DIFFERENTIAL RELAXATION AND COGNITIVE RESTRUCTURING IN THERAPY WITH A "PARANOID SCHIZOPHRENIC" OR "PARANOID STATE"

To the extent that a psychiatric case is considered qualitatively different from so-called normals, afflicted with organic and/or psychic diseases which underlie the observable deviant behavior, one might tend to overlook in therapy the various procedures in general experimental psychology for modifying behavior. On the other hand, if one assumes that "mental illness" entails a categorization made in relation to social norms (cf. Bandura & Walters, 1963; Szasz, 1960; Ullmann & Krasner, 1965), an approach similar to the study described below might be undertaken.

CASE HISTORY

The patient was a 44-yr.-old white, married, male, Protestant truck driver, admitted for the first time to the psychiatric division of a large Veterans Administration Hospital. His history as summarized here is extracted from information obtained by the psychiatric resident who, 2 mo. later, referred the man to the author. Upon admission he had been diagnosed by the OD as "paranoid schizophrenic," although this diagnosis was changed by the resident to "paranoid state."

He had come to the hospital upon his wife's insistence, and structured his concern as finding out why he had twitches over his right eye, heart, and solar plexus. After a medical discharge from the service in 1944 for an eye imbalance, the patient frequently encountered difficulties arising from actions and schemes having a "paranoid flavor."

Mr. B's psychiatric problems seemed to begin 4 yr. prior to hospitalization, with the suicide of his only brother. It was during this time that he began to be preoccupied with "pressure points" over his right eye, which he interpreted as being caused by a spirit either inside or outside his body, helping him make decisions. His marriage of 3 yr. held, from the very outset, little more than continuous arguments with his wife and her family. He would often be squelched by being called a "mental case."

Upon admission his speech was described as tangential, with loose associations, its with grandiose schemes and persecutions by others, but centering around information from his pressure points. There was no evidence of hallucinations.

Up until his referral to me, Mr. B. had participated in group therapy on his ward, as well as the usual clinic assignments. He had been maintained on acetophenazine ('Tindal' ), 20 mg. tid, which, he felt, had quieted him down somewhat. However, there had been little change in his "paranoid delusional system," in spite of the removal of a cyst over his right eye, an operation which he had requested and been granted in the explicit hope of eliminating his pressure points.

THERAPY

The man was referred to me for "behavior therapy" to deal primarily with his pressure points, which were troubling him not only for the reactions which discussion of them elicited from others, but also for the fact that he was beginning to receive conflicting messages from them.

In the first session, when asked to relate as many instances as he could of their occurrence, the patient brought up several situations which were clearly anxiety-provoking, e.g., losing his way on the freeway, being late with a truckload of goods, and then, along with severe anxiety, receiving "messages" of which turns to take. In every case Mr. B. volunteered that he had been extremely tense and upset in these situations. Towards the end of the hour, I suggested to him that, while he had his own ideas about the nature of these sensations, he entertain another notion. At this point I requested him to extend his arm, clench his fist, and slowly bend his wrist downwards so as to bring the closed hand toward the inside of the forearm. A definite feeling of severe muscle tension was thereby produced in the forearm, at which time he smiled slightly and muttered that it felt very much like a "pressure point." I then suggested that perhaps these sensations were purely natural phenomena, a consequence of his becoming very tense in particular kinds of situations. To appeal to his interest in philosophy and anthropology (which may account for his construction of the sensations), I cited Malinowski's (1948) discussion of how Man's need to explain phenomena probably gives rise to mystical explanations in areas where scientific, naturalistic explanations are lacking. To test my hypothesis, I asked him to undergo training in deep muscular relaxation, designed to reduce his generally high level of anxiety and especially to determine the nature of the pressure points and perhaps to control them. The first session was closed with a half hour's training in relaxation by means of a tape recording (Davison, 1965a, 1965b; Jacobson, 1938; Lazarus, 1963; Paul, 1966; Wolpe, 1958; Wolpe & Lazarus, in press). After completing the relaxation exercises, the patient reported spontaneously: "I feel relaxed inside like I haven't felt in a long time."

There were eight additional sessions over a 9-wk. period. During these meetings, Mr. B. was instructed in differential relaxation (Davison, 1965b), in order to enable him to eliminate pressure points when they arose, as well as to reduce his maladaptively high levels of anxiety. He began to report on the occurrence of pressure points at the hospital, all of which confirmed the hypothesis that we were testing; he was also succeeding in reducing them markedly by relaxing. After 1 mo. he began to refer to them as "sensations," and his conversation generally was losing its "paranoid flavor."

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In the fourth session I initiated a game of black-jack with him, feeling that it would provide the occasion for a pressure point. This, indeed, turned out to be the case, and being able actually to produce the sensation into a manner analogous to real life and then to eliminate it by relaxing provided further evidence, for both of us, as to the utility of both the hypothesis and the therapy.

During a week-long leave of absence at home, Mr. B. began to assert himself to his wife and in-laws, as had been suggested; the favorable effects of this behavior, in terms of clarifying some misunderstandings, were augmented by his feeling that it would provide the occasion at home.

For the remaining 3 wk. of his hospitalization we spoke often about the effects which our behavior has on others; how these effects can in turn influence our own feelings; about the advisability of asserting oneself in the appropriate situation so as to avoid the buildup of tension and often the subsequent, sometimes "crazy" outbursts; and especially about the benefits to be derived from the control of one's tensions through differential relaxation.

A follow-up of 6 wk. was obtained by letter. Mr. B. reported that the "pressure points" (his quotation marks) were far less frequent, fairly amenable to relaxation, but most importantly, of no concern to him. He has been far less tense generally and has managed to complete a correspondence road-building course which he had been able to work on very little the previous 2 yr. His marital relationship has also shown continued improvement.

**DISCUSSION**

As with every case study, variables beyond the control of the therapist no doubt played a role, e.g., the ward program, the home visit, and so on. On the other hand, there are good reasons to assign only minimal importance to these factors. The patient had been taking Tindal, as well as participating in the ward program, for 2 mo. prior to the therapy described here, with no significant change in the major complaint. Moreover, he had failed to take the even in the small dosage prescribed, during most of his leave of absence, without losing ground. In addition, the orderliness of his response to therapy is difficult to construe as fortuitous: specific situations were designated as giving rise to the pressure points; an alternative construction was offered; it was tested by applying relaxation to them, as well as by creating them through a contrived decision situation and then eliminating them with relaxation.

It would appear that improvement was due, in greatest part, to the combination of differential relaxation and cognitive restructuring of the pressure points. In addition, the general use of relaxation is assumed to have made the patient less tense overall and perhaps also to have occasioned "in vivo desensitization" of various aversive stimuli (Davison, 1965b; Lazarus, Davison, & Polefka, 1965). The reduction of tension and the shift of ideational and verbal behavior from socially unacceptable to socially approved patterns seem to have consolidated the improvement by changing the reactions of others to him, thereby setting the stage for still further gains.

In this short report one can only allude to earlier work with paranoid cases. In spite of radically different orientations, such workers as Cameron (1959), Salzman (1960), and Schwartz (1963) seem to agree strikingly with the present therapy to the extent that the paranoid's constructions of the world should be subtly challenged, with alternate explanations being offered.

Is this "behavior therapy?" Surely an answer depends on one's definitions. As techniques derived from "modern learning theory" (cf. Eysenck, 1960), especially from studies in classical and operant conditioning, this certainly is not the case. The intentional appeal to cognitive processes points to this therapy as being perhaps "neobehavioristic," in the sense used by Peterson and London (1965), who report the first case in the behavior-therapy literature which explicitly extends the therapist's concerns into cognition. Perhaps it is more fruitful to characterize the treatment as therapy which makes no assumptions about organic or psychic disease processes, and which therefore can, with some optimism, employ procedures analogous to experimental manipulations from the general area of psychology, as opposed to psychopathology.

**REFERENCES**


