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Speaker: Frances Cheek, Ph.D.
Bureau of Research in Neurology and Psychiatry
Box 1000
Princeton, N.J. 08540

Topic: Personal psychosynthesis in groups for alcoholics, drug addicts and schizophrenics.

Participants:

Akter Ahsen, Ph.D.
Fran Borst
Jack Cooper, M.D.
Mrs. Rena Cooper
N. Friedman
M.L. Goldmintz
B. Grant
Frank Haronian, Ph.D.
Frank Hilton
Mrs. Hilda Hilton
Stuart Hochman
Wm. Horowitz
Patricia Jacobson
H. Lichtblau
Dorothy Morgan
John O'Neill
Paul Peloquin
Marnie Potash
James Rascati
Jason Richter
Will Sawyer
Mrs. Claire Warhaftig
Jeff Maloney

Psychosynthesis Research Foundation
Room 1902
40 East 49th Street
New York, N.Y. 10017

Personal Psychosynthesis in Groups for Alcoholics, Drug Addicts, and Schizophrenics

Frances Cheek, Ph.D.

INTRODUCTION:

Dr. Frank Haronian: Our speaker tonight, Frances Cheek, has one foot insociology, and one foot in psychology; plus an interest in anthropology. She's a Canadian from Toronto; she has a master's degree from there and also from Duke University, and a Ph.D. from Columbia.

She has been working at the New Jersey Bureau of Research in Psychiatry - headed by Dr.Humphrey Osmond.She's always been interested in groups, how members interact, techniques for understanding and changing behavior in groups.

She feels that it's important that research be applicable as much as possible and as soon as possible, and her research has led immediately to a practical program which is growing and expanding. Herapproach has been non-idealogical, and therefore she has been willing to follow her nose and experiment with different techniques. So she drops the useless, and incorporates in a practical way a variety of techniques that are very effective.

Naturally, this leads to a measure of psychosynthesis in what she does, because there's a lot of use of the imagination, visualization by the use of imagery, as well as kinds of will training and meditation on spiritual topics. I think she's very much in the spirit of the times, in that her program is teachable to non-professionals, the so-called intelligent housewives can learn to do this and become very effective therapists.

DR. FRANCES CHEEK: Frank Haronian came to visit me the other day to make arrangements for me to come up here this evening, and told me a new word which is a very good word and really expresses what has been happening to us in New Jersey at the Neuropsychiatric Bureau over the past few years, where we have developed these programs. The word is a Jungian word, anantiodromia. It refers to the fact that if you go far enough in one direction you find you have arrived at the opposite from the point of departure. In other words, if you go far enough on one particular path you're going to find that you are approaching the opposite of your original intention and style.

We have been doing this in a number of ways, and I think it's a very fitting concept. In the first place, we started out by being interested in how other individuals may be controlled; how to control people in the environment around them. We found, as we began to work with this concept of how to control others, that we were beginning to learn how to control ourselves, and we were beginning to teach people self-control. That was one of the paths that we took that ended in another very important direction.

In another way we took a path that ended in a direction that we hadn't thought of. We started with a Pavlovian and Skinnerian orientation, and Frank tells me that we have ended up very close to psychosynthesis; we're very close to those who practice medicine; we're very close to the knowledge that is beginning to come to this country from the East.

So starting out with the Western technology of behavior with Pavlov and Skinner, we have come completely to its opposite, and we have happily, I think, begun to see in the programs we've been developing how Western technology and Eastern spiritual consciousness technology, and other control and self-control, come together.

We always stress, when we begin to explain what we are doing in New Jersey, that though we are working with Skinnerian and Pavlovian ideas, we are very much interested in the control of the individual over himself and over his own behavior.

Skinner and many of the others who write and think and work in this area are at present expressing rather dismal notions of what will happen in relation to the development of behavioral technology. Among the behaviorists and within this "school" there are other voices that are beginning to be heard. A number of experimenters and writers are beginning now to talk about the concept of self-control.

From a very practical point of view, I will describe to you how we started off on Skinner and other controls, and how by simply following that route we discovered ourselves training people in self-control by using these techniques. We are really delighted that, apart from whatever theory is going on about what will happen about behavior therapy or behaviorism, when you really apply it you very rapidly come to the end of the road of control of the other, and get very much into self-control.

Americans and Russians always argue about who started what first, and I think with this particular development it's pretty clear that the Russians with Pavlov began a whole important move in the understanding and control of behavior. And Pavlov, of course, discovered something about how pieces of behavior get glued together.

Watson, in the United States, decided also to work on this problem but he did another thing. He took a small boy who was not afraid of rabbits, and put the child into a room with a rabbit and then made loud banging noises and managed to glue together two other kinds of behavior. He managed to put together fear and rabbits for this child where previously rabbits were not associated with fear. So he had done another kind of interesting gluing together of items of experience.

Then a psychologist, Mary C. Jones, examined this gluing together from another point of view. She decided to see whether you could unglue fear from an experience, and again she took a small child, put the child into a room with furry animals, of which the child was afraid, and then presented the child with reassuring, calming stimuli to make the child not afraid. What she had done was to unglue fear from furry animals.

So psychologists were now beginning to experiment with this business of gluing and ungluing bits of behavior and certain kinds of stimuli, and this whole trend initiated by Jones - this was really the first therapeutic experiment with these techniques in this country - was later assisted by Wolpe, a South African psychiatrist with extraordinary success with an interesting new twist.

He said by just putting the individual into a relaxing situation and having them imagine the feared object you could remove the fear from the imagined situation; and that would then make the individual not afraid of the real situation. He thereby developed a process of what he called covert desensitization. What he did was to get the individual to work with the most feared object. For instance, if it was an airplane phobia, he didn't have the individual imagine he was sitting in a pla

taking off, which would have been terrifying.

The individual relaxed and was asked to think of a very calm scene; a scene that made him calm and happy. Then he would have him imagine, something like three weeks before he was to get in that plane, that he was buying the ticket, and he would have a certain amount of tension.

So he moved from his calm scene, which he imagines, visualizes - and this will be familiar to those of you who have worked with psychosynthesis - and then begins to work with the uptight thing - buying the airplane ticket. He goes back and forth, back and forth, in a state of relaxation until the patient no longer imagines the tension in the imagined scene. Then he works up a "hierarchy," which is what Wolpe called it, moving from three weeks before to two days before he gets on the plane. Finally, the individual no longer is tense in the imagined scene. Subsequently he imagines being actually in the plane. Then when he actually gets into the plane, the fear is gone.

This technique worked very successfully on Dr. Cyril Franks, a psychologist who was at the Institute and a major figure in behavior modification, who had an airplane phobia.

I have another friend, an anthropologist, who worked with me for a while, who had an absolute terror of speaking in front of a group. He would actually turn bright red and begin to perspire and completely lose his voice. He had unbearable anxiety. We would sometimes sit and hold his hand and try to get him to talk in front of groups and we couldn't do it. He used to drink and take drugs and all kinds of things and still went into these panic attacks.

Shortly after he left us he went to Philadelphia. He had also been in analysis - he had done a hundred things to try to get rid of his panic. He went to a behavior therapist and afterward he told me that after three sessions he was able to speak in front of groups; he was desensitized, and he now is teaching at one of the New York universities. He's a marvelous teacher, no longer having problems with anxiety.

Recently at the Institute - to leap a little bit ahead - we have been running behavior modification training for alcoholics, drug addicts and other kinds of patients, and our groups are run by paraprofessionals. In one case we had a woman who had had only a high school education; she's a volunteer from the community. She was working with a group of alcoholics a few weeks ago, and a man came into the group. First he went through a relaxation practice at night; the next day he went to one of her meetings and subsequently he was cured of a twenty-one year-old agoraphobia.

He had been unable to go further than three blocks from his home for twenty-one years. He'd fall into an absolute fit of panic and turn red and think he was going to die. After attending only two sessions - where she didn't even know that he had agoraphobia, but simply taught him about calm things and desensitization - the man desensitized himself. He went out the day after her group session to walk around the Institute grounds, which ordinarily filled him with panic; he started to get a panic attack; the calm came to his mind; the panic went away and the patient went on his way and successfully walked around the grounds. It happened twice to him, and both times the calm came to his mind, the panic went away. This woman with a high school education had been the instrument of curing a twenty-one year-old agoraphobe who had been worked on by all kinds of therapists. The man had finally taken up alcohol as a final attempt at therapy. This was a very remarkable situation, and illustrates, I think, the extreme power of these techniques, and how they may also be used by the individuals themselves to help themselves.

We are not recommending that psychiatry be done by paraprofessionals; the use of the techniques is different. We use them in rehabilitation, and I'll explain that to you, but it is quite true that very remarkable things can be accomplished with what came out of Pavlov's and Skinner's labs.

This work of Wolpe's was one kind of trend in behavior modification, but another whole style emerged in what went on in Skinner's labs at Harvard - the pigeons who were taught how to play ping pong, etc. He focused not on the stimuli that preceded the behavior, but on how the behavior was influenced by the rewards and punishment which followed the behavior. He worked with behavior as it happened, and attempted to shape behavior by the judicious use of rewards and punishments.

The impressive work that Skinner did with animals soon was followed by other psychologists who began to think, "Well, after all, can this be done with man?" They wondered whether he, also, was subject to the same kind of control by rewards and punishments; can we schedule them and manipulate his behavior as Skinner has so miraculously done with animals.

In the early experiments, one I remember as a sort of classic, he reinforced the man he was interviewing. Every time the man said a plural noun like dogs or cats or men or women he'd smile and say, "Yes, uh-huh," and he found that without the interviewee's knowledge of what was going on he could increase the number of plural nouns simply by the verbal reinforcement and by the smile. So it now became apparent that human behavior, perhaps without awareness, could be influenced very strongly by the judicious use of rewards and punishments.

A psychologist by the name of Lindsley, associated with Skinner, began to build human Skinner boxes, to work on chronic schizophrenics; he had the patients pulling levers for rewards of candy and cigarettes and dirty pictures, which he found very reinforcing. Lindsley began to find that indeed he could bring behavior under control, and he could examine how behaviors were influenced by different kinds of schedules of rewards and punishment.

At this point a very imaginative young man by the name of Theodore Ione spent a summer in Saskatchewan at a hospital that was under the care of Dr. Humphrey Osmond, who was Superintendent at this time. Dr. Osmond is Director of the Bureau of Research where I work (and the man who first gave mescaline to Huxley),an imaginative and creative man, very open to new ideas, and Ted asked if he might be permitted to try out some of these ideas on patients who were in the psychiatric wards. Dr. Osmond said"yes";he felt that was a good kind of experiment, and Ted said for his first patient he wanted an exceedingly difficult one; one who had great trouble managing.

They gave him a man who had been continuously in bed for fifteen years or so, who was organically sound but who simply wouldn't get out of bed. As most of you well know, chronic patients in our mental institutions usually exhibit very deteriorated behavior. It's unclear to what extent this is a function of the disease process itself, and to what extent it's the function of institutionalization.

These patients are very difficult to control by rewards and punishment. They don't respond as normal people do, and in institutions it's just easier for the staff not to try to affect their behavior. Patients, as a result, very often deteriorate and become so deteriorated that it's very difficult to get them back to the community, no matter what symptomatology, so to speak, is showing.

At any rate, Ted began to work on this man who had been in bed though organically sound, and he told the attendants that no longer were they to place the

man's food tray by his bed; it was to be over near the window on a table, where the man couldn't reach it. So the first time this happened the poor man said, "What's going on, here? I can't reach the tray." And the attendant said, "Oh, things have changed around here." So the poor man for three days could not eat, but they gave him water. The hospital staff got every upset and came to Dr. Osmond and said the man was going to die, and Dr. Osmond said, "Indeed, he is not going to die; he's actually a rather plump and healthy man; he's in no danger whatsoever."

So the third day the poor man sadly got out of bed, walked across the room and ate his food. Two years later he was still up and walking around, and Dr. Osmond, meeting him, said, "What's this? You used to be in bed all the time. What happened?" And the man said, "Oh, things have changed around here!"; and indeed they had, because now the psychologists were eagerly hopping around after all these difficult and unmanageable patients and setting up reward and punishment situations, to get them out of these bad behaviors they had nurtured for so long.

Ted also worked with a famous case; the woman with the clothes and towels, the one of whom we have some interesting movies. This was a lady who had loved to wrap herself. She was a human mummy in clothes and towels and wandered around this way, and they couldn't get her to stop.

Ted said when she got to the dining-room she was told that she had to be weighed before each meal, and after she was weighed she was told that she was too heavy and must lose and therefore would have no dessert and only a tiny amount of food. The lady was a very enthusiastic eater, and when she heard this she was very dismayed and said, "What am I to do?" And they said, "I don't know; it's too bad."

After one very tiny meal with no dessert she appeared at the next meal minus a few towels. In the course of three weeks the poor woman gradually began emerging from this cocoon, until at the end of the three weeks you'd see this sad-faced lady walking around, no happier, but at any rate out of her cocoon of towels and clothing.

Then the psychologists developed a new idea. Instead of just working on the individual patients and finding out what was rewarding to that patient, and setting up a reward or punishment situation, what they decided to do was simply set up what they called a "token economy."

So they would first decide that if the patients brushed their hair, cleaned their teeth and put on makeup, if they were females, cleaned up the ward, whatever they wanted, they were given tokens. Then they would use these tokens to buy candy, cigarettes, and various other things that they might want. In this way the psychologists began to bring the behavior of whole groups of patients under control.

Subsequently, these kinds of token economies were used and are being used in prisons and classrooms and in a variety of kinds of settings.

Ted tells an interesting story about his first introduction to token economies. They found out that they had to pay the patients to go to the psychiatrist; they didn't wish to go, and they had to pay them tokens. But the patients would pay any amount of money to go to church, and the longer the sermon, the more they would pay.

They really found out what people wanted and what they didn't want when they began to have to pay for things. At any rate, token economies have proliferated

and are now exceedingly popular. We ourselves, in New Jersey, have some anxieties about token economies, because we feel that what happens with these situations is a manipulation of the individual by the external environment, a form of external control, and we feel that this is a danger, even though it is often an effective way of dealing with patients or prisoners or whatever. For this reason we prefer the kind of thing we do, which I will tell you about shortly.

We got into behavior modification at the Institute I think about 1965 or so. I had been doing studies of the characteristics of family interaction with schizophrenics using the Bales technique. And the one thing that really emerged startingly from the studies, when you really looked at the families, was that the fathers and mothers of the schizophrenics used rewards and punishment differently from fathers and mothers of normal young adults.

This very much intrigued me, and I spoke with Dr. Osmond about it and he wrote a memorandum on it. Dr. Osmond is a prolific memorandum writer, and he sends them off all over the state, and the world, which is fine, and sometimes provokes interesting results, as it did in this case. We shortly received a deputation from Marlborough State Hospital; they were interested in what he was writing about rewards and punishments, and wondered if attendants could be taught how to use rewards and punishments to change behavior of the disturbed patients. So they asked if I could go down and help them set up a training program for attendants, in which they would be taught how to do that. In this way I got involved with what I guess was one of the first attendant training programs in behavior modification in the country, when Marlborough very courageously decided to embark on this.

The group who worked successfully at Marlborough did find that the attendants were very pleased when they learned that what they must do first was observe the patients and find out what behaviors were desirable and set up norms of standards for what they want of a patient, and then they were to begin to find out what rewarded each patient, and then begin to try to change the behavior of the patient in order to come closer to the kinds of normal standards which they felt should be met.

The attendants liked it very much. It made a lot of sense to them; they never really cared much for psychoanalytic jargon; it sort of went over their heads, but they liked to actually do something for patients, not simply to be told to love them or relate to them, but to be given something practical to do, and something also entertaining to them intellectually, because it was fun to try to change the patients.

One of the major successes they had at Marlborough was with a woman by the name of Gertrude, a woman of fifty or so, who for twelve years had said nothing but, "Bury me in the ground." She had long gray hair and used to wring her hands and say, "Bury me in the ground." This was terribly distressing, because it made her a very dull companion, and people wouldn't talk to her. So they decided to work on Gertrude. First of all, they had to discover what she liked, which happened, fortunately, to be chocolate pudding, which made the whole thing very simple.

First of all they told the attendants and nurses that when Gertrude said "Bury me in the ground," they were simply to tell her, "I'm sorry, but when you talk that way I'm not going to stand beside you and listen to it," and just walk away. Also, they told Gertrude that she could come into the trainer's office and would be given chocolate pudding as long as she didn't say, "Bury me in the ground." But the minute she said it, she would have to leave and would not have her chocolate pudding ration for the day.

They found that after about three weeks of this, poor Gertrude stopped saying, "Bury me in the ground." But now they had the task of teaching her social conversation, of which she had none. So they had to reward her, at this point, for what she said, and they had to teach her to talk about what people wore, and what they had for lunch, and at this point I visited them and sat with Gertrude, and she said, "I have had beans for lunch," and I said, "My, that's very interesting," and she would say, "That's a funny-looking red dress you're wearing," and I'd say, "Yes, you're right. That's a very odd red dress." You had to reinforce her so that she would begin to become a conversationalist. So after six months she did indeed leave the hospital and went to her minister brother, which was marvelous, because she had been continuously hospitalized for about fifteen years. This was a very remarkable achievement. I doubt she ever became a really sparkling conversationalist, but I think she was a little better than she had been for twelve impossible years.

It was also interesting that the attendants prior to behavior modification had tried an experiment with Gertrude to see if they could stop her, and instead of rewards they were using punishment, which Skinner has pointed out is not a good way. What they tried with her was they took her out in the yard and they got a shovel and they began to dig a hole. At this point Gertrude said, "I won't say it any more, I won't say it any more," and they filled up the hole and took her back to the ward. The minute she got in the door she said, "Bury me in the ground!" thereby illustrating Skinner's point, that when the punishment is removed you're back in trouble again.

Anyway, we were so fired by the success of what happened at Marlborough that we decided we would like to see whether we could teach parents of convalescent schizophrenics how to use these techniques to improve the difficult behaviors of their offspring when they came back from the hospital. We had found in our earlier study that parents often found it terribly difficult to get help with these problems. Usually, the more they asked the psychiatrist what should be done for a patient, the more the psychiatrist said that they were overprotective parents who had caused the illness in the first place. The psychiatrist seemed to give very little concrete help and advice about what to do with things like cursing at the dinner table, and taking two or three hours over dinner, or this kind of thing.

So we decided to use the technique of "pinpoint, record and consequate," which had been developed by the psychologist Linsley who had made the human Skinner boxes. His technique was a very powerful and a very simple one. In the first place, "pinpoint": if you're trying to change some behavior, rather than attack the fact that the individual, say, is a lousy husband, what you do is pinpoint the fact that this gentleman is nagging constantly at the dinner table. You pinpoint a recurring behavior that you can record, write them down and check every time the husband nags at the dinner table.

The next thing ("consequate") the wife can do is tell the husband that when he nags at the dinner table she is going to look unattractive; she's not going to use makeup or comb her hair, which distresses him. Therefore, what she is going to do is use some kind of punishment which will tend to affect his behavior. Naturally, in a husband-wife situation you probably wouldn't use that technique, but this illustrates the point.

I've heard Lindsley discuss this technique. He points out that it's so simple that it could be used by an eight year-old; and indeed, he was giving classes for parents in how to change behavior of kids who are disturbed in the school setting, and an eight year-old boy met his father in the classroom and waited with him while the class was going on, and then decided to see if he could change the behavior of his three year-old brother who was a thumbsucker.

So the child went home, and first of all made a recording of the number of thumb-sucks per hour, and then he put a glove on his brother's hand and produced another chart, showing how he had managed to get rid of the thumb-sucking behavior. Lindsley described this little experiment before a group of psychiatrists and psychologists to illustrate the fact that the techniques were powerful and could be used even by a small child very successfully.

So indeed, we decided to see whether we could teach these parents of schizophrenics how to use this technique in order to change behaviors of their offspring. We set up a program over ten weeks meeting Sundays for a couple of hours, in which we first of all gave lectures, showed movies about behavior modification, and then began to have the parents practice with this technique.

We found at the end of the ten weeks that many of the parents had, indeed, managed to change behaviors, but mostly we found the parents were very encouraged by the fact that they now had something to do. As with the attendants, they felt that they now had a method, a technique, they were no longer helpless in the face of these behaviors that previously had often led to an exacerbation of the illness. Now they really had something to do that would change behaviors.

Generally we found communication increased among the family members, and the patients themselves were quite delighted with the program and with what happened to their parents in relation to it. Parents also began to tell us that what they were finding was that they were increasing in self-control; they managed to control their own behavior better because they didn't become as tense and anxious when they knew there was something to do. The first time we heard this mentioned we really paid little attention to it; we really didn't realize what they were saying. What they were beginning to tell us was that they were growing in this very important matter of self-control.

We were so fired by our success with the parents of convalescent schizophrenics that we decided to tackle a really difficult problem, the interaction of the wife with her treated alcoholic husband. We had been doing a study of the use of LSD as a therapeutic aid for alcoholics, and we had found that one of our major problems, when we sent the husband home in the typical LSD honeymoon, where he was serene and happy and ready to take on responsibility, was that he went back to a very angry, tense, hostile wife, who after years and years of abuse and difficulty was not ready to give up her anger, her resentment and her hostility towards her husband.

So that the wives would call us up and complain, "I don't know what to do with my husband, he's no longer acting like an adolescent; I don't know how to handle him," or they'd say, "I don't know what to do, he wants to handle the family finances," or "He's going out to AA meetings," so it was very evident that the husbands were running into a lot of problems simply as a result of the way their wives were acting and feeling - justifiably perhaps, because these ladies had been abused. But the kinds of feelings and the kinds of behaviors they were evidencing were not helpful to their husbands. They would do things like reminding them of all the years of suffering, and they'd be bitter and angry and resentful towards them,which didn't help.

So we began to set up a program in which we planned to teach the ladies that the effects of their behavior on their husbands might change their husbands' behavior through the techniques of "pinpoint, record and consequate."

We soon found that the ladies would have none of it. They said that no matter what they did it made no difference to the husbands, that nothing that happened

was their fault at all, that everything unfortunate that happened was due to their husbands and their husbands' bad behavior, so we found that we were going to have to take stronger measures.

At this point we decided to introduce another behavior therapy technique. We began to move into Wolpe, and we decided to see whether, if we relaxed these ladies who were so tense, bitter and hostile, and taught them how to desensitize themselves to their husbands, and to the anger they felt in relation to them, we might be able to get them to examine their interaction objectively.

Sure enough, we discovered the ladies loved the relaxation; they liked the idea of desensitization, and they began, for the first time, to begin to look objectively at what they had been doing in relation to their husbands. The husbands also began to come to the meetings, and they, it turned out, liked the relaxation and desensitization even better than their wives.

So we now set up a new program, in which we had husbands, while they were in the treatment unit for five weeks, go through a program, and their wives go through a similar program, meeting once a week for two hours. Then for five weeks after the husbands left the unit we had the husbands and wives together for five weeks for two hours on Sundays.

In this new program we taught them, first of all, relaxation, two or three methods of relaxation, and then desensitization. Then we began to work with health image training, a technique of relaxing the individual and having him visualize situations that were problematic for them, visualize their handling of these situations in a successful, poised and confident manner.

Also, we taught them behavior analysis, behavior control, and assertive training (another behavior therapy technique) because we discovered that once the alcoholics and their wives had a tendency to hold back their feelings, to fail to express their needs, to fail to express what they thought they were due in a particular situation, they would explode violently, the husbands often using alcohol in order to help them be more assertive, at the wrong time and in the wrong way.

So we began to teach them how to answer themselves appropriately at the right time, coolly, and in a constructive, rather than a destructive way. We found with this program that it was very successful with both the wives and husbands, and the people at the treatment unit liked it so much that they wanted to continue it themselves, which we felt was a good test of the effectiveness of what we were doing.

Also, we began to realize again, even more strongly, that what we were doing was increasing self-control, because relaxation enabled individuals to examine situations objectively, and to act rationally and coolly, and to act constructively, rather than blowing off and causing a lot more trouble and being unable to really control the consequences of situations they were involved in. The assertive training helped them control their behavior; the self-image training helped them control their behavior and to act in the way they really wanted to act in situations that were going to happen to them. So we found that we had very greatly increased self-control of these individuals. Now we began to think that it would be interesting to try these techniques with another addictive disorder, namely drug addiction and heroin addiction. We had been doing a study of the social role changes as the addict moves from heroin use to methadon maintenance, and we had been much impressed by the severe problems the addict faces as he attempts to structure his life in these terms. First of all, he has to deal with a hostile society which fears and hates him, and mistrusts him;

he has to go through all kinds of things of this nature. They had been through every kind of therapy program that existed, before they came to go on methadone as a kind of last resort.

We set up an eight-session program of self-image training, behavior analysis, assertive training and decided we would put all the material into a Work Book. The addicts were exceedingly interested in this program, and in fact became fanatical about their Work Books. Not surprisingly, they also liked the rest of the program. We did a pilot program last November in which forty individuals, roughly, went through this kind of training, and we did pre- and post-measures, using the Taylor Manifest Anxiety scale, and the Rotter I-E scale of inner versus outer control, and also the scale of level of assertiveness and the self-image scale developed from the Gough Adjective Check List. The pre- and post-measures differed at the point 001 level in the directions that we had hoped and anticipated they would. In other words, we got very highly significant differences on all of these measures.

Also, on a six months' outcome measure with the drug addicts we discovered that we had not significant, but almost significant, differences in terms of level of adjustment of the addicts who had been in our group, as opposed to those who were not given behavior modification. So we were quite encouraged by these findings, and have hoped since then to be able to set up a very rigorous control study if we can ever get the money to do that.

We did find that the addicts themselves were very enthusiastic. I spoke after the program with one of them who had sat most of the time relatively silently, and asked him how he had reacted. He said, "Well, it's the only program I've ever been involved in where I actually did something, where I actually got involved and took part," which was very important, he felt. The other thing was, he said, "It's the only program I've ever been involved in that I felt anybody really cared what happened to me," and this was quite interesting, because the program is very didactic and highly structured. It's almost like teaching somebody how to play tennis; you're really teaching them a number of techniques.

First of all, in the lecture you explain why the technique is of special value to a drug addict in terms of the kinds of problems he has. Then you tell him what the technique is in very explicit detail. Then you give the addict practice in the technique and then you give him homework assignment. In the behavior analysis and behavior control part of the program, we also had playlets which they acted out, so they would understand the concepts, and they very, very much enjoyed the playlets.

The first three meetings of the program focussed on inner experience. We explained to them that in order to control yourself you first have to begin in your head, and we would begin with the relaxation, which was the beginning of control, then the desensitization and then self-image training. Then we told them they had to move outside to their interaction with others, and then began the analysis of behavior; the control of behavior and the assertive training.

Also, we added another meeting on rational therapy. This is Albert Ellis' new kind of therapy, and we find it very important, because the addicts had many wrong and false ideas. They'd have notions that all "straight"people are not to be trusted, that "straight" people look down on addicts, etc. They also had ideas about the police that were faulty. So we felt that it was very important for them to have a course in rational thinking, and they liked that very much. They found it very illuminating and many of them found that one of the best parts of the program.

At any rate, when we finished the program we had hoped to have it picked up by the psychologist working in drug addiction, but it turned out that he couldn't because he was too busy to do the therapy. He was devoting all his time to testing, so they were testing them before they had the methadone and after, and had no time to do therapy with them!

We were really dismayed about this, but fortunately my secretary, who had sat with me throughout the program, had been doing some interviewing, also, with the addicts in the early study, and therefore knew something about addiction. I said to her, "Theresa, we don't have anybody to do this now, can you do it?" and she said she'd try. So this girl, who had only a high school education, walked into that drug unit with a Work Book and within two or three months she was a fabulous group leader with drug addicts, using behavior modification. She's intelligent and has good social skills, and she understood what was in the Work Book very well, managed to communicate it to the addicts, communicate why the techniques were important, how they can be used, and particularly could communicate to the addicts that they must use the techniques themselves.

In the program we had no dependency between the group leader and the patient; it was not encouraged or allowed. The idea is that the patient is to learn these techniques and to learn in what situation he uses which technique; and he's on his own. Many of the patients write letters and come back to see us, and we always find that they themselves have taken over, for instance, their own judgment of what is right or wrong for them, and their own judgment of which technique to use in which situation in order to help themselves. We don't program the therapy for the patient, the patient programs his own, once he knows what techniques are available to him.

At any rate, Theresa became a really remarkable group leader with the addicts, to the extent that once we had Arnold Lazarus, who is a remarkably good therapist, visit our programs and he said that he couldn't have begun to accomplish what she did with this group; she was really extraordinarily good with them. This was mostly, I think, because she follows very closely what is in the Work Book, which has been very useful.

So we set up an ongoing program in the drug addiction unit, and now we began to get a lot of requests from staff working with the addicts in the program. We found that at some meetings we had nine or ten staff members sitting in on the program, unless we could get them out, which we finally had to, because there were too many staff members present to make the patient meetings go well. But we also began to get requests from all over the State as the addicts left and went to parole officers or probation officers, or methadone clinics or therapeutic communities who got all kinds of people saying, "What is this behavior modification and what is the Work Book and what are you doing?"

So we decided to set up a staff-training program. We rewrote the Work Book so that we added an original first meeting in which we discuss the background and overview of behavior modification, and a last meeting in which we tell them how to set up and run behavior modification training programs.

We now, first of all, put the staff of the Institute--the drug addiction staff--through this program, and then we began to do statewide programs, writing to various facilities that served addicts in this State, and we have to date had four such training programs for staff working with drug addicts. Each program that we do gets heavily subscribed ahead of time, so that the program which will take place in March already has forty people enrolled in it. It has proven to be exceedingly popular.

Interestingly, it is very, very popular with correction people. A few of the correction institutions have programs for addicts, and a number of people, even those who don't work with addicts, have been sent to the program, and the correction people are amongst our most enthusiastic supporters. We also had people from parole and from pretrial and rehab, and from various kinds of agencies.

In fact, the New Jersey Division of Narcotics sent a psychologist to see us last week because they said they were getting very suspicious because they thought there must be something the matter with the program, people who were going to it were so enthusiastic about it. They were convinced we were doing some evil thing, and they sent a psychologist. I told him what we were doing, and he went off to one meeting and came back and said, "Marvelous!"

The relaxation is a very powerful technique. The staff members used to say, "You've got those men hypnotized," yet we told them it wasn't hypnosis; it's milder and at a higher level than hypnosis. We're not hypnotizing them, but it sometimes seems like that anyway. It's probably self-hypnosis, too. But it is true that the relaxation is a very powerful technique with which to begin any program. We, of course, used relaxation with ghetto children as a means of improving their ability to learn, and their receptivity to learning and it's well known that individuals become more susceptible in states of hypnosis or even light relaxation.

We were very pleased with what happened in drug addiction, and then we went back to alcoholism and rewrote our program. We are now doing work with the alcoholics at the Institute with success.

We decided to see if we could do it with psychotic patients who were hospitalized at the Institute and we set up a program for adolescents, mostly schizophrenics and put twenty-four of them through the program and found they reacted to it very strongly and very intensely.

One young man, at one point, escaped from the hospital and he took his behavior modification Work Book, and they picked him up in a bar explaining behavior modification to all the customers, and he was greatly enthusiastic.

Another one, who had been a compulsive actor-outer, a very violent patient, a young man who used to be baited by other patients in order to get him into his rages, managed not to get into rages by thinking about the diploma. He badly wanted to get the diploma that we give the patients at the end of the training course, and he managed to control his rages by imaging the diploma in his mind. He thought of this himself.

When he graduated he asked for three diplomas instead of one, and we gave him three. What he did with them I'll never know. Apparently it was useful; he was very enthusiastic.

The psychotics reacted in their own way, and it seemed to be useful to them.

We set up another program for adult mentally ill and are now just finishing that. Again, we had people 72 years old in that and they really seemed to like it.

Most of the work we've done at the Institute has been done with volunteers because we simply didn't have the money to run these behavior modification training sessions. Usually they're under two group leaders. The reason for this is that the program is highly structured, and it takes place, of course, in the eight sessions,

and one individual can't necessarily run the whole group comfortably. You can do it but it's a rather heavy task. Another thing is that you may be sick or away, so it's useful to have two group leaders. One can be a trainee and gradually take over the lectures or some parts of it.

So we began to ask for volunteers from the Ladies' Association, and we began to take in housewives, some of them only with high school education, and many of them again, turned out to be very remarkable group leaders. We had some very strong groups running. We're now running groups in all these areas and starting staff training on a statewide basis in alcoholism at the end of this month. We have written a Staff Training Book for the mentally ill and we're going to start very soon.

Finally, we're moving into correction, and we're now engaged in re-writing this manual to work with inmates in prisons and hope to set up an inmate training program and training program for staff working in prisons. We're now going to see this used for inmates who have great problems of tension, and problems of tension in specific situations which could be helped by desensitization.

Basically, I think what we have found at the Institute is, by taking this road that led to Pavlov and Skinner, that we are increasing the ability of patients who have severe problems of tension and anxiety which may well impede the very difficult transitions they have to make in their life-style from living in an institution to living in the community, and we have managed to give them more control over their own lives by teaching them these very highly specific, powerful, simple techniques which they can then use when they get out.

We do feel that in order for the individual to continue to use the techniques and to use the program ideally, we should treat and we should teach, first the patient, then the inpatient staff, with a kind of reinforcement of what the patient is learning, then the family - we're now working on family books in drug addiction, alcoholism and mental illness - and the outpatient staff with whom he deals.

If we can get these four groups trained, we feel that we'll have a very powerful system that will keep the individual using the techniques and thereby managing to control his own behavior and in that way facilitate his rehabilitation.

Are there any questions?

Mr. Goldmintz: I wanted to ask whether you used any of these techniques concurrently with antabuse?

DR. CHEEK: No our unit does not use physiological treatment of that kind. The drug addiction is a methadone maintenance unit only, and so it's always a psychological adjutant to that.

Mr. Pascate: Referring to this relaxation you talk of, what--?

DR. CHEEK What does it consist of? We teach three techniques, all developed from the techniques that are used by Dorothy Susskind, who is a behavior therapist in New York and is very good at relaxation. She got her techniques from Wolpe and they're basically developed from Jacobson's techniques. The first is the mental relaxant; the second the lightness and the third is heaviness. They're all in the Work Book we compiled, which is circulating among you.

If you had time I would put you through a relaxant technique. Would you rather have questions or do you want to take fifteen or twenty minutes to go through relaxation.

(There was a consensus for going through the relaxation technique.)

DR. CHEEK: I need the Work Book back. (Book was passed back to Dr. Cheek.)

In order to use this technique, and so that you'll get the most from it, you're going to have to develop a calm scene, okay? I want you to be able to image in your mind a scene that makes you feel calm, that makes you feel relaxed.

When we're teaching this to patients what we do is read them descriptions of a couple of calm scenes like lying on the beach or walking through the woods. You can either use a scene where you're lying down, or you can use a scene where you're moving. We have found that some people aren't relaxed by lying down scenes; they need moving scenes. You can do this sitting in a chair or lying down on the floor.

When you image your calm scene do it in as much detail as you can. Get in as much that you can see, as much that you can hear, as much that you can feel on your body, as much of your emotions as feeling as you can. You should get all affects into your calm scene.

Some people, we discovered, are better imagers of sound than they are of visual things, and this is one thing you can begin to discover as you work. Some people are better imagers than others, generally. We have a test of imagery that we use.

But when you think of your calm scene, think of it very completely. Visualize the scene in full detail. If lying on the beach you see the clouds; you see the sky; you feel the hot sun on your body; you feel the sand under you; you feel the sensation of relaxation and lying back.

When you use a calm scene we caution people to have a calm scene in which you are by yourself. We used to allow people to have calm scenes where they were with somebody else, somebody they loved or something like that. But we found particularly with the addictsthat if they had a calm scene that was with the wife, just as they left the hospital the wife would separate from them. Therefore, it was safer to have them select a calm scene where they were by themselves.

You can move, if you want, during your calm scene, if it is where you're walking slowly. The main thing is that you should experience and associate the feeling of relaxation with the calm scene. The advantage of this is, of course, that subsequently, what you're doing is conditioning yourself to put the image of the calm scene with the state of relaxation so that now, if you want, you can get the feeling of relaxation simply by imaging the calm scene.

I find that just saying these words, dropping my voice in the relaxation speech often will be enough to put me practically in a trance and to get really relaxed. Sometimes it really interferes when I'm trying to talk to people; I'm getting into it now.

Has anybody any problems with developing a calm scene, first of all? Is there anybody who doesn't have a calm scene? (There was no response) You're good imagers, but you would be, as psychosynthesis people, of course.

I'm going to make a suggestion to you. If anybody starts to snore it's not going to bother you because sometimes people do; they do drop right off to sleep and it can be disturbing, or somebody will start laughing. So if you hear somebody snoring, or if somebody starts to laugh or some interruption occurs, don't pay any attention to it; just stay in your state of relaxation and enjoy yourself and don't worry about it.

Question: Are you supposed to close your eyes?

DR. CHEEK: I'll tell you all that. Another point is, I'm going to tell you to close your eyes, but if you feel better, you can keep your eyes open.

I'm going to show you what you're going to be doing, because that way you can close your eyes and you'll know exactly what you're going to be doing. First of all you're going to stretch your legs out and you're going to tighten muscles. Then you're going to lift your hands and you're going to tighten them, and then you're going to drop them back. You're going to raise your chest and drop it back, and then you're going to screw up your face and then relax it. That's the beginning of it, all right?

I'm showing you these things so that you'll know subsequently what you're going to get into. Now we are going to begin:

Please lean back in your chairs, place both feet on the ground and close your eyes. Now atretch your legs as far as they can go, turn your toes under and tighten the muscles very, very tight. Hold it, and now also tighten the muscles in your calves and those in your thighs; let your entire leg be as tight as a drum and hold it, hold it, hold it.

Now relax all the muscles in your toes, all the muscles in your calves, all the muscles in your thighs. Let your legs go completely limp, and now feel that wonderful relaxation coming up from your toes, up your calves, up your thighs; feeling wonderfully relaxed, beautifully relaxed; very calm; very relaxed; feeling beautiful, just beautiful, wonderfully relaxed. (Pause)

Now I want you to raise your arms, stretch out your hands, make a fist and feel the tightness, and now make it tighter, tighter, hold it; and now also tighten the muscles in your wrists, in your forearms, in your upper arms, and hold it; hold it; hold it.

Now let go; just let go, and get that wonderful feeling of relaxation, right through your fingers, your hands, now through your forearms and upper arms. Let your arm go completely limp, feeling wonderfully relaxed, beautifully relaxed, very calm, very calm, very relaxed; beautiful, just beautiful. (Pause)

Now I want you to raise your chest, arch your back backward and tighten your stomach muscles. Make them as tight as you can, tigther, tighter. Hold it; hold it, hold it. (Pause)

And now let go, just let go and get that wonderful feeling of relaxation. Just feel the muscles relax from your back, from your chest, from your stomach, all over your back, all the muscles, just feeling wonderfully relaxed. (Pause)

And now I want you to tighten the muscles in your face, around your mouth, the muscles in your chin, around your eyes, and your forehead. Make them tighter,

tighter, tighter, tighter. Hold it; hold it; hold it; now let go, just let go. Let go and get that wonderful feeling of relaxation, and all the muscles in your forehead, the muscles around your eyes, the muscles of your cheeks, the muscles of your chin, the muscles around your mouth, feeling wonderfully relaxed, beautifully relaxed, very calm, very relaxed, wonderfully relaxed.

Now I want you to take a very deep breath and hold it; hold it; hold it. (Pause)

Now slowly, slowly, let it out, and you're letting out all your tensions, all your frustrations, your anxieties; feeling wonderfully well, wonderfully well.

Once again, take a deep breath, a very deep breath, and hold it; hold it; hold it. Now slowly, slowly let it out. Relax your tensions, your frustrations; your anxieties. Feel wonderfully well; wonderfully well; wonderfully well.

Now as I count down from ten to one, think of that scene that makes you feel calm, that makes you relax and that gives you a feeling of wellbeing. With your eyes closed see that scene in all its detail. As I'm counting down from 10 to one, you're going to find yourself deeper and deeper relaxed, and you will have a feeling of wellbeing; calm and relaxed, and wonderfully well; just relaxed.

I'm going to count ten; nine; eight; seven; six; five, very deep, deeply relaxed; four, three, very deep; two; one. Very calm, very relaxed, very calm, deeply relaxed.

Think of nothing now but relaxation; feel wonderfully relaxed, feel calm; feel wonderfully well; just relax, feel calm; feel wonderfully well.

When I count to three you will open your eyes and you'll feel calm, you'll feel relaxed, you'll feel wonderfully well: One, two, three. Feel wonderfully relaxed.

That's muscle relaxation. How many people got relaxed? Raise your hands, those who got relaxed. (There was a show of hands) Some people have more trouble than others in relaxing. I myself had great trouble in the beginning, but I found I finally got it.

Mr. Goldmintz: I am familiar with the record called "How to Relax," or something like that, and I met one or two psychologists who made the record and it's almost verbatim, what you're doing, even to the image of lying afloat. Do you know the record?

DR. CHEEK: I don't know that particular one, but if you look through the various relaxations - there's Lazarus and Jacobson and Wolpe and Susskind - they're all very similar. Susskind uses this one and then she uses two others, one called "Lightness" and one called "Heaviness" where you image feeling heavy and down or feeling light and going up.

When we use these techniques we usually put them one on top of the other. We always begin with the muscle relaxant, and then we usually use heaviness. People like heaviness. Some people prefer lightness and we find statistically more people like heaviness than lightness. You feel heaviness; it's a hot summer day and you're lying down and sinking back. Your body feels heavy, heavy, heavy.

With lightness you imagine that you're floating, and some people have trouble. I don't know whether it's a coincidence, but many young people who have used marijuana like lightness. I don't know whether it has something to do with feeling high and they can associate with that which makes them feel relaxed. But many of the addicts like heaviness. Many of the schizophrenics like lightness.

Comment: There are more Calibans than Ariels. (DR. CHEEK: That's very good.)

Rena Cooper: The Work Book that you're working out of, is that for mental patients, drug addicts, for whom?

DR. CHEEK: What we did was rewrite the book for each group that we worked with, and this one here is for drug addiction staff training. We have one for drug addicts, this green one; and then the yellow one is for staff working with addicts. Then we have an Alcoholic Book and a Staff Book for Alcoholics, and also a mental patient one, and they each have different pictures and a different approach.

All of the examples in the playlet in the drug patient book will refer to drug patients, and for the staff it will refer to the experience of the drug staff. When we wrote them we had to write them, really, "from inside the head," whoever it was we were dealing with. So with the drug patient we say, "You are now entering methadone, etc.," so it always depends on the point of view of the person who is in the program.

Mr. Hilton: I was quite interested in your remarks about discovering self-control developing. Could you say more on that? This seems to be in line with Dr. Assagioli's work.

DR. CHEEK: Oh, yes. Frank Haronian told me that I would find a very sympathetic group in terms of a number of things we are doing, that it is very similar to psychosynthesis.

We felt that the kind of self-control that people were beginning to talk about getting as a result of going through our program was the result, first of all of their gaining more control by being able to relax. When they could relax it put them in better control over the situations into which they got themselves. They could think clearly; they could act more reasonably and rationally, and they could comport themselves as they really felt they wanted to, rather than flying off the handle or getting into trouble.

We also felt that the more control that one has over one's own feelings or emotions, the better; for instance, people would say to us, "When I get angry, isn't it better for me to get into a rage and express the rage?"; and what we would say to them was, "When you have gone through our program you'll still feel angry if somebody has done you an injustice, but you won't have a lot of tension attached to it because rage involves the annoyance plus the tension that's built up."

But we teach people to stop and say "I'm angry but I'm relaxed, and I will do something constructive about this annoyance I have." It's that kind of thing; the control of your ideas; the control of your emotions by the self, by not allowing tension to take over.

Mr. Hilton: That was my second question, about how you develop the self apart from the behavior.

DR. CHEEK: I would agree that they do develop a stronger sense of self and a stronger sense of identity, because they feel there is something there that helps them. If they're drug addicts they themselves are not giving into the drug; they're not becoming something that's put into their body.

When they take the drug, essentially they themselves are lost as individuals. When they can control a situation and don't need a drug in order to control their minds; and don't let a drug control their minds or their bodies, there is more sense of identity. And they're usually very relieved to find that they do have that control of what is in their own head. It's usually a great surprise to them that they can do that with their own experience, because they'll often take a drug or depend on their environment - they're often very dependent individuals. When they discover that they can do these things, they're amazed.

Mr. Paul Horowitz: I was very interested in your statement about your discovery of reward and punishment as regards parents of schizophrenic children. Could you elaborate on what your findings were?

DR. CHEEK: We had them take part in specific little experiments, like we had one family whose son cursed at the dinner table. We had another family where the son spent 3 hours over a meal. We had another family where the son would stay in bed late in the morning and wouldn't get up on time--little disturbing things that the kids did; such as a girl who kept saying, "I'm ugly."

What we did was to get the parents, first of all, to make a decision about which bit of behavior they wanted to work on, and then we would get them to decide what would be rewarding to the child. The girl who kept saying she was ugly didn't get much attention from her father, and also liked to collect records. When she went through a week without saying she was ugly her father would take her out to the record shop and buy her a record.

We got the parents to make these decisions and to begin to work with these bits of behavior. What we found was--we had to tell the parents that if they were going to be good behavior modifiers they would have to increase the number of positive rewards to the child apart from the particular situation to be worked on. For instance, they would have to give them more attention, give them more affection, communicate more with them in general and then the reward system would work better.

So we found that the parents were giving a lot more attention to the children and more positive behavior, and the findings on a rating scale of patient behavior showed that the patient changed a lot in other things than the little bits of disturbing behavior the parents were specifically working on. There was more communication in the family; the children went out socially more; there were many, many changes generalized, in the sense that a number of things happened as well as the particular things, and the families would say, "Even his brother gets along better with him." Previously they couldn't leave the two of them alone because that would mean a terrible fight and a big uproar. So that communication and positive feelings generalized through the whole family.

Mr. Horowitz: You mentioned that reinforcing a child by taking it up while it's crying would tend to encourage it to cry. Possibly the previous experience of the parents of the schizophrenic children may have been to give in too consistently.

DR. CHEEK: Right. What was found was, with the schizophrenic families, that rather than a lot of positive behavior, we weren't really getting much on the part of the mothers. In the interaction study we found the mothers were not putting that much positive reward in the interaction. We felt that that was because the schizophrenics weren't reinforcing the mothers for giving the positive reward. When you give somebody a reward of attention or whatever, then you want something back; and the schizophrenics weren't giving anything back, and the mothers then were negatively reinforced, so the positive behaviors on the part of the mothers had actually dropped in those families. Often they're talked about as cold, but this might well be

because the schizophrenic hasn't been reinforced by the parents to give positive behaviors. So we told them in the beginning, as when you're working with autistic children, to sit and cuddle them and give them a lot of positive behavior, particularly touch behavior, but then zero in on the specific behavior you want to work with, and give that, every time, a hundred per cent attention; but don't give the reward for the behaviors you don't want. Give the rewards for things you want. If you want the child to talk at the dinner table,then,when the child talks,give it attention and talk to it. Don't just give it out for everything; give it for positive behaviors, but give it differentially for what you expect and want from the child.

But you are right, that it is possible that one can reinforce the wrong kinds of behavior, and then you're getting what you don't want.

We found with kids with temper tantrums - when we made observations - that the parents were reinforcing the temper tantrum, but that wasn't what we had advised. We advised giving a lot of positive rewards for what you do want.

Mr. Goldmintz: When you deal with the alcoholic husbands who explode at inappropriate times, you said you had some techniques for dealing with this.

DR. CHEEK: You use the technique of assertive training. Often the reason they explode is because when the wife does something they don't like, instead of being able to say calmly and rationally, "You're stepping on my foot," what they do is they hold it in. So assertive training involves a whole set of procedures which we spell out in the Work Book, and when you have the Work Book you'll see exactly what I mean.

Basically the advice that we give the individual is, first of all keep calm and look at the other person's point of view. Make a statement about, "I understand why you're doing so-and-so; however," and state your own position clearly. The other thing is that in some situations they just have to get out of them. Assertive training will not always work; you won't always get what you want by being assertive about it. If you have an addict living with his family who are destructive to him then maybe it's better for him just to get out of the situation.

The other thing is, we have a number of drug addicts who come to us from the ghetto and they say, "Isn't there ever a time when you should burn down the ghetto?"; and we say, "If you're going to burn it down, do it in a cool frame of mind. Don't do it when you're angry."

Mr. J. Richter: I'm wondering what techniques the addicts have been able to preserve?

DR. CHEEK: After they've worked on them, okay. We have found that the relaxation is something they continue with; we have reports of addicts relaxing other addicts in candy shops! That's something they like very much. They also report that they do continue the desensitizing, but they do it their own way. Many times they'll be in a situation and they'll flash their calm scene, or sometimes they will think ahead - if they have a job interview they'll sit and systematically flash the calm scene and the interview scene.

What happens is that they latch onto different things. One of them who had recently married got very involved with the business of behavioral control and tried it on his little four year-old new son! We have had them make comments, for instance, that they had never heard of assertiveness before. When they just learn the word "assertiveness" that makes a difference to them because they have an

alternative - it is appropriate to behave assertively, if you can be cool and if you don't have to fight. So we have had reports of their using the self-image a lot - females particularly seem to like the self-image training, and they continue with that after they leave.

Our followups usually indicate that any particular addict will select one or two techniques to play around with a lot. They like the Work Book, many of them take it away and reread it and give it to their family members to read, and they begin to talk about what's in it and try to modify the behavior of the family members, which seems to work very well for some of them.

They practically all report that they reread the Work Book and get a lot of use from it. They like the last lecture particularly, which is a meeting called "Guidelines," on how you use all the techniques; how you decide what you're going to do in such and such a situation. So they seem to spottily use the whole thing. The one that they don't talk about too much is the rational thinking; they don't like what takes place, and we feel that's partly our own fault - Ellis' work is a little complicated and a little different - and perhaps we have not simplified it enough for them; we haven't made it strong enough for them.

Mr. M. Freidman: What's the name of the last book by Ellis?

DR. CHEEK: He has a book called "A Guide to Rational Thinking," which is what we use basically. That's a very, very good book. I know people who have gone through his therapy program, and I'm very impressed by what Ellis says. It's something that's hard to encapsulate as a technique in one lecture. We've had an enormous amount of enthusiasm from people, but I don't know that they're really using it that much. I think we haven't done well enough ourselves.

Question: How do the relaxation techniques work with adult schizophrenics?

DR. CHEEK: Just fine.

Question: Concerning the high anxiety and things like that.

DR. CHEEK: We worried about that and wondered about it. Maybe because of the high anxiety it does work very well. In fact, we were amazed by it, because we thought that some of the patients were so disturbed and anxious that it would be very difficult to get them into relaxation; but quite the reverse, they love it.

You have to have a group leader who approaches them very gently and very slowly and reassures them. Sometimes they want to do it with their eyes open because they're frightened or anxious, and we let them do that. The other thing about relaxation is that you run into people who won't get into relaxation immediately, and then we have private sessions--although most of our work is done in groups--at which you work with the individual very slowly and establish the calm scene that you're working with and get them into the relaxation.

We haven't really had that much trouble getting them into a state of relaxation. That's not out severest problem. The major problems really are those with the addicts; you have to have group leaders who are very strong individuals to handle the groups, because they usually come in very angry and hostile and defensive. We find that the more difficult they are at the beginning, once they go under, the easier they are to handle. They become strong adherents, as in the Pavlovian situation sort of. You have to handle every situation that comes up in the group, or with a

patient,with behavior modification; that's one thing we insist on, because in that way we illustrate what the program means, and that you can use it.

Mrs. Hilton: You just mentioned that they were hostile to begin with. Have they already expressed a desire to cure themselves, or do you have to work on that aspect first?

DR. CHEEK: The addicts who come to us are already in the methadone program, so they have really expressed a desire. There is some motivation to cure themselves; they're not just there to detox and get their dosage down. Some of them might have come from prison and might have chosen to be there rather than to have a more extended prison sentence. So the major problem is not so much that they want to do something about their lives; statistically most of them do. The problem is that they think they can do it with a drug, and that that, as opposed to heroin, is a new answer.

They also don't like therapy and therapists. They've had it, you know, and they just don't want to be bothered. The trouble with most of them is that they have been exposed to therapeutic communities, and they haven't liked encounter and they haven't liked sensitivity. They tell us things like, "I just didn't like it; everybody was screaming and I had to stand in the corner with a dunce cap on," this kind of thing. One woman said, "I had to stand in front of a mirror and say to myself 'I am a whore', and how would you like to do that if you were one?" So they're very anti-therapy when they arrive. The female addicts, particularly, are very tough customers, and they can be very rude and difficult.

Mrs. Hilton: More than the men?

DR. CHEEK: Yes. The women are much more difficult to work with than the men, a hundred times more difficult.

Mr. Freidman: Would you mind just giving a little list of the techniques you've been talking about?

DR. CHEEK: Surely. The muscle relaxant; lightness; heaviness; desensitization; self-image training; behavior analysis; behavior control; assertive training; rational thinking, and that's it.

Mr. Hilton: Could you speak briefly about your self-image training?

DR. CHEEK: It begins with the relaxation, and what we attempt to do is to get the individual to develop an image of how they would like to be in a situation that would ordinarily be problematic, and this is to take place a month, two months from the present date. Try to get them not to want to be President of the United States, seeing themselves giving an inauguration speech, but to have an image that is practical and realistic and positive. For instance, with alcoholics we often do things like having them image being offered a drink at a party and how they refuse it. Or, with people who are nervous about social occasions,being present at a party and walking around and talking.

You get them to image things rather completely, not just to image the beginning of an interaction, but to go through the whole thing and doing it well. We feel that in this way they can model on themselves, and they will already have gone through the situation, so they can learn from their own behavior. It's a kind of pre-role playing.

Mr. Pelaquin: Could you speak about the follow-up, about the results?

DR. CHEEK: With the drug addicts, what we do routinely is to have this pre- and post-evaluation. In the post-program evaluation, we ask them which parts of the program they liked, and we repeat this at three months and at six months. In that way we find out which techniques they're still using and what they're doing. The six months' evaluation was a measure of the outcome with the drug addicts obtained from social workers' reports and how they were functioning. And the social workers were asked to rate them on a three-point scale, depending upon the level of function. The social workers knew intimately how they were doing because they were coming in for the methadone every day, so that way we could have a fairly good evaluation of how they were functioning.

We evaluated our treatment group for the individual, as opposed to a group who went through the unit just before we instituted behavior modification, and I don't have the figures right here with me, but the more meetings they attended the better the outcome, and the outcomes are matched statistically and are better than the previous group; notably better.

When I first went through the program, they were really not functioning that well; it was our first try, so we were not doing as well as we subsequently did. After that I think we sharpened up and improved a lot and instituted a number of better things. Now I think our outcomes would be even better. But the changes on the measures were really remarkable.

What we would like to do is a really good evaluation study with our own interviews and staff ratings and a number of other things. What we're doing now is, rather than going back and evaluating and developing new programs, we keep rewriting the Work Book for a new group, and trying it out and doing kind of pilot studies and also rewriting for new staff programs.

We feel that if we stopped and evaluated, and if we waited for money before we tried to do it, it would take years and years. We feel that we want to do something now, while the patients, the drug addicts and the alcoholics and the staff are there. We're getting very positive reactions, and we figure we can't be doing them any harm. That's one thing about the program; you will notice that we have a number of behavior therapy techniques, and we don't have, for instance, implosion therapy, which is where you build up a level of anxiety.

The reason we don't have anything like that in it is because the techniques are used by paraprofessionals. We're not doing therapy; we're doing rehabilitation. We're teaching people, who will teach addicts or alcoholics or whatever, techniques they can use to cope with their own life problems.

Our group leaders are trained in case a problem comes up - like the agoraphobia patient, where the woman who was the group leader would never have worked on it if she had known; she would have gone to the psychiatrist and said, "Mr. So-and-So, a difficult case of agoraphobia is here, and if you wish to use behavior therapy you might use such and such a technique." The psychiatrists at the Institute don't use behavior therapy techniques; they are typically not oriented in that direction, but she could have told him how to do it, and he could have done it, but she wouldn't have done that herself, and we wouldn't have encouraged her to.

Mr. Hilton: Can copies of the study book be bought? Are they available for anyone?

DR. CHEEK: We sell them for two dollars if they're picked up at the Institute and three dollars if you order them and we have to mail them. If you don't have money - if your institution doesn't have money, we give them away, but if anybody does have money we take it.

Dr. Haronian: Behavior control is one of the things that you teach in this sequence. Could you tell us how you teach this?

DR. CHEEK: Because our program is one that emphasizes self control we have been instituting self-contracting procedures. The individual may be someone who suffers from overweight and makes a contract with herself, and if she eats more than a thousand calories on any particular day the next day she does not make any telephone calls or look at TV, whatever it is that rewards her. So that individuals will set up contracts with themselves to control their own behavior. We also teach contingency contracting between individuals, where a husband and wife, for instance, might wish to set up a contract whereby the wife will look neat and tidy if the husband doesn't nag, etc.

You work both with positives and negatives, like nagging produces untidiness and not nagging or praising produces neatness. So you always work with both a positive and a negative in that sense.

Basically, our leaning on behavioral control follows the pinpoint, record and consequate technique. A large part of it is devoted to that and we teach them how to pinpoint behavior, to do it experimentally, to record and change the consequences. In particular, if you're working with any behavior you work with the positive and negative aspects of it; rewarding for what you want and withdrawing rewards.

The other thing is that in the Skinnerian terminology there is positive reward, a positive reinforcement. Negative reinforcement is actually withdrawal of the positive. Punishment is the application of something obversive. We prefer positive; we use negative reinforcement and we avoid punishment wherever we can because it's not that effective.

Dr. Cooper: On behalf of the Psychosynthesis Research Foundation I want to thank Frances for a delightful presentation. (Applause) I think it fits in exactly with what we've been doing and working with, and I see it overlaps with a lot of the work we're doing at the penitentiary. Thank you.

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