Egypt. J. Psychiat (1979), 2,63—76

Therapeutic Interrelations of Patient, Physician, Hospital and Community in The United States

By Jules H. Masserman

ABSTRACT

The topics of the various concepts of individual, group and community therapy were treated by the author. He formulated briefly the essence of therapy. Then, he proceeded in collaboration with his associates to the validation, clarification and elaboration of such inclusive statements through comparative research in animal experiments as well as through the clinical analysis of therapeutic fronts. Parrallel to his findings in animal experiments he could elaborate corresponding modes of therapy applicable to human patients. In this context he formulated the seven "Pil-R's" of therapy namely the Reputation of the therapist, the early Rapport, the reassuring Relief, a Review of the patient's life experiences, a guided Reconsideration of previous patterns of behaviour and Reorientation to more suitable objectives and values, Resocialization and finally Recycling.

After discussing the hospital and clinical application to community psychiatry, he concluded that what produces therapeutic results are facility with which the psychiatrists and collaborating mental health professionals utilize their empathy, their knowledge, their talents and their sociocultural orientations in restoring and promoting the patients' welfare.

Any cogent discussion of the topic of various concepts of individual, group and community therapy must confront two fundamental issues (Masserman, 1953): (1) what are the **essential** needs of all human beings, many of whom become our patients, and (2) how can we serve them? To avoid an encyclopedic discussion, we must invoke William of Occams' famous "Razor" of discourse: **Entia non sunt, multiplicanda praeser necessitatum**, translatable into idiomatic English as "cut out the

unnecessary verbiage". If, then, what follows seems oversimplified, I apologize, but perhaps oversimplification is still preferable to over-obfuscation. In briefest statement, man's basic requirements can be reduced to only three :

First, for physical well-being, retained skills and reasonable or unreasonable longevity.

Second, for secure interpersonal alliances.

Third, and more subtly, for a system of mystic or religious beliefs to provide cosmic serenity.

Correspondingly, it is only when our patients **think** that one or more of their ultimate or Ur-needs may be threatened that they appeal to us for therapy (from Greek **therapeien,** service) on one or more of our assigned professional roles, to wit ; (Masserman, 1956; Masserman, 1966; Masserman, 1973).

First, as physicians, when their physical welfare and required skills **seem** endangered by trauma, disease or deteriration (Ur-Need I).

Second, as confidantes and counsellors, when familial, sexual, social and cultural interralationships **appear** to be failing (Ur-Need II).

And third, as metapsychological mentors, when previously cherished faiths are no longer **regarded** with eschatologic comfort (Ur-Need III).

The modifying terms "seem", "appear" and "regarded" were deliberately used in the above statements to emphasize the patient's concepts of his current or impending difficulties ("I'm sure my symptoms mean cancer"... "My neighbors want to burn down my house"... "I'm doomed to hell for my sins") imbue his appeals for help, irrespective of his "real" physical fitness, social status or moral integrity. Manifestly, the patient's internal as well as external universe requires restoration to what he/she would consider "health" — a term derived from the Anglo-Saxon roots **hal** or **hol** triply significant for physical "haleness" (Ur-I), "hail friend" for social harmony (Ur-II), and the metapsychologic "wholesome" or "holy" (Ur-III).

CORRESPONDING APPROACHES TO THERAPY

Long ago, in writing the preface to my "Practice of Dynamic Psychiatry" (Masserman, 1956) I was challenged by the publisher to condense the essence of therapy into a single sentence. Requesting only the privilege of one semicolon, I wrote as follows :

"The therapist should employ every ehical, medical, interpersonal and cultural means to induce the patient to relinquish his previously cherished but physiologically injurious and socially regressive, evasive, subversive, hostile or dereistic (i.e., 'neurotic', 'sociopathic' or 'psychotic') patterns of behavior; concurrently, however, the patient must also be guided psychologically and pragmatically to explore new modes of physical, and philosophic adaptations that he or she will then adopt as more personally and socially profitable".

This contrapuntal sentence was synthetic enough, but hardly what Maimonides would have regarded as a "Compleat Guide for the Perplexed". Since validation, clarification and elaboration remained necessary, my associates and I proceeded as best we could both on comparative research and clinical therapeutic fronts as follows :

Aniaml Experimental : Over four decades ago we undertook a long series of experiments designed to induce analogues of so-called "neurotic", "sociopathic" or "psychotic" behaviour in animals. In summary, we found that by subjecting cats, dogs, or monkeys to repeated motivational conflicts and environmental uncertainties we could induce progressively intense and enduring inhibitions, compulsions, drug addictions ,egressions, severe somatic dysfunctions, intraspecies and extraspecies dependencies or hostilities, and even what appeared to be hallucinatory and delusional behavior. These studies made it possible to investigate ways to restore relatively "normal" conduct; that is, favoring physical survival and appropriate milieu adaptations. Among the procedures found to be effective in animals, and significantly reminiscent of human therapeutic modalities, were these : (Masserman, 1955).

Removal to a more salutory (conflict-free) environment.

Forced satisfaction of an inhibited need, such as for food, sex or mobility.

Guided mastery of a previously feared situation.

Participation in group activities with normal animals.

Administration of tension-relaxing drugs (which often led to addiction.)

Disruption of deviant behaviour by electroshock or various cerebral lesions, followed by retraining.

Or, perhaps most significantly analogous to human psychotherapy, cultivating the animal's confidence and inducing it by gentle, persuasive guidance to overcome inhibited, phobic, compulsive or regressive hebavior, and instead resume spontaneously adaptive conduct. As but one example, animals exposed to conflicts between hunger and fear, or to uncertainty as to the satisfaction or frustration of feeding, sexual, mobility or other needs may, if offered alcoholic fluids, seek toxic forgetfulness in alcoholic addiction. However, they can when be induced by a trusted mentor gradually to re-explore the adaptional impasse, resume normal feedings, and concurrently return to their previous preferences for non-ethylated milk rather than for Alexander cocktails. (Masserman, 1946).

Comparative Studies: During these many years, as a psychoanalyst and co-chairman of a department of neurology and psychiatry, I also surveyed some fourscore psychiatric therapies, ranging alphabetically from "abreaction" (permissive emotional discharge) through so-called sex therapies **(seductio ad absurdum)** and Zen (pay no mind) to zootherapy (even if no one else cares, your parrot may bank you for a cracker and your loyal dog will take you for a walk). As to their essential dynamics other than their experimental parallels, I have proposed that common to all these modalities were what, to paraphrase T.E. Lawrence of Arabia, could be called the Seven Pil-R's of Therapy. (Masserman, 1978) Specifically:

First, the Reputation of the therapist, not only as an expert in his or her field, but as a potential friend and mentor.

Next, the establishment of early Rapport through effectively sensing and meeting the special needs of the patient.

Tihrd,the reassuring Relief of symptoms by combinations of medical, transferential and environmental means.

Fourth, a Review of the patient's life experiences not only as to past traumata and current vulnerabilities, but also with respect to his or her special talents and potentialities.

Fifth, a guided Reconsideration of previous patterns leading to a Reorientation as to values, objectives and projected modes of attainment.

Sixth, Resocialization by applying merely verbal "insights" toward more pragmatic improvements in physical, familial, occupational and social patterns of behaviour.

And finally, Recycling, requiring an additional plethora of R's such as Recognizing that, as in other forms of Re-education, it is often necessary to Re-establish faltering rapport, Relieve Recrudescences of symptoms, Recall previous understandings, Reconsider Remaining Retreats from Rational conduct and Review other Reformulations and Reforms until Retained recovery.

Hospital and Clinical Applications to Community Psychiatry (Masserman and Schwat, 1972, 1974) : Under each of these rubrics of dyadic, group and milieu therapy we may now consider the added advantages afforded by the hospital and community. To recapitulate brief, these comprise the following :

Reputation : It is not likely that any hospital psychiatric ward or catchment center can achieve the anticipated thaumaturgic potentialities of famous centers of healing such as the Shrine of Bernadette in Lourdes, or the Church of Jesus of the Mountain in Bogotá, where

crutches, casts, bandages and even stretchers are discarded by pilgrims who struggled painfully to such hallowed locales to experience instant relief. Yet any mental health facility can approach the advantageous panache of a Menninger Institute or a Mayo Clinic (I modestly omit mention of my office and University) by earning and retaining a reputation for dedicated, comprehensive and effective therapy through medical and social as well as metapsychologic modalities.

Rapport: However, such salutory anticapations must be reinforced by reassuring welcomes and implicit promises of individualized concern from registration clerk through social worker, clinic nurse and intern to medical director. This is especially important in the case of patients who had resisted externally initiated and court-ordered hospitalization, entailing the therapist's responsibilities for adequate care as well as the troublesome issues of involuntary commitment and "patients' rights" which sometimes seem to include homicide and suicide. Permit me to quote an historically reminiscent passage from a biography of one of our most humanitarian predecessors. A hundred and seventy year ago Jean-Etienne Esquirol, brilliant assistant to Philip Pinel at the Saltpetriere, (Masserman, 1976; Masserman and Schwat, 1972, 1974).

"Addressed a memorandum to the Prefect of police opposing an administrative order requiring that a mentally deranged person must be declared mentally incompetent before he could be admitted to an asylum. The memorandum argued persuasively that such an order could lead to unwarranted decisions of incompetence in cases of temporary delirium, that it would violate a family's right to secrecy under the civil code, and it woul pose formidable problems for the judiciary [as well as the hospital]. The Prefect of police withdrew the legal complications" Esquirol, 1972.

Relief: Under this rubric the clinic (Greek **kline** "to lean upon") should be at least a temporary haven from stress, and the hospital an hospitable hospice, offering when necessary, a diurnal, nocturnal or continuous protective escape from the physical, familial, industrial and

cultural (though regrettably not financial) traumata of extra-mural life. Pharmacologic, physiotherapeutic, dietetic and other carefully supervised medical measures (Ur-Need 1) can then facilitate dyadic, group and occupational and ancillary therapies based on extended personalized data as obtained below.

Review : Here the hospital and the CMHC have many other advantages over the private practitioner. The social worker can supplement the patient's psychiatric history from familial, school, industrial, military and other sources. The psychologist can furnish valuable leads as to the patient's intelligence, fantasy life and special talents as well as affective or dereistic susceptibilities. Nurses and other personnel can make cogent observations as to the patient's actual conduct on the ward or clinic, so that current behavior patterns can be viewed more meaningfully and critically by both therapists and patients as to their significance, and desirable modifications — the prime purpose of dynamic evaluations.

Reorientation, Resocialization and Recycling: Here again the well-organized clinic as well as the hospital can offer therapeutic modalities usually not available in a private office. Supervised or spontaneous interactions in discussion, music, dance, art, work or other therapeutic groups reveal the patient's difficulties in, or capacities for, various interpersonal adaptations. The latter can be enhanced after discharge if the patient is led to participate in one or more of several score communal and community groups organized to meet his or her special needs. (Masserman, 1978) These range from Addicts Anonymous and Alcoholics Anonymous, which help to continue hospital-initiated abstinence, through Crooks Anonymous, Mistresses Anonymous, Overeaters Anonymous, Parents Anonymous and so on to Recovery, Inc. Added to these, the YMCA, the YMHA, and various municipal agencies can also satisfy the second Ur-need for interpersonal contacts through educational and recreational facilities, while the churches, mosques and synagogues may fulfill the third Ur-yearning for "spiritual" comfort. The private practitioner can utilize these facilities only tangentially, but the clinic or hospital can coordinate therapy with such agencies more directly and comprehensively through follow-up social service.

Recycling: Almost inevitably, as in private practice, all of the therapeutic modalities outlined above may have to be rehearsed and repeated while the patient, to use sailing terms, takes only zigzag tacks toward, or even jolting reverses jibes away from, the goal of reasonable physical, social and metapsychologic adaptations.

MIRACLES IN MINIMAL MANAGEMENT

Composers not infrequently append a **coda** as a terminal re-statement of the principle theme of a musical movement. Since this conferences seeks to emphasize the utilization of minimal facilities for maximal effects, let me cite two relevant experiences that further illustrate personal, social and cultural influences in therapy.

Eighteen months ago, as President of the International Association for Social Psychiatry, a group of delegates and I, during a tour of India, had the privilege of visiting Dr. M. Vijas, Professor of Psychiatry at the Medical School of Jaipur and Director of the Jaipur Psychiatric Hospital. In the course of our seminar he remarked casually that th average length of stay at this facility was about ten days for most behaviour disorders, but that some highly disturbed psychotic patients sometimes required as long as three weeks. We found the hospital to be an aged, one-story stucco structure with no encircling fence, open wards and courtyards, and only two confinement rooms for 120 patients. Medical, nursing, physiotherapeutic, occupational and recreational facilities were no provisions for psychologic testing or social services. However, after observing Dr. Vijas in action, we began to undertand how, with remarkably few assistants, he obtained such astonishing results. Again briefly marshalled under the Seven Pil-R's erected above, his procedures were these :

First, Reputation: Dr. Vijas personally and his institution derivatively, are honored and trusted throught Western India for direct availability, personalized treatment and rapid results. Patients therefore come with favorable expectations that are all the more readily fulfilled.

Second, Rapport : After extensive training in traditional etiologic, nosologic, pharmacologic and dynamic psychiatry in America and England, Dr. Vijas decided soon after his terun to India that most of this knowledge was irrelevant to his work in Jaipur. Instead, he made an intensive study of the complex caste systems, differing dialects and cultural orientations of the patients his hospital was to serve, so that when two to five a day were admitted, Dr. Vijas could rapidly win their respect and confidence by talking to each patient and to his or her family in terms of their geographic locate, lexical idioms social orientations and religious values. Preliminary explanations and reassurances about treatment procedures were understandingly given, and the cooperation of all concerned secured.

Third, Prompt Relief : Surcease provided by the congenial hospital milieu from the physical and social stresses that are the lot of many Hindus often in itself mitigated initial regressive, depressive or paranoid states. Benzodiazepines, tricyclics, phenothiazines and other medicaments were prescribed if necessary, but in dosages ranging from only a fourth to a third of those employed here; indeed, Dr. Vijas avoided prolonged medication as leading to psychologic addiction. Vitamin supplements were added to the native diets both for their necessary nutritional was well as incidental placebo effects.

Fourth, Rapid Reorientation : Here Dr. Vijas' method were remarkably dynamic. The patient's tension-relieving dependencies on the staff and hospital were at first encouraged, but were never allowed to lead to regressive invalidism; on the contrary, there was a continuous awareness that the patient's stay was in essence a preparation for an early and successful return to an extramural milieu. To expedite this, the following procedures were employed :

The patient was carefully placed in a ward with others of his or her own caste and culture in advancing stages of recovery. These concerned companions, as is obligatory among caste Hindus, would admonish the new patient that his regressed, delusional or violent conduct

was "a disgrace to his caste and religious training", and that more appropriate behavior was mandatory, thus constituting a group influence that was often remarkably effective.

Members of the patient's family were concurrently given the use of a tent on the hospital grounds, and allowed to visit him as often as possible, bring him meals, news of his village and greetings from his neighbors, and thus encourage his early return to a receptive extramural milieu.

These and other interpersonal modalities such as discussion, recreation prayer and work groups, were expertly orchestrated by the personal influence of Dr. Vijas, who seemed to know every patient by name and relevant history, visited each, however necessarily briefly, at least every other day, planned and kept account of his or her progress through staff conferences, and personally furnished encouraging directives at discharge. To extend these, Dr. Vijas also wrote letters to the village magistrate, the local guru and if available, the physician of the region as to how best to expedite the patient's extraumural adaptations commensurate with his capacities and available opportunities.

Finally, Recycling: To modify his account, Dr. Vijas reported that he too had a "regrettable recidivism rate": depending on recurrent economic and social stresses and community extrusions, from 10 to 15 per cent of his patients had to return for one or more periods of treatment, although less than half of these remained hospitalized.

Morita Therapy

Limitation of space-time dictate a much briefer description of a contrasting but almost equally instructive experience a year later at the prestigious Suzuki Morita Hospital in Japan. There, following the methods introduced by Prof. Shoma Morita some seventy years ago, psychiatric patients are taught literally to "will themselves out of their faults" by strict adherence to the following routine:

A week of "thought-corrective" bed rest and minimal diet, during which no reading, writing, music visits or other distractions are allowed.

Two to four weeks of minutely directed work therapy interpersed with attendance at authoritative lecture and supervised group discussions as to the necessity of one's unselfish, inescapable but ultimately self-rewarding duties to his family, neighbors, employers, community and Emperor.

A final week during wich a highly regarded **sensei** (enlightened guide) who had previously attained prper self-discipline through Morita therapy, instructs the patient that he/she must hence-forth conduct himself/herself as every culturally-oriented and thereby socially acceptable Japanese should, and must do so despite any persistence of anxieties, obsessions, fears, depressions, hostilities or other inadmissable preoccupations. The slogan **makuleki heni:** "hold firm to that purpose" is deeply ingrained, and the patient is discharged with follow-up beneficial recults statistically comparable to any in our country.

True, in the less authoritative, more democratic Japan of today Morita therapy is losing some of its appeal to emerging individualisms. Nevertheless, with some modifications, it is still a highly effective procedure for the majority of Japanese who adhere to their more traditional Shinto culture. (Kora, 1965).

L'envoi: The hospital and community facilities furnished to us are undeniably useful; however, what produces therapeutic results are the facility with which we psychiatrists and collaborating mental health professionals utilize our empathy, our knowledge, our talents and our sociocultural orientations in restoring and promoting our patients' welfare in their eventual **milieu.**

REFERENCES

Esquirol, E. (1972) In MD (February, 27) P. 163.

Kora, F. (1965) Morita therapy. *Int. J. Psychiat.*, **1** : 611—640.

Masserman, J.H. (1946) *Behaviour and Neuroses.* Chicago, Illinois : U. of Chicago Press.

——— (1953) Faith and delusions in Psychotherapy : the Ur. delusions of man. *Am. J. Psychiat.*, **110** : 324—333.

——— (1955) *Principles of Dynamic Psychiatry.* 2nd ed. Philadelphia : W.B. Saunders.

——— (1956) *Practice of Dynamic Psychiatry* 2nd ed. Philadelphia : W.B. Saunders.

——— (1966) (Ed.) *Handbook of Psychiatric Therapies.* New York: Grune and Stratton.

——— (1973) *Theory and Therapy in Dynamic Psychiatry.* New York : Aronson.

——— (1976) (ed.) *The Range of Normal in Human Behavior.* New York : Grune and Stratton.

——— (1978) Three score and thirteen Psychiatric therapies : an integration. In Masserman, J. H. (ed.) *Current Psychiatric Therapies.* Vol. 18. New York : Grune and Stratton.

Masserman, J.H. and Schwart, J.J. (1972) (eds.) *Man For Humanity.* Springfield, Illinois : Charles C. Thomas.

——— (1974) *Social Psychiatry.* New York : Grune and Stratton.

AUTHOR

Jules H. Masserman, M. D., Professor of Psychiatry and Co-Chairman Emeritus of Psychiatry and Neurology, Morthwestern University.

الموجز

العلاقات العلاجية المتداخلة
بين المريض والطبيب والمستشفى والمجتمع
فى الولايات المتحدة

يعالج المؤلف موضوع المفاهيم المختلفة للعـــلاج الفردى والجماعى والمجتمعى ، فيعطى تصورا مختصرا لروح العلاج ، ثم يتجه الى شرح ما قام به بمعاونة زملائه من اثبات وتوضيح وتطوير لهذا المفهوم الضام بواسطة بحوث مقارنة وتجارب على الحيـــوانات ومن خـلال التحليل الاكلينيكى للاتجاهات العلاجية المتقدمة · وقد وجد أنه بالاضـــافة الى الاستنتاجات المستوحاة من التجارب على الحيوانات فانه يمكن تطوير أســاليب موازية فى العلاج يمكن تطبيقها على الآدميين ·

ومن خلال هذا المضمون يسوق الأساسيات السبعة التى يراها لازمة للعلاج النفسى وهى : سمعة المعالج وشهرته ، الألفة المبكرة والطمـــأنة المريحة ، واستعراض خبرات المريض الحياتية ، واعادة التقييم لأنمـــاط السلوك الســـابقة مع اعادة استيعاب ورؤية أهداف وقيم أكثر ملاءمة ، واعادة التهيئة للحياة الاجتماعية ، وأخيرا ربط المفاهيم بصـــورة دائرية متصلة ·

وبعد مناقشة التطبيقـات الممكنة لخبرة المستشفى والعمل الاكلينيكى فى مجال الطب النفسى المجتمعى ، استنتج المؤلف أن ما يؤدى الى النتائج العلاجية الايجابية هو درجة السهولة التى يمكن بها للأطبـــاء النفسيين ، وأولئك المعاونين الذين احترفوا مجال الصحة النفســـية من أن يستغلوا قدرتهم على التقمص العاطفى ، ومعرفتهم ومواهبهم وادراكاتهم للمجتمع والبيئة فى استعادة وتنمية صالح المرضى ·

ABSTRAIT

Les relations thérapeutiques entre malade, physicien, hôpital et communauté dans les Etats-Unis

Les topiques des différentes conceptions du traitement de l'individu, du groupe et de la communauté ont été traitées par l'auteur. Au début, il a formulé brièvement l'essence de la thérapie. Puis, il a poursuit son étude en collaboration avec ses associés afin de valider, clarifier, et élaborer son argument inclusive à propos de la thérapie. Il a conduit une recherche comparative sur les animaux ainsi qu'une analyse clinique des aspects thérapeutiques. Parallèlement à son étude experimentale sur les animaux, it a pu élaborer des modes thérapeutiques qui peuvent être appliquées pour les maladies mentales. Dans ce contexte, il a formulé les 7 "Pil-R S" de la thérapie. Ceux-ci sont : la Réputation du thérapiste, le Rapport rapide avec le malade, le soulagement (Relief) réassuré, la Revue des expériences du malade, la Reconsidération de modèles de conduite précédente avec re-orientation vers des objectives et des morales plus convenables, la Resocialisation et finalement le (Re)-encerclement.

Après avoir discuté les applications des modes de thérapie dans les cliniques ainsi que dans les hôpitaux, il a conclu que ce qui est capable de produire l'effet thérapeutique est la facilité avec laquelle les psychiatres ainsi que les professionnels travaillant en collaboration avec les psychiatres utilizent leur empathie, leur connaissance, leur talent et leur orientation socio-culturelle dans la restoration et la promotion du bien-être des malades.