one-to-one relationship, following a pattern of more primitive oral dependency wherein a person, the "feeder," is substituted for the pill. One might wonder whether the patient would adopt the pattern of overindulgence in the person and then attempt to break this habit when closeness became too great, leading to a repeated cycle of overindulgence and flight.

The authors state that the development of transference was discouraged, but one might question whether transference phenomena can be discouraged at all. It is true that a group membership of 15 or so would limit the intensity of familial phenomena, since it would permit better distancing and hence less arousal of the anxiety generated by closeness that is a great problem for the type of patient described. On the other hand, it could create a problem if the total group membership was so large that there was a constantly shifting group membership, as was implied, or if the patient was in the similar position of finding himself in a group only some of whose members were ever there at one time. Furthermore, the rotation of leadership is a fiction based on formal role playing. It is doubtful that actual leadership can be rotated by "assignment." There is a large body of literature in social psychology that discusses this problem. In addition, there is a type of patient whose transference may not be tied to a particular person but is rather applied to "any port in a storm." There is, for example, the relatively new social phenomenon of people who rotate from one encounter group to another as they read about them in the newspapers.

If these patients are indeed changing because they are receiving a new pattern of gratification and understanding through participation in the family setting, a controlled study should include the results (measured along the same parameters) for a group whose members would continue together beyond the particular inpatient treatment. I doubt that new values and characterological traits could be incorporated during this second time of participating in a family. A more plausible explanation for the behavioral change in the members of these groups is: 1) contingent fear of the ever-present punishment meted out by the group leadership, 2) gratification of the dependency needs that give rise to addiction, and 3) continual expression of the hostility that had been directed elsewhere in society before becoming a member of this group.

There is no doubt that this is an excellent form of treatment for the type of patient described here and that it has a greater chance for success than the more "traditional" modes, but I question whether the "traditional" modes are used any longer.

The Psychodynamics of Quitting Smoking in a Group

BY JOHN S. TAMERIN, M.D.

The psychodynamics of quitting smoking were identified from observations of small groups established to study the cessation process. Three major issues emerged: 1) the expectation of failure, 2) the feared loss of control, and 3) the affective significance of the loss. Belief in success was a necessary precursor to actual success. A feared loss of control was common but seldom materialized to the degree anticipated. The dynamics of grief with associated tearfulness were central to the process of quitting.

It has been estimated that over 300,000 excess deaths occur every year in the United States as a result of cigarette smoking (1). The seriousness of this problem has resulted in a massive public health campaign aimed at communicating the hazards of smoking to the general public (2). As a result, 90 percent of the adult population now recognizes the dangers of smoking (3). However, despite an intellectual awareness of risk and a desire to quit, millions of smokers are unable to stop smoking. The same survey (3) found that 22 million adults who are currently smoking cigarettes made at least one serious but unsuccessful attempt to quit during the four years between 1966 and 1970.

In view of the seriousness of smoking as a

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health problem and the apparently involuntary aspects of this behavior for many smokers (4), it is striking that there has been so little psychiatric interest in smoking. Specifically, the psychodynamics associated with smoking and the cessation of smoking have received virtually no attention in the scientific literature. The purpose of this study is to examine the psychodynamics of quitting smoking as they emerge in groups specifically established to explore and study the cessation process.

Method

The study was conducted at the Silver Hill Foundation, a private psychiatric hospital, with three small groups of smokers from the community who volunteered to participate in a research program designed to help them quit smoking. The groups met five mornings a week for two weeks; the meetings lasted for an hour and a half.

The subjects (N = 16) were primarily college-educated middle-aged women (mean age = 45 years), and with one exception were housewives. All were heavy smokers (mean = 33 cigarettes per day) of many years duration (mean greater than 20 years). Each subject had made at least one serious and unsuccessful attempt to quit on her own. None of the subjects reported overt psychiatric symptomatology before the initiation of the study. None were in psychiatric treatment or contemplated the need for it.

At the initial meeting the subjects completed an intake questionnaire and the tests in the Smoker’s Self-Testing Kit (5). They were then instructed to halve their cigarette consumption on each successive day, stopping entirely by the fourth day of the study. The meetings were led by a dynamically oriented research psychiatrist and focused on issues central to the process of giving up smoking. A follow-up interview was conducted with each subject three months after the program ended. In addition to the 16 subjects reported here, nine other smokers attended one or more meetings but did not complete the two-week program.

Results

Three major findings emerged as central to the problem of quitting: 1) the expectation of failure, 2) the feared loss of control, and 3) the affective significance of the loss of cigarettes.

The Expectation of Failure

The expectation of failure was evident in each subject. This feeling was clearly expressed by one woman at an initial meeting: “I don’t really believe I can stop. I’ve failed so many times before.” On the tests in the Smoker’s Self-Testing Kit, these subjects scored extremely low (mean = 3.7 with a scale range of 3 to 12) on the factor measuring “capability for stopping.” Conversely, the subjects scored very high on factors measuring “psychological addiction to cigarettes” (mean = 13) and “use of cigarettes to reduce negative affect” (mean = 12.8), on a scale with a range of 3 to 15. This constellation of scores reflected the anticipation of extreme difficulty in quitting and general feelings of inadequacy to achieve the desired goal. The expectation of failure was particularly painful for these subjects, who clearly recognized and accepted the health benefits of quitting. Five of the 16 subjects had either emphysema or coronary artery disease, and on a factor measuring “value of stopping,” the total group mean was 10.6 on a scale of 3 to 12.

Fears of failure led many subjects to conceal their attendance in the program from their families, particularly from their husbands. Many perceived their husbands as being highly critical of their inability to stop smoking. In some instances this had already led to patterns of “closet smoking,” with regressions to adolescent practices of surreptitious smoking in such places as the bathroom, garage, or basement. Low self-esteem was generally evident. Repeatedly, the feeling was expressed by subjects that they were missing some quality that others possessed: “I know I should. I want to quit, but I just don’t have what it takes.”

The Feared Loss of Control

The fear of losing control in areas as diverse as cognition and motor function, affect, and overall personality organization was frequently expressed. In cognitive and motor spheres, these subjects expressed fears of being unable to concentrate, organize thoughts, remember, drive a car, focus on housework, or even write a letter—all of which, in the past, had been intimately associated with smoking.
The fear of losing control of affect was particularly striking. Repeatedly, subjects expressed anxiety about the possible emergence of uncontrolled hostility. It became evident that cigarette smoking had been used by many as a prosthetic technique—to keep the lid on—and the fear of what might happen if they were to quit was clearly revealed in such remarks as: "People say I'm very patient and that I never get angry. It's because I have these tranquilizers in my pocket. They keep my anger so suppressed that it doesn't come out at all. I think I've used smoking like a blasting mat—you know, the thing they put over a place where they are dynamiting, which keeps the rocks from flying off in all directions and hurting people." A corollary of this fear of expressing hostility was the general preference among these subjects to adopt a masochistic solution to their anger within the family setting. One subject remarked, "Getting angry hurts others. When I smoke I feel a release in my whole body from anger and tension, and the cigarette won't hurt anyone but me."

Much of the concern about losing control of their anger focused on the role of these women as stabilizers within their suburban families—often a role that they accepted with more than a little ambivalence. One subject remarked, "Our husbands can explode when they come home, but we can't. We are supposed to absorb the frustrations of everyone else in the family and still maintain the image of superwife and supermother. I don't want to scream and yell at the family and hurt people terribly, so I smoke." Another woman even went so far as to say, "I'm afraid the family will fall to pieces if I stop smoking and lose control."

Some subjects anticipated complete psychic and personal disorganization with the cessation of smoking. One subject, waxing poetic but obviously reflecting the depth of her need, remarked, "Cigarettes are the rudder on my sailboat. They stabilize my life. In the toughest day or the darkest night, cigarettes are always there."

A number of the feared changes did occur with cessation of smoking. Subjects reported lapses in concentration, a problem remembering things, occasional difficulty when driving, and in some instances, a definitely altered threshold to the effects of alcohol, so that amnesic episodes (blackouts) were reported following ingestion of small amounts of alcohol. Regarding anger, many subjects found themselves not only more irritable and more aware of their own rage, but more likely to express anger than when they had been smoking. One remarked, "I've seen a lot more rage in myself since I've given up smoking." Another said, "I really blew it. Last night I threw a hamburger at my husband." A third subject remarked, "I felt furious last night, completely out of control, like I was having a seizure. I've never felt this out of control in my life." Even more graphic and symbolic was another woman's statement: "Yesterday I was so angry I felt as if I'd bite the neighbor's mailbox."

Despite the fact that some loss of control did occur, this generally lasted no more than a few days and was never as serious as the subjects had feared. Furthermore, it was always reassuring when the brief storm blew over. One woman remarked, "I'm relaxed today and really encouraged that I didn't explode or go crazy or any of those things I expected."

The Affective Significance of the Loss of Cigarettes

A transient period of grief with considerable tearfulness appeared as an almost routine clinical accompaniment of the cessation process. One subject said, "I usually love to cook, but I haven't cooked all week. I have almost no control of my tears. I'm crying all the time." Another subject remarked, "I expected that I would feel exhilarated at stopping but I'm not. I'm depressed. I feel sad and I'm sleeping a lot." The depression was so pervasive in each group that, on the day the subjects were to stop smoking, they all looked as if they were attending a funeral.

The dynamics of grief and loss appeared to be central to the entire cessation process. When these subjects finally contemplated a future without cigarettes, the extent of their emotional involvement became evident. One remarked, "Smoking has been a close part of my life for over 30 years. I smoked before I met my husband. It's a dear friend." Another said, "I think my cigarettes are more like a lover than a friend. I see this as a terrible personal loss." The permanence of the loss was particularly difficult to bear—one subject expressed the feeling of the group when she...
said, "The reason I'm so sad is that I know this time it's forever."

Subjects also became increasingly aware of how they had used cigarettes in the past as a companion and defense against experiences of loneliness or rejection. One subject remarked, "I don't see the cigarette as evil. It personifies all the things I need. When someone turns his back on me, we are together. It takes the sting out of a rebuff. I don't want it to disappear." Another said, "I was alone waiting for my daughter. I lit a cigarette, and I felt I wasn't alone anymore."

**Discussion**

Can one generalize about a large group of cigarette smokers from findings with a sample that is relatively small (N = 16) and obviously skewed from the point of demographic and socioeconomic variables (i.e., upper-middle-class, well-educated suburban housewives)? A recent study on a larger and more diverse sample of smokers from another cessation program in Philadelphia (6) revealed a strikingly similar profile on the Smoker's Self-Testing Kit. As in this study, there was a high score on the factor measuring "value of stopping," clearly suggesting that the educational aspect of the antismoking campaign had been successful. Moreover, a similar pattern of high scores on "psychological addiction" and on "use of cigarettes to reduce negative affect" in combination with an extremely low score on "capability for stopping" indicates that there are now a growing number of smokers who need psychological rather than educational assistance.

In treating cigarette smokers, the first problem that must be dealt with is their overwhelming expectation of failure. Schwartz and Dubitzky (7) found that feelings of low self-esteem correlated with an inability to stop smoking. A national survey of smokers (8) revealed that the anticipation of failure was associated with a subsequent lack of success in quitting. The initial goal of treatment, therefore, must be to help smokers gain the belief that they are capable of succeeding in this area. In this study, it was repeatedly observed that belief in success was a necessary precursor to actual success.

The first step in this process, particularly in a group setting, is to help smokers who feel guilty about not being able to quit recognize that they are not unique and that there are others just as addicted, just as frustrated, and just as unsure about their capability for stopping. Second, the mechanism of identification with others going through the same cessation process is essential to recognizing that the process is not as overwhelming as the individual smoker may have anticipated, and that "if they can do it, I can do it, too."

The relevance of peer identification to belief in one's own capability for quitting has important implications for mass media approaches. Since continued smoking may in many instances be related to fears of failure, messages to influence this behavior are more likely to be successful if they come from "average" smokers who were able to quit in spite of extreme anxiety and fears of failure. The present tendency to use movie stars or white-coated physicians as models for identification does nothing more than to annoy and frustrate the helpless and self-depreciating smoker, without in any way enabling him to feel that "if they can do it, I can do it, too."

The groups in this study were so successful in providing support, empathy, encouragement, and the opportunity for shared identifications that by the end of the two-week period, the sample as a whole had reduced their average daily consumption of cigarettes from 33 to 1.5 per day, and 11 of the 16 subjects had stopped smoking entirely. With the termination of the groups considerable backsliding occurred, however, so that by the three-month follow-up the average daily cigarette consumption was up to 14 a day. Although five subjects (31 percent) were still not smoking, an equal percentage had returned to their previous level of cigarette use. The problem of recidivism following group termination would suggest that, just as in the area of alcoholism, long-term support is indicated, and that a voluntary, nonprofit organization modeled in some ways on Alcoholics Anonymous might be useful.

The central role of cigarettes in the defensive structure of the chronic smoker explains the intense fear of loss of control when this act is abruptly terminated. The smoking cessation group can be particularly helpful in this regard by reducing anxiety through shared fantasies of loss of control. In addition, the group enables the individual to relax his or her own rigid controls and permits not only greater affective expression but even lets
temporary loss of control occur.

The significance of smoking as a means of controlling affect and regulating psychic equilibrium has implications not only for smoking cessation groups, but also in the psychotherapy or psychoanalysis of any patient who smokes. In view of the ubiquity of cigarette smoking, the importance of this activity in the life of the smoker, and its compulsive, risk-taking, and addictive aspects (4), it is striking that psychiatrists have paid so little attention to this act. What amounts to almost a selective inattention may be related to the unusually high prevalence of cigarette smoking among psychiatrists (9), or possibly to Freud's own addiction to tobacco (10).

More likely, it is related to the fact that, until recently, cigarette smoking has not been perceived as unhealthy to society or ego alien to the individual. Whatever the cause, the tendency to regard cigarette smoking as a relatively unimportant behavior or habit, hardly worthy of the same serious attention and analysis as a neurotic symptom, a sexual perversion, or a compulsive act, deprives the smoker and his therapist of a unique opportunity for the reexamination and working through of unresolved adolescent conflicts.

For many heavy smokers, smoking was instituted in adolescence as a developmental defense against stress; as a means of coping with drives and affects, particularly in conflictual social situations (11); or as an attempt to deal with anxiety arising out of identity conflicts (12). Cigarette smoking may also be initiated during adolescence with a feeling of defiance for authority (13). Cessation of smoking may be helpful in opening up these strong and flexible defenses, this may provide an unusual opportunity to uncover conflicts previously obscured and masked by compulsive smoking. On the other hand, in the borderline patient, it is equally important to recognize that precipitous cessation of smoking may be a profoundly disorganizing experience that may throw the individual into frank psychosis (14).

Regarding the concept of loss, it was generally observed that the recognition, acceptance, and working through of the loss was almost a necessary prerequisite to a successful outcome in these groups. One woman remarked, "I recognized that this was my pal, whether at a party or in a catastrophe. Once I realized that, I felt I could give it up." The working through, however, was invariably a painful process. Subjects generally agreed that they had never before in their lives given up anything as meaningful or with as much pain. The group was particularly helpful in providing a setting where individuals could express their grief and pain without feeling strange or abnormal. In fact, the experience of crying in the group became normal and natural in a setting with others going through the same process. Furthermore, the unique intimacy of these groups of persons with a common goal and facing loss together provided genuine concern and support, which decreased the intensity of each subject's individual suffering.

There is little question that cigarette smoking statistically represents a form of extreme risk-taking behavior (15). It is important to recognize, however, that statistics may be far less meaningful to the chronic smoker (even one with emphysema or coronary artery disease) than the immediate threatened loss of "a dear friend" (the cigarette). For most of the women in this study, and for millions of other smokers, cigarettes represent one of the few consistent and stable objects in their lives. One subject remarked, "My husband travels. My youngest son is now off to college, and I'm home alone. A cigarette is really one of my best friends. I don't know how I could possibly give it up." Anyone who works with the chronic cigarette smoker should be sensitive to these dynamics and must be prepared to deal with the affective consequences of loss that may result from quitting.

In conclusion, certain dynamics that appear to be related to the process of quitting have emerged from a study of 16 women who were chronic heavy smokers in a group cessation program. In order to determine whether these dynamics are meaningful and relevant to the majority of the estimated 9.5 million heavy smokers in America (16) (i.e., adults who smoke at least 30 cigarettes a day), further clinical studies in this area must be conducted.

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The differences between reaction to object loss in childhood and adolescence, loss of a parent is dealt with by denial, blocking of affect related to the parent's death, increased identification with and idealization of the dead parent, and persistent unconscious fantasies of an ongoing relationship or reunion with the dead parent (1). Adults react in the manner described by Freud, with gradual and painful emotional detachment from the inner representation of the person who has died (2). Freud's notions have recently been reconfirmed by Clayton and associates (3) in a study of bereavement in adults. Depressed mood, sleep disturbance, and crying were the symptoms experienced by more than half the study group immediately following bereavement. In a follow-up study within three months, 81 percent were improved and only four percent were worse. Those who had improved dated their improvement to six to ten weeks after the death occurred. One woman concluded, "I can't mourn forever" (3).

The quality of the relationship between the addicted smoker and his cigarette, as indicated by the feeling "I can't give it up," expressed by many smokers prior to entry into group treatment, coupled with the real grief felt during treatment, suggests a mixture of childish and adult reactions. The attempt of the therapist to instill hope of success is tantamount to dealing with the regressed, or fixed, aspect of the patient by reassurance that it can tolerate a significant object loss. On the other hand, we know that this aspect of the ego deals with object loss by increased identification and hope of being reunited with the lost object. It need not be demonstrated that smokers who have difficulty "kicking the habit" have suffered object loss in childhood. The point is that they function to a degree, in relation to cigarettes, as a child to a love object.

In the report of a psychoanalytic panel on addiction, it was suggested that the essence of addiction is the substitution of a fantasized object relation for a real one. Self-administration of the addictive substance was seen as a psychological incorporation of the fantasied object that relieves the pain of frustration. In adolescent drug-takers there was a significant history of parental death. The most important therapeutic tools seemed to be a continuing relationship with a helping person who provides supporting ego and superego functions and a group treatment situation involving confrontation and acceptance (4).

What are the implications of these findings for treatment? The mature ego, or adult aspect, of the habituated cigarette smoker requires a reasonable period of time to mourn the loss of an important companion. The fixed or regressed ego, or childlike part, requires a substitute relationship. I agree with Dr. Tamerin that group treatment seems a promising approach to the treatment of the habituated smoker, not only because of the inherent group therapeutic factors of universalization and identification but also because group treatment offers the possibility of "real" relations.
with other group members during and after the adult grief process has been worked through, which is a more appropriate gratification of the childish wish to be reunited with the lost object.

The study of normal bereavement cited above indicated that a three-month period allows adult grief to be worked through. After the termination of the grief process, time must be allowed for the consolidation of new relationships. How much time is required for this I do not know, but I do know that it is facilitated by the use of alternate sessions, which encourage increased interdependence among group members rather than upon the leader and promote a continuation of relationships among group members that will provide the long-term support that Dr. Tamerin feels is necessary. A reasonable alternative to formal therapy is, as Dr. Tamerin suggests, an organization of lay persons designed to provide mutual ego support in attempting to promote more rewarding, less life-endangering object relationships than that which obtains between the cigarette addict and his cigarette.

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Group Psychotherapy in the Soviet Union

BY ISIDORE ZIFERSTEIN, M.D.

The decisive influence on the theory and practice of Soviet collective psychotherapy came not from psychiatry but from the field of education. Thus a major aspect of it is education and reeducation—employing the powerful influence of the peer-group collective under the therapist’s guidance. The major emphasis is on emotional support, guidance, and reeducation. The author discusses the historical development of collective psychotherapy and the four major contributors to it.

ON TWO RECENT research sojourns in the Soviet Union, in 1970 and 1971, I spent several months making direct observations of Soviet group psychotherapy, familiarizing myself with its history, theory, and development. (The Soviet psychiatrists whose work I observed prefer the term “collective psychotherapy,” to distinguish their work from the Western type of treatment in groups.) In tracing the origins and development of collective psychotherapy, I found that four persons stand out as major contributors: S.S. Korsakov (1854-1900), V.M. Bekhterev (1857-1927), A.S. Makarenko (1888-1939), and V.N. Myasishchev (1893—).

Distinctive Characteristics of Collective Psychotherapy

Several significant factors lend to collective psychotherapy its distinctive characteristics:

1. The decisive influence on the essence of collective psychotherapy was exercised not by the three psychoneurologists listed above—Korsakov, Bekhterev, and Myasishchev—but by the educator, Anton Semyonovitch Makarenko; i.e., the basic influence on the theory and practice of collective psychotherapy came not from psychiatry, but from the field of education. This means that a major aspect of collective psychotherapy is education and reeducation—employing the powerful influence of the peer-group collec-

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