CLINICAL NOTES

CHRONIC BRAIN SYNDROME TREATED WITH TRANSACTIONAL ANALYSIS*

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For the past two years at VAH Roseburg, we have been using Transactional Analysis in the treatment of neurotics, character disorders, manic-depressives and schizophrenics in remission. We have had little experience with patients with chronic brain disease and thus when the patient R. S. came to our attention, it was with some interest that we followed his course for over a year.

This patient is a 45 year old, white divorced male who was admitted to our hospital for the fifth time in January of 1960. His primary complaint at this time was convulsive seizures. He had had numerous hospitalizations at other hospitals as well as ours over the past fifteen years, both for seizures and for assault with a belligerent behavior. He was commonly diagnosed "Chronic brain syndrome associated with convulsive disorders, with behavioral reaction manifested by temper outbursts, hostility, aggressiveness, low tolerance for frustration and mental deterioration." He also had a low tolerance for alcohol. The patient draws 100% pension for disability because of a shell injury with skull fracture and concussion in 1943 while in the South Pacific. He was in the Marine Corps from 1942 to 1945, was married shortly after his return from overseas, had three children, was divorced in 1948. He was first hospitalized in this country in 1947 in a State Hospital and has been in and out of both State and Veterans Hospitals frequently, and almost constantly, ever since. He has had epilepsy, with grand mal seizures and psychomotor seizures since April of 1949. During the past ten or twelve years he has been in trouble frequently with the police because of assaultive, belligerent behavior both when under the influence of alcohol and while sober. At one time he attempted to kill his mother by throttling her; another time, he took a gun out of a policeman's holster in a small town in the northwest, and proceeded to fire shots randomly about the main street.

On admission in 1960 his electroencephalogram was grossly abnormal, and compatible with generalized severe brain damage, especially localized in the midfrontal area with spread to the entire cortex. There was a focus from the frontal and anterior temporal area. The patient has been on dilantin and phenobarbital or similar drugs for many years. He was taking thyroid as well — one grain three times a day — because of a rather severe adult myxedema.

Psychological testing at the time of his admission in 1960 demonstrated an extreme lack of frustration tolerance, and a drop of 20 points in his full Wechsler since being examined five years previously: 33 points deterioration in performance and 8 points deterioration of vocabulary. Since April of 1961, he has been on daily doses of thyroid gr. iii and dilantin 100 mgm. He has also been given occasionally chloral hydrate at bedtime, darvon for headache, and benadryl p.r.n, for itching. He has had no tranquillizers since 1962; before that he occasionally required an injection of thorazine when he became extremely assaultive or belligerent.

In February of 1962 I started a group therapy session three times a week on the ward. Although criteria for selection were very loose, this patient was left out of the plans. At the initial session ,however, he wandered in and sat down and was permitted to stay. During the first hour, he listened to what was going on for a time and then asked very politely if he might say something. I chose to treat the transaction involved here rather than the content and asked him why he felt it was necessary to ask if he might talk when the other patients were all speaking quite freely. The patient stated that when he was a small child he was not per-

*See Berne, loc. cit.

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mitted to speak unless his father allowed him to, and still always asked permission to speak. He was one of the youngest of 18 children. He was reputed to have had many temper tantrums when he was a child and many fights while he was growing up. Over a period of several weeks of group therapy the patient's Child emerged more and more clearly as potentially assaultive and belligerent. It became evident that his pathological behavior in recent years was similar to his behavior as a child. The group wondered if this was not still the same child acting out in him. We started to encourage his Adult to control this Child better; to look at his childlike actions and distinguish them from Adult behavior. This concept appealed to him. He seemed to understand it rather clearly in spite of his deterioration and showed a marked change in behavior over a period of two or three months.

During February and March, he was kept on the hospital grounds except for attending Church Sundays with another patient, or with a volunteer. Over the next three months, he was allowed to go downtown by himself on passes, then to stay overnight one night, and later his passes were increased to 72 hours.

During this entire time, there was no repetition of his old bellicose behavior; he did not get into any fights nor assault anyone. He became outwardly amiable and friendly, although he had many episodes of brief anger which he referred to as "his Child." Each time this anger would flare up within him, he would, in fact, talk to himself and say such things as "Now, little Raymond, let's just take it easy."

The patient eventually convinced his family that he was no longer the same alarming individual, and they began to make efforts to help him get out of the hospital. In August, 1962, after seven months of group therapy, he was given a 7-day leave of absence to visit his sister; following that, he made several visits to other members of his family in various parts of the state. In October he was released on Trial Visit for 90 days, reporting to the hospital every 30 days to check on his progress. This visit was extended indefinitely. He still reports to the hospital every 30 days and is getting along quite well. He is now working in a gas station, and has been in no difficulty with the police since his release.

This report illustrates the use of Transactional Analysis in a patient with chronic brain syndrome and a history of assaultiveness and belligerence. The patient had no changes in medication and is still on thyroid and dilantin. He has had no psychotherapy (except his check-ins once a month) since August, 1962. He still refers laughingly to his Child and remembers when his Adult did not have control over his Child.

The writer feels that the change in his behavior is primarily due to his understanding of his Child, and his conscious efforts to control childlike behavior and act Adult. The primary goal in this case was to modify the patient's behavior so that he could adjust to living in the community without frequent outbursts of violence, and this goal has been satisfactorily achieved.

LATE BULLETIN

A newly uncovered game is now under study: "I Can Recognize That," played by patients with doctorate degrees and by therapists.