had tried to keep secret). She went to the house, rang the bell, passed the woman who opened the door and went straight to the room in which she had seen her ex-husband through the window. She stabbed him to death with a knife she had taken with her.

The man had a drinking problem, was a crook (as his juridical files showed), and had had incestuous relations with his sons in the past; so he was far from being an ideal partner. The woman in observation, however, was extremely narcissistic. She said that she had cared for her husband for more than thirty years and that it was due to her that he was kept out of prison, which was possibly true. However, she was really convinced that it was now up to the Dutch government to compensate her for all these efforts in her coming trial. She had an urge (fulfilled for most of her life) to be needed by others. Her already adult children needed her in an extreme and rather bizarre way (e.g. some of them lived in tents near the observation center in order to blow kisses to mother and to have continuous communication through gesture language). As for her ex-husband he had needed her even after their legal separation in every possible way, until the other woman came along. His ex-wife said that she was in such a blind rage, especially because he had broken his promise, which was to come back when all the children had left home. When she divorced her husband she was so sure of his need of her, that she could easily set him aside, put him away in a drawer so to speak as you do with lifeless objects until you want to use them again. It was not a question of jealousy, she said; apparently she did not know such base feelings in herself. She mentioned in this context that she had often asked herself if she was not more god-like than human, because of her self-sacrifice.

Our conclusion was that she was of diminished responsibility during the time of the crime to a high degree. We did not advise a TBR measure, since it did not seem likely that such a tragedy could happen again. The woman could not be considered dangerous in the sense of the penal law.

Mr C. strangled his dearly beloved girlfriend and molested her sexually with his fists when she was already dead. He was legally separated from his wife, but continued to care for her and the children. He lived by himself in a caravan but visited his family every day, to ensure that everything was going according to his wishes. The sexual relations between the ex-partners never ended, but even in this relation he had the dominant fatherly role. He was a good craftsman, a hard but solitary working man.

He fell in love with his girlfriend in a way which was completely foreign to him; for the first time in his life he became dependent. He did not have everything under control any more. After a while the girlfriend began to find his love oppressive; she wanted to leave him, but came back

again: this happened several times. When she finally decided to leave him indefinitely, Mr C. had been drinking heavily for weeks and was physically completely exhausted. In their final conversation she trivialized the love affair by saying that she had not felt much love for him, even in the good days of the affair. At this moment he killed her, in a narcissistic rage. During the observation we tried to examine the interaction between the lovers and in what way there was some relation to the crime. However, when we tried to figure out how she had contributed to the tragedy, he became enraged again, and wanted to break off the observation. It was his crime and nobody should snatch away the slightest part of his responsibility; he and nobody else was the author.

We considered him to have had diminished responsibility to a moderate degree at the time of the crime, and advised treatment in the TBR setting. Repetition of such a crime seemed to us to be a real danger without intensive treatment.

In the extended transcultural experience of the Pieter Baan Center we have ascertained that even an imagined third party could be reason enough to kill a partner. In these cases it was often the inevitable emancipation of the wife in Dutch society which was the origin of the psychotic deterioration of the husband and his imagining of an intruder.

The questions here are:

- what are the psychodynamics underlying this kind of partner killing?
- and why did we (and the legislators) not recognize the fact that this kind of partner killing is (in number) more represented in the forensic case histories than the "crime passionel"?

In the given case histories there is notably a period of "on" and "off" between the partners, before the final tragic ending. Typically, this "on" and "off" is in the power of one of them until just before the crime; a couple of days or sometimes hours or even minutes before the explosive crime, the roles change, and the 'victim' who was abandoned several times becomes the one who is abandoning the others.

The research of Mahler et al. (1975) gives us one explanation of what is happening in these tragic partner killings. Mahler describes the behavior of normal children in their rapprochement crises, when they (as two year olds often leave their mothers to seek some interesting experience) are left by their mother. "During the(se) times of intense emotional anguish after being left, the toddler would attach himself closely to one of the observers, wanting to sit on the observer's lap, and occasionally even regressing into sleeping drowsiness. At such times the observer was clearly neither a love object nor merely some person in the other-than-mother-world, but rather a kind of mother substitute as extension of the self. In forensic experience we again and again find evidence that the aggressive outbursts take place when there is a sudden switch of power in this "on and off" relation - in other words, the leaving one is suddenly abandoned or feels abandoned.

Very often, in the recent history before the crime during the "on and off" period, behavior such as Mahler described is observed in which the Mental Health Services are in exactly the same position as the observer in the quotation mentioned above. These Services, in our case material, seldom realize the seriousness of the situation. It is, of course, quite easy to make a reconstruction of how things went wrong in retrospect, but information about these matters might nevertheless help a little in the future. In any case, the similarity between what happens during the observed rapprochement crises and what happens shortly before the killing of a partner is quite striking. The question of whether the adult could

utilize other behavioral alternatives at the moment of the crime is closely related to his or her development during the separation and individuation phases of early childhood.

In the same way, the prediction of possible dangerousness of the suspect cannot be answered without taking into account these elements of the personal development. Criminological research can possibly conclude that the repeating of such family tragedies is statistically not to be expected, but that will not help us a bit in the prediction of possible dangerousness of the individual who killed a partner. For these questions I would assume that psychoanalytical assessment, theory and practice are far more helpful.

The second question was why we did not recognize these things before. I suppose that crimes which are (in unconscious intention) so close to parenticide could not have been an object of research until now; to kill the dearest was unthinkable. There certainly is a possibility, and perhaps historical research could inform us about this, that the "crime passionel" meant by the legislators was in fact a fierce and tragic crime that happened much more in those days. I have my doubts, however, because the romantic killing of the intruder is more adult, and more comprehensible behavior, and thus more apt to become part of the philosophy underlying penal laws in those days. Most European laws dating from a century or more ago, originally had this philosophy of adult men and women choosing their way at free will. Killing your partner because he or she is not so exclusively yours as you wished, expected and thought, is much more infantile, narcissistic behavior. It is like ruining your own toys as a child might when you have to share them.

I suppose that thinking of people being so unreasonable and so childishly coercive, was not possible in the days when the penal laws were made.

However, we now know that child battering and sexual abuse of children happen in the family in a far higher degree than we ever dared to think. Knowing, however, that there are hardly any parents who do not want the best for their children, we have to admit that many of them are not as adult and reasonable as the penal laws presume them to be. The same is true of partner killing. While the penal laws more or less excuse the killing of an intruder by a jealous and enraged partner, the presupposition is that the suspect is an adult and reasonable human being.

The reality of the disturbed development of suspects who kill their own partner, like children who destroy their belongings, has to be explained to the courts by forensic experts.

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ADDICTIVE BEHAVIORS

PSYCHOLOGICAL APPROACHES TO DRINK PROBLEMS:

A HISTORICAL REVIEW

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Alcohol problems have been conceptualized in different ways over the centuries. This conceptual evolutionary process has been directly and indirectly influenced by the social, political and economic climate of the times.

In Western Europe and America, in the 17th and most of the 18th century, in keeping with the current philosophical view of man as a being of freewill and volition, drinking and drunkenness were perceived as the individual's responsibility. Alcohol was freely and widely available and consumption was high (the 'gin epidemic' in England). Alcohol problems as evidenced by drunkenness (not alcoholism)* were regarded as self-indulgent behavior which the individual engaged in because he or she chose to. 'Drunkards' were mostly ignored and left to their own devices, yet there were instances of severe punishment such as public flogging. There was also some moralistic outcry from the more educated quarters of society about the 'sin' or 'vice' of drunkenness. Whether viewed as troublesome or sinful, drunkenness was seen as the individual's choice.

In the 19th century, the causal emphasis changed from the individual (indulgent out of choice) to the substance (alcohol as an addictive agent). Rush, an American physician, described drunkenness as a "disease of the will" marked by an inability to refrain from drinking (thus the origins of the modern concept of 'loss of control'). Such a disease explanation of drunkenness immediately resulted in the assertion that total abstinence was the only solution. Rush's formulations laid out the groundwork for the American Temperance Movement, which in turn firmly established the addictive disease model. Temperance supporters viewed the addict drunkard sympathetically as the victim, and directed their scorn mostly towards moderate drinkers. Prohibition, which lasted in the United States from 1919 to 1933, was an example of massive social and legislative control in dealing with alcohol problems.

*Throughout this paper, the terms alcoholism and problem drinking have been used interchangeably for the sake of convenience, and the use of the former does not imply agreement with the traditional concept of 'alcoholism'.

The 1930s and 40s saw the establishment of Alcoholics Anonymous (AA) and yet another significant paradigm shift. This time, the source of the addiction was in the individual, and not the substance - only certain individuals could become addicted to alcohol. Since the AA model has dominated the theoretical conceptualizations of drink problems and treatment practices up to the present day, and its essential components have been embraced by the modern Alcohol Dependence Syndrome, it needs to be discussed briefly in this review. (See Levine, 1978, for a historical account of the origins and development of the addiction and disease concept of alcohol problems).

The key concept of the AA model of alcoholism is the notion of 'loss of control'. Accordingly, alcoholics experience a subjective compulsion to drink, and one or two drinks inevitably lead to heavy consumption. This is what the maxim, 'One drink, one drunk' signifies. The loss of control argument is a circular one. As the chief symptom of the disease, it necessitates complete abstinence from alcohol. However, if a previously diagnosed alcoholic subsequently demonstrates control over his drinking, she/he is said not to have been a real alcoholic in the first place. The second major component of the model is its irreversibility. Alcoholism is described as a progressive disease which can be arrested by total abstinence, but never be cured - thus the maxim 'Once an alcoholic, always an alcoholic'. AA advocates who may have been abstinent for many years will call themselves 'recovering alcoholics'.

In this model, there is said to be a qualitative difference between alcoholics and non-alcoholics. Independent of environmental contigencies and life events, an alcoholic can never handle alcohol normally or safely. In other words, 'one is born an alcoholic'. This notion is tied in with the biological argument that some physiological or biochemical mechanism prevents the alcoholic from drinking normally. The early concept of an 'alcoholic allergy' has lost its prominence due to lack of scientific evidence. Despite the vast amounts of research effort expended on looking for physiological mechanisms specific to alcoholics, the evidence is at best equivocal, at worst non-existent.

AA has evolved over the years and although these criteria continue to be the central elements of the disease, they are not always interpreted with as much fervour and rigidity. In recent years, causal explanations have been modified, with less emphasis on biological aetiology. Abstinence is still essential; though, at least in some areas, one hears of a softening even in this respect from AA members. (Since AA meetings are 'closed', direct observation and first hand experience of groups is not possible to outsiders).

The Alcohol Dependence Syndrome, which is the most recent significant development in the alcoholism field, was described by Edwards and Gross in 1976. These authors were also part of a WHO group working on identification and classification of alcohol-related disabilities. Although there are some discrepancies between the Alcohol Dependence Syndrome proposed by Edwards and Gross and the description put forward by the WHO group, most of the essential elements are shared.

Edwards (1977) describes what he means by syndrome as "an observable coincidence of phenomena" and that "not all the phenomena need always be present, or present in the same degree." He states that the syndrome is mainly based on intuitive clinical impression, and consists of seven core elements:

1) Narrowing of the drinking repertoire. This describes an inverse relationship between the degree of dependence and the variability in the drinking pattern of the individual.

2) Salience of drink-seeking behavior. This describes the primacy attributed to drinking over other behaviors (e.g. disregard for adverse consequences, neglect of responsibilities).
3) Increased tolerance to alcohol. Ability to drink increasing quantities without necessarily experiencing or showing the effects of alcohol, due to CNS tolerance.
4) Repeated withdrawal symptoms - frequency and intensity of their occurrence determining degree of dependence.
5) Relief-avoidance of withdrawal. Drinking in order to relieve or avoid withdrawal symptoms.
6) Subjective awareness of compulsion to drink. This is said to be "difficult to phrase objectively" but akin to obsessive ruminations. There may also be involvement of impairment of control where "the patient knows that after a certain priming quantity of drink, he will strongly desire to go on drinking." Impaired control is the leading symptom of the syndrome.
7) Reinstatement after abstinence. Rapidity with which the above elements are reinstated is a function of the previous degree of dependence. It is claimed that in severely dependent individuals physical dependence would be reinstated within a matter of a few days.

In the WHO report (Edwards et al., 1977), three diagnostic components of the syndrome are described. These are: (1) altered behavioral state, (2) altered subjective state, and (3) altered psychobiological state. All the seven elements of the syndrome outlined above are included in the description of these altered states.

There are a number of conflicting statements, inconsistencies and logical problems in the description of the syndrome. Edwards (1977) stresses the role of learning in alcohol problems and in places uses operant language in the description of the syndrome. However, specific components of the model (most importantly, the leading symptom of impaired control) and, arguably, the model as a whole, are incompatible with an operant model. The Severity of Alcohol Dependence Questionnaire (Stockwell et al., 1979), which assesses the degree of dependence, measures mainly physical dependence. As Thorley (1980) points out, strong physical dependence does not always implicate severe problems or harm from alcohol. In other words, degree of dependence does not necessarily correlate with severity. Heather and Robertson (1981) very eloquently point out the contradiction in the claim that the ADS model is continuous, not a unitory phenomenon like the original disease model. They write, "In appealing at the same time to the existence of a continuous distribution in the drinking population and the reality of a core syndrome, the authors of the Alcohol Dependence Syndrome appear to wish to have their cake and eat it too. It seems that a disease entity is being simultaneously rejected and objectified." Edwards (1977) suggests that the degree of dependence is important in deciding goal choice. He argues that if dependence is minimally developed, moderate drinking may be a possibility; if it is severe, abstinence must be the goal choice; and if it is medium, abstinence should be recommended to be on the safe side. Since evidence relating to the predictive value of dependence or severity to outcome is equivocal, and since a range of environmental and personal factors in relation to goal choice are of major importance, such an assertion runs the risk of becoming a new clinical dogma. As a full critical discussion of the Alcohol Dependence Syndrome is not possible within the confines of this review, the interested reader is referred to the following: Heather and Robertson, 1981; Shaw, 1979; Thorley, 1980; and Chick, 1980.

Models discussed thus far are mainly medical models of alcoholism; however, no psychological model of drink problems can be discussed in isolation from the background of the area. Much of the moralistic attitude

in society toward drinking is still reflected in treatment. Strong conflicts in paradigms and theoretical stands get expressed in the most emotional terms amongst prominent professionals with terminology such as "naive fools," "misguided intellectuals sadly misinformed about 'reality' of alcoholism," "unwitting murderers" flying around (cited from Miller, 1983). Advocates of the traditional disease model tend to ignore, deny or reject scientific evidence. Lovern (1982) declared that "the kind of science and technology that tries to teach alcoholics to drink is, in my mind, a warped Frankensteinian thing." This sort of emotional outcry over the controlled drinking controversy is not at all atypical in the American literature. As Miller outlines in detail, the conflict between disease vs. non-disease orientations in Europe is nowhere as extensive, established or hysterical as in North America. Evolution of the scientifically based psychological models of drink problems must, therefore, be viewed in this light.

Initial psychological approaches to drink problems were psychodynamic. In such approaches, alcoholism is mainly seen as a symptom of some underlying psychopathology such as intractable personality disorder or a neurotic disorder (e.g. McCord and McCord, 1960; Lolli, 1952). In conjunction with this type of approach, much research was also carried out on personality factors in an attempt to find the 'addictive personality'. No correlates of personality traits or types to alcoholism have been discovered (Miller, 1976).

Traditional formulations of alcoholism are based on clinical observations, the 'expert' clinician's intuition and the alcoholic's personal experience. Methodologically sound scientific studies were late to arrive in the drinking problems field. A set of innovative and radical observational experiments were carried out by Mello and Mendelson in the '60s. These authors systematically observed the drinking behavior of physically dependent alcoholics, using operant methodology, in an attempt to study the functional relationship of environmental contingencies to drinking behavior (Mello, 1972). These experiments were radical because Mendelson and his colleagues were the first ever to give alcohol to alcoholics for scientific reasons, a practice considered to be unethical in those days (and considered to be so to a large extent now (Miller, 1983)). They were crucial because they directly tackled the issue of loss of control, which is central to the disease concept (and now central to the ADS in its modified form).

At least in the scientific community, these series of experiments destroyed the myth of total loss of control of drinking in alcoholics, demonstrating some degree of control exhibited by the alcoholic subjects as a consequence of manipulation of environmental contingencies. Heather and Robertson (1981) have outlined the major conclusions of these studies. No subject drank himself to a state of unconsciousness even when allowed total freedom over quantity and frequency of consumption. No subject drank all the available alcohol even when no effort was required to obtain it. In the experiments spanning a shorter period of time (e.g. 2 weeks) subjects tended to maintain high but stable Blood Alcohol Concentrations (BACs). Where they had to 'work' for alcohol on an operant task, they tended to work for and consume moderate amounts of alcohol, not drinking it as soon as it became available. Over longer experimental periods (one or two months) subjects tended to simulate 'bout' drinking in real life, with self-initiated and terminated periods of heavy drinking alternating with days of abstinence. As part of this cyclical pattern, subjects were experiencing withdrawal symptoms during abstinent days, yet still preferred to work for alcohol for a day or two before drinking the available alcohol. The authors observed a number of other interesting and informing aspects of drinking behavior. For example, one subject voluntarily terminated the

experiment despite having access to unlimited amounts of alcohol when his co-subject developed gastritis and had to withdraw. Some subjects voluntarily gradually reduced their drinking towards the end of the experimental period to avoid withdrawal symptoms. Another significant finding was that consumption level was directly related to the effort required to obtain it, that is, its 'cost'.

Following from Mello and Mendelson's pioneering work, a number of other investigators conducted experiments in controlled laboratory/hospital settings using an operant framework. These studies, conducted mainly in the first half of the '70s, make a stark contrast to the writings on alcohol problems previous to that. In line with the growth of operant approaches to the study of human behavior in many other areas, drinking behavior of alcoholic subjects was studied and described in an objective, reliable and precise manner. Reading these papers a decade later, some of it appears rather simplistic and naive. For example, experiments were designed to dispense alcohol to patients, who were required to do a simple operant task, from automated machines on various schedules of reinforcement. However, to start looking objectively at specific aspects of the problem drinker's behavior rather than an all-encompassing aetiology, to start studying the functional relationship of environmental conditions to drinking behavior rather than assume some were born different with an alcohol allergy, was an important change in emphasis in the study of 'alcoholism'.

Some of the important work from the operant literature included the following. Reinforcement value of alcohol versus other sources of reinforcement was studied, e.g. socialization (Nathan et al., 1970; Tracey et al., 1975) and ward privileges (Cohen, 1971). A number of investigators found drinking to be a partial function of the effort or work required to obtain it (Mello and Mendelson, 1971; Nathan and O'Brien, 1972; Bigelow, 1973). In 1974, Miller's group published an investigation of operant response rates in alcoholics and non-alcoholics in the presence or absence of visual drinking cues and stress conditions (Miller et al., 1974a, and b). These types of observation pointed in the direction of the resemblance of alcoholic drinking to non-alcoholic drinking in its variability and in being affected by discreet environmental conditions.

With the central role of loss of control questioned, drink problems started to be looked at in a new light. Drinking was experimentally studied by psychologists as one of numerous other types of behavior. Contingencies operating on normal and alcoholic drinking were investigated in a series of analogue and direct observational studies. Some of these will be briefly described here.

Miller and Hersen (1972) devised an analogue 'taste-test' experiment borrowed from Schachter's assessment procedure for obese patients. Subjects were given access to alcoholic and non-alcoholic beverages with instructions to rate the taste where the experimentor in fact measured the amount of alcohol consumed. Miller et al. (1973) also used this procedure in treatment outcome evaluation.

Sobell, Schaefer and Mills (1972) directly observed the drinking behavior of problem and non-problem drinkers in a simulated bar. Not only quantitative but also qualitative differences were found in the drinking patterns of the two groups. Problem drinkers tended to select 'neat' drinks rather than mixed, took larger sips and drank more quickly.

In a widely quoted study Marlatt, Demming and Reid (1973) employed a 2 x 2 factorial design (called the balanced placebo design). Alcoholic and non-alcoholic subjects who believed they were participating in a 'taste-

rating task' were randomly allocated to one of four groups. These were:

1. Told Vodka - given Vodka.
2. Told Vodka - given Tonic.
3. Told Tonic - given Vodka.
4. Told Tonic - given Tonic.

After consuming their 'priming dose', subjects were instructed to drink as much as they wanted to in order to make some taste ratings about their beverage. While each subject was consuming his beverage, his drinking behavior was observed by a 'blind' experimenter. Alcoholics drank significantly more than non-alcoholics and consumed more per sip. The main finding of the study for both groups, however, was that both groups drank more when they believed the beverage contained alcohol whether it actually did or not. In other words, the significant factor in consumption was the expectancy effect, alcohol content having no statistical effect on consumption, neither was there an interaction between expectancy and alcohol content.

Many further studies employing the same experimental design have been conducted examining the effect of alcohol and expectancy in relation to various behaviors. Some of these have included aggression (Lang et al., 1975), anxiety (Wilson and Abrams, 1977), and sexual arousal (Wilson and Lawson, 1976). In these studies expectancy effect has been found to be stronger than the pharmacological effect of alcohol, pointing at the importance of cognitive factors in the phenomenon of loss of control.

In addition to its use in assessment, psychological theory and methodology was also applied to the treatment of alcohol problems. The 1960s witnessed the widespread use of aversion therapy in the treatment of alcoholism (though chemical aversion was being used in 1940s and 1950s as well). Aversion therapies are based mostly on a classical conditioning paradigm. The sight, smell and taste of alcoholic beverages (CS) are repeatedly paired with aversive stimuli (UCS), so that alcohol comes to elicit nausea or anxiety (CR). There is no experimental evidence, however, to show that classical conditioning per se is instrumental in the success of the technique (Miller, 1976). The most common methods include chemical aversion (an emetic which induces nausea), electrical aversion or covert sensitization (verbal and imaginal suggestions and descriptions which induce nausea). Aversion therapies have usually been used with a goal of total abstinence.

Chemical aversive stimuli are difficult to administer reliably and accurately. Given that precise timing of events is the crucial factor in conditioning, this becomes a methodological problem. As Miller (1976) suggests, if alcohol is administered too early, it can have a relaxing effect thus reducing the efficacy of the technique. Similarly, alcohol given after the onset of nausea does not comply with the theorectical principles. Other limitations include side effects and unpredictable individual variations in the response to the drug. Although electrical aversion therapy can be administered with more precision and control, it too has the disadvantage of being a similarly unpleasant therapeutic technique.

Electrical aversion therapy has also been used within an escape or avoidance learning paradigm. In an avoidance learning model, the subject can avoid the shock by engaging in a required behavior. For example, McCullock et al. (1966) randomly presented subjects with a range of alcohol related and non-alcohol related stimuli. Eight seconds after the presentation of the alcohol related stimulus, the subject was given an electric shock unless he terminated this stimulus in the intervening period (at

which point he would automatically be presented by the aversion relief stimulus). In an escape learning paradigm, shock is administered upon taking a sip of alcohol and is terminated when it is spat out (e.g. Blake, 1965).

In covert sensitization (Cautela, 1966) imagined scenes of drinking are paired with imagery of nausea and vomiting, in an attempt to establish a conditioned aversion to alcohol. Imagined scenes of avoidance or rejection of alcohol are paired with imagery of relaxation and of well-being.

None of the aversive conditioning procedures have been experimentally demonstrated to be definitely effective (Nathan, 1980; Miller, 1976). Many of the reports are clinical studies with no proper control groups and compare the efficacy of aversion therapy to other types of treatment or to no-treatment controls. Many of the studies have combined aversion therapy with other techniques like relaxation, systematic desensitization or conventional treatment, making it impossible to judge the relative efficacy of each of these individual components. Miller and Hester (1980) conclude that in the few studies where the efficacy of electrical aversion was selectively compared with other components of the treatment program, its contribution "appears to be minimal at best, and in certain cases may even exert a negative influence." On a theoretical level, some aversion studies have combined classical with operant conditioning mechanisms.

Another method of treatment that is based on classical conditioning is cue exposure. After an analysis of the stimuli that elicit drinking or craving in a patient (for example, certain places, drinks, people, internal feelings) such conditioned stimuli are repeatedly presented to the patient without alcohol (UCS) in an extinction paradigm (Hodgson and Rankin, 1976). This technique has not yet been adequately evaluated.

As in the assessment area, in parallel with increasing sophistication in clinical psychology, unimodal treatment models have been gradually abandoned to be replaced by more comprehensive behaviorally based treatment packages. These typically include social skills training, relaxation, self-control procedures, counseling of spouses and so on. This multifaceted approach was first described by Lazarus (1965).

In their "community reinforcement approach to alcoholism," Hunt and Azrin (1973) aimed at altering the patients' natural reinforcers. Patients were given vocational counseling, family and marital counseling and social skills training. Modelling, role play, verbal reinforcement and identification of competing responses were amongst the techniques employed. Reinforcement access counseling included newspaper and magazine subscriptions, installation of telephone and television in the patients' homes. Full cooperation of family and friends was obtained for social reinforcement to be provided only during periods of sobriety. An alcohol-free social club was established in the community for the use of the patients. Patients in the community reinforcement program were compared with patients in a standard hospital treatment program over a 6 month follow-up period. On multiple measures of outcome, collaborated by a family member, the experimental group did significantly better. In this study the reinforcement group received not only different but also much more treatment than the traditionally treated group. Follow-up period was also too short to judge the stability of outcome. The Hunt and Azrin study is atypical in its emphasis on extensive environmental engineering. With changing emphasis from unimodal classically based aversive procedures to multimodal operant based programs, and with increasing experimental validation of a number of therapeutic techniques in clinical psychology, comprehensive behavioral packages became the vogue in alcoholism treatment in the 1970s. For examples of these comprehensive behavioral programs, see Miller (1976).

Before we proceed any further with developments in psychological approaches to treatment of drink problems, an issue which has caused more discussion than anything else in the field ought to be included here. In 1962, D. L. Davies, a psychiatrist from the Maudsley Hospital in London, published a paper reporting that 7 out of 93 former 'alcohol addicts' were found on follow-up to have been drinking socially for 7-11 years after discharge. When this paper was originally submitted to the Lancet, it was rejected on the grounds that it was not of sufficient interest to the medical community. In fact, a number of previous studies had reported similar findings without creating much impact. (Lemere, 1953; De Morsier and Feldman, 1952; Selzer and Holloway, 1957). In his paper, Davies included enough information to refute a possible allegation that these patients were not real alcoholics in the first place. This paper caused great alarm and concern in the alcoholism community. Experts were shocked and concerned that it might lead abstinent alcoholics to temptation, to experimentation with alcohol and to destruction! Davies was severely criticized by many alcoholism treatment experts, and in fact, the storm of controversy he generated has continued to this day in various shapes and forms.

In the face of this continuing controversy, outcome studies of abstinence oriented treatment programs were published reporting on successful non-abstinent outcomes. In the earlier studies this was referred to mainly as social or normal drinking. In their 1968 review paper Reinert and Bowen coined the term 'Controlled Drinking', making a distinction between this term and normal drinking.

They wrote, "a normal drinker imbibes alcoholic beverages on occasion with the knowledge and complete confidence that well before he gets into any trouble he will have simply lost his appetite for more. In contrast, the controlled drinker has no such feeling of security and has learned from past experience the bottomless pit that may sometimes be opened by the taking of a few drinks. He must be on guard. The controlled drinker must choose carefully and even compulsively the time, the place, and the circumstances of drinking, and he must rigidly limit the amount he drinks. These are protective devices which we have seen operating in many of the reported cases."

The authors pointed out that some 'one-time alcoholics' drinking socially may be normal drinkers, but they felt the majority were controlled drinkers. The only way to accurately make this distinction was to know the patient's 'inner experience, his perceptions of the situation and degree of comfort'. In this early paper, Reinert and Bowen were not only making specific behavioral recommendations in planning controlled drinking, but also emphasizing the importance of cognitive factors. 'Controlled Drinking' has become the most widely used term to describe successful non-abstinent outcomes. Others include harm-free, moderate and attenuated drinking, as well as previously mentioned normal and social drinking.

A vast body of evidence has accumulated that shows previously diagnosed and treated alcoholics can drink moderately. Pattison et al. (1977) reviewed 74 mostly abstinence oriented studies reporting such outcomes, and estimated that an average range of 5-15% of treated problem drinkers subsequently moderate their drinking. Miller and Hersen (1980) studied the same papers Pattison et al., reviewed and found that a separate analysis of the 17 moderation oriented studies yielded a 63% controlled drinking rate (over 1600 patients). Incorporating ten subsequently published papers into their review, Miller and Hersen found that an average 33% of clients achieve moderation when this is the actual treatment goal.

Thus, existing evidence shows beyond doubt that controlled drinking outcomes do occur. Most of such evidence also comes from strictly abstin-

ence oriented treatment programs. Rates of controlled drinking vary widely between studies. For example, Anderson and Ray (1977) found 44% of a sample of 110 to be 'non-destructive drinkers' at one-year follow-up despite a total abstinence approach to treatment. Vaillant et al. (1983), on the other hand, found only 4% of a sample of 100 to be 'drinking asymptomatically' in an 8 year prospective study. As Emrich (1974) suggests, variability in outcome rates seems to be due to idiosyncratic definitions of controlled or normal drinking; or be due to a lack of definition or quantification which makes it difficult to judge the validity of conclusions. Anderson and Ray's definition of non-destructive drinking was "drinking, but never to excess during follow-up period." Vaillant et al., defined stable remission as "community residence and no known alcohol-related problems in the previous two years." Both of these definitions are vague and obviously open to biased interpretation. Sobell (1978) suggests that attempting a uniform, universal definition of controlled drinking would be fruitless because 'controlled drinking' in treated problem drinkers is bound to parallel 'normal' drinking in its heterogeneity and variability in the normal population at large. Any clinician in alcoholism treatment would appreciate this to be the case; however, an operational definition of controlled drinking would allow comparability between studies as well as an evaluation of the validity of the findings.

Another possible source of lack of uniformity between outcome rates is due to differences in the populations studied. To date, evidence on predictors of differential outcome are scarce and equivocal, but certain subject characteristics or an interaction of characteristics appear to be more favorable for a controlled drinking outcome. Some of the predictor variables for controlled drinking include less severe drinking problems at admission (Armor et al., 1978; Orford, 1973), lack of contact with Alcoholics Anonymous (Armor et al., 1978; Finney and Moos, 1981), and cognitive factors (Heather et al., 1982; Orford, 1973). Since most of the evidence is based on abstinence oriented approaches, treatment programs with a goal of moderation probably yield higher controlled drinking outcome rates. Sobell and Sobell (1978) found assignment to a controlled drinking goal to be significantly predictive of a controlled drinking outcome.

On the controlled drinking issue a couple of studies have caused much excitation and public controversy. The first of these concerns what has come to be known as the Rand Report. The US government founded the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1971 to "develop and conduct comprehensive health, education, training, research and planning programs for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholism." The NIAAA established 45 Alcoholism Treatment Centers (ATCs) throughout the country and sponsored their evaluation. Following routine data collection at intake, about one-third of all treated patients were followed up at 6 months. Since comparison between this sample and the parent population revealed no differences on intake variables, the sample was reduced to eight selected ATCs for an extended 18-month follow-up. The Rand Corporation took over responsibility at this stage of the study and published its first report in 1976 (Armor et al., 1976).

The results showed that both at 6 and 18 months two-thirds of the clients were in remission, but the percentages of outcome categories had changed slightly, the proportion of 'normal drinkers' increasing from 12 percent to 22 percent. Relapse rates were not significantly different for normal drinking and abstinence outcomes; in fact, normal drinking appeared to be a more stable outcome. Clients who were less severely impaired at intake were more likely to achieve normal drinking. Clients treated at the ATCs showed substantial improvement on a number of outcome indices, especially so if they had received high amounts of treatment rather than low.

Findings on resumed normal drinking in the Rand Report led to another storm of controversy in the alcoholism world. In fact, there was nothing new or controversial in relation to controlled drinking contained in the report that had not been published in the previous twenty years. The only difference with the Rand Report was that the media got involved and the topic became a public matter. Much of the criticism of the study, though politically motivated, was directed at methodological issues. The authors of the study conducted a four-year follow-up introducing a number of modifications in their procedures in an attempt to correct the justified criticisms of the earlier study. A greater effort was made to locate clients and the follow-up rate increased from 60% at 18 months to 85% at 4 years. Validity of self-reports was increased by including Blood Alcohol Concentration checks and collateral sources of information without prior notice. The drinking assessment period was increased from 30 days to 6 months and resulted in a reduction of the remission category from 67% at 18 months to 54% at 4 years. Definition of normal drinking was made stricter, reducing the proportion of normal drinkers from 22% to 18%. Broadly speaking the findings and conclusions of the 4 year study were not contradictory or substantially different from the 18 month study (though it was on occasion interpreted as so by the media).

Treatment programs set up with a goal of controlled drinking have been based mainly on behavioral principles. The best known study is the Individualized Behavior Therapy (IBT) designed and carried out by Sobell and Sobell (1973, 1976, 1978). This study is famous because, as Heather and Robertson (1981) state, it is "one of the most methodologically sophisticated studies in the alcoholism treatment literature." Those who were not familiar with the work for its scientific merit and clinical interest, heard of it when it became the center of the 1980's stormy controversy over controlled drinking. (Still reminiscent of their presidential embarrassment, it became known as the Bottlegate Scandal in the American Alcoholism circles).

The IBT was "based on the rationale that alcoholic drinking is a discriminated, operant response." Seventy male, hospitalized, Gamma alcoholics were allocated either to a non-drinking (ND) or a controlled drinking (CD) goal. Clients who requested abstinence, who could socially identify with AA and/or lacked social support for controlled drinking were assigned to ND. Those who requested CD, had social support for CD and/or had successfully practised controlled drinking previously were included in CD. Subjects in each group were then randomly allocated to an experimental group or a control group. The experimental groups (CD-E and ND-E) received the full 17 session IBT program which emphasized determining the antecedents for each clients' drinking and teaching alternative appropriate responses. The treatment program included videotape replay of drunkenness, stimulus-control training, problem-solving skills training and electrical avoidance conditioning. The two E groups differed in that only the CD group had sessions in which they practised appropriate drinking behaviors. The control group received a conventional treatment program including AA, group therapy, chemotherapy, physiotherapy and industrial therapy.

An intensive and highly sophisticated two year follow-up was conducted by the authors to evaluate the study. Outcome measures included monthly reports of daily consumption, marital, occupational and vocational status, physical health, use of therapeutic supports and collateral ratings of general adjustment. Additionally, a three year double-blind follow-up was carried out by an independent team (Caddy et al., 1978). A comparison of the CD groups showed the experimental group treated by behavioral methods to function significantly better than the control group which had received traditional hospital treatment. The ND groups, on the other hand, were not significantly different at two and three year follow-up.

In 1982, Pendery et al., published a paper titled "Controlled Drinking by Alcoholics? New Findings and a Reevaluation of a Major Affirmative Study," making allegations of fraud against the Sobells. Once again much public scandal followed. An independent scientific Committee of Enquiry, the Dickens Committee, was appointed to investigate the allegations, and after 5 months reached the "clear and unequivocal conclusion" that there was "no reasonable cause to doubt the scientific or personal integrity" of the Sobells. A further congressional inquiry also fully supported the conclusions of the Dickens Committee. Since it was the allegations which received wide media coverage rather than the scientifically oriented support of the original study, this yielded an opportunity for advocates of the traditional total abstinence model to publicly and hysterically attack controlled drinking.

Many other multimodal behaviorally oriented treatment studies with a goal of controlled drinking have been published. See Miller and Hester (1980) for a review of these. Of a possible 17 therapeutic techniques, various studies have used different combinations ranging in number from one to seven treatment components. Methodologically these studies are more sophisticated than other areas of alcoholism treatment research. A comparison of the multimodal 'broad-spectrum' treatment programs with simpler, drinking-focused behavioral approaches does not show significant differences in outcome rates.

The question of intensive versus minimal treatment modalities has received increasingly more attention in the alcoholism treatment literature. Apart from some correlational findings between length of treatment and successful outcome (i.e. Armor et al., 1976), most of the evidence points towards there being no difference between lengthy intensive treatments and brief simple interventions applied across the board.

Orford et al. (1976) allocated male patients to either intensive in-patient or out-patient treatment or to a single advice session. At one and two year follow-ups, there were no significant differences between the groups. In this much quoted study, the patients were all married and socially stable (which is a positive prognostic indicator). In fact there was some evidence suggesting that patients with more severe symptoms benefited more from intensive treatment, whereas this approach appeared detrimental to clients with less severe symptoms. Patients in both groups were visited in the community by professional staff on a regular basis for follow-up evaluation. These visits probably provided continued therapeutic contact for the patients as well as outcome data for the research team.

A number of controlled studies have shown the ineffectiveness of in-patient treatment compared with out-patient treatment (e.g. Edwards and Guthrie, 1967); and of long in-patient treatment compared with short in-patient treatment (e.g. Willems et al., 1973). Despite these findings, the mode of treatment continues to be comprehensive in-patient programs in most treatment agencies both in the United States and in Britain.

In the light of research evidence, Miller and Hester (1980) suggest that, given the limited therapeutic resources, instead of offering intensive treatment to all clients, minimal interventions should be routinely given, with an option to go on to more intensive treatment if the client has not benefited. Miller (1984) recommends matching clients with different modes of interventions with a view to achieving superior outcome results. He suggests that clients can be matched to treatment goal, method, setting or therapist type. There is some limited evidence to suggest that more socially stable clients and those with a less severe alcohol problem may be more suitable for a controlled drinking goal. There is also some evidence implicating more intensive treatment for more dependent/severe

symptomatology clients and for those with cognitive impairment. Non-directive methods of treatment are suggested for clients with a high conceptual level and for those with internal Locus of Control. Obviously a lot more experimental research is necessary to increase the level of confidence and accuracy with which clients can be matched with interventions. As well as having more scientific face-validity, this approach also seems much more cost-effective in terms of professional time and facilities. A central consideration in improving the appropriateness of treatment type is the client's personal choice in relation to various criteria (e.g. goal choice, length and intensity of treatment).

Since in general one type of treatment service does not appear to be superior to others, much more evaluative research is needed to establish the efficacy of specific intervention techniques. Clinical psychologists are usually the people in treatment services who incorporate research into their practice. With more and more psychologists being attracted to the addictive behaviors field, it is to be hoped that there is a significant increase in clinical research built into alcoholism treatment programs.

There are some methodological problems inherent in alcoholism research, some specific to the field, but most similar to those prevalent in other areas of clinical research. Maisto and Cooper (1980) summarize the major methodological problems involved in evaluation studies in addictive behaviors as the following:

a) Failure to allocate subjects randomly to different treatment conditions.
b) Failure to collect baseline or pretreatment data on subjects.
c) Use of retrospective rather than planned treatment outcome studies.
d) Use of intensive measures of treatment outcome (drinking behavior as the main or only criterion of outcome).
e) Failure to evaluate the reliability and validity of outcome measures (despite the fact that most measures are based on the subject's self-report).
f) Attrition of follow-up subjects.

Treatment evaluation needs to be incorporated into the service from the beginning as a routine component. Regular follow-up can serve the function of both research and aftercare. Recruiting the involvement of community nurses and social workers would be desirable. The majority of evaluation studies have a one-off follow-up, for example at one year, requiring the client to provide exact information on drinking behavior and other measures. Frequent and regular follow-up would not only increase the reliability and validity of information on outcome measures, but also more realistically reflect fluctuations in such measures over time. As Caddy (1980) suggests, it is not necessary to follow-up all patients who receive treatment at a given agency over a given period of time. A random sample of the parent population will provide a reasonably valid index of treatment efficacy. See Sobell et al. (1980) for a thorough coverage of methodological issues and ways of improving the quality of treatment evaluation research in addictive behaviors.

In summary, psychological approaches to drink problems initially involved the application of principles of classical conditioning. Subsequently, operant conditioning mechanisms were applied in treatment. A social learning model, incorporating both classical and operant learning, came to view drink problems as learnt behavior triggered by antecedent cues and defined by their consequences. The last two decades have witnessed various paradigm shifts, with increasingly more sophisticated and integrated conceptual models emerging.

Such a model is continuous: individuals, problems and treatment choices are perceived as lying on a continuum and as changing position on that continuum depending on various personal and environmental factors. It is a multivariate model: problem drinking is viewed as a result of an interaction of social, economical, psychological and biological systems. It takes into account psychological principles which govern normal drinking and all other types of behaviors, and utilizes empirical evidence from experimental psychology. There is also a strong emphasis on the role of cognitive processes. The best application of a cognitive-behavioral analysis has been by Marlatt and his team who have used it to study the phenomenon of relapse (Marlatt et al., 1978).

For an example of a recent, integrated psychological model of problem drinking, see Robertson et al. (1984). These authors describe drinking problems as a pay-off matrix of social, psychological or psycho-physiological elements, where treatment needs to aim at altering the balance of such pay-offs for each individual.

Another important change that has occurred is to approach addictive behaviors in a unifying fashion rather than as individual problems. Traditionally addictive behaviors have been researched and clinically treated as separate areas. The present emphasis is to work towards a cohesive theory and practice applicable to a range of 'addictions'.

The Department of Health and Social Security report on "The Pattern and Range of Services for Problem Drinkers" in Britain, published in 1978, does not refer to psychologists specifically as a group to play a significant role. However, the number of clinical and research psychologists working in the field of addictive behaviors has been rising rapidly in recent years. As a group with training and experience in research methodology and oriented toward a critical evaluation of their practice, psychologists have much to offer. Also as a group who tend to participate to a large extent in training others, they exert influence.

In Britain, there is a supportive network of psychologists who work full or part-time on the problems of addictive behaviors, with opportunities to meet together at conferences or workshops at a national or regional level. A group that provides an excellent platform for discussion of scientifically based issues and developments is the "New Directions in the Study of Alcohol Group" which was founded in 1975 by D. L. Davies.

Despite much political controversy, some of which has at times hampered nonpolemic endeavor, there has been much progress in the theory and clinical practice of drink problems. Psychologists have been responsible for much of this through an empirical approach. It is an exciting and rewarding field to work in with still a lot of progress to be made.

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ALCOHOL-FOCUSED TREATMENTS FOR PROBLEM DRINKERS: ARE THEY NECESSARY?

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A recurring theme in attempts to understand the nature of drinking problems concerns the direction of causal relationships operating between alcohol abuse and the host of physical, social and psychological problems with which it is frequently associated. Though the role of drinking as a cause of physical illness is frequently overlooked in many health-care settings, it is well established that alcohol abuse may be responsible for a bewildering variety of types of physical harm (e.g. Pequignot and Tuyns, 1984). With regard to the equally encyclopedic range of social and mental health problems known to be associated with heavy alcohol use, the direction in which causality operates is less easy to discern and sophisticated research designs are required to elucidate these in general terms.

When presented with the individual client who is, for example, drinking heavily within the context of family discord or with accompanying depressive or phobic symptoms, to what extent should treatment efforts focus upon these other problems as opposed to focusing on the client's alcohol-use itself? Do we need to focus upon the alcohol at all or will this look after itself following sessions of family therapy or cognitive-behavioral therapy for the accompanying disorder? The answers to questions such as these are very likely to be determined by the treatment agent's beliefs about cause and effect relationships which typically obtain between drinking and other presenting problems.

While I do not accept that there are any simple one-sided solutions to these puzzles or that the research evidence is so compelling as to allow room for dogmatism, I do believe that as psychologists we are frequently guilty of erring in one particular direction; that is to see heavy drinking as invariably symptomatic of psychological problems and to focus on these in treatment rather than on the drinking. I would even venture to suggest that many clinical psychologists regard specialists in the alcohol field as being narrowly obsessed with their client's drinking behavior at the expense of more psychologically stimulating areas such as family dynamics, social skills deficits or mood disorders. It is not necessary to look very far for explanations of this state of affairs; there are numerous theories which seek to explain alcohol abuse in terms of psychological factors. For example, there are the personality theories depicting the individual who is vulnerable to abusing alcohol as having inadequate, neurotic and/or dependent personality traits. Learning theories of problem drinking frequently emphasize the reinforcement value of drinking in terms of, for example,

reducing anxiety and depression or facilitating pro-social behavior. The currently fashionable Systems Theory refers to "Alcohol Marriages" and "Alcohol Families", rather than to individuals who are afflicted with that condition we used to call "alcoholism'; the alcohol abuse here is taken to reflect pathology within the family system (Steinglass, 1984). Corresponding to each of these examples are widely-used therapeutic approaches - respectively psychotherapies, cognitive-behavioral therapies and family therapies. While I firmly believe each of these theoretical and therapeutic approaches have their place in understanding and treating drinking problems, I feel they may sometimes be adopted prematurely and that alcohol-focused approaches are sometimes inappropriately overlooked. In defence of this viewpoint I will now try to argue that recent research findings increasingly point to the surprising conclusion that much psychopathology is the result, and not the cause, of alcohol abuse - as is also the case for the physical complications of heavy drinking. Furthermore, failure to recognize the primacy of alcohol use in the genesis of numerous physical and mental health problems can be a costly oversight for several reasons:

(i) Treatment that does not include alcohol in its focus is unlikely to succeed and may be wasted and expensive effort. For example, continued drinking will wipe out the therapeutic effect of anti-depressant medication for depression or of tranquilizers for a sleep disorder or anxiety-state as it will for cognitive or behavioral interventions.

(ii) Drug therapies in particular are likely to be additionally harmful when drinking continues. The list of drugs whose actions are interfered with or potentiated in some way by alcohol with the possibility of serious and sometimes fatal consequences is long. It includes anti-coagulants, hypnotics, major and minor tranquilizers, tricyclic anti-depressants, analgesic, anti-epileptic, anti-diabetic, anti-hystamines, anti-hypertensive and some antibiotic drugs (Laurence and Bennett, 1980, BNF, 1984).

(iii) By failing to emphasize the link between drinking and the presenting complaint - again be it physical or psychological - an opportunity is missed for challenging the client or patient to help themselves or seek more appropriate help. A recent survey of Liver Unit patients with serious alcoholic liver disease yielded the astonishing fact that 60% claimed never to have been advised by anyone - let alone their GP - to cut down on their drinking. Collateral sources such as other family members and GP records confirmed this finding (Saunders et al., in press). Even if only a tiny percentage of at-risk drinkers respond to such simple advice - as seems to be the case with advice to stop smoking (Russell et al., 1979) - the possible benefits of applying such a minimal intervention on a large scale could be to prevent a great number of cases of alcoholic liver disease from ever occurring. Maybe the same could be true of alcohol-induced mental health problems.

Disentangling causal relationships between drinking and impairment of psychological health is not straightforward. However, some convincing evidence for the frequent primacy of alcohol in the genesis of psychological ill-health has recently emerged and will be briefly discussed here.

ALCOHOL AS A CAUSE OF MENTAL HEALTH PROBLEMS

Firstly, numerous investigations have demonstrated an association, if not a causal relationship, between heavy alcohol use and mental health problems.

Surveys conducted with both clinical and non-clinical populations have repeatedly found such associations. For example, prevalence rates of 18%

and 32% for severely disabling phobic anxiety states (agoraphobia and social phobias - Marks, 1969) have been reported for clinic samples of problem drinkers based on clinical interview and questionnaire data (Mullaney and Trippett, 1979; Smail et al., 1984).

Many studies employing personality scales such as the Minnesota Multiphasic Personality Inventory (MMPI) and the Eysenck Personality Inventory (EPI) have shown consistently that measures of neuroticism and anti-social behavior are elevated among captive samples of problem drinkers (Kammeier et al., 1973; Shaw et al., 1975; Orford and Edwards, 1977; Rankin, et al., 1982). In addition, such studies have also shown personality measures to be more abnormal both with severer degrees of dependence upon alcohol (Rankin et al., 1982) and in individuals with longer histories of alcohol abuse (Loper, 1973; Barnes, 1979).

Whether we consider phobic anxiety states, depression, neuroticism or anti-social behavior in relation to alcohol abuse, what research methods will distinguish various types of causal relationship? Representative evidence from four sources will now be considered: (i) retrospective studies relying on self-reports of problem drinkers; (ii) prospective studies of cohorts followed up over many years; (iii) genetic studies; (iv) observational studies of behavior during prolonged bouts of heavy drinking.

(i) Studies Using a Retrospective Design

Mullaney and Trippett (1979) found a prevalence-rate of 32% for severe phobic anxiety states among in-patient alcoholics. For subjects assessed as having both phobic problems and a degree of physical dependence upon alcohol, a majority reported an earlier age of onset for the phobia than for either drinking becoming a problem or developing physical dependence. While strict criteria were employed for rating a current phobia as "severe" this was not the case for the retrospective report of "age of onset" and the important dimension of problem severity was not addressed in this study.

A subsequent study with a similar retrospective design (Stockwell et al., 1984) required a sample of phobic problem drinkers also to estimate the age at which their phobias had been most severe. As shown in Table 1, this was, on average, eight years later than the onset of problem drinking. The ordering of these items was highly reliable on test-retest and also statistically significant ($p<0.001$). In addition, this study employed retrospective assessments of the severity of alcohol dependence and of phobic anxiety states employing previously validated questionnaires. Again the data collected were found to be highly reliable both across repeated

Table 1. Median ages given by subjects in answer to questions about the history of their drinking and phobic problems

Question	Median age
When fears first a problem	28
When drinking first a problem	30
When first aware of need to drink alcohol in the morning	31
When first began drinking to get rid of the "shakes"	32
When fears most troublesome	38

tests and different interviewers. It was found for these subjects that past periods of heavy drinking and dependence upon alcohol were associated with an exacerbation of agoraphobia and social phobias. Conversely, subsequent periods of abstinence were associated with significant improvements in these phobic anxiety states. These temporal relationships are demonstrated in Figure 1 showing mean scores on the Agoraphobia (Ag) and Social Phobia (Soc) sub-scales of the Fear Questionnaire (Marks and Matthews, 1979) rated for past periods before the onset of alcohol dependence, during a period of dependent drinking and after this (a period of virtual abstinence for 6 months or more) (Stockwell et al., 1984).

These data are strongly suggestive of alcohol having a causal role in the presentation of phobic anxiety states for this special clinical sample of 'phobic alcoholics'. Despite the evidence provided for the reliability of the retrospective methods employed, a hardened sceptic will more likely be swayed by the findings of studies with a prospective design.

(ii) Studies Using a Prospective Design

George Vaillant (1982) reported a 40 year prospective study of alcohol use of 184 men who had attended an American College. When the men were aged 50 an independent rater classified 26 of the sample as being alcohol abusers according to strict research criteria. Early measures of childhood adjustment and personality stability at college were shown to predict adult mental health over 25 years later - in particular, poor early adjustment predicted adult personality traits such as pessimism, passivity, self-doubt, fear of sex and dependence on others. However, none of these measures of early adjustment predicted adult alcohol abuse. Since alcohol abuse in adult life was correlated significantly with adult mental health and personality problems, it is suggested that these problems were a consequence and not a cause of their alcohol abuse.

In a similar prospective study of American college students, Kammeier et al. (1973) administered the MMPI to subjects twice with an interval of 15 years. Subjects who had developed problems with alcohol abuse over the intervening period, subsequently developed abnormal or, supposedly, pathological MMPI profiles on the second test where these were absent on the first test occasion.

In a carefully conducted longitudinal study of an adult community sample of 742, Aneshensel and Huba (1983) studied the relationships between

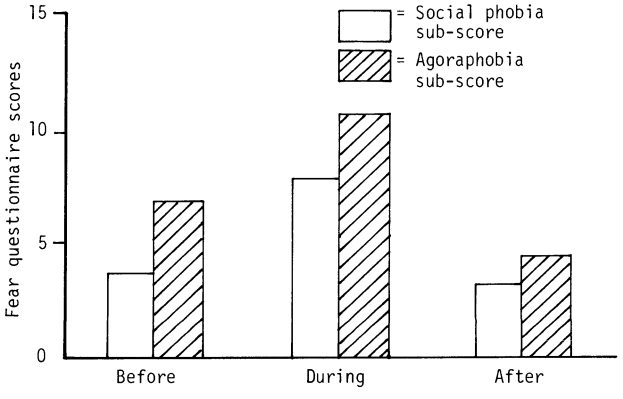

Fig. 1. Mean fear questionnaire sub-scores for 9 agoraphobic and 7 socially phobic individuals reporting on periods before during and after the development of alcohol dependence. (Maximum score 15).

alcohol use at four points over four years. They report that in the short-term alcohol use lead to decreased levels of depression but that the long-term causal effects, which may take a full year to unfold, are for heavy alcohol use to heighten depression levels.

If the above studies indicate that periods of alcohol abuse worsen mental health, the converse has been found when alcohol abuse ceases. For example, Orford and Edwards (1977) report that 12 months after a sample of 100 male alcoholics first made contact with a treatment unit, those who became mostly abstinent or in control of their drinking displayed significant reductions in their neuroticism (N) scores on the EPI. Those whose drinking did not improve, however, still scored at a high level on the N-scale.

(iii) Genetic Evidence

One quite powerful test of the "alcohol primacy" hypothesis was performed by Mullan et al. (in press) using a co-twin control method. Eight monozygotic (MZ) and 13 dizygotic (DZ) twins discordant for alcohol dependence were identified and assessed using the Schizophrenia and Affective Disorders Schedule (Spitzer and Endicott, 1975), the Eysenck Personality Questionnaire (EPQ) (Eysenck and Eysenck, 1975) and the Severity of Alcohol Dependence Questionnaire (SADQ) (Stockwell et al., 1983). The design of the study assumed that twins discordant for alcohol dependence have similar pre-morbid personalities and hence any consistently abnormal personality attributes across all the alcohol dependent twins are likely to be secondary effects of alcoholism. Several studies have established a high degree of heritability in personality traits measured by the EPQ (Eysenck and Eysenck, 1976; Keskenvuo, 1983). It was found that intrapair differences in psychoticism, neuroticism and extraversion on the EPQ were significantly correlated with differences in severity of alcohol dependence scores. Furthermore, the frequency of diagnoses made for neurotic disorders (e.g. panic disorders, obsessive-compulsive disorders) in the alcoholic co-twins was twice as high as for the non-alcoholic co-twins. Again, the results were interpreted as suggesting that neurotic and other abnormal personality traits supposedly known as the "alcoholic personality" are a consequence, not a cause, of alcohol abuse.

(iv) Observational Studies of Drinking Behavior

Both the twin-study described above and the other investigations of fluctuations in alcohol use and mental health problems over periods counted in years may not, it could be argued, rule out a subtle causal factor independent of both these variables - possibly even selectively affecting the "alcoholic" co-twins in Mullan et al.'s study. This possibility might seem less plausible if mood disturbance and general psychopathology could be shown to worsen over shorter time periods of heavy alcohol intake in a constant environment. In fact, there exists a very consistent body of experimental work indicating that prolonged alcohol consumption by in-patient alcoholics can lead to a marked deterioration in their affect, consisting primarily of heightened anxiety and depression (Freed, 1978; Mendelson and Mello, 1979). These studies typically employed both self-report and observational measures and assessed changes in behavior and psychopathology over an abstinent baseline period, a heavy drinking period of up to two weeks and a subsequent "dry" period. Alterman et al. (1975), for example, reported that patients who took the available option of continuing to drink throughout an experimental treatment program experienced increasing subjective discomfort, while those who did not drink at all experienced a global improvement in mood.

Perhaps the last word on this issue could be left with the collective opinion of a sample of problem drinkers who reported experiencing at least one fear on Marks and Matthews' (1979) Fear Questionnaire. When asked "Do your fears get worse after a period of very heavy drinking?" A resounding majority of 69% replied, "Yes" (Stockwell et al., 1984).

Implications for Prevention and Treatment

To suggest on the above evidence that much other psychopathology associated with alcohol abuse is the consequence not the cause of drinking, is not to deny that in many instances heavy alcohol use might begin in response to, for example, a degree of mood disturbance whether this be mild or moderate. Several studies indicate that a degree of depression or phobic anxiety frequently precedes alcohol abuse (e.g. Mullaney and Trippett, 1979). What is being argued here is that prolonged periods of high alcohol intake will exacerbate pre-existing psychopathology and may even create this where none existed before. The roots of alcohol abuse lie in society, culture, family life, economics and trade as much as in individual psychopathology. The studies reviewed here simply testify collectively to the (perhaps sometimes overlooked) consequence of alcohol abuse that in addition to the endless varieties of physical harm it creates should be added serious harm to mental health.

Should this knowledge affect clinical practice in any definite direction? In the first place, it should alert members of health service and caring professions to the possibility of a drinking problem underlying other psychological harm. Problem drinkers are notorious for slipping through the net of treatment services unnoticed, frequently being treated for other conditions symptomatically, such as stomach disorders or insomnia. In the United States it has been estimated that only 30% of problem drinkers in the community are identified and involved in any kind of help (Rubington, 1972). As mentioned earlier it has recently been reported that the majority of patients admitted to a Liver Unit for alcoholic liver disease had never previously been advised to cut down their drinking (Saunders et al., in press). How many problem drinkers come forward for help with depression or an anxiety state, for example, and are treated for this without the underlying drinking problem being identified by either party? In the practice of clinical psychology this is a particularly pertinent question. I have personally encountered clients who were failing to respond to lengthy courses of desensitization for phobic anxiety or cognitive therapy for depression whose therapist failed to discover or discuss their heavy alcohol use - and who subsequently improved dramatically when their alcohol consumption was reduced. In short, I am suggesting that any intervention or treatment approach with adult mental health problems should consider the client's alcohol use and that this should be controlled within safe levels prior to commencing other treatment. This applies equally well for time-consuming and expensive psychotherapies as for sometimes equally expensive, and potentially dangerous, drug therapies.

If adopted on a wide scale by health-care agencies the following simple procedures could contribute dramatically to both the prevention and early detection of drinking problems:

(i) a preparedness to routinely ask clients about the quantity and frequency of their typical alcohol intake;

(ii) the provision of information in a verbal or written form concerned with "safe" levels of intake and the consequences of exceeding these;

(iii) withholding active treatment of other complaints or problems where this would be jeopardized by continued heavy drinking - until alcohol intake has been reduced to safe levels;

(iv) provision of self-help material concerned with controlling alcohol consumption. Several self-help manuals for controlled drinking are available and have been found to be as effective as more intensive treatment methods (e.g. Miller and Baca, 1983).

It is a shortsighted strategy that overlooks the need for alcohol-focused treatment, however minimal, until the harm is so apparent that referral to a specialist treatment unit, or even Liver Unit, is the only recourse.

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MINIMAL TREATMENT INTERVENTIONS FOR PROBLEM DRINKERS

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The term "minimal interventions" or "minimal treatment interventions" has been gaining currency in recent years, particularly in the area of addictive behaviors, but it is sometimes not clear what it means. I shall not attempt a pre-emptive definition here but merely describe the way the term will be used in this chapter.

A treatment intervention is considered minimal if it entails a significantly lesser amount of professional time and/or resources than are typically involved in conventional face-to-face treatment, whether in an individual or group setting. In short, compared with more intensive interventions, minimal interventions are shorter, cheaper, or both. It will be convenient to leave the definition as vague as that for the present.

In contrast to some uses of the term, however, minimal interventions are taken here to include the effects of self-help manuals, with or without direct therapist involvement. This is because it is assumed that self-help is an essential ingredient of all minimal interventions and, indeed, of successful interventions of any kind. Thus, it is not useful to make a distinction between self-help manuals and other forms of short intervention in which manuals are not used. Written self-help materials represent only one type of intervention based on the principle of self-help among a range of possible ways of attempting to encourage beneficial changes in behavior. The common feature of these minimal interventions, and the property which mainly gives them interest at the present time, is that they succeed in breaking away from the mould of the traditional treatment delivery system which has been inherited from the medical context in which clinical psychology has developed and which, it can be argued, has seriously constrained our attempts to disseminate the results of advances in self-management theory and practice.

In this chapter, I will first provide a general background to the topic of minimal interventions, with particular reference to problem drinking. I will then discuss research on the use of "bibliotherapy" with problem drinkers and briefly describe the results of some recent research into the effectiveness of self-help manuals with this target-group. Finally, I will mention some other research projects which are planned or currently underway in the Addictive Behaviors Research Group, Department of Psychiatry, University of Dundee and outline a general program of research into minimal interventions.

Perhaps the most important implication of having abandoned disease-type explanations of problem behaviors is that the behaviors in question are not seen as dichotomous but as lying on a continuum running from normal to highly abnormal. Thus, in the problem drinking area, it is no longer seen as profitable, certainly by psychologists but by many psychiatrists too, to divide problem drinkers into diagnosable 'alcoholics' and those showing some qualitatively lesser degree of impairment. Rather, drinking problems are seen as lying on some hypothetical continuum and as involving varying degrees and types of harm. That being the case, it would appear logical to envisage treatment responses to drinking problems as also lying on a continuum. This possibility is simply illustrated in Figure 1 where the intervention continuum is seen as ranging from mass media 'health education' campaigns aimed at altering the behavior of large numbers of individuals to face-to-face treatment aimed at a single person.

Although Figure 1 has been referred to as a continuum of treatment, the point along the continuum where 'education' ends and 'treatment' begins is essentially arbitrary. Indeed, given an explanation of problem drinking in the terms of social learning theory (see, e.g. Heather and Robertson, 1985), the distinction between education and treatment is meaningless. Perhaps it would be better to abandon these terms altogether and talk simply of 'interventions', 'interveners' and 'targets' or 'clients' of intervention.

In an older, medical terminology, the continuum in Figure 1 is clearly that between primary and tertiary prevention and, seen in these terms, the minimal interventions which lie at various points along the continuum are located in the traditional province of 'secondary prevention'. However, a reversion to these essentially medical concepts is not to be encouraged, because they imply that problems will inevitably get worse unless prevented from doing so. There is now, of course, copious evidence of 'spontaneous remission' from drinking problems without any outside intervention (e.g. Tuchfeld, 1976; Saunders and Kershaw, 1979). But although many problem drinkers do solve their problems on their own, many do not and, in any event, temporary problems may cause significant damage to people's lives and are therefore proper targets for intervention.

There are several ways in which the ordering of minimal interventions along the continuum described in Figure 1 can be conceptualized, but this will be left until the presentation of a general program for research at the end of this chapter. Apart from the degree of intensity, however, the way in which minimal interventions may be delivered to potential clients is also variable, both with respect to the means by which such clients are identified and the means by which the intervention is communicated to them. In the problem drinking area, clients may be identified by General Practitioners, in general medical wards, by the courts, at the workplace, or simply recruited via newspaper, radio or television advertisements. Many problem drinkers self-select for minimal interventions by reading self-help manuals or other materials.

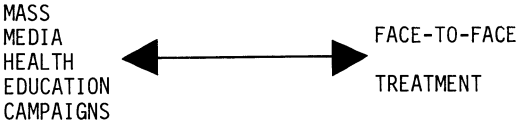


Fig. 1. A hypothetical continuum of treatment intervention.

With regard to the medium of intervention itself, most prominent is the printed word - 'bibliotherapy' - in the form of self-help manuals or articles in newspapers or magazines. As well as being on sale, such materials may be made available in GPs' waiting rooms, libraries, information centers or sent through the post. Alternatively, the medium used could be audiotapes or videotapes, which may be especially appropriate for clients with poor reading skills or weak reading habits. For the future, one could imagine minimal interventions being prepared for use on home computers.

Self-help materials may be supplemented by various levels of professional or paraprofessional contact, of a kind which could not reasonably be described as treatment in the traditional understanding of the term. Such contact may be made either in person, or by post or telephone, including the use of an answering service in which clients merely give regular reports of progress. In addition to trained workers, interventions may be supplemented by the involvement of spouses, friends or workmates. All these possibilities have been interestingly explored by Christenson et al. (1978).

We must not forget also the effects of self-help in the special sense of 'mutual aid' (Robinson and Henry, 1977). Although self-help groups of fellow sufferers, like Alcoholics Anonymous, often eschew the involvement of professionals or any kind of outside influence, others may be initiated by professional workers and may continue with varying degrees of professional involvement or supervision. A full definition of minimal interventions would have to embrace the modern phenomenon of mutal aid groups.

Reasons for Interest in Minimal Interventions

Given that the idea of self-help has a long history (Robinson and Henry, 1977), why is there a particular interest in self-help, and minimal interventions generally, at the present time? There may be many reasons, but five, ranging from the most general to those most specific to the problem drinking area, will be identified here. These are seen as trends which have recently converged, mainly during the 1970s.

1. It is now clear that, in most industrialized nations of the world, health services appear to have reached the limits of their expansion. (Whether or not this is a political inevitability will not be debated here). At the same time, the number of problems with which these health services have been designed to deal have continued to increase. For example, the rate of problem drinking in Britain is estimated to have increased fourfold over the last twenty years or so (Saunders, 1985). This expansion of need has been accompanied by expanding definitions of what constitutes a problem, particularly if a constrictive disease formulation of the problem is being abandoned, as in the problem drinking area.

Although there remain many powerful arguments for radically increasing the number of clinical psychologists working in the National Health Service, most observers would agree that, in any realistic scenario, there will never be enough psychologists to deal with all the problems which are now considered legitimate targets for intervention in a rational and humane society. The same is true for psychiatrists or for any other professional group working in the mental health services. If this is true for industrialized countries, it is even more true of developing nations where anything approaching an adequate response to behavioral problems in traditional terms is economically unimaginable. Hence the pressing need to develop more cost-effective ways of improving the quality of people's lives.

2. At the same time as the need for more cost-effective services has become an economic imperative, there has emerged an ideology of self-help which fits conveniently with it. This arose from the libertarian sentiments of the 1960s and is characterized mainly by objections to bureaucratic social control. It is exemplified by resistance to professional dominance and imperialism, and by the call for a higher degree of self-determination in the solution of life's problems. In addition, there has been an awareness of the dangers of medical iatrogenesis, as shown particularly in the work of Illich (1977) and, of course, a rich sociological literature on the deleterious effects of the labeling process (e.g. Kubington and Weinberg, 1968). One of the chief advantages claimed for minimal interventions is that they are more likely to avoid iatrogenic and labeling tendencies.

Combining the last two reasons for interest in minimal interventions introduces the possibility of a danger which will be mentioned for the first time here. The late Peter Sedgwick (1982) astutely pointed out that precisely those libertarian ideals associated with the counter-culture of the 1960s are now being used by anti-collectivist governments to justify cutting back on essential medical and social services. Enthusiasm for minimal interventions could perhaps be used for the same purpose.

3. Self-help approaches to human problems have been popular before, especially during the last century, but it could be argued that never before has enthusiasm for self-help been supported by a scientifically-based set of principles, such as that derived from self-management theory (e.g. Thoresen and Mahoney, 1974; Karoly and Kanfer, 1982). This has made available for the first time a systematically-formulated behavioral technology with which to buttress individual attempts at self-help, although it remains an empirical question whether the use of such a technology gives significantly superior results to spontaneous and naive 'boot-strapping', at least with respect to problem drinking.

Leaving this objection aside, it is clear that clinical psychologists are ideally placed to take advantage of the self-help ideology mentioned above, by following the precept advocated by George Miller (1969) (in his famous presidential address to the American Psychological Association) of "giving psychology away." Some psychologists have considerable reservations about the dangers of degrading psychological principles and practices by delivering 'behavioral packages' to other helping professions, but there are surely fewer reservations about delivering practical advances directly to the clients themselves. In any event, psychology is hopefully better placed than other professions to avoid that almost definitive property of professionalism, the attempt to mystify and acquire exclusive rights over a body of specialized knowledge.

4. A major limitation of the disease theory of alcoholism, which incidentally was acknowledged by Jellinek (1960), is that it restricts attention to the upper end of the spectrum of harm and dependence by defining alcoholism exclusively in terms of the stereotype derived from Alcoholics Anonymous. Lesser but significant degrees of harm and different kinds of drinking problem either went unrecognized or were regarded as less deserving of therapeutic attention. With the demise of the disease theory, the treatment of drinking problems has been opened up, so that types of problem which do not necessarily involve a severe degree of withdrawal symptomatology are now regarded as perfectly legitimate targets of intervention. This is not merely in the interests of 'secondary prevention', since the assumption that problem drinking is subject to a relatively inexorable sequence of symptoms and phases has also been contradicted by the evidence (e.g. Clark and Cahalan, 1976). Studies of drinking problems in the real world have shown that they differ markedly from those typically encountered

in the clinic (Room, 1980). Apart from showing a higher level of physiological dependence and a higher mean age, clinic alcoholics are more likely to include the 'spare' people of our society - the unemployed, the unattached and the homeless. This has led to increased efforts to intervene in that 'other world' of drinking problems in the natural environment.

It is also important to note that the traditional treatment goal of total and lifelong abstinence from alcohol is not always necessary in the successful solution of such problems, and may be actually counterproductive in the treatment of less serious problem drinkers (Polich et al., 1980; Sanchez-Craig, 1980). Although the use of controlled drinking treatment methods should not be confined to less serious or lower dependence problems, this is their optimal area of application at the present state of our knowledge (see Heather and Robertson, 1983).

5. More directly relevant to the topic of minimal interventions is the accumulated evidence, too extensive to describe in any detail here, that full intensive treatment is in many cases unnecessary in the amelioration of drinking problems or, at least, is less cost-effective than shorter and more simple interventions. Three publications during the 1970s did much to substantiate this view. It was essentially the conclusion of Emrick's (1975) influential analysis of over 400 outcome studies of alcoholism treatment; it was confirmed in Orford and Edwards' (1976) already classic comparison of intensive versus minimal treatment for married, male alcoholics; and, although clients were not randomly assigned to treatment conditions, the same picture emerged from the extensive follow-up study of alcoholism treatment in the USA known as the Rand Report (Armor et al., 1978). Added to this is a great deal of evidence suggesting that, in comparison with pre-treatment characteristics of clients (e.g. Baekeland, 1977) and events occurring in the client's life after treatment has finished (e.g. Brommet and Moos, 1977) treatment itself is a relatively insignificant factor in the change-process.

In the specific area of controlled drinking treatment, and quite apart from the work of Miller and his colleagues which will be described below, studies from several parts of the world (Alden, 1980; Duckert, 1984; Berg and Skutle, 1985) have shown that minimal controlled drinking interventions are not inferior in effectiveness to more intensive treatments. It is therefore surprising that recently completed research in Dundee found that low-dependence problem drinkers, given conventional out-patient controlled drinking treatment, reported a significantly higher number of days of complete abstinence during the last month at one-year follow-up than those given only evaluation and advice, although the difference in measures of reduction of consumption was not statistically significant (Robertson et al., 1985). But whatever the reasons underlying these apparently discrepant findings, they are unlikely to undermine the main trend of the evidence in favor of the cost-effectiveness of minimal interventions.

None of this should be taken to mean that treatment for alcoholism "does not work." This issue is complicated by the possibility that conventional treatment fails to match clients to appropriate treatment procedures and goals (Miller, 1985) and by many other important considerations. (For a full discussion of this issue, see Heather et al., 1985a). But what can be asserted with come confidence is that the evidence justifies an elevation of the status of minimal interventions from mere control groups with which to assess the effects of treatment proper to a topic of interest in their own right.

Curiously, in Glasgow and Rosen's (1978) review of self-help behavior therapy manuals, no research with problem drinkers was listed and the area was mentioned only in passing. This may have been because the dominance of the abstinence treatment goal in the past did not lend itself readily to self-help approaches.

Since Glasgow and Rosen wrote, of course, an extensive program of research into controlled drinking self-help manuals has been carried out by William R. Miller and his colleagues from the University of New Mexico, Albuquerque. A first paper (Miller, 1978) reported a 'serendipitous' finding that clients in treatment who had received a self-help manual outlining the principles on which their behavioral self-control training had been based were faring better at three-month follow-up than those who had not. There then followed a series of studies (Miller and Taylor, 1980; Miller et al., 1980; Miller et al., 1981) which directly compared the effects of a self-help manual given on its own with various versions of intensive behavioral treatment, and found that clients in the manual groups were at least as improved at follow-up as those in the formal treatment conditions. A more recent paper (Miller and Baca, 1983) reported an extended follow-up of this cohort of clients to 24 months, with an overall improvement rate of 73% in the manual group which was equal to that found in the group who had received behavioral self-control training from an individual therapist.

Recognizing that, although highly interesting, the above findings relied on 'proving the null hypothesis' of no difference between groups, rather than showing the superiority of the manual to some control condition, Buck and Miller (1983) compared a self-help manual group to a group who received instruction in self-monitoring only and a further group of no-treatment, waiting list controls. At the termination of the treatment phase after 10 weeks, the bibliotherapy group was found to be superior to the other two on measures of alcohol consumption. However, there are clearly problems associated with the use of waiting list controls who may simply defer the attempt to cut down drinking until they begin receiving treatment. It must also be recognized that the majority of clients in Miller's studies reported a comparatively low level of alcohol consumption, with a low level of associated problems.

Nevertheless, this research has clearly demonstrated the general viability of a self-help approach to problem drinking. It is, however, subject to certain limitations, the most important of which are an inevitable consequence of the conventional service delivery setting in which self-help manuals were evaluated. These limitations are as follows:

a) Most clients in bibliotherapy conditions were self-referrals to an outpatient treatment facility and were therefore presumably highly motivated to change. The same cannot be assumed for all those who buy self-help materials commercially or are sent them through the post by helping agencies.

b) All clients were seen at least once by a therapist for assessment purposes and were given self-monitoring cards to be filled in and posted to the clinic each week. In Glasgow and Rosen's (1978) terms, minimal therapist contact was present, rather than the manual being entirely self-administered. Thus, assuming that distribution of self-help materials beyond the clinical setting is intended, the design of the research infringed Glasgow and Rosen's recommendation that self-help materials be evaluated in conditions as similar as possible to those of their eventual use. It is therefore essential to

undertake an evaluation of a self-help controlled drinking manual without any personal contact whatever, despite the methodological problems this entails.

c) The design and relatively small numbers of clients taking part in the Miller studies did not allow the investigation of such variables as take-up rate (i.e. the proportion of relevant clients who will take up use of the manual after having been exposed to it) and follow-through rate (i.e. the proportion of clients who follow through with the advice and instructions given in the manual after having taken it up). These are clearly issues of some importance in evaluating the impact of larger-scale self-help interventions.

d) Although it was shown that a self-help manual was superior to self-monitoring alone and to a waiting list control group, this comparison was restricted for ethical reasons to behavior after only ten weeks. A longer-term evaluation is necessary in which the superiority of a manual to some control intervention is predicted.

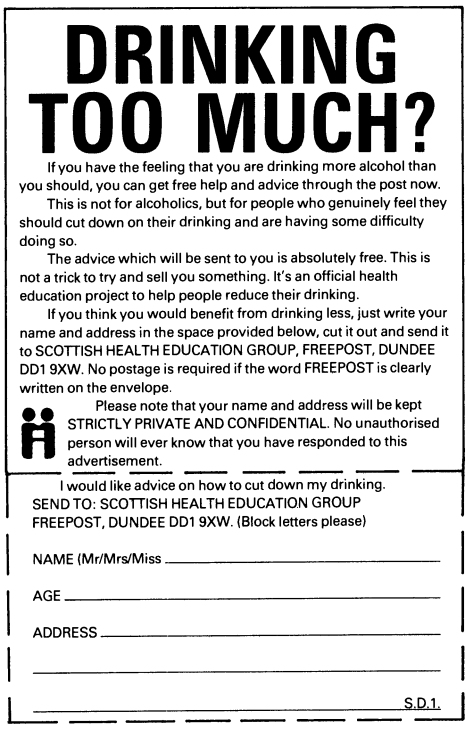
e) It is also essential to compare a self-help manual to a condition which controls for the non-specific effects of bibliotherapy. In other words, it is necessary to establish whether it is the self-management principles embodied in a self-help manual which make for effective bibliotherapy or the act of reading any well-intentioned and reasonably relevant material.

f) Finally, although it may have been established that a self-help manual for problem drinkers works in the United States, it is possible to imagine reasons for believing it may not work in Britain. The viability of a self-help approach must be shown to generalize to other cultures.

Evaluation of a Scottish Self-help Manual for Media-recruited Problem Drinkers

For the reasons mentioned above, we decided to evaluate the effectiveness of a self-help manual with as large a number of problem drinkers as it was possible to recruit through the Scottish national and local press. The advertisement shown in Figure 2 was printed in leading Scottish newspapers on several occasions during the earlier part of 1983.

Altogether 785 people responded to the advertisement. These were sent, in strictly alternate order, either a controlled drinking self-help manual or a general advice and information booklet (Grant et al., undated) available from the Scottish Health Education Group. The self-help manual was specially prepared for the project (Robertson and Heather, 1983) because other manuals we inspected were unsuitable for a variety of reasons and because we wanted something that reflected Scottish language, customs and attitudes. The contents were similar to other manuals (e.g. Miller and Munoz, 1982) and included information on the effects of alcohol, an analysis of reasons for drinking, instruction in self-monitoring, functional analysis of drinking behavior, limit-setting and self-reinforcement, advice on methods of rate-reduction, an exploration of alternative behaviors to drinking and instruction in relapse prevention. As in the advertisement, it was stressed that the manual was not for 'alcoholics', and those who were better advised to adopt total abstinence for various reasons were also advised not to use it. A list of addresses was given for those who felt the need for further help. The control booklet satisfied the requirement of controlling for the non-specific effects of relevant bibliotherapy; it contained no specific instructions on how to cut down drinking but it did include addresses which clients could use if they wanted more personal attention.



DRINKING TOO MUCH?

If you have the feeling that you are drinking more alcohol than you should, you can get free help and advice through the post now.

This is not for alcoholics, but for people who genuinely feel they should cut down on their drinking and are having some difficulty doing so.

The advice which will be sent to you is absolutely free. This is not a trick to try and sell you something. It's an official health education project to help people reduce their drinking.

If you think you would benefit from drinking less, just write your name and address in the space provided below, cut it out and send it to SCOTTISH HEALTH EDUCATION GROUP, FREEPOST, DUNDEE DD1 9XW. No postage is required if the word FREEPOST is clearly written on the envelope.

Please note that your name and address will be kept STRICTLY PRIVATE AND CONFIDENTIAL. No unauthorised person will ever know that you have responded to this advertisement.

I would like advice on how to cut down my drinking.
SEND TO: SCOTTISH HEALTH EDUCATION GROUP
FREEPOST, DUNDEE DD1 9XW. (Block letters please)

NAME (Mr/Mrs/Miss _____

AGE _____

ADDRESS _____

_____

_____ S.D.1.

Fig. 2. Advertisement used in self-help manual evaluation.

Of those who responded to the advertisement, 92 were placed in a subsample in which they were telephoned and asked to take part in a more extensive assessment interview than was used for the main postal sample. They were sent the sum of £5 for this and for subsequent follow-up interviews. This subsample was included because of possible objections to the validity of data obtained solely by post and also because it provided the opportunity to collect more detailed information than could reasonably be requested through the post. In addition to the measures of the previous week's drinking, current alcohol-related problems and general adjustment obtained in the postal sample, telephone respondents gave information on the degree of alcohol dependence, problems associated with drinking in the past and a month's 'window' on drinking behavior.

It will not be possible here to describe the results of this evaluation in any detail. The interested reader is referred to the research report of six-month follow-up results (Heather et al., 1985b). However, the following are the main conclusions from this follow-up:

1. Of the 785 respondents who were sent materials, only 247 returned usable assessment forms, with 127 of these being in the manual group and 120 in the control group. Since we had their addresses, we could have written to the missing individuals asking for reasons for their failure to respond further but, if any had replied, they would be very unlikely to be a representative sample of the missing respondents.

Future research might investigate ways of increasing the proportion remaining in the evaluation, perhaps by making the provision of materials subject to a small charge or the receipt of completed assessment forms, but both these conditions might decrease the numbers initially responding. Although it cannot be assumed that the missing respondents made no use of

the materials sent, the only conclusion possible is that the take-up rate of self-help materials was found to be at least approximately one third, with no superiority of the manual to the control booklet in this respect.

2. Of the 247 remaining in the evaluation, 132 responded by post to the six-month follow-up or were successfully contacted and interviewed by telephone. At this stage, there was a significant different in proportions between the groups, with about 40% being lost from the manual group and 60% from the control group.

However, the most curious finding to emerge here was that respondents who were lost to follow-up were significantly more likely to be married and in full-time employment, and had significantly higher scores on measures of Income/Employment Stability and Residential Stability. These characteristics are almost definitive of higher "social stability", a concept which has a long history in the alcoholism treatment literature (Straus and Bacon, 1951) and is firmly associated with a better prognosis in treatment and a greater likelihood of successful follow-up. The paradoxical nature of our finding suggests that we are far from being in a conventional treatment evaluation situation.

The reasons for this puzzling result are difficult to find. It may be that respondents lost to follow-up, in virtue of their superior social stability, tended to improve rapidly without resorting to the materials received and therefore felt no need to remain associated with the project. On the other hand, if it is assumed that they tended to fail to improve, as is usually the case with clients lost to follow-up, their higher social stability and presumed higher self-esteem may have made them more reluctant to admit this failure.

It may be possible to cast some light on this issue by writing to lost respondents at the one-year follow-up point but, again, the representativeness of those who replied would make for problems of interpretation. Incidentally, it should be noted that, if these individuals did have a poorer outcome, the significant difference in follow-up rates between the groups is likely to have resulted in an underestimation of the efficacy of the self-help manual. Once more, although it cannot be assumed that those lost to follow-up did not use the materials, the follow-through rate for the entire sample is calculated at 53% at least, with a definite superiority for the self-help manual in this regard.

3. In a direct comparison of manual and control groups among those who were included in the six-month follow-up, the manual group was found to have reduced consumption from a mean of 61.9 units of alcohol in the last week to 35.5 units, while the control group reduced from a mean of 65.9 to 48.9 units. This difference was statistically significant ($p < 0.05$). The manual group also reported a significantly greater improvement in Physical Health and Well-being. Moreover, when 30 respondents, 12 from the manual and 18 from the control group, who said that they had sought and obtained treatment for a drinking problem after having received the materials were excluded from the analysis, the greater mean reduction shown by the manual group remained statistically significant ($p<0.05$). Thus, there is some evidence that the manual was superior in effectiveness to the control booklet.

4. Although those with more serious problems were warned that the materials were not intended for them, it is inevitable that some should have stayed in the evaluation and it is of great interest to know their outcome. Firstly, it was found that those drinking initially above 100 units in the last week showed significantly greater absolute reductions than those drinking below this level (see Table 1). In terms of percentage

reduction scores, high consumers reduced by an average of 47% while low consumers reduced by an average of 31%. Thus, there is evidence that high consumers show at least as large average reductions in consumption as lower consumers. Secondly, no significant differences in reductions were found between respondents in the telephone subsample giving evidence of late dependence compared with those reporting only early or no dependence (Table 1). For both definitions of seriousness, these findings cannot be explained by any greater tendency on the part of more serious problem drinkers to have become total abstainers or to have sought alternative sources of treatment. There was also tentative evidence that manual group respondents were more likely than control group respondents to reduce their drinking from above to below 100 units in the last week, although the number involved in this analysis was small (n = 24).

The main interest of these particular findings is the implication that, at least among the sample under study, there was no upper limit to seriousness above which self-help materials were ineffective, or even less effective than among those with less serious problems. Compared with recent findings showing that alcohol price increases reduce the drinking of high consuming excessive drinkers at least as much as those drinking lower amounts (Kendell et al., 1983), this suggests that much more work needs to be done to establish the limits of applicability of minimal interventions. Certainly, we know from laboratory investigations of 'alcoholic' drinking that it is not the completely uncontrollable activity it was once thought to be (see Heather and Robertson, 1983).

5. The telephone subsample was included in the design primarily as a check on the validity of any results obtained from the main postal sample. The suggested superiority of the manual to the control booklet mentioned above was obtained after the effects of the two different methods of interviewing had been statistically extracted from the results. Nevertheless, it was also found that those in the telephone subsample did significantly better on average than those contacted only by post. For example, 58.8% of those in the postal sample reduced their drinking by more than 10 units in the last week, compared to 83.9% in the telephone subsample. This difference was significant at the 5% level of confidence.

There are two possible kinds of explanation for this finding. Firstly, it may have been an artefactual consequence of "demand characteristics", especially since respondents interviewed by telephone had received a total of ten pounds following the six-month follow-up. Secondly, it may have been a genuine effect. Telephone respondents gave evidence of somewhat higher Income/Employment Stability, without the difference being significant, but this may have given them a marginally better prognosis for reducing drinking. More interesting, however, is the possibility that the telephone interviews themselves may have had a therapeutic effect. That follow-up research interviews in general may have some such effect is now

Table 1. Changes in Mean Previous Week's Consumption (standard units of alcohol), According to Two Definitions of "Seriousness" of Drinking Problem

	Initial assessment	Six-month follow-up
High consumers (i.e. >100 units) (n = 25)	139.3	63.3
Low consumers (i.e. ≤100 units) (n = 102)	44.9	32.8
Late dependence (n = 10)	78.3	24.8
Early or no dependence (n = 22)	56.4	43.3

well-recognized (e.g. Sobell and Sobell, 1981). Moreover, although the evidence is somewhat conflicting, there is a suggestion from the weight reduction and smoking cessation areas that very limited forms of therapist contact may increase the effectiveness of minimal interventions (Brownell et al., 1978; Glasgow et al., 1981).

This raises the possibility that minimal interventions in the problem drinking area may be improved by the addition of some brief and inexpensive form of added intervention. This could range from supportive home visits, through regular telephoned checks on progress, to telephone progress reports to an answering service or mailed diaries of self-monitored consumption as used in Miller's self-help method. Arrangements for meetings between similarly-placed clients could also be used in an attempt to bolster the effect. Assuming that the effectiveness of a self-help manual without any personal contact has been demonstrated, possible ways in which this effectiveness may be inexpensively increased are important areas for further research.

With regard to present findings, we have attempted to determine which explanation for the superiority of the telephone subsample is correct by conducting lengthy personal interviews with consenting respondents at the one-year follow-up point, and by taking blood samples and interviewing collateral sources of information. The results are not yet analyzed.

6. Ignoring any differences between the materials sent or the method by which information was gathered, the results of this exercise in minimal intervention were highly impressive. In the total follow-up sample, besides significant reductions in consumption and alcohol-related problems, there were also significant improvements in marital, employment, residential, physical health and social adjustment. Overall consumption was reduced by approximately one third, and 60% of respondents drinking above recommended levels at initial contact (i.e. 50 units per week for men and 35 for women) were drinking below these limits and had reduced by at least 10 units per week at six-month follow-up.

Without a no-intervention control group, it cannot be concluded, of course, that these changes would not have occurred spontaneously among individuals sufficiently motivated to respond to a newspaper advertisement. But what can be safely concluded is that minimal interventions which abolish the distinction between 'health education' and 'treatment', which are based on the goal of reduced alcohol intake, and which are effective outside the traditional treatment delivery system, are deserving of further investigation.

OTHER RESEARCH AT THE UNIVERSITY OF DUNDEE

This section will briefly describe other research which has recently been started or is planned to start in the Addictive Behaviors Research Group. There are three relevant projects:

An Evaluation of Alcohol Education Courses for Problem Drinkers

An alcohol education course for problem drinking young offenders referred by the courts was previously described by Robertson and Heather (1982), but this has not so far been properly evaluated. The course was based on the usual self-management principles and consisted of six weekly meetings lasting one-and-a-half hours each.

It is now intended to conduct controlled evaluations of such courses in a variety of settings and for a variety of types of problem drinkers,

including young offenders on probation, adult offenders released from prison, drunk drivers, problem drinkers identified in an industrial setting and others recruited via local press and radio. After developing appropriate courses for each context, the running of them will be passed on to less specialized personnel, such as voluntary counselors and social workers.

An Evaluation of the "DRAMS" Scheme in a General Practitioner Setting

DRAMS (Drinking Reasonably and Moderately with Self-control) was developed by the Scottish Health Education Group for use by general practitioners. The scheme involves an interaction between the GP and patient, with a structured assessment, self-monitoring cards, feedback on liver-function tests and a self-help guide to be used in conjunction with the GP. The feasibility of the scheme has been tested in the Highland Region with encouraging results.

We now intend to conduct a controlled evaluation by randomly allocating identified problem drinkers to a group receiving the full DRAMS procedure, a group receiving simple advice from the GP during the consultation, and an assessment-only control group. With the exception of a non-assessment control group, this is essentially the same as the design used by Russell et al. (1979) in their important study of the effects of GPs' advice to give up smoking. Ours is a joint project with the Department of General Practice, University of Dundee.

The Effectiveness of Minimal Interventions with Problem Drinkers Identified on General Medical Wards

It is well known that between 10% and 30% of patients on general medical wards suffer from identifiable alcohol-related problems (e.g. Quinn and Johnston, 1976; Jarman and Kellett, 1979). With the co-operation of medical personnel, we intend to compare four interventions with problem drinkers identified in this setting. Group 1 will receive a fairly extensive assessment only; Group 2 will receive in addition a half-hour session of simple, structured advice; in Group 3 will be added a self-help booklet for the patient to take home which summarizes the conclusions of the advice session; Group 4 will receive monthly, supportive home-visits by non-clinical personnel in addition to the other procedures. It is hoped to conduct parallel studies for patients whose physicians advise complete abstinence, if only on a temporary basis, and those who are allowed to drink in limited quantities.

A GENERAL PROGRAM OF RESEARCH

Having given a flavor of some research which is possible in this area, I will now attempt to outline very briefly the main parameters of a general program of research into minimal interventions. Returning to the continuum described in Figure 1, there are several different ways of imagining how this dimension might be ordered:

1. The most obvious way of ordering the continuum is in terms of the seriousness of the drinking problem which is the target for intervention, with more serious problems requiring more intensive attention. However, as this chapter has hopefully shown, the points along the continuum at which interventions should be increased in intensity are matters for empirical research and cannot be merely assumed on the basis of received wisdom.

2. If 'seriousness' is regarded simply as a degree of alcohol-related damage to people's lives, a more rational ordering might substitute degree

of alcohol dependence rather than seriousness. Although they will naturally be highly correlated, alcohol dependence and alcohol-related impairment are conceptually distinct (Edwards et al., 1977) and would lead to different strategies of intervention. Since degree of dependence is presumably a measure of the degree of difficulty experienced in attempting to change the problem behavior, the intensity of interventions would seem more logically related to dependence rather than manifest harm. It should be pointed out, however, that there are reasoned objections to the predominance of the concept of alcohol dependence in the treatment of drinking problems (see Heather et al., 1985a).

3. A collection of separate variables bear on the issue of the cost-effectiveness of minimal interventions. These include: a) the number of clients who can be reached and the proportions of these who respond positively; b) the cost of preparing and distributing or communicating self-help materials; c) the level of training of professional or paraprofessional workers who may be involved and the costs of however much of their time is needed.

4. On a more theoretical level, a further way of thinking about the continuum is in terms of some model of the change process. For example, Prochaska and DiClemente (1982) have proposed that both self-change and therapeutically-induced change involve four stages: Contemplation, Determination, Active Change and Maintenance. There is some empirical evidence to support this model (e.g. DiClemente and Prochaska, 1982). It may be that the intensity of the intervention required for effectiveness will be determined by the stage of change the client has reached. Certainly, one could well imagine qualitatively different types of minimal intervention aimed at clients in different stages of the change process.

It is now clear that the continuum shown in Figure 1 is a vastly oversimplified representation of the real situation. In fact, there are a number of interacting dimensions which describe the conceptual universe of minimal interventions and which could form the basis for innovative research. It should also hastily be added that, despite the emphasis in this chapter, interest in minimal interventions is by no means confined to the problem drinking area and that their potential usefulness in the response to other addictive behaviors, and indeed to many other types of behavioral problem, is at least equal.

Finally, this chapter should not end without a note of warning. Despite the promise of minimal interventions, there will always be many problem drinkers, including those who have sustained permanent cognitive impairment as a result of their drinking, who are unlikely to improve without the benefit of full-scale intensive treatment. Enthusiasm for minimal interventions should never be used as a justification for cutting back on existing treatment resources for those who appear to need them. This is not a blanket defence of 'alcoholism' treatment of any kind; much that goes under the name of treatment in the alcohol field, especially that which takes place in specialized in-patient units, has neither theoretical justification nor empirical support, and should be abandoned in favor of more rational and effective treatment in the community. But the present point is that minimal interventions should be regarded as supplementing rather than as replacing effective face-to-face treatment, and as being aimed at making the total treatment response as wise and cost-effective as possible. They should never be used as an excuse for the second-rate.

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DIALECTICAL DRINKING AND THE PROBLEM OF BALANCE

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Thomas Szasz, in the "Myth of Psychotherapy" (1979) continues his efforts to change the metaphors we see by. He seeks to move psychotherapy from a niche within medicine back to its homeland. This he considers to be that space occupied at various times in history by priests, and the rhetoricians of Ancient Greece. The modern psychotherapist is, or should be, according to Szasz, the secular equivalent of the curers of souls, the philosopher with the art of persuasive speech. Szasz is concerned that the non-pharmacological therapies break free from an inappropriate and suffocating metaphor.

R. D. Laing also sought to change meaning. He contributed a chapter to the Dialectics of Liberation (1968) entitled "The Obvious". In this he refers to the enclosure of the medical metaphor and the 'obvious' fact that those who embraced the metaphor - doctors and patients - could not see that diagnosis made illness, and that illness was unable to speak back and inform diagnosis. In the degenerate system that he describes it is necessary for sincere and concerned people to be blind to the significances of their acts, so that the system is perpetuated. Laing, in his idiosyncratic way, came to see that he was involved in the study of situations, not simply of individuals.

The alcohol field has been going through a prolonged attempt to throw off a medical metaphor. The creative forces have been a public health orientation to alcohol problems (Room, 1984) and the description of resumed normal drinking amongst labelled alcoholics (Davies, 1962). The result has been a number of research projects which have examined and largely rebutted some of the central implications of the disease model; phenomena concerning craving, loss of control, irreversibility, and the bimodal distribution of alcohol problems. In recent therapy research the main concern has been with the visibility of the 'new' drinking goal - controlled drinking (Heather and Robertson, 1981).

Therapy practice has seen the increasing influence of training style interventions (problem solving, social skills, self management). While controlled drinking studies have established the need to take controlled drinking seriously, the evidence for specific treatment methods continues to require a greater leap of faith.

The first two examples of attempts to escape from an inappropriate nonconducive metaphor or myth, those of Szasz and Laing, were not concerned with science. They have, and have had, implications for how distress is understood, and for therapy. However, they are based upon conceptual analysis, appeal to values, and assertions about what should be the case. The claims for alcohol studies are those of science, of paradigm shift based upon the scientific discovery and accumulation of anomaly with respect to the old theory (Heather and Robertson, ibid.). There is a little contention about the status of this asserted change. Is the disease model a scientific theory? Is this an ideological game in which empirical evidence is used to invite the alcohol field, at one time into mainstream physiology, at another into psychology? Do the specific contents of the alcoholism field really merit a separate field of study, or of intervention? Is the field a sociopolitical convenience, a societal bad object, necessary in various respects for the upkeep of the system? Is the disease model there to rationalize medical property acquired by history and retained by dint of superior social standing? On a less conjectural basis Levine (1984) would have it that claims for a new paradigm are premature because there is insufficient unity and unifying principle in what he terms the new view.

Whatever the nature of the change substantial and reasonably substantiated claims are being made. I welcome the attempt to remove a metaphor that has had its day. Of particular importance is the crumbling of the concept of irreversibility and the view that alcoholism is not a distinct entity, but that alcohol problems are phenomena that are continuously distributed in the population (all drinkers are equal, but some drinkers are more equal that others (apologies to Eric Blair)).

I welcome the call to personal responsibility, which disease notions can hide, the conventional call for evaluation, and the prominence of learning concepts. The introduction of more than one admissible drinking goal goes some way to removing the temptations of coercion from treatment. However, in this productive time, I am concerned that one baby will be thrown out with the bathwater. That baby is therapy.

In this statement of concern I should declare my interests. My major professional identity is that of therapist. So as a Szaszian secular priest I will borrow one of the devices of the ordained - a text - from which to develop the rhetoric. Like all good texts this creates its own reality by that which is left out, and the context from which it is extracted. This is, of course, quite deliberate, and not science.

My text is from 'Implications' pages 254 and 255 (Heather and Robertson, 1981). "It is however true that treatment is probably one of the least important determinants of recovery from alcoholism.... Nevertheless, so long as alcoholics request help, and so long as treatment can be shown to have some influence on outcome, it cannot be dismissed". "It cannot be dismissed". This sounds suspiciously like the tone of union-management talks in a dying steelworks in the West Midlands. When will the redundancy notices for therapy come round? Next year? The year after? What new attractions are moving in to provide more effective and appropriate forms of intervention, and before we dismiss it, how do we understand this business of therapy?

Certain alternative modes of action, open to the clinical psychologist and others, are of concern. These are: educational interventions, the lure of politics and prevention, and research. Clearly all of these have a potential usefulness. They act in a negative manner if championed in an exclusive or imperial fashion; hence comes the image of therapy being dismissed. This is akin to Joynson's (1970, 1972) image of psychology

disappearing into physiology. (In fact this was an ironic argument put in the service of rehabilitating introspection. Rhetoricians are not necessarily straightforward). These alternative modes of action chance a common theme. They allow the clinical psychologist to avoid or dilute the difficult business of being face to face with clients. Moreover, in the course of risking dismissal, therapy within the alcohol field seems to show a stereotyped response to threat rigidity combined with a predilection for throwing everything in a confined repertoire at the patient, while attempting to deny the existence of the therapist.

I have little to say about educational and other non-intensive interventions. Non-specialist or self-help groups (Winters, 1978), particularly with specialist back-up readily available, may serve an important consciousness raising role, allowing people to vary their self-control strategies. Research here, and into educational interventions, is too young to provide anything like the substantial platform for comment, which traditional therapy research provides. The logic of such developments is self-evident. The skills required, particularly for effective teaching, are less evident. It is not clear that clinical psychologists necessarily have them conferred upon them. The empirical results require ageing. I include this paragraph merely to point to the imperial aspects of proper enthusiasm.

Politics is a major vehicle for the public health paradigm that seeks to diminish the availability and attraction of the 'harmful aspect'. Politics - the attempt to engineer change through legislation - is many steps away from the difficult client. The empirical basis for activity at this rarefied level is slight. Arguments are put forward on the basis of the logic of 'upstream' interventions (i.e. solve the leak in the bathroom by turning off the house water supply), mathematical models of what might be the case (e.g. Ledermann, 1956, 1964), and the exercise of post hoc arguments upon uncontrolled data which we call 'history'.

The study of per capita consumption levels and their relationship to alcohol-related problems has demonstrated a statistical relationship between large changes in consumption, and the prevalence of heavy use (Skog, 1981). The degree of 'imperfection' in the statistical relationship, and the difficulty in isolating control factors is exemplified by Halford and Fitzgerald's (1983) study of drinkers, in Iowa. Between 1961 and 1979 per capita sales of alcohol in Iowa rose by 81 per cent. Six indicators of problem drinking remained stable. Cirrhosis death rates in 1979 approximated those in 1961; they had, strangely, risen until 1967 and had then fallen away as consumption continued to rise. A similar confounding of the public health argument has been reported for the years 1950 to 1975 for the Netherlands by De Lint (1981), and Popham (1970) has reported a null relationship between the cirrhosis death rate and consumption levels for the United Kingdom. Skog (1980) correctly implies that a greater understanding of the complexities of time-lag may, at some future time, bring the data back into line. However other complexities such as predicting response to new conditions of supply abound. Horverak (1983), reporting on the effects of a nine week strike of the Norwegian Wines and Spirits Monopoly, found that most people swiftly accommodated to the beer-only, home brew or illicit alcohol diet, and per capita consumption was hardly affected. Those who seemed unable to adapt, and whose consumption, use of detoxification centers, and liability to commit drunkeness offences, were reduced, were so-called skid-row alcoholics. The scarcity of alcohol produced adaptation and (often illegal) initiatives recalling, in a small way, a Chicago of days gone by.

Halford and Fitzgerald (ibid) take the view that present attempts at forecasting and therefore of controlling "the alcohol problem" through

change in consumption levels, is like forecasting a change in the weather by relying solely on a shift in wind direction. They conclude that our understanding is, as yet, too primitive to generate effective remedial action at this level. With other researchers (e.g. Maynard and Kennan, 1981) who seek to study the social weather, they look to that hypothetical future time when the epidemiological data is in.

Looking back can feel more secure than plotting the uncertain future. David Lloyd-George offers himself up as an example. In 1915, through the ruse of scapegoating the munitions workers, his government introduced the Central Control Board. This body had the duty to control consumption. Subsequently licensing hours were cut by half in Scotland and by two thirds in England and Wales. Various fiscal measures were taken and a top proof level set for spirits. By the 1930's per capita consumption levels were down, compared to 1900 levels, by one half for beer and by threequarters for spirits. (Wine was then drunk in relatively small quantities). Leaving the complexities of the relationship between consumption levels and harm, it might appear unequivocal that Lloyd-George, through political means, decreased consumption levels. However peak per capita levels were obtained in the 1870's. Lloyd-George caught a tide that was already on the turn. Weir (1984) considers that changes in leisure patterns (the development of the cinema, 'wireless' and car, and the growth in allotment use) played a part along with legislation. In similar vein the post World War II rise in consumption is, in part, explained by Roberts (1983) by the redefinition of alcohol as an appropriate accompaninent for a range of leisure activities, and in general the spread of alcohol consumption from within the walls of the public house. While it is reasonable to infer that legislation has had some effect, it is likely that deeper social currents, and I have focused only on changes in leisure patterns, add significantly to the moving picture. My point is that 'upstream intervention' is not straightforward. Political intervention broaches an ethical debate which I have not attempted to address. Leaving that maze aside and looking purely in terms of efficacy and sound judgement there are risks aplenty in fiddling with the supply of society's drug.

My final cause for concern is research. Is research promoting the 'dismissal' of therapy? This subject is more complex than education or politics because research and therapy are, or should be, more closely intertwined. There are two ways in which research impinges upon therapy: at the level of professional role, and at the level of science informing, or failing to inform, therapy. The professional role issue - to what extent to be a practitioner, and to what extent a scientist - is intrinsic to being a clinical psychologist. Eysenck (1984) has described his wish to produce clinicians who were applied experimental psychologists, thus combining the two roles in one; he notes that this has not come to pass. Barlow (1981) comments upon the lack of research amongst clinicians in the United States. This mismatch between practice and expectation would seem to be fertile ground for anxiety. One way to resolve the anxiety is to become one or the other: a scientist or a researcher. The latter option is proposed by Hawks (1971, 1981). He suggests, for clinical psychologists in general, the role of clinical researcher, ideally working in a clinical research team on coordinated projects. The function of this researcher is primarily preventative. The research would be aimed at discerning psychological principles, particularly those to do with coping, and vulnerability or resilence. Theory, in this model, is justified, if at all, by the need to obtain therapeutic credibility, and to provide a test bed for skills that can be given away. In this case, if your basic science does not fit the problem, change the problem (i.e. dismiss therapy).

Hawks' suggestions, while prompted in part by the mismatch between the number of potential clients and the number of therapists, seems very

similar to a classical research orientation such as Bandura's (1978). In Hawks' case the team go out, in Bandura's case they stay in the laboratory isolating basic mechanisms and seeking principles. How these are then conveyed to other change agents or to clients seems a secondary matter.

These examples from without the alcohol field exemplify one option in the therapist-researcher problem. Within research itself a similar bias can contribute to an emphasis, in research, upon outcome (i.e. the goals of therapy) over and above process issues. Superficially an outcome-oriented research design looks like a laboratory experiment. Laboratory experiments typically seek to illuminate a hypothesis - but in this arena is this hypothesis about the nature of drinking or about therapy?

Undoubtedly the controlled drinking debate will continue because there continue to be ideological positions to defend. To those without a theoretical axe to grind continuing emphasis on the issue of goals perpetuates neglect of equally important therapeutic questions. Three recent studies give a flavor of the situation.

Controlled drinking can be highly marketable, approaching 50 per cent of client choices in some establishments (Booth et al., 1984). Early stage problem drinkers with, on average, a 5 year history of problem drinking, are inclined (approximately 70 per cent) to moderate their drinking after six sessions of cognitive behavioral therapy. Randomized allocation to control or abstinence goals make little difference: In the 6 month follow-up, approximately 5 per cent are abstinent. Drinking measures hold steady at follow up (two years) averaging 13 to 14 Canadian drinks (0.60 oz (13.6 g) of ethanol) per week. At the start of therapy these people averaged approximately 51 drinks per week, and all admitted to at least one problem on the mast or Alcohol Dependence Scale. These individuals in their mid-30's found controlled drinking a more suitable goal than abstinence, and showed it in subsequent behavior (Suches-Craig et al., 1984). Of particular interest to the therapist is how the clients achieved their goals. These researchers intimate that the different treatment groups reached the controlled drinking goals by following different paths and, by implication, used therapy differently. More detail would be welcome.

Foy et al. (1984) present another traditional well-designed study in which, over a 2 year follow up period, there was little difference between abstinent and controlled drinking groups. This paper looks at more traditional subject matter - male Americans in, on average, their mid-forties, admitted to a 4 week inpatient package. The package focussed on skills training, and a problem-solving approach. The clients, on intake, had average problem drinking histories of some ten years. They spent a mean of 160 to 200 days drinking more than six Canadian style drinks (8 oz of 40 per cent alcohol per day. At 6 months post-treatment those averages were between 20 and 45 days, and at 12 months 50-90 days. The study showed that skill training, including training controlled drinking skills, are acquired in the short term, but make no difference on 12 months outcome. The skill training did not generalize beyond the treatment setting. A negative effect of controlled drinking appeared as an increased liability for that group to have abusive (6 plus drinks) drinking days in the 6 month period following treatment. Preliminary results suggest that this risk of any post-treatment drinking being abusive drinking is greatest amongst those providing evidence of three or more withdrawal symptoms in the initial assessment.

These studies serve to confirm a view that a controlled drinking goal could be tried by most people, but that the risks of the endeavor are moderated by pretreatment characteristics. With Cronkite and Moos (1980) I would suggest that post-treatment variables - those that intervene between

treatment and follow up -are also of importance, and largely neglected. Cronkite and Moos show that while direct treatment effects may be small, a more substantial total effect is obtained by cumulative indirect effects. Commonly this occurs through reducing stressors and facilitating more effective coping responses. This critique of traditional research seeks to put therapy as a catalyst amongst the turbulence of life's events, rather than isolating it as a unitary intervention. In this sense alcohol therapy research is guilty of perpetuating an element of the medical model and risks throwing therapy out with it. It is also guilty of perpetuating the uniformity myth (Keisler, 1966). Foy et al. (1984) do examine a specific aspect of technique but much research focuses on clients and drinking goals. This leaves the complexity of therapy unattended. Of course clients and drinking goals are of crucial concern to a theory of alcohol problems, but are only part of an approach to therapy with people with alcohol problems.

Yates and Norris (1981) provide a critique of treatment evaluation studies which questions their relevance to the impact of treatment upon the lives of the clients. They point to variations in drinking patterns over time, which are inadequately captured by many outcome studies, and therefore by meta-analytic techniques. They note that treating treatment as 'an independent variable' (the statistics of the uniformity myth) works against investigating treatment components, and that the treatment experience is extremely difficult to quantify. The scope of the endeavor is broadened by acknowledging that treatment and drinking, like other events, may mean different things to different people. From this Yates and Norris develop the notion of treatment-use, drawing an analogy with how a person might 'use' a new job. Within this perspective one implication for outcome lies in the extent to which the actual use corresponds to the agencies' or therapists' planned use. This provides a perspective for service planning and seeks to pay more attention to those non-drinking parts of the drinker. This perspective also commends the use of intensive rather than extensive research designs.

A similar breadth of view is evident in Christie's (1983) study which included both clients' and assessors' perceived needs for the clients' treatment. Treatment tended to be seen as relating to a number of complications in the clients' lives, not simply to drinking. Only one quarter of the sample (both staff and clients) were specifically drink oriented with respect to treatment needs. The study serves to underline the complexity of the treatment experience, because threequarters of the eventual treatment foci emerged after the initial assessments (referred to above). The major emergent foci implicated various types of counseling (marital, job, financial) and social skills/assertion training.

Some efforts have been made to locate therapy within life, to take account of the complexity of the therapeutic experience, and to contextualize drinking within the person's biography. On a more conventional note Cartwright (1981) points out that the alcohol field has neglected the therapist. Most outcome studies assume that the therapist is a uniform entity. Two recent studies by Miller and colleagues (Miller et al., 1980; Miller and Baca, 1983) have indicated that this is a complex area full of promise. Both studies demonstrate a strong relationship between successful outcome for problem drinkers, and the degree to which counselors display the skill of accurate empathy. Cartwright points out some parallels between general psychotherapy research and alcohol therapy research, indicating that the latter could benefit from the former (cf. Gurman and Raxin, 1977). Heather and Robertson (1981, p.209) also pick up the neglect of therapist variables, and, referring to unpublished work by Miller and associates, suggest that therapist variables may be at least an important, if not more important than treatment variables in determining outcome.

I have sought to outline some escape routes from the task of therapy. To repeat, each of these escape routes, education, politics and research, has its own value and rationale. The first two have not been subject to the same functional critique as has therapy. Therapy research, within the alcohol field, has tended to keep to a conservative model which has served alcohol theorists more than therapists. This hypothesized tendency to retreat from therapy, actually and conceptually, is dealt with for the broader field of clinical psychology by Parry and Gowler (1983). They outline various ways in which the clinical psychologist might attempt to cope with the pattern of stresses and strains that they term 'the cruciform effect'. The cruciform effect is "a set of demands which pull in opposing directions, such that whichever way one twists or turns it is not possible to find a comfortable position" (Parry and Gowler, 1983, p.153). Such is the posture of the clinical psychologist. I have sought to tug in one particular direction.

The rhetoric thus far has been tilted at defending therapy within the alcohol field from dismissal. There are more positive signs, some of which have been mentioned in the critique of orthodox evaluation studies. In particular these are the attempts to examine therapist effects, to broaden the concerns of the alcohol problems therapist, and to place therapy in its place as a catalyst amongst life's events. Work on relapse prevention (e.g. Marlatt and Gordon, 1980) plays a part in recontextualizing therapy. Developments in group therapy (Flores, 1982) and family therapy (Usher et al., 1982) are present but underexploited. Similarly rare, but hope-arousing events, are process studies. An example is Davies' (1981) study of initial consultations for alcohol problems in an outpatient clinic. A major finding was the mismatch between the expectations of the therapists and the clients, concerning the goals and ways of behaving in the session. Process studies, and particularly those process studies with links to outcome, produce material that can directly inform the business of being a therapist.

Perhaps the most hopeful sign of all is the rediscovery of psycho-therapy (Miller, 1983). Mentalism has been swinging back into favor for some time (Hodgson, 1981) and now we have 'motivational interviewing'. Motivational interviewing complements more explicit technique by using the process of interaction to address issues of self-esteem, self-efficacy and dissonance between behavior and beliefs (one aspect of a concept called ambivalence?). Clearly Miller has been influenced by client-centered approaches, and it is refreshing to read his description of accurate empathy as a complicated skill that is easily done badly. There is little that is new; even the reformulation of denial as a function of the thera-peutic situation, rather than something in the person, can be found in the psychotherapy literature (Kopp, 1977, p.13). However, this attempt to bring therapy relationship and behavioral technique together points to unexploited resources.

For the alcohol problems therapist, traditional extensive outcome studies are sterile unless complemented by the alternative approaches that have been described above. The model of man assumed by the traditional studies is of some mechanical device controlled by a crude homeostat, like the governor on a steam engine: the governor cuts off the energy flow to the system at a present level, for instance no pints or two pints per day. Is it wise to make a limit the major premise around which to organize a therapy? Not being too keen on control per se I offer you an alternative model. The focus is upon behavior with alcohol, but this need be only one facet of an n-faceted model.

The dialectical drinker is an exemplary character: part-time puzzler, part-time paradigm shifter. To this drinker the key issue is that alcohol

is taken to make some sort of a difference. When the form and the extent of the difference is approved by the relevant audience the challenge lies in sustaining the equilibrium (puzzling). When some relevant audience is affronted by the difference the dialectical drinker considers the thesis, that is the present drinking behavior, and the antithesis, the negative feedback, and produces a new form of indulgence (synthesis). This is destined in its turn to fall from grace, each error producing new knowledge about drinking, and about audiences.

This researcher-drinker is a rule-following agent who has a vague feeling of being in a project, but is uncertain of the exact goal. His or her rule system is designed to detect anomaly, and to allow a given quotient of anomalies to trigger off change. Alternative non-dialectical role systems can be designed to freeze the drinker into repeated social rituals which evolve their own raison d'etre, and reputation. An alternative security is the deliberate embrace of failure. These are attempts to fend off risk and insecurity. Then, there is the failure to be competent in any rule system. I would like to work towards the dialectical drinker, complementing this by training up competencies where required. I suspect that therapists, and clients under the containing influence of therapists, should be confronting risk rather than imposing some negotiating control.

Unfortunately, this cannot be an attempt at a paradigm shift. I have played out this paper as a rhetorician, rather than as a man of science. However, I can hope that meditation upon our original text has had some effect upon a few souls.

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COMMONALITIES IN THE ADDICTIVE BEHAVIORS

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If a stranger to the study of mind-altering substances were to consider how societies respond to problems related to their use, he or she would be forgiven for accepting that different drugs result in quite distinct problems, thereby requiring different responses. For example, in Britain, responses to the consequences of, say, opiates and alcohol use are the remit of different governmental departments: problems related to alcohol use are deemed the remit of the Health Department, whereas response to opiate-related problems are the remit of the Home Office. As a result of this compartmentalization, different agencies exist to deal with each drug (e.g. Alcohol Treatment Units; Drug Dependence Clinics further reaffirming any distinction that already exists between these substances. This has abetted a compartmentalization of responses, discouraging any cross-fertilization of ideas, an isolation of clinical researchers in different drug related areas and a duplication of research and services. This duplication and compartmentalization of services exists outwith any sound empirical evidence and in defiance of an accumulation of accepted evidence that most drug users are not exclusive users of one substance, but rather, are multiple drug users. For example, Dight (1976) in a survey of alcohol use in Scotland reported that the best predictor of heavy alcohol use was heavy tobacco use and the recent report by the Advisory Council on the Misuse of Drugs (1982) noted:

> "For some years, it has been accepted by experts in the field that most drug misusers are not now solely dependent on one drug. The same person may be using a number of drugs and may be dependent on more than one of them". (p.23).

More recently, this contention has been supported in a survey of drinking habits and illicit drug use amongst a sample of Scottish teenagers (Plant et al., 1984). The authors reported:

> "...a relatively high degree of association between levels of alcohol consumption, tobacco and illicit drug use and in the case of males, serious alcohol-related consequences". (p.199).

This evidence of multiple drug use suggests the possible redundancy of specialized services and emphasizes the need to consider areas of common ground across the 'addictive behaviors'. As noted by Miller (1980), recent years have seen an increasing recognition of a need to approach this issue,

resulting in an increase in journals and conferences devoted to expanding a recognition of common ground and providing a forum for the debate on commonalities across the addictions. Continued debate is implied in that:

> "...although there is much accumulated knowledge, it is clear that we are only beginning to scratch the surface and there are so many fascinating, challenging and potentially significant avenues to explore". (p.4).

It is intended in the present discussion to continue the debate in relation to the issues of problem perception, dependence, treatment and the giving up of addiction.

Before discussing the evidence for or against commonalities in the addiction behaviors, it is appropriate to provide some definition of what is 'addictive behavior'. For the purposes of the present discussion, addictive behavior is described as being characterized by an individual engaging in a behavior which may be enjoyable and subjectively beneficial in the short term, yet has the potential to accumulate adverse consequences in the longer term. Accepting this definition immediately suggests its applicability across a wide range of behaviors, including not only the use of substances such as tobacco, alcohol or opiates, but also behaviors such as overeating, working or obsessive disorders. Although not wishing to imply that these latter behaviors have no commonalities with, or implications for, drug-taking behavior, the major focus in the present chapter will be upon the use of mind-altering (psychoactive) substances.

PERCEPTIONS OF DRUG USE

There is no doubt that most people use some form of drug to alter their state of arousal, emotion or perception. This universality of drug use is demonstrated in the energy put into the cultivation, manufacture, distribution and use of substances such as cocaine, opium, cannabis, alcohol, tobacco and tranquilizers. As Edwards (1971) has sagely noted;

> "The money at stake is immense and countries might finance their treasuries to a large extent from drug resources...You could conclude that one of the main businesses of the world was to cultivate, manufacture, advertise, legislate on, to consume, adulate and decry mind acting substances" (cf Plant, 1981, p.2).

However, despite this widespread use, it is also apparent that society is ambivalent about many forms of use, or even of certain drugs irrespective of their mode of use. On the one hand, certain forms of use are condoned, or even encouraged, whilst other forms of use are viewed as mysterious and deviant and actively discouraged through informal and formal mechanisms. Historically, this ambivalence has resulted in different drugs facing similar prevailing attitudes of the time whilst passing in and out of favor. For example, the following quotation exemplifies what many contemporary individuals would consider as the archetypal description of illicit drug users:

> "The sufferer is tremulous and loses his self-command; he is subject to fits of agitation and depression. He loses color and has a haggard appearance... As with other such agents, a renewed dose of the poison gives temporary relief, but at the cost of future misery". (cf Gossop, 1982, p.5).

However, this description was applied to coffee users in the early twentieth century and not to opiate 'addicts' of the 1980's. Drugs such as

alcohol and tobacco have been similarly represented throughout history. For example, conceptualizations of tobacco have ranged from the benign to its present increasingly malign image. Similarly, despite the present unpopularity of opiate users, and stereotypes applied to them, many would be surprised that one hundred years ago the typical user, if such a person exists, was middle-aged, middle-class and female. Coincidentally, opiates played a large part in Britain's trade in the nineteenth century, apparent in any study of the relationships between Britain and China. At this time, Britain's trade with China depended to a great extent on the former supplying opiates to the latter in order to balance payment of the large quantities of tea bought from China. This dependence was particularly illustrated by the two Opium Wars (e.g. see Berridge and Edwards, 1981), when Britain forced a reluctant China to continue the trade. These differences in attitude and behaviors over just 100 years are also apparent between cultural groups. It is unlikely that the South-Eastern opiate user or Central American cocaine user perceives him/herself as deviant or ill, as many Westerners perceive such substance users, just as it is unlikely that these same Westerners perceive themselves in this manner for using alcohol, as many Islamic people might.

Most drugs have suffered campaigns of moral outrage and panic which when scrutinized have been found to have little basis in fact and which frequently bear no relationship to the extent of consequences of such drug use when taken in context. Thus, despite an estimated 8,000 deaths related to tobacco use in Scotland alone in 1980 (ASH 1982) compared to 39 deaths in the whole of Britain related to solvent use in 1981 (Anderson et al., 1982) there is no comparative outrage or concern expressed either in the media or in government circles regarding the toll of tobacco use.

One distinction between the socially acceptable and unacceptable drugs relates to these same prevalent attitudes and media coverages, which emphasize, almost exclusively, the negative impact of this latter group of substances. This can only encourage the view that users of these substances are mysterious and deviant, demonstrated in the oft repeated question "why do they do it?" A return to the definition of 'addictive behavior' basically answers this question and demonstrates the false premise on which such distinction is based: drug use of any kind is encouraged by its benefits which may be in the form of cultural or subcultural acceptance, the intoxication effected by drug use or any other of a myriad of subjectively positive and relatively immediate consequences. A recognition of this common ground across different substances will go some way towards demystifying their use and negating the use of unhelpful labels such as deviant or 'addict'. This latter label is a common source of many of the misconceptions about drug use and related problems. A central theme of many debates on drug problems centers on problems related to 'dependence' and the words addiction and dependence are used interchangeably with 'drug problems'. Frequently it is conceptualized that it is something that 'they' have and 'we' do not. Any consideration of commonalities across substance use therefore needs to consider whether any common theme exists across dependence on different substances.

DEPENDENCE

A common feature of many of the addictive behaviors is the importance and clinical relevance attached to dependence. This relevance is implicated in many reports of the predictive ability of different measures of dependence. For example, Orford, Edwards and Oppenheimer (1976) reported that a measure of dependence on alcohol predicted that those individuals who are severely dependent are less likely to achieve controlled drinking than those who are less severely dependent. Similarly, other workers

reported that smokers who subjectively perceive themselves as 'addicted' are less likely than those who do not hold this view to even attempt to give up smoking (Eiser et al., 1978). Despite these, and many other reports of the relevance of dependence to the study and treatment of the 'addictive behaviors' this issue has raised a great deal of controversy. Much of this is owed to the chauvinism of different disciplines. Thus, there exist exclusively biological, sociological and psychological explanations of dependence.

Irrespective of these explanations, it is apparent that no single one is sufficient to describe or explain dependence. Unfortunately, much of the debate surrounding dependence is conducted in the context of its uniqueness to drug use in general or even to specific types of substances. Greater understanding of dependence and its determinants would probably come from setting a broader approach. This would evolve from arguments which imply the normality or universality of dependence (Russell, 1976). Here it is argued that dependence on drugs is not dissimilar from dependence on many things and that frequently any distinctions are societal or value judgements. Thus, people are dependent on cars, other people, various activities, certain types of food and drugs. Consequently, it is argued, dependence on drugs should be seen in this broader context and common factors can be discerned across different substances. The relevance of the definition of addictive behavior given earlier is yet again apparent with the inclusion of a further clause: the degree of dependence is related to the degree of difficulty an individual has in refraining from the substance use (or any behavior). Thus, dependence is set on a continuum whereby all people are likely to experience some degree of dependence on some behavior. The distinction that drug dependence enjoys is that it is generally less socially acceptable, or more accurately, certain degrees of dependence on certain substances are less acceptable than other behaviors. As with a society's choice of favored drug use, the acceptability or otherwise of type and degree of dependence is governed by social and cultural values. Thus, recent years have seen changes in attitudes towards tobacco dependence.

For those who might reject the idea that they are dependent to any degree on substances such as alcohol, they might consider the action of a cricket team recently on tour in Pakistan. The dominant religion in Pakistan is Islam and the government actively prohibits the sale of alcohol, except in special circumstances. These 'special circumstances' dictate that in order to purchase alcohol, all the prospective drinkers were obliged, to which they consented, to sign declarations that they were dependent on alcohol (or were 'alcoholics') and as a result they received a prescription of alcoholic beverages for their 'illness'. Little consideration is needed to recognize that cultural influences dictated definitions of 'dependence', and it is equally apparent that these influences easily apply across different substances.

Further arguments for non-substance dominated explanations of dependence can be found in much of the research aimed at highlighting the determinants of dependence. This is especially the case in the work which emphasises situational determinants. Siegel and his colleagues (Siegel, 1979; Hinson and Siegel, 1980) have hypothesized environmental determinants of tolerance and withdrawal symptoms, classically accepted features of drug dependence, which apply across different substances. The researchers demonstrated that rats which have developed tolerance to drugs such as opiates or alcohol in one specific environment do not exhibit this tolerance in environments not associated with the drug administration. Similarly, they have reported that withdrawal symptoms are attenuated by non-drug associated environments. It is evident that reports such as these,

which focus on the environment rather than the substance used, by definition describe common features across substances.

Similar conclusions can be drawn from research relating to dependence in humans. For example, the work reported on by O'Brien and his colleagues (O'Brien et al., 1977) with opiate users has obvious implications for substances such as alcohol or tobacco. These researchers reported that withdrawal symptoms in opiate 'addicts' could be classically conditioned. Subjects were injected with naloxone, a narcotic antagonist, which usually initiates withdrawal symptoms in individuals dependent on opiates. This injection was paired with experimentally controlled changes in the environment (the sound of a bell and a smell were introduced into the room at the same time as the naloxone was administered) and eventually, withdrawal symptoms could be cured by the sound and smell, irrespective of whether or not the naloxone was administered. These experimental results parallel clinical anecdotes where individuals, dependent on many different substances, report that tolerance and withdrawal symptoms are evident in some situations and not others.

The importance of environmental determinants is again implicated by reports of the very low 'relapse' rates of opiate users amongst the US armed forces who served in Vietnam (Robins et al., 1974). During the Vietnam War, cheap, high quality heroin was easily available to troops who were under stress, bored and with no social controls from sources such as family or employment. It was estimated that between 15-20% of the troops were 'addicted'. However, in a follow-up study conducted 12 months after identified users had been detoxified and returned home, only 7% were reported as having relapsed. This compared strikingly with the usual relapse rates of 60-90% reported in the literature on treatment outcome. The proposed explanation emphasizes the difference in cures in the different environments: the war/drug associated environment and the home/non-drug associated environment.

Investigations of biophysiological mechanisms involved in dependence also have implications across substances. Snyder (1978) has reported on specific sites of action of the opiates in the brain and on the identification of endogenous substances ('endorphins') similar in structure to opiates, which bind at these sites. Possible relationships between these endorphins and dependence to alcohol as well as opiates have been speculated. For example, it has been reported that metabolism of alcohol reduces activity at the opiate receptors (Summers and Lightman, 1981). Similarly, there have been reports of naloxone, usually employed as a narcotic antagonist, reversing the effects of severe alcohol intoxication related coma in humans (Lyons and Anthony, 1982), and of cross-tolerance between morphine and alcohol in animals (Blum et al., 1977). Further research will determine the relevance of this work to common mechanisms in dependence on different substances.

The implications of this evidence suggest that dependence should no longer be perceived in terms of substance-specific dependence in isolation from other substances or even environmental influences. Consequently, researchers and clinicians concerned with dependence should be considering the implications and relevance of work in one substance area for other substances, especially in terms of the similarities/distinctions in problems related to dependence on different substances and ways of responding to these. For example, should we respond to dependence on alcohol in a different manner to dependence on opiates? If one accepted the popular assumption that the focus of drug problems is dependence, then it would be reasonable to conclude from the discussion above that responses to different substance use should be very similar. What basis is there to suggest that we should respond to one set of drug problems differently from

another? An attempt to answer this question is often confused by a simple lack of a common currency in which the issues can be debated, and any differences in response are frequently historically or subjectively rather than objectively justified.

A useful model for conceptualizing drug problems has been described by Thorley (1980) which, whilst initially applied to alcohol, is applicable across various drugs. In this model, he distinguishes three categories of problems related to drug use - problems related to intoxication, problems related to regular use and problems related to dependence.

Problems of intoxication tend to be related to the acute effects of the substance used and in the main are legal or social in nature (e.g. impaired driving ability, public intoxication, family discord) or acute medical problems (e.g. accidents whilst intoxicated). Problems of regular use relate more to the physical damage which can accrue from long periods of drug use, such as malnutrition or chronic illness. Finally, problems of dependence are more elusive to define but may include the experience of withdrawal symptoms or the difficulty in refraining from the use of a particular substance or group of substances.

Applying this model across different substances allows a recognition of the similarities and distinctions between them and will assist in the organization of comprehensive response strategies tailored for each substance. For example, most responses to opiate and alcohol use are geared towards problems of dependence and regular use. Whilst this is probably appropriate for opiates, it is being consistently argued that for alcohol, problems of intoxication are the greatest area of neglect in terms of responses and perhaps even the greatest area of concern related to alcohol use (e.g. Chick, 1984).

Unfortunately, little work has been conducted which directly attempts to comparatively highlight the main areas of concern for each substance or substance group and this restricts the ability to suggest potential commonalities in appropriate interventions. Despite these restrictions, it is relevant to consider common issues in the efficacy of intervention and the role treatment has in the changing of addiction behavior.

THE IMPACT OF TREATMENT

Despite the fact that many different responses exist within and between different substances, there is one common theme which emerges in treatment outcome evaluation: there is little evidence which demonstrates the effectiveness of one treatment over another. The evidence for this statement can be found amongst the many reviews assessing the effectiveness of the treatment of alcohol and narcotic problems (Callahan, 1980; Moos et al., 1983; Mulford, 1979) and of smoking cessation methods (McFall, 1978).

The conclusions of these studies have represented a common theme and concern for the treatment of addictive behaviors; research evaluation historically and consistently fails to demonstrate the superiority of one strategy over another or of the positive impact of treatment itself. This calls for a reappraisal of treatment on two fronts - through better research and better treatment strategies, and a consideration of the role of treatment in the context of remission outwith formal intervention.

REMISSION IN THE ADDICTIVE BEHAVIORS

There are several studies which report remission from problematic substance use. In reviewing these one is struck by the similarities in the

process of remission across substances. Whether one considers independent studies of remission from alcohol problems (e.g. Tuchfeld, 1976; Vaillant, 1983) or opiate use (Wille, 1980) for example, similar conclusions are apparent.

The overriding impression from these reports is that the process of remission can be conceived as being in two stages. They suggest that the initial change in drug-taking behavior is the result of the individual perceiving that the drug-taking is causing problems - that is, over a period of time, or on some occasions instantaneously, the negative consequences of the drug-taking (ill-health, complaints from family, interference with other enjoyable activities etc.) come to outweigh the positive consequences. Thus, the individual recognizes a need or desire to change his/her behavior. As already indicated above, this process is documented in the literature irrespective of the substance reported on.

Once indicated other factors are apparent in maintaining the resolution to change the behavior. Essentially, the studies indicate that the first stage interacts with the second stage maintenance factors, which include the opportunity to initiate new interests, support from other people, a sense of mastery over the drug-taking problem and in general a new way of life.

The compelling feature of these reports relates to the commonality across different substances in the process of remission and they have serious implications for the design and practice of therapeutic intervention.

This consideration is further supported by a report from Prochaska and Di Clemente (1983). In this study, the authors interviewed a large sample (N = 872) of media-recruited individuals about their smoking behavior and categorized them into one of the following groups: 'long-term quitters' (who had stopped smoking for over six months); 'recent quitters' (who had stopped smoking for less than six months); 'contemplators' (who although still smoking were seriously considering stopping); 'immotives' (who gave no indication of wanting to stop) and 'relapsers' (who had made a recent resolution to stop but who had failed to maintain this). In utilizing a questionnaire designed to measure behavior change strategies, the authors determined that the different categories of their sample employed different strategies. For example, the 'immotives' reported utilizing fewer strategies of change and were not as aware of, or concerned by, smoking-associated health hazards than 'contemplators'. The authors concluded that:

> "Rather than assume that all smokers coming for treatment are ready for action, clients would be grouped according to which stage of change they are in. Research with clients applying for therapy indicates that there are clusters of clients in each of the stages of change... Thus, smokers in the contemplation stage would begin with consciousness raising and self-evaluation processes while smokers ready for action could begin to apply the more behaviorally-based processes". (p.10).

The implications of this work are apparent for all addictive behaviors. As with other drugs, change appears to be initiated by internal events, wherein recognition and the impetus for change arises from a perception of adverse consequences outweighing the benefits of substance use. This suggestion reaffirms the view that therapeutic intervention should be seen in the broad context of 'giving up' and that the responses should be individually tailored. Thus, in Prochaska and Di Clemente's terms therapy for pre-contemplators and contemplators should be aimed at

increasing/balancing in favor of commitment to change, whereas in other groups, therapy should perhaps concentrate on developing skills to help maintain change and manage/avoid relapse. As Edwards (1984) has succinctly noted, studies such as these imply that 'Treatment must be syntonic with the natural process of recovery' (p. 178) and the evidence suggests that this should be the case for all substances.

INTERVENTION: CAUSE FOR OPTIMISM

Despite the rather pessimistic conclusions of treatment outcome evaluation, there are more recent reports which suggest at least a cautious optimism.

In reports of investigations carried out by Miller and his colleagues relating to interventions with problem drinkers where controlled drinking was encouraged rather than abstinence, it was found that the controlled drinking treatments were more effective than either no treatment (being placed on a waiting list) or discussion-based therapies (e.g. Miller and Munoz, 1976; Miller and Taylor, 1980). One interesting aspect of this work was highlighted by Miller and Taylor who demonstrated the value of minimal therapist contact and self-help manuals in helping reduce a client's drinking. It is relevant, however, to note that the subjects were described as being relatively intact, possessing characteristics associated with successful outcome. Rather than this weakening the implications of the research, it demonstrates that it is possible to encourage relatively intact clients into therapy, with consequent good outcome. The preliminary results of a similar study, where subjects were sent a booklet on how to control drinking behavior or a control booklet giving only information on alcohol problems, are encouraging. Across both groups of subjects, 60% of those who were identified as drinking at predetermined unsafe levels were found on follow-up to be drinking at designated safe levels, and the experimental group had, overall, reported a greater drop in consumption (Heather et al., 1984). (See also Heather, in this volume).

In relation to the evident good economics of such approaches, it is possible to imagine various applications across the addictive behaviors. Indeed, in the light of these results, we need to ask that if there is a move away from the conceptualization that problem drinkers are, of necessity, in need of intensive and specialized care, how far we can generalize across different substances.

Support for such a generalization is to be found in a report by Russell and his colleagues (Russell et al., 1979). In this study, a randomly selected group of smokers were simply advised to stop smoking by their doctors, given an information leaflet on 'how to stop smoking' and informed that a follow-up would take place at one month and one year intervals. At the one year follow-up, it was apparent that subjects receiving this sort of treatment (or 'influence' would be a more appropriate word) were significantly more likely to have stopped smoking than a randomly selected control group of smokers who only had their names recorded for follow-up purposes. The conclusion of the study was impressive - the authors suggested that if all the general practitioners in Britain adopted a similar procedure, the results would be "... unlikely to matched by setting up 10,000 specialized smoking withdrawal clinics" (p.234). (See also Hallett, in this volume).

Finally, a recent report (Sourindhrin and Baird, 1984) indicates the utility of a minimal intervention strategy with solvent users who voluntarily attended a clinic held in a police station in Glasgow. Children up to the age of 16 were referred from a variety of sources, such as parents,

teachers, general practitioners and the police. The intervention consisted of a detailed psychiatric and medical assessment, an educational input and advice to parents and the solvent user. Additional input was available on request whereby a community involvement police officer would supervise and potentiate access to community centers, clubs, swimming pools and so on for up to two months. As the investigators reported, intervention was minimal:

> "One parent families were given extra support and some cases were referred elsewhere. The children were usually seen only once at the clinic". (p.228).

The outcome of this study is again encouraging. Only 19% (N = 40) of the referrals were re-referred for a second time and 6.7% (N = 14) for a third time. The investigators concluded:

> "Minimal intervention at an early stage appears to be effective..." (p.231).

Although the present authors are unaware of any reports supporting the validity of such an approach with opiate users, self-help manuals do exist (e.g. The Blenheim Project, 1983). Considering the positive results cited above, it would appear appropriate to encourage the evaluation of the effectiveness of minimal intervention strategies with such groups.

One very common feature of the addictive behaviors is the apparent frequency of 'relapse' following therapeutic intervention. For example, Hunt and his colleagues (Hunt et al., 1971) in a review of 'relapse' rates over time in smoking, alcohol and heroin treatment programs, illustrated comparable 'relapse curves': 90 days after treatment, approximately 66% of clients in all three drug categories had 'relapsed' (i.e. returned to some use such as a drink or cigarette) - the vast majority of these occurring in the early stage of post-treatment. This similarity in rates suggests that there may be common processes that are independent of the particular substance or therapeutic response. This consideration has been augmented by Marlatt and his colleagues (Cummings et al., 1980) who reported on an examination of reported reasons for relapse across several addictive behaviors. It was apparent that across all the addictive behaviors reported on (heroin, alcohol and tobacco use, overeating and gambling), there were similarities in relapse determinants. For example, with smokers, heroin 'addicts' and 'alcoholics' some of the most commonly reported determinants were reported as 'negative emotional states' (e.g. feeling depressed) and 'social pressure' (e.g. pressure from friends to engage in the addictive behavior).

To a large extent, the problem of relapse has, until recently, been largely neglected in all the addictive behaviors, both in research and clinical practice. In a sense, this is possibly one of the reasons why treatment has recorded so little impact, for to deal effectively with relapse is in effect successful treatment. Part of this neglect is due no doubt to disease models of addictive behavior wherein relapse was perceived as a symptom of the re-emerging disease and outwith the control of the individual. This conceptualization of relapse has been widely criticized, coincidental with evolving models of relapse developed simultaneously and independently by Litman (Litman et al., 1979; 1984) and Marlatt (Marlatt, 1978; Marlatt and George, 1984). Both of these workers have stressed that relapse occurs because of an intervention between the individual, the drug and situational factors.

These new models open up a range of potential strategies, for a variety of drug therapies, in relapse prevention and management. It is now accepted that relapse is related to cognitive and behavioral factors, which

are open to therapeutic influence rather than to the more immutable biological factors implied in the disease model of relapse. The applicability of these models across the addictive behaviors is apparent, yet to date, little assessment of their clinical implication have been made, although Chaney reports encouraging results (Chaney et al., 1978) and at present, various strategies are being assessed independently by Annis and Allsop and their respective colleagues (Annis, 1984; Allsop et al., 1984). However, greater attention needs to be paid to this potentially fruitful areas across all the addictive behaviors.

Despite these recent causes for optimism in the treatment of the addictions, much of this work is still to be evaluated and researchers and clinicians alike should still heed the cautions implied in earlier treatment evaluation. This should encourage a recognition of the limitations of treatment and militate against allowing these new approaches becoming hailed as the definitive approaches to dealing with the addictive behaviors.

CONCLUSION

In conclusion, it appears that there are commonalities across the addictive behaviors in terms of the ways in which problems are perceived and defined, the mechanisms involved in dependence, the impact of treatment and the processes of remission. Although not a comprehensive discussion (e.g. not covering etiology, or the role of education) these commonalities have implications for research and the implementation of responses to drug-related problems. This is especially the case in the light of evidence relating to multi-drug use.

In a situation where there are limited resources available to respond to any one set of substance-related problems, it is reasonable to consider the feasibility of maximizing their effect by pooling resources where applicable thus avoiding needless duplication of services and research and hence potential competition for resources. This would also avoid a situation developing where no resources are available for a particular substance group due to low demand (e.g. in an area where there were few opiate problems, utilization of existing services for other drug related problems would be appropriate). This is in line with recommendations recently made by the Advisory Council on the Misuse of Drugs (1982).

Similarly, consideration of these commonalities would go some way to demystifying certain types of drug use. For example, many workers who feel competent at dealing with problems from one set of drug problems often feel 'de-skilled' when faced with a client using other drugs. A recognition of the commonalities, although of course coupled with a knowledge of any distinctions, would encourage a recognition of the applicability of their existing skills.

The overwhelming message from a study of the effectiveness of treatment and processes of recovery across several drugs is clear: the emphasis in the future should be on aligning therapeutic intervention to the processes of remission, utilizing those factors that initiate, encourage and maintain change in the problematic, drug-taking behavior. This should be coupled with an encouragement of utilizing minimal intervention strategies with relatively intact clients rather than investing all effort in the more difficult and severe cases.

The models of remission, especially that presented by Prochaska and Di Clemente, add further weight to the demand that across all the addictive behaviors intervention be tailored to individual needs. Recent sugges-

tions and research provide tools through which this may be attempted. Thus, the 'motivational interviewing' strategy suggested by Miller (1983) may be an appropriate emphasis to encourage those clients contemplating change into some action, and the community-reinforcement strategies of Azrin and his colleagues (Azrin, 1976; Azrin et al., 1982), problem-solving techniques (D'Zurilla and Goldfried, 1971) or self-help guides may be appropriate emphases, along with relapse management/prevention techniques to help maintain those who have initiated change.

Finally, emphasis also needs to be placed on developing further models such as that presented by Thorley (1980) so that commonalities can be debated along with distinctions, encouraging the construction of priorities of response in different substance areas to enable systematic, objective and adequate responses to all the addictive behaviors.

Acknowledgement

We are grateful to Susan Anderson for her comments on earlier drafts of this chapter and to Georgina Barr for her usual high standard of secretarial skill.

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BENZODIAZEPINE DEPENDENCE

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INTRODUCTION

In recent years, increasing concern has been expressed about the use of benzodiazepine hypnotics and tranquilizers, particularly with regard to the numbers of patients who take the tablets regularly for a long period of time. This paper addresses the problems of long-term use and dependence and suggests ways in which patients can be helped to give up reliance on these drugs.

EXTENT OF USE OF BENZODIAZEPINES

The benzodiazepines represent 75% of all prescribed psychotropic drugs (King et al., 1982). It has been estimated that one in five women and one in ten men are prescribed benzodiazepine medication in any one year (Lader, 1983a). Of these, two-thirds will take the drugs for longer than one month: 1½% of the adult population are chronic users, with three quarters of a million people having taken the drugs for more than 7 years. In studies of long-term users, half the patients were found to have taken benzodiazepines regularly for more than 10 years (Cormack and Sinnott, 1983; Dennis, 1979).

Twice as many women as men are prescribed benzodiazepines (Balter et al., 1974; Skegg et al., 1977) and this ratio is maintained for chronic users (Mellinger and Balter, 1981). The maximum use of anti-anxiety agents occurs in the age group 50-64 years; hypnotics are used most by those aged 65-79 years (Mellinger and Balter, 1981). Nearly 90% of prescriptions for nitrazepam go to patients over 65 years (Swift, 1981).

HISTORY OF USE

The benzodiazepines replaced the barbiturates: they are safer in overdose and at the time they were introduced they were thought to be non-addictive. The first drug on the market was Librium (chlordiazepoxide) in 1960, followed by Valium (diazepam) in 1963, and Mogadon (nitrazepam) in 1965. Since then, a number of other benzodiazepines have been produced such as the short-acting hypnotics triazolam (Halcion) and temazepam (Normison, Euhypnos) and the tranquilizer lorazepam (Ativan). The majority of the drugs are 1-4 benzodiazepines - a term referring to the molecular

shape. Clobazam (Frisium) is a 1-5 benzodiazepine with a different structure and supposedly acting with less sedative and muscle relaxant effects than the other compounds (Hindmarch, 1979a).

THERAPEUTIC USE

The benzodiazepines are used as hypnotics and as minor tranquilizers for anxiety, but doctors prescribe the drugs for physical illness also. Two fifths of men and one-third of women who received benzodiazepines had them prescribed for physical complaints (Williams, 1978; Williams et al., 1982). Often they are used for patients with gastro-intestinal complaints and cardiac conditions (Lasagna, 1977); sometimes they are given to patients with pain, although evidence suggests that they should not be used for patients with chronic pain as pain tolerance thresholds may be lowered (Hendler et al., 1980).

Not infrequently, benzodiazepines, particularly hypnotics, are prescribed by GPs following a patient's hospitalization (Tyrer, 1978) and are continued for no clear reason. One fifth of patients regularly taking hypnotics started in hospital (Johnson and Clift, 1968). The hospitalization may have been for a physical condition and the hypnotic may have been offered as ward management policy to ensure that patients sleep at night. On discharge, a list of the drugs the patient is taking may be sent to the doctor with a request for these to be repeated. Thus, the patient is prescribed a drug which is unnecessary, but which will be repeated and dependence can then develop.

PHARMACOLOGICAL PROPERTIES OF THE BENZODIAZEPINES

The drugs have five major properties (Hindmarch, 1983).

1. Sedative: the benzodiazepines will induce sleep at sufficiently high dose and may produce side-effects of drowsiness at lower doses.

2. Anxiolytic: the drugs work centrally to reduce symptoms of anxiety and to make the patient feel more tranquil. Those who respond most well to anxiolytics are non-psychotic anxious patients suffering primarily from emotional and somatic symptoms of anxiety. The depressed patient or person with interpersonal problems is less likely to benefit (Rickels, 1980). However, Harris et al.(1977) showed that psychoactive drugs had no curative effect whatsoever in terms of psychoneurotic scores on the Middlesex Hospital Questionnaire.

3. Muscle relaxant: muscle relaxants may help anxiety by providing peripheral feedback congruent with the feelings produced when the individual is tranquil.

4. Anti-convulsant effects: the drugs may be of use in epilepsy to control and prevent convulsions.

5. Amnesic effects: one reason for using a benzodiazepine as a relaxant and sedative prior to surgery is that the administration of the drug produces amnesia for the events following. The extent to which amnesic effects occur in short-term therapeutic use is questionable, but poor concentration and memory commonly develop in patients on long-term benzodiazepine medication (Ashton, 1984). Shader and Greenblatt (1981) report a time-limited anterograde amnesia syndrome, similar to Korsakoff amnesia, in some patients receiving lorazepam (Ativan).

PSYCHOLOGICAL IMPAIRMENTS DUE TO BENZODIAZEPINES

A number of studies over the past few years have investigated aspects of performance deficits following administration of these drugs (Hindmarch, 1979b, 1981; Nicholson, 1979; Skegg et al., 1979; Wittenborn, 1979; Kales, 1980; Lader et al., 1980; Lader, 1983b). The findings show deterioration in performance on simple repetitive tasks such as digit symbol substitution and card sorting, decrements in learning and memory, critical flicker fusion, reaction time and tasks requiring the combined use of sensory and fine motor skills. On tests of actual and simulated car driving, decrements in performance have been observed (Lader, 1983b). The combined effect of diazepam and alcohol endangers driving as diazepam enhances the effect of alcohol (Linnoila and Hakkinen, 1974).

Little work has been published demonstrating the long-term effects of the drugs, but Lader (1983b) reports brain scan appearances intermediate between those of controls and those of alcoholics.

PROBLEMS ASSOCIATED WITH THE USE OF BENZODIAZEPINES

Some hypnotics are sufficiently long-lasting to provide hang-over effects in the morning so that the patient feels drowsy and has impaired performance (Nicholson, 1981). These hypnotics may also lead to disturbance of sleep and rebound insomnia on withdrawal. Shorter-acting drugs also provide difficulties such that the patient may experience an increase in anxiety during the day because the effects of the drug have worn off quickly (Morgan and Oswald, 1982; Oswald 1983). Thus the patient may feel the need for an additional benzodiazepine to cope with the day-time anxiety caused by the hypnotic.

Because of changes in metabolism, the elderly are particularly at risk of toxicity from the normally therapeutic doses of benzodiazepines (Mendelson, 1989). Evans and Jarvis (1972) identified a syndrome of confusion, general mental deterioration and frequent falls caused by nitrazepam, with recovery to normal occurring rapidly when the drugs were withdrawn.

DURATION OF USE

In 1980, the Committee on the Review of Medicines issued guidelines reiterating that the drugs should be used only in the short term. Evidence cited about the efficacy of the drugs suggested that hypnotics may become ineffective after three to fourteen days, and day-time tranquilizers may be of no use after four months. However, it is obvious that many prescriptions are issued over far longer periods of time. Varnam (1981) assessed the average time on psychotropic therapy as 4.3 years for patients who had repeat prescriptions and 2.7 years for those whom the GP saw regularly. Fleming and Cross (1984) reported an average of 51% of psychotropic prescriptions being repeats, and Kales (1980) found that over 40% of prescriptions for sleeping pills extend for over three months.

DEPENDENCE

Unlike some other drugs of addiction, the benzodiazepines tend not to be taken in ever-increasing quantities, but some evidence of tolerance is apparent. Oswald (1983) demonstrated tolerance to nitrazepam by the third week of administration with no shortening of sleep latency and only minimal increase in sleep duration over baseline measures.

The problems for patients are not that they necessarily crave more and more of the drug: often they maintain themselves on doses below those recommended by the doctor (Tessler et al., 1974; Lader, 1981). It is when the patient attempts to stop the medication that the dependence becomes apparent and some patients undergo a period of physical withdrawal similar in some respects to the withdrawal from drugs such as heroin (Winokur et al., 1980; Petursson and Lader, 1981; Shader and Greenblatt, 1981; Tyrer et al., 1981).

The withdrawal syndrome includes symptoms evident in anxiety but has been shown to have distinctive features which prove that it is not merely a resurgence of the anxiety which led to the prescribing. Common withdrawal effects, unlike anxiety symptoms, are perceptual disturbances, with the environment appearing brighter or shimmering, leading to unsteadiness in movements. Muscle spasm and pain, particularly in the jaw, often occur. Most patients experiencing withdrawal complain of severe sleep disturbance, irritability, increased tension and anxiety, panic attacks, hand tremor, sweating, difficulty in concentration, nausea, weight loss and palpitations.

The withdrawal reaction represents the converse of the action of the drug: thus, anxiety and muscle spasm would be expected from a drug which was anxiolytic and muscle relaxant. While taking the drug, the body relinquishes control in certain areas to the drug. The withdrawal period represents the time when the body is having to re-learn its operation of those mechanisms. One of the major symptoms of withdrawal after administration of an hypnotic drug is insomnia. There are also reports of fits occurring after abrupt discontinuation of benzodiazepines in patients who had no history of convulsions (de Bard, 1979; Howe, 1980). Benzodiazepines should always be discontinued on a reducing dose over a minimum of four weeks and often over a longer period of time.

REASONS FOR DISCONTINUING LONG-TERM USE

It may be questioned why a patient who has survived for several years on repeated prescriptions for benzodiazepines should be encouraged to stop taking the medication. The possibility of brain damage from chronic use has already been mentioned. Patients can exhibit changes of mood and behavior, becoming depressed, irritable or dependent, and there are some reports of paradoxical aggression linked to child abuse (Hall and Joffe, 1972; Lynch et al., 1975; Hall and Zisook, 1981; Lader and Petursson, 1981). While taking benzodiazepines, patients may become agoraphobic (Ashton, 1984).

ALTERNATIVES TO PRESCRIBING

Many problems brought to the doctor are not medical, but the doctor may be prepared to alleviate the symptoms when the cause of the problem cannot be tackled easily. Often the doctor feels impotent and the prescription is then a gesture of doing something for the patient (Marinker, 1973). Alternatives to the prescription include helping the patient to work on ways of solving the problem or teaching the patient to control anxiety by means other than pharmacological ones.

Evaluation of the effects of counseling and psychotherapy in primary care settings has shown that drug consumption falls as a result of therapy (Anderson and Hasler, 1979). Counseling may be the first choice of treatment and may replace the need for a prescription. A reduction in prescriptions of over 50 percent has been demonstrated in patients who had psychological treatment (Ives, 1979; Koch, 1979).

General practitioners have effected changes in the long-term use of benzodiazepines by requesting in a letter or interview that the patient stop the medication (Hopkins et al., 1982; Cormack and Sinnott, 1983). A directive from the person who prescribes the medication seems to have a strong impact and has produced worthwhile results.

Training in anxiety management or simple relaxation has also been effective (Giblin and Clift, 1983). Coupled with information about the drugs and expectations of possible withdrawal effects, the method gives back to the patient power over their own reactions. Self help groups have developed which have the potential to support the individual to overcome dependence and to deal with life more effectively.

STRUCTURAL WITHDRAWAL

Withdrawal should ideally be supervised medically and must be gradual. At one time, it was hypothesized that the slower the withdrawal, the less the chance of symptoms arising (Tyrer, 1980). More recently, it has been felt that a very slow period of withdrawal will merely prolong the agony (Lader, 1983a). Not all patients will experience withdrawal, but all should be advised to reduce medication gradually.

Suggested regimes of withdrawal are from two to four weeks with medical supervision and from four to six weeks without. Dosage should be reduced by approximately one eighth of the original daily intake at each step in the program. Some patients have difficulty stopping short-acting benzodiazepine medication such as Ativan (lorazepam). In these cases it is advisable to switch to a longer acting compound such as diazepam when the dose has been reduced by half (Ashton, 1984).

Again, there may be value for some patients to take a beta-blocker (propranolol) to combat some of the withdrawal symptoms. Tyrer et al. (1981) suggested this approach but it may be that its effectiveness is idiosyncratic (Lader, 1983a).

THE FUTURE AND THE ROLE OF THE CLINICAL PSYCHOLOGIST

Already trends in prescribing have changed (Mapes and Williams, 1979; Williams, 1980). Doctors are far more aware of the current use of the tablets and of the alternative to the prescription. Knowing that dependence has to start somewhere, the medical profession are becoming wary of even a short course of prescribing.

There is scope for involvement of the clinical psychologist at a number of levels. Not only can the psychologist help the patient to stop medication, but the need for the initial prescription may be averted by an alternative of psychotherapy. However, to do more than merely scratch the surface, given the very few clinical psychologists and the very many people suffering anxiety or dependent on benzodiazepines, skills need to be directed in other ways as well.

Teaching in medical schools allows for dissemination of information and broadening of treatment perspectives. Involvement in general practitioner training courses can influence the understanding and decision-making of the future general practitioner. More informal interdisciplinary meetings can provide the opportunity for discussion of problems and ideas. Suggestions for alternative treatment may be adopted by the doctor without necessarily involving the clinical psychologist or other professionals.

If doctors are more able to offer alternatives to patients then future dependence on benzodiazepines will be reduced.

Acknowledgement

The preparation of this paper was supported by a research grant from Mersey Regional Health Authority.

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SMOKING CESSATION: TREATMENT AND RELAPSE PREVENTION

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INTRODUCTION

In Britain about 37% of women and 42% of men still smoke cigarettes (OPCS, 1981) - a total of some seventeen million people. In the United States there are some 54 million cigarette smokers (Surgeon General, 1979). The total annual death toll in Britain from smoking is not less than 100,000, making smoking the major preventable cause of death in this country today. Some 50 million working days are lost to industry each year as a direct result of premature death from smoking-related illness (Royal College of Physicians, 1983). Of men aged 35 who smoke more than a pack of cigarettes a day 40% will die before age 65, as compared with only 15% of non-smokers, and there is no reason to believe that the same is not true for women cigarette smokers (Royal College of Physicians, 1977). It is clearly necessary to try to provide those smokers who already want to stop with help; to try to persuade those who do not wish to stop that they should; and to prevent young people from taking up smoking to try to prevent further unnecessary loss of life and health. The main focus of this paper is to discuss what is on offer to those smokers who already wish to stop.

Surveys have repeatedly shown that the majority of smokers - over 90% - want to stop smoking, and that most have tried at least once and have failed (USPHS, 1976). Public education campaigns have, over the years, raised the level of awareness of the health risks of smoking to the extent that most smokers acknowledge that their behavior is very hazardous, yet few are able to stop permanently, though they acknowledge they ought to do so. When compared with other drug-dependence behaviors, the relapse rate among smokers is very similar, though Sutton (1979) has demonstrated these figures need to be taken with a certain amount of caution.

The most likely factors in precipitating relapse in smokers are the physical and mental symptoms experienced during nicotine withdrawal. Nicotine is dependence-inducing and it has been demonstrated that there are well-defined patterns of withdrawal symptoms (Shiffman, 1979) which, especially during the first few days and weeks of abstinence, can precipitate a relapse crisis. Other social and emotional factors are also likely to play an important role in relapse according to the model of the relapse process put forward by Marlatt and Gordon (1979). Raw (1978), pointed out

that the most urgent question in the treatment of smoking is how to prevent smokers who have stopped from relapsing.

TREATMENT APPROACHES

Three main models of why smokers smoke have been developed; the learning model, the nicotine dependence model and the attitude-behavior model (Surgeon General, 1979; Sutton, 1984). To an extent all three models seek to explain why smokers start to smoke and persist, and moreover why they continue in the light of increasing evidence that doing so is very hazardous. It is likely that any comprehensive explanation of smoking behavior will have to incorporate elements of all three models. However, it is also likely that although people smoke for a variety of social, psychological and pharmacological reasons, they start smoking for social reasons but continue to smoke for a combination of pharmacological and attitudinal reasons.

It is important not to underestimate the role of nicotine in the maintenance of smoking. It is unlikely that people would smoke (or chew tobacco, or take snuff) at all if tobacco did not contain nicotine (Russell and Jarvis, 1984). There is also strong evidence from a variety of sources that nicotine depletion underlines the withdrawal state (West, 1984). A range of physiological changes occur when nicotine is withdrawn from the system, accompanied by the experience of craving, nervousness, irritability, hunger, etc. (Jarvik, 1977; Schachter, 1978; Shiffman, 1979). These withdrawal symptoms may exert a global influence which wears down a smoker's determination, resolve and ability to cope till they relapse, or alternatively (in the classical addictive sense) the smoker may simply start smoking again to alleviate them (Shiffman, 1982). Whichever is the case, the result of the withdrawal state for most smokers is relapse to smoking. Helping smokers overcome the withdrawal state and preventing longer-term relapse are the two main goals of any smoking treatment.

As tobacco dependence has both pharmacological and social/behavioral components, it lends itself to a wide range of treatment approaches. These approaches can be grouped, roughly, into five general categories, which are by no means mutually exclusive or exhaustive. The five approaches are; simple self-control, minimal intervention strategies, behavioral treatments, drug-based therapies, and smoking clinics. No attempt is made to review treatments based on hypnosis or acupuncture as there are currently no acceptable controlled studies incorporating validated long-term success rates. However, both approaches are extensively used by some therapists and occupy a prominent place in the smoker's fantasy of what constitutes treatment for smoking. Adequate controlled studies of these approaches are overdue.

Crucial to establishing the efficacy of any approach to smoking cessation is its success rate. But how should success be defined? Many studies have reported short-term (immediate, or within a few weeks or months post-treatment) results, and/or exclude dropouts from the final calculation of success rate. A more stringent set of criteria for success would include;

1. complete abstinence post-treatment for twelve months;
2. biochemical validation of reported status of long-term and intermediate follow-ups by means of expired air carbon monoxide, or salivary thiocyanate, or urinary nicotine;
3. inclusion of all dropouts in the final calculation of the success rate.

It is often extremely difficult to assess whether reported treatment studies have met these three criteria. A further problem is how stringent a definition of post-treatment abstinence is used - is the person who has three or four cigarettes in the year after treatment to be counted as a failure? Would somebody who had reduced their consumption to a regular one cigarette a week be a failure? The only clear solution to this difficulty is for all treatment studies to pre-set definitions of what will be accepted as abstinence to facilitate any later comparisons between studies.

In summary, comparison of the success rates of different treatments is difficult, if not currently largely impossible, as there are no standard outcome criteria with which to assess them (Sutton, 1984). This warning should be kept in mind when considering the summaries of the five approaches discussed below.

Simple Self Control

The most straightforward approach to smoking cessation is simple self-control. Unaided, the smoker must take the decision to quit, implement it and adhere to it. This approach is fraught with difficulty. Many smokers have little or no idea what will happen when they stop and are caught unprepared by the withdrawal symptoms; other suddenly find reasons why smoking is attractive and should be continued (for example, because they develop a cough or put on weight after stopping). Other smokers find they cannot cope with an unexpected personal, or family crisis without resorting to cigarettes. It is an oversimplification to say that smokers use these types of event purely as excuses for returning to smoking - it is more accurate to say that the aspiring ex-smoker is very well informed about why he or she should stop, but not how to do so or what to expect once stopped. Smokers who want to stop are also not provided with any fully organized, or easily available, public health service facility to help them in stopping (Row and Heller, 1984). This lack of preparedness means straightforward self-control is not an especially effective method of giving up smoking, though as a component in any smoking intervention program self-control it is clearly fundamental to long-term success.

In Britain, a majority of smokers (three out of four) have tried to stop at some time or another (Royal College of Physicians, 1977). However, it is likely that only one in four smokers succeeds in stopping permanently before the age of 60 (Lee, 1976). In a study by Russell et al. (1979) on the effects of General Practitioners' (GPs) advice against smoking, 10.3% of the non-intervention control group had stopped smoking by the one year follow up, but only 0.3% had stopped and stayed off for one year. The cumulative annual success rate is therefore likely to be about 3.6%. Although the proportion of long-term stoppers is small, because most smokers try to stop on their own at one time or another, the actual number is very large. It is likely that numerically more people will stop each year using simple self control that stop using all the other treatment methods combined. An estimated eight million smokers have stopped on their own in Britain without any outside "professional" help (Ashton and Stepney, 1982), yet we know very little about the decisional processes involved or the characteristics of those whose attempts proved to be successful in the long-term. The majority of those smokers who do try to stop alone, however, fail and often fail repeatedly. This cycle of attempt followed by failure is bound to result in the progressive erosion of the smoker's self-confidence and desire to stop. It is therefore of great importance that as most smokers are unlikely to try, or to have access to the treatment methods discussed later that we make their attempts at simple self-control more effective by providing them with more information on how best they can treat and help themselves. Mobilizing the resources of these millions of smokers quickly and simply forms the basis of the minimal intervention approach.

Minimal Intervention Strategies

The essence of the minimal intervention approach is how little can we do to treat smokers and still have a useful effect? The less we have to do to help people stop smoking, and the simpler the intervention is, the greater the number of smokers it can be applied to in any given period.

Resources are always limited, and a health professional's time is an expensive and continually diminishing one. Smokers far outnumber those health professionals who might be in a position to offer treatment for smoking and consequently some way of reaching large audiences with useful information about smoking cessation is a pragmatic and attractive alternative to the more costly and time-consuming therapies discussed later. Minimal interventions can take the form of radio and television programs, or brief interventions given to large groups of people simultaneously (such as in workplaces), or simplified versions of behavioral and drug-based therapies applied on a routine basis. These types of strategy are appealing for two reasons. Firstly, a minimal intervention may be relatively ineffective in terms of the proportion of participating smokers who actually stop, but the actual number may be large because the number of participants may be very large. Television programs, for example, can reach audiences of millions of people. Secondly, not much skill is required to administer these approaches, though preparation of the materials (a special film, for example) may. Showing videotapes to large audiences backed up with standardized instructions does not require much training or skill on the part of the administrators.

There are three areas where minimal interventions of one form or another can be optimally exploited. Firstly, about 95% of the population see their GP at least once in every five year periods, and some 75% attend at least once a year (Baker, 1976). GPs are therefore in an ideal position to intervene against smoking in their practice population. Secondly, industry has a large number of occupational physicians and trained nursing staff who could run routine minimal intervention and treatment programs on large industrial populations. Thirdly, television and radio have a largely unexplored, and almost wholly unevaluated, potential for educating the public on matters of preventive health measures. Various attempts have been made to put across the health risks of smoking and how to go about stopping, but these have not been adequately evaluated.

Of the three possible areas of application, evidence for the effectiveness of GPs' advice suggests this could be the easiest area with which to make substantial inroads against smoking. In an important study, Russell et al. (1979) randomly allocated all cigarette smokers (2138 in all) in a one month period at London practices to one of four groups. These were, firstly, a non-intervention control group; secondly, a group who filled in a questionnaire about smoking; thirdly, a group who were advised to stop smoking by their GP; and fourthly, a group who were advised to stop smoking, given a leaflet on how to do so and were warned that they would be followed up. The effect of the advice was to motivate smokers to make an attempt to stop, and in the long-term 0.3% in the control group, 1.6% in the questionnaire group, 3.3% in the advice group and 5.1% in the advice plus leaflet group stopped and stayed off smoking for a year. Russell et al., calculate that if all GPs routinely advised their patients to stop smoking this could yield some half a million long-term ex-smokers each year. Therefore although the apparent success rate of 5.1% may seem low, the cumulative effect could be very large. It seems possible that occupational physicians and nursing staff could make a similar contribution in the workplace, but as yet no large scale studies have been reported.

Minimal interventions could also be exploited using media approaches (films, videotapes, presentations to large audiences etc.). Evidence of the risks of smoking is, however, couched in probabilistic terms, and research suggests that most people have difficulty dealing with this kind of information because it conflicts with their well-established misperceptions of just how risky smoking actually is (Lichtenstein et al., 1978). These misperceptions arise from the application of a number of well-understood mental heuristics, or biases, to inadequate information, especially news media reports and personal experiences (Tversky and Kohneman, 1974). Our inability to offer each smoker proof that his or her smoking will definitely result in his or her illness and premature death leads smokers to reject the assertion that the risks apply to them personally. The essential job of health professionals using a media-based minimal intervention approach, especially when applied to a mass audience is to overcome these misperceptions and misunderstandings and to take into account the mental heuristics that smokers will use to deal with probabilistic risk information. If we are unable to do this then well-meaning minimal approaches to educating or informing smokers about the risks of their smoking and how they should go about stopping will be misdirected and ineffective (Slovic et al., 1980). It is only when the smoker perceives that the risks of smoking apply to all smokers, including themselves, that they are likely to want to take action. It is one thing to acknowledge that smoking is dangerous, it is quite another to say 'my smoking is dangerous to me'.

In an effort to breach the barriers of indifference and misunderstanding about the risks of smoking, health educators have used persuasive communications to attempt to influence peoples' smoking behavior. This approach tends to concentrate on the use of fear-arousing communications to drive home particular health recommendations to the audience, who will then hopefully take them up to alleviate the aroused fear. There is evidence that this approach may be effective in persuading people to try to change their health-related behaviors (Sutton, 1982). Sutton and Eiser (1984) found that a fear-arousing film about smoking was effective in both making smokers try to stop and actually getting them to stop, but more recent research in industrial settings (Sutton and Hallett, 1984) has indicated that this type of effect cannot be consistently demonstrated and attributed to the nature of the film used. Films seem to be at their most effective in helping to motivate smokers to try to do something about their smoking, and their best use may be as the first step in a multi-component program, followed by other kinds of therapy and support.

In conclusion, minimal interventions have an important role to play in the treatment of smokers on a large scale. Advice from health professionals, such as GPs could have a substantial cumulative effect. Television programs and media interventions in general could help prepare and motivate smokers to take action and provide them with information (for example, on simple behavioral techniques like self-monitoring and stimulus control) on how to do so. These types of minimal approach might help thousands of smokers to stop, but inevitably many will fail. What treatments can we offer these perhaps more dependent, or less motivated, smokers?

Behavioral Treatments

Smoking may be reported as either positively reinforcing (the pleasurable effects of nicotine) or negatively reinforcing (continuing to smoke to alleviate the unpleasant symptoms of nicotine deprivation), or both (Russell, 1976b, Ternes, 1977). These ideas have given rise to a number of behaviorally based treatments which attempt to help the smoker "unlearn" their smoking behavior. Behavioral treatments for smoking fall into three

main categories; aversive conditioning, systematic desensitization, and self monitoring or contract management.

By far the most popular behavioral treatment for smoking is based on aversion therapy. The idea of pairing a noxious stimulus with the target behavior has been widely applied to other drug problems as well as to smoking (Litman, 1976; Row, 1977). Essentially aversion therapy applied to smoking comes in two forms: pairing smoking with an electric shock or a nausea-inducing drug, and rapid smoking. Controlled studies have indicated that there is no specific effect for electric aversion therapy, or therapy based on the use of nausea inducing drugs, and that in the long-term they have proved consistently ineffective in treating smoking (Russell et al., 1976; Lichtenstein, 1982). One problem with this form of aversion therapy is that the choice of aversive stimulus is wholly arbitrary and its effects are unlikely to generalize to situations outside the laboratory (Ashton and Stepney, 1982). Covert sensitization (the smoker pairing mental images of smoking with images of nausea and vomiting) attempts to bypass this problem by making the aversive stimulus internal and therefore portable, but has not proved to be especially effective in the treatment of smoking (Danaher and Lichtenstein, 1978). A more plausible approach would be to use tobacco smoke itself as the aversive stimulus, and this is the idea behind rapid smoking. Patients are, for example, instructed to take one puff from their cigarette every six seconds to the limits of their tolerance, or have warm smoky air continually blown in their face. Rapid smoking has apparently yielded long-term success rates as high as 34% (Lichtenstein and Rodrigues, 1977). Unlike other kinds of aversion therapy, rapid smoking carries potentially severe health risks to the patient, notably cardiovascular complications due to increased blood carbon monoxide and nicotine levels and therefore needs to be used with considerable caution. However, of the aversive treatments rapid smoking does appear to be the most successful.

The problem with all forms of aversive conditioning is that the smoker is aware that once outside the treatment situation, the aversive stimulus linked to their smoking will no longer apply. The unpleasant effects associated with taking and smoking a cigarette are likely to diminish rapidly once the smoker returns to those situations where they normally smoke. It therefore seems logical to try to help the smoker deal with the causes of the desire to smoke. Some smokers use their cigarettes to help them cope with feelings of stress and anxiety, and systematic desensitization has been used to try to teach them alternative ways of dealing with these feelings without resorting to cigarettes. However, not all smokers smoke to relieve stress and this approach is not effective when used alone (Bernstein and McAlister, 1976), though it may be useful in combination with other behavioral based therapies. The same can be said for the third behavioral approach: self-monitoring and contract management. The rewards and punishments in this approach are usually internal mental events. The smoker routinely rehearses the long-term consequences for health of continuing to smoke every time the temptation to have a cigarette arises, or tries to gradually reduce consumption according to some pre-set self-administered schedule. Alternatively, the smoker can enter into a 'contract' with self or others which can take the form of a financial deposit which is refundable if the smoker remains abstinent for a given period (Rachlin, 1976). While self-monitoring may help smokers understand their behavior more clearly, and contracts may help to increase attendance on cessation programs, they are not in themselves useful therapies (Row, 1978; Lichtenstein and Brown, 1980).

In summary then, of all the behavioral treatments currently available for smoking (and this has by no means been an exhaustive review), only rapid smoking may have a useful long-term outcome. However, rapid smoking is not without potential health risks and is likely to stay within the

confines of the behavioral laboratory or specialist smoking clinic. The attraction of the behavioral approach has been in the hope that a mostly self-administered, truly "portable" strategy could be developed, but this does not appear to have happened. These approaches are, however, extensively used within the context of smoking clinics, which are discussed later. An alternative approach is based on the evidence that dependence on nicotine is probably the most powerful component in the maintenance of smoking.

Drug Therapies

People start to smoke cigarettes for a variety of reasons, but it is probable that within a short time the pharmacological action of nicotine in inducing a dependent state takes over. None of the approaches discussed so far really address the problem of nicotine dependence. The central idea behind all drug-based approaches to smoking cessation is to try to alleviate the withdrawal symptoms associated with nicotine deprivation, and the most logical way to do this is to provide nicotine, or its pharmacological action, from some other source than tobacco smoke. Other drug approaches involving the use of tranquilizers (either alone or in combination with amphetamine) have been tried but have had poor, or negative, results, and may actually hinder cigarette withdrawal (Row, 1978).

The only currently available alternative to nicotine is the drug lobeline, which is reputed to have similar pharmacological characteristics. However there is no evidence that lobeline aids withdrawal from smoking beyond a simple placebo effect (Ashton and Stepney, 1982). It follows that if nicotine withdrawal is the major factor in causing relapse, then providing it from some other source than tobacco smoke should significantly reduce the problems of stopping. The most widely researched nicotine substitute approach is based on the use of nicotine chewing-gum (Nicorette). The gum contains nicotine in a buffered resin base, and this is released for slow chewing and is absorbed through the lining of the mouth. Though the released nicotine takes several minutes to get into the blood stream and build up appreciable levels (as compared to about seven seconds from inhaled tobacco smoke) it does provide the smoker with noticeable relief from the nicotine withdrawal symptoms (Jarvis et al., 1982). Validated success rates of around 40% at one-year post-treatment seem typical when the gum is used in a clinic setting (Row et al., 1980; Fagerstrom, 1982; Schneider et al., 1983), and long-term dependence on the gum has not proved to be a problem (Russell and Jarvis, 1984). If used correctly in this setting, there is little doubt that Nicorette appears to be the most effective treatment approach currently available (Russell et al., 1980).

One other advantage of the gum over other treatment methods is that with minimal instruction, the smoker can self-administer the treatment program. A study by Russell et al. (1983b) divided GPs' patients into three groups. In the first, control, group no advice or information about smoking was offered to patients and only 3.9% were abstinent after one year. In the second, advice, group GPs advised their patients to stop smoking and gave them a booklet on how to go about stopping, and in this group 4.1% were abstinent at the one year follow up. The patients in third, Nicorette, group were advised to stop smoking and were offered Nicorette. Of this group, 8.8% were abstinent at one year post-treatment. While a success rate of 8.8% in the Nicorette group may not seem impressive when compared with 40% in clinic settings, it must be remembered that achieving this figure represented a minimal investment of time by the physician as the treatment was largely self-administered by the smoker. Russell and Jarvis (1984) calculate that if all GPs were to routinely intervene in this way, it could produce a million ex-smokers a year. This

approach relates to the minimal interventions discussed earlier and is an area where there is considerable potential for further research.

Though nicotine chewing gum is, in a clinic setting at least, currently likely to be the most effective treatment for smoking, it is not without its problems. Some people cannot use the gum because they wear dentures, or find that using the gum causes dyspepsia or nausea, or that its taste is too aversive. Chewing the gum is a relatively inefficient way of delivering nicotine to the brain as much of the released nicotine is swallowed before it can be absorbed through the lining of the mouth into the blood stream. An alternative to nicotine chewing-gum, a 2% nicotine solution (liquid snuff) placed in the nose using a single dose applicator, produces higher blood levels of nicotine than the gum in a shorter period of time and is currently under evaluation. Preliminary results suggest that it may be more effective in alleviating withdrawal symptoms than nicotine chewing-gum (Russell et al., 1983).

Treating smokers with either behavioral or drug-based therapies is a skillful process and requires the supervision of a health professional. Even though nicotine chewing gum can be used largely without supervision, the evidence suggests that more instruction and supervision increase its effectiveness. It seems logical, therefore, to make specialized treatment clinics available to smokers where these approaches would be optimally effective.

Smoking Withdrawal Clinics

The fundamental idea behind the smoking withdrawal clinic is to provide the smoker with group support and encouragement while they make their attempt to stop. The first smokers' clinic established to treat large numbers of smokers was started by Ejrup in Stockholm in 1956. Ejrup's idea was that smokers' clinics should cater for those smokers who were heavily dependent, not as a means of substantially reducing overall smoking prevalence (Ejrup, 1961). In other words, smokers' clinics are for those smokers who have tried to stop but find they cannot do so without outside help.

While the details of what occurs in smokers' clinics may vary, treatment methods are substantially the same. On the whole, all groups tend to offer the smoker a mixture of information on the risks of smoking and to go about stopping, together with support and management from other group members and the therapist (Lichtenstein and Brown, 1980). Most clinics offer some variation on the 5-Day Plan developed by the Church of the Seventh Day Adventists (McFarland, Gimbel et al., 1964). Typically a number of frequent (often, initially, daily) group sessions are arranged when smokers are instructed on how to stop, often with the help of simple behavioral measures such as cue exposure, together with longer term support, encouragement and reinforcement meetings. Reported studies tend not to include dropouts and often regard reduction in smoking rather than cessation as a successful outcome, so long-term success rates tend to be inflated. Surveys of the literature point out that typically these types of clinic have a 15-20% success rate at one year follow-up (if success is taken to be long-term abstinence) and that this is likely to be due mainly to nonspecific treatment factors such as encouragement and support (Row, 1978; Schwartz, 1979). In other words by attending a clinic, the patient's own resources for stopping are mobilized and encouraged. In the clinic context particular treatment strategies (for example, nicotine replacement) may be optimally effective, as progress can be closely supervised. Concerted action by health professionals in this area, though cost-intensive, could produce a substantial yield of ex-smokers.

There are currently about 55 smokers' clinics in Britain, but these tend to be poorly funded, to run on an irregular basis and to be staffed by small groups of committed doctors or health educators and a few enthusiastic, but largely unskilled, volunteers (Row and Heller, 1984). These clinics each tend to attract only about one hundred smokers a year and at best can yield only a few thousand ex-smokers altogether. However, if backed with a clear DHSS policy together with adequate funding and politics, there is little doubt that smokers' clinics could provide an important service, especially to more dependent smokers. If all health districts in Britain had at least one smokers' clinic this could result in some 10-15 thousand ex-smokers each year (Row and Heller, 1984). Smokers' clinics could provide the ideal vehicle for the more intensive behavioral and drug-based therapies for those smokers who have especial difficulty in stopping.

Summary and Conclusion

In general, the long-term outcomes of the various treatment approaches are very similar (between 15-20%) and suggest the operation of nonspecific factors rather than specific treatment effects. The major exception to this rather bleak picture is nicotine substitution, particularly nicotine chewing gum, which can achieve validated long-term success rates of around 40% in clinic settings. The possible role of this approach in non-clinic settings has not yet been adequately explored, though initial results with the gum being prescribed by GPs are encouraging. While nicotine substitution is a very promising, and highly effective, new treatment approach it is still appropriate to try to develop the full potential of smokers' clinics and minimal mass intervention. Clinics could be optimally effective when treating those smokers who find it very difficult to stop, while others who may find stopping easier could be the focus of mass media campaigns designed to disseminate self-treatment packages and information on the health risks of smoking. In other words, because people smoke for a variety of reasons and will have different degrees of psychological and pharmacological dependence, and will be motivated to a greater or lesser extent to try to stop smoking, we need to try to tailor the treatment approach to the particular individual need. It is also essential that we try to help successful ex-smokers to avoid relapse.

AVOIDING RELAPSE

Hunt, Barnett and Branch (1971) reviewed data from 87 studies which had used a wide variety of therapies for smoking and found very similar patterns of relapse. Once treatment was complete, there was an immediate reduction in the number of patients still not smoking so that after three months only 35% were abstinent, after six months 25%, and beyond this point a more gradual reduction to about 20% still abstinent. How long the physical withdrawal effects resulting from smoking cessation last is not known with certainty, but for most smokers they seem to subside within a few weeks. However, as Hunt et al. (1971) showed, many smokers relapse several months after stopping; it is unlikely that physical withdrawal is the main factor in precipitating relapse in these cases so one must examine the role of psychological and behavioral factors. From this perspective, relapse should not be thought of as a simple outcome, but as an active process in which we can try to intervene. Marlatt and Gordon (1979) have developed a model of the relapse process which emphasizes the role of affective and situational factors in increasing the likelihood of a full relapse. Shiffman (1982) reported that the major antecedent factor in over two-thirds of relapses is the smoker experiencing a negative mood state - especially anxiety, anger or depression. In alcoholics, heroin addicts and dieters, experiencing a negative affective state is also the main factor

leading to relapse (Cummings et al., 1980). The keys to whether the smoker has a 'slip' or a full-blown relapse seem to be whether or not they exhibit some kind of coping response to deal with relapse crises and whether other smokers are present. Shiffman's data suggest that those smokers who are most successful at avoiding relapse are those who cope behaviorally (i.e. leave the situation) and cognitively (i.e. review their commitment and reasons for stopping). For these coping strategies to be effective, however, the ex-smoker needs to be taught to recognize environmental and affective high-risk situations as they occur, and to apply the pre-rehearsed behavioral and cognitive coping strategies consistently. In theory, success of dealing with relapse crises using coping strategies leads to an increased sense of self-efficacy and control, or mastery, over the smoking behavior and hence an increased degree of self-confidence and commitment to continued abstinence. Initial research (Lichtenstein and Brown, 1980) has, however, been equivocal about the results of such a maintenance approach, but it is too early to conclude that it is not appropriate. The role of the health professional in providing behavioral education and support of this kind to smokers is not one which has been developed, exploited, adequately researched, or integrated into treatment programs. The problem of long-term relapse prevention is central to any adequate smoking treatment strategy and should not be overlooked in the development of future programs. The emphasis in Marlatt and Gordon's (1979) model that the smoker can take an active role in dealing with relapse crises, rather than passively enduring them using 'will power', is clearly a step forward - the smoker becomes a master of his (or her) fate rather than a victim of his habit.

In conclusion, pharmacological, cognitive, affective and situational factors can all play a role in bringing about relapse. Pharmacological factors may play a more important role in short-term relapse (and, of course, it is during the first few weeks of abstinence that most smokers do relapse) while the cognitive, affective and situational factors appear more important in longer term relapse. In a clinic setting, nicotine substitution combined with support and encouragement appears to be the most effective way of preventing both short and long-term relapse. However, in more normal populations of smokers nicotine substitution may not always be the most appropriate strategy for relapse prevention, and therefore the development of properly evaluated minimal mass interventions and more freely available clinic-based behavioral treatment prorams should not be neglected.

FUTURE PROSPECTS

The clinical psychologist, GP, nurse, occupational physician, other health professional and teacher can all have a role in the treatment and prevention of smoking. As smoking seems, inevitably, to combine both pharmacological and psychological factors in maintenance, then optimally some kind of combinative therapy incorporating an initial educational stage (perhaps using a persuasive communication), followed by a withdrawal stage, accomplished using nicotine replacement (probably with Nicorette), followed by monitoring and structured support and encouragement, could have a useful outcome in terms of the numbers of successful long-term ex-smokers. Obviously this approach could be costly in terms of therapist time per patient, and therefore mass approaches to the problem of smoking must not be neglected. In the final analysis, smokers are responsible for their own health, so providing them with adequate information on the health risks of smoking, the benefits of stopping, and how best they can help themselves to stop smoking is clearly of great importance.

There is great potential for the expansion of treatment for what, after all, has been described as the major preventable cause of illness and premature death in this country today (Royal College of Physicians, 1983). Precisely what form treatments should take, and what combination of therapeutic elements should be used by health professional depends on the time and resources available to them, and on how high a priority they, and the health service in general, place on the need to reduce the prevalence of smoking.

Acknowledgements

I would like to thank my colleagues Peter Hajek and Robert Merriman for their helpful comments on earlier drafts of this paper.

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ADDICTION: AN EVERYDAY "DISEASE"

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The history of British policy and legislation on addiction is an extraordinary tangle of compromise between conflicting opinions and interests. Berridge (1974) has shown how the way in which legislation was formulated in the early years of this century was essentially a result of the rivalry between the Home Office and the then newly established Ministry of Health for control of the treatment and legislation response mechanism to drug-use. The report of the Advisory Council on the Misuse of Drugs (1982), "Treatment and Rehabilitation", provides us with a more recent example of this process. Although the report is clearly a radical move away from the outmoded disease-model of addiction, the implications of its recommendations are to extend the power and control of the specialist drug treatment units (the 'clinics') whilst concurrently restricting the role of general practitioners.

Unfortunately the effect of this process is to enhance the aura of mystique and hysteria which surrounds addiction. If addiction is seen as a rare and exotic phenomenon which can be managed and treated only by specialist experts, this perception increases the feelings of impotence amongst non-specialist practitioners and can lead to the effective withdrawal of a range of generic services, for example, housing, primary health care, work-experience schemes, for a client group in grave need of resources. Indeed there is evidence that this is becoming increasingly so: Strang (1984) argues that as the drug-subculture expands it begins to encompass individuals whose lifestyles and behavior are remarkably 'normal'. If this is the case then our efforts should be directed more towards ensuring the involvement of non-specialist practitioners than to undermining their self-confidence and credibility. To achieve this aim requires the development and vigorous promotion of straightforward treatment and intervention strategies which, whilst not ignoring the continuing debate regarding the nature and diversity of addictive behavior, are not hampered by it in their practical application.

Perhaps the most damaging effect of the promotion of addiction as a strange and highly specialized emotional/biological disorder is the assumption that it is therefore a single, identifiable phenomenon. In practice, use of drugs and its implications for the user are as varied as the individuals involved. Drug-use can be crudely divided into three basic categories (Kay, 1983, 1984):

a) Experimental where the selection of drug-types is often indiscriminate, as is the choice of setting. Incidence will generally be spontaneous and therefore often spasmodic or infrequent.

b) Recreational where the selection of drug-type is usually more discriminate. Usage will generally form a response to a specific set of situational cues, such as immediate setting, time, company, financial resources.

c) Dependent where drugs are consumed regularly with scant regard for the appropriateness of the situation. Dependent drug-use is often a singular activity carried out in isolation where decisions regarding quality of experience and drug-types are increasingly less important.

Thus, most young people will experiment with alcohol in their mid-teens. The incidence of drunkenness within this age group is significantly higher than in any other, since the ability to control and channel the effect has not yet been learnt, (Flint 1974).[1] The majority will go on to become recreational (or social') drinkers. By this stage the process will have become more selective with alcohol type usually restricted to two or three particular drinks. Recreational drinkers will often discriminate between different drinking places and even brand names. They will also have learnt to distinguish between appropriate and inappropriate situations. Thus the recreational drinker will recognize the inadvisability of excessive intoxications during a business lunch whilst she/he might consider such behavior acceptable in other situations. Some recreational drinkers or even experimenters may move into a more dependent phase of drinking. For some this may be a short-term change in response to a specific problem such as the loss of a spouse, redundancy, or pressure of work. For others the change may appear more permanent with the original cues becoming compounded and reinforced by continued drinking.

However, the three basic categories do not represent a structure through which drug-users will inevitably progress. With many drugs, the majority will experiment for only a short time before changing or reverting to a more personally satisfying activity. Even dependent usage is unlikely to prove the irreversible condition we often assume. Stimson, Oppenheimer and Thorley (1978) surveyed a large group of heroin-users attending drug-treatment units in London, and in a seven-year follow-up almost one third were found to be no longer physically dependent. Since there is also evidence (Blumberg, 1976; Lukoff, 1973), that those attending such clinics are often particularly problematic drug-users for whom prognosis is normally poor, it might be assumed that the actual self-recovery rate is significantly better than even this study would suggest, and there are a number of other studies (Robins, 1974; Zinberg, 1971; Winick, 1962), which also support Stimson's findings.

The importance of separating drug-use into the three categories lies in the implications for selecting the appropriate treatment response. Thus the fifteen year-old who is experimenting with a variety of substances is unlikely to benefit from long-term therapy in a residential rehabilitation hostel. Similarly, the dependent heroin-user of ten years standing is likely to take a fairly dim view of a stern lecture on the dangers of that particular drug. Clearly the appropriate treatment response depends upon an accurate assessment of the nature and implications of drug taking in each individual case. Failure to employ such criteria will almost certainly lead to an ineffective and occasionally counter-productive intervention.

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[1] See also: Report of the Departmental Committee on Scottish Licensing Law, Edinburgh, 1983.

The aim of any constructive intervention is to identify and resolve two distinct and separate sets of problems:

Primary Problems - which stem directly from the nature of the drug being used, the mode of application, and societal and familial responses. Thus the user of an illegal drug will almost certainly have problems with the law; injectors run the risk of contracting hepatitis; and users of heavy intoxicants will face problems in operating complex machinery (e.g. drinking and driving).

Secondary Problems - Some, though by no means all, drug-users may also present in treatment with a second series of problems which do not arise out of their drug-use but are problems to which drug-taking was originally, or has become, a response. Thus, those who believe themselves to be in some way inadequate may well find comfort and solace in drug-use. The use of minor tranquilizers can mask dissatisfaction with an unrewarding marriage or frustration with an inability to cope with the demands of work or parenthood.

This breakdown is not, of course, simply related to drug-use but is apparent in every activity we indulge in to alter our mood. Every experience which radically changes the way we feel has a capacity to draw us back into its comforting embrace; to become a habit whether good, bad or indifferent.

'Drug addiction' is little more than a specialized term for a habit which has gone out of control and which is generally regarded by society and often by the drug-user him/herself as bad. Peele (1975, 1981) suggests that addiction can be more readily understood when it is seen, not as a pathological condition, but rather as an uncontrolled behavior which lies at the end of a spectrum or continuum of normal behavior. The aim in treatment then is to identify the degree to which drug-use is a significant factor in an individual's life and the problems to which such an activity provides a solution, however transitory.

In exploring the problems which might lie behind an individual's use of drugs, or which might result from it, the following model may prove useful as a mental note to clarify the issues both for the doctor/therapist and for the customer or drug-user (Yates, 1982).

The model assumes three interacting factors in the use of drugs or any other mood-changing experience. Determining the relative importance of

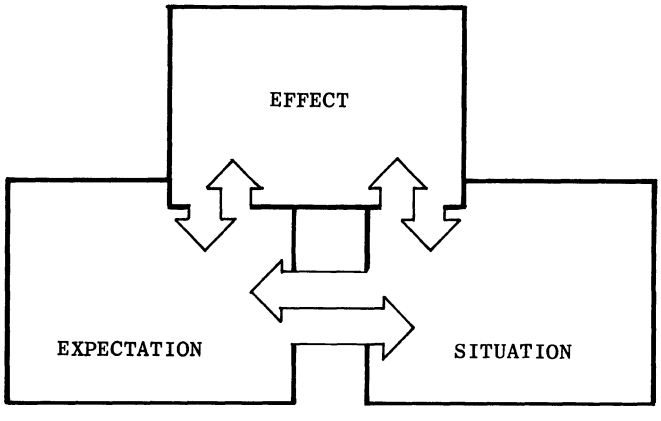

Fig. 1

each factor to an individual's pattern of drug-use should lead to a logical assessment of the appropriate treatment response.

EFFECTS[2]

It is clearly not possible to become dependent upon an experience which does not have the capacity to change the feelings or mood of the user. Radical alteration of mood may cause problems for the user in terms of impaired ability. In cases of heavy intoxication, accidents or even non-deliberate overdose may result. Clearly the toxic effects of some, though by no means all, substances and/or the means of application can constitute a serious health risk. Moreover, some drug-users may continue the activity simply through a fear of the after-effects of 'withdrawal'.

Addiction is not a search for 'kicks' but a retreat into a comfortingly predictable experience. Logically, therefore, recreational or controlled drug-use is likely to be marked by an emphasis on the 'quality' of the experience, and the recreational drinker will make a series of decisions in embarking upon the chosen course. What type of drink? What drinking place? Who with? Conversely the alcoholic, according to the degree of dependence, will find his/her choices progressively limited. The alcoholic who happens to have a fancy for single-malt whisky is thus unlikely to refrain from drinking if such a commodity is for some reason unavailable. Addiction is an indiscriminate process. Many specialist practitioners[3] have noted a progressive decrease in selectivity with some individuals, often characterized by a drift away from 'glamorous' drug-use (heroin and the opiates) towards the more mundane end of the market (alcohol, valium and anything that is easily accessible).

SITUATION[4]

Many people will use drugs in response to a particular situation; or the way in which they use may change to reflect an altered circumstance. For instance, almost one-third of all US troops in Vietnam were believed to be heavily addicted to heroin. Alarming predictions were made about the probability of an explosion of heroin addiction in America when and if those troops were returned home but the explosion never happened. Robins (1974) found only 7% became readdicted after they had been flown home. Indeed one of the surprising findings was that many of those who continued to use heroin did so in a recreational way and appeared to have achieved a large measure of control over their habit.

The reasons are not hard to find. Whilst in Vietnam, young Americans found themselves directly involved in a war for which there was mixed support at home. They were separated from the influence which would normally exercise some control over their behavior such as family, work, academic career, and the antipathy of American society towards heroin use. Most important of all, they found themselves in a situation where heroin was readily available and where they were in real and continual danger. Perhaps in such a situation heroin begins to look like a rational solution, at least for as long as that situation lasts.

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[2] See also Peele, S., Redefining Addiction, 3rd Annual Summer Institute of Drug Dependence, Colorado Springs, 1979.

[3] Although this drift is regarded as common knowledge in practice, I am not aware of the observations having been written up.

[4] See also Jaffe, J., As far as heroin is concerned, the worst is over, Psychology Today, August 1979.

Where situation is a significant factor there may well be an identifiable 'pay-off' to using drugs. It may even by regarded as an occupational hazard (e.g. the use of amphetamines by long-distance lorry drivers). Alternatively the phenomenon might be a group response to frustration and boredom and will probably continue in some form until more interesting/exciting/rewarding activities can be found, or for as long as the group or individuals within it are unable to perceive such alternative options. In such cases actual changes in the situation, e.g. falling in love, obtaining employment, removal from the war-zone, can precipitate dramatic changes in an individual's use of drugs. Many people continue to use drugs for years simply because they do not know of or do not understand the alternative options/strategies.

EXPECTATION[5]

The experience of drugs is largely conditioned by expectations. Various experiments with inert substances or placebos (Shapiro, 1971) have shown that an individual's belief in the efficacy of a treatment regime can override even acute pain. In one classic study Lasagna (1954) found that 3-40% of patients could not tell the difference between morphine and a placebo when these were administered for severe post-operative pain.

We can take this argument a stage further and suggest that not only the physical effects of drugs but also the way in which we use and experience them are strongly influenced by the beliefs and expectations of the society in which we happen to live. Inglis (1975) has described in detail the way in which opium has been regarded in different ways by different cultures, sometimes as a depressant, sometimes as a stimulant and occasionally (as in Victorian England) as a hallucinogenic. Similarly, tobacco was originally used by native American Indians as a hallucinatory substance, yet no such usage has been recorded in this country.

Furthermore, there is a wealth of evidence that where drugs are adopted by, or imposed upon, cultures, the impact in terms of social and personal disruption is far greater than in those countries where their usage is part of the traditional fabric. Marais (1969) has described the devestating effects of tobacco on the Hottentot society of nineteenth-century Africa. Yet the use of marijuana amongst these people had been accepted and commonplace for generations. The introduction of alcohol to native American Indians is known to have had similarly disastrous effects. Again, Inglis (1975) records how the smoking of opium in the Indian sub-continent, where this was a commonplace practice of long-standing, was not associated with any serious social or moral decline. Yet its imposition by British warlords upon the Chinese caused untold damage.

It is clear therefore that where a substance is relatively unknown and where it is accompanied by a backlash of moral indignation and panic, its actual effect becomes severely distorted through the manipulation of the expectations of prospective users.

However, expectation is not simply a belief in the power and effect of specific substances. It also encompasses personal value systems: how you see yourself: your belief (or lack of it) in your own ability to cope with certain situations; and your perspective on what life might hold in store for you. Thus an individual's involvement with, and continuation in, destructive patterns of drug-use is often related to his/her lack of self-

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[5] See Lindesmith, A.R., Addiction and Opiates, Aldine, Chicago, 1968. Also Becker, H., Outsiders, Free Press of Glencoe, London, 1963.

belief and to the failure to comprehend his/her own power to change or control a situation. It follows that any intervention or treatment model geared towards achieving abstinence will founder if it fails to offer alternative strategies which serve to readjust the level of self-belief and esteem. Conversely, any response which underlines and condones the drug-user's patient or victim/inadequate role will automatically reinforce the addictive behavior.

Assessment models of the type outlined above are useful in developing an approach to addiction treatment which has a rational problem-solving base. This approach, whilst it does not ignore the complexities of drug-using behavior, places it in perspective by analyzing its relationship to the difficulties which stem from it and/or those to which it has become a response. Thus a constructive intervention would begin with a careful assessment of the relative importance of each of the three factors:

EFFECT

Do you use more than one type of drug?
Are there any particular drugs you would not use?
How do they make you feel?
Have you ever achieved this feeling in other ways?
Did you ever attempt to stop - How did that feel?

SITUATION

Do you have any friends who do not use?
Have any of your friends stopped - what happened to them?
What are your prospects in terms of employment, relationships, housing etc?
Are you and/or your friends interested or involved in any other activities?
Is your usage regular or is it restricted to specific times and places?

EXPECTATION

How would you describe yourself?
How do you think other people see you?
How do you feel about the differences between these two pictures?
What would be the perfect picture and what would you have to do to achieve this?
What do you believe might happen to you if you stop using drugs?

The use of such a model does not preclude consideration of the physical components of addictive behavior. Nor is it to deny their existence or importance. Rather it is to recognize that a complicated interaction of physical and psychological factors is in operation, a process about which we know little and understand less. We know, for instance, that stomach ulcers have a psychological, stress-related component. This does not mean that they are 'all in the mind'. They can be seen on an X-ray. And they hurt! The remedy however lies not simply in a physical cure. It is also important to identify social and emotional strategies which can minimize the pain and, more importantly, prevent recurrence.

The prevention of recurrence or re-addiction is a crucial question; to leave behind a comforting reassuring behavior and enter a more threatening existence is a hazardous move which most individuals will take slowly and

may well not achieve at the first attempt. Marlatt (1978) has shown that most relapses are preceded by a small (and objectively unimportant) lapse which undermines the self-belief of the individual as an 'abstainer'. If these findings are correct, then specialist treatment units with their emphasis on abstinence as the only worthwhile and meaningful goal have a great deal to answer for.

Experience with tobacco suggests that most individuals achieve abstinence not in a single quantum leap, powered by that elusive beast 'motivation', but that the majority of those who successfully abstain do so at the tag-end of a number of unsuccessful attempts, just like riding a bicycle, the process of changing a behavior pattern through which abstinence is achieved is a skill which must be learnt. Falling off a bicycle does not mean that you are never going to be able to ride one. The drug-using customer should be discouraged from seeing every lapse as a relapse and encouraged to use the experience to learn new strategies for overcoming particular difficulties and situations.

The view of the drug addict as an exotic and incurable sufferer from a mysterious disease has underlined the formation of British policy and legislation through the twentieth century. It has been responsible for a series of draconian edicts on the statute book. The influence of such legislation coupled with the extraordinary power of the 'yellow' press has encouraged even more strident, even more hysterical public opinion. The attitudes involved appear to be based more on an atavistic belief in possession by devils than a rational assessment of the actual nature of addictive behavior.

With a rapidly expanding blackmarket in imported opiates, increasingly high levels of unemployment and a lamentably inadequate specialist treatment system, the task which faces society in Britain is not one of ever increasing containment and law enforcement but one which demands a radical re-alignment of our current beliefs. If we are to come to terms with the management and control of addiction we will have to put on one side the current popular view of drug-taking.

Until we can begin to use addiction as an extension of normal, and thus reversible, behavior it must inevitably remain the 'untreatable' preserve of a specialist elite. Until we can adopt a more pragmatic approach which encourages the involvement of the generic services, the 'drug problem' must remain within the shadowy pigeonhole to which we have consigned it: a menacing and dangerous disease which can be produced on occasion as an ogre to frighten young children; a symbol of the immorality of youth; and a degenerate spectacle with which to titillate the masses.

Two decades ago, Trocchi (1963) wrote scathingly of the unhelpful and misinformed way in which addiction is viewed. Sadly, little has changed to contradict his depressingly sharp insight:

> 'It's a nice tangible cause for juvenile delinquency. And it lets most people out because they're alcoholics. There's an available pool of wasted looking bastards to stand trial as corrupters of their children. It provides the police with something to do, and as junkies and potheads are relatively easy to apprehend because they have to take so many chances to get hold of their drugs, a heroic police can make spectacular arrests, lawyers can do a brisk business, judges can make speeches, the big peddlers can make fortunes, the tabloids can sell millions of copies. John Citizen can sit back and watch evil get its just deserts'.

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(This paper first appeared in "Approaches to Addiction," no. 10 in the Research Highlights series, Department of Social Work, University of Aberdeen, published by Kogan Page Ltd., 1985).

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