A syndrome of nondominant-hemisphere deficits primarily affects some women, often causing them to seek the company of adults instead of their peers. Finally, the parent may note that children, often baffled until presented with abundant written verbiage that can twist and turn in any direction and the content of which is reminiscent of two adjacent motorized sidewalks in an airport moving in opposite directions. That is, what one says means little or no relationship to what he is saying—almost as though they were oblivious to virtually every aspect of the relationship except for the comfort that each other obviously feels in rattling off with verbiage that can twist and turn in any direction so long as the air remains filled with words. It is not uncommon to observe both parties talking about different things at the same time, and seeming completely engaged. A history of dyslexia, the syndrome of nondominant-hemisphere pathology, as Strang pointed out, such patients are frequently referred for psychotherapy, and when their deficits are not recognized, this work, too, is doomed to end in failure. Several adjectives have been used to characterize the syndromes that receive the most attention. Right-hemisphere patients tend to be weakly organized, with language that is often exact but easily misdirected. Nondominant-hemisphere patients, on the other hand, are more hyperverbal and may have a verbal woman, or young woman, this person may be the employer who herself may be verbal, and mail with your payment.

Case History

The patient, 34, was a married schoolteacher who had been encouraged to seek psychotherapy because of "rigidity" in the classroom, according to the school principal. She was in good general health with no prior psychiatric history and no history of substance abuse. Family history was strongly positive for affective illness; the patient's mother and maternal grandmother had been hospitalized for depression.

The therapist was soon perplexed. This was a verbal woman, obviously not psychotic, but something was wrong with her thinking. When the therapist attempted to gently probe her about the nature of the patient's problem, he was brushed aside with a clique at the patient kept talking.

The therapy sessions were unusually alike. They met near in the morning during one sunny summer. The patient would sit down and launch into a long monologue. The therapist, to his mortifying consternation, found that he was unable to remember even a semblance of what this woman's life story. Filled with detailed descriptions of disconnected people and events, the therapist felt increasingly frustrated and seized upon the beginning of a new school year as an excuse to terminate.

Several years later this woman was hospitalized for an episode of severe depression.

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clumsiness, good verbal and reading skills and poor performance in math.

**Therapist's Reaction**

Therapists (not unlike employers) initially may respond to this group of patients with enthusiasm, especially to the more intelligent, higher functioning ones. These are, after all, highly verbal people who are superficially engaging and have spent years learning how to please teachers and parents.

Pleasure at meeting a "verbal" patient with whom one can do traditional psychotherapy rapidly dissipates once a session or two of history-taking ends. In a less structured session, in which one might want to talk about what seems most important to the patient and to begin to develop an idea of repetitive patterns of difficulty, the patient talks and talks, flooding the listener with endless adjectival detail, but with no sense at all of what the problem really is or what the patient considers important. The therapist soon becomes aware that he or she has no ability to accurately and effectively understand this patient's inner experience. The therapist, in other words, tries to empathize with the patient and only becomes confused.

As time goes on and no movement occurs, the therapist will invariably label the patient's mode of thinking as a "resistance" that needs to be clarified and "understood" so that important material can emerge in the therapy. This is a pivotal mistake. Depending on the vigor with which the therapist launches this confrontation, the reaction in the patient will range from apparent bafflement to feeling assaulted. In any case, the result is invariably the same: The patient continues to talk.

The therapist is then placed in a situation not unlike that which confronted Breer Rabbit and the Tar Baby in Uncle Remus: *His Songs and Stories*, only in this case it is not the Tar Baby but the therapist that invokes increasing frustration. Aided by the process of denial, the patient talks, perhaps even more earnestly, in an attempt to hold the therapist with words, and is mystified when the therapist inevitably communicates disinterest.

Once stuck, the therapist often remains so. Many endeavors in psychotherapy that are not going well end mercifully quickly with a tacit acknowledgment from both parties that something is not clicking. With a patient in whom nondominant-hemisphere deficits exists, however, it is usually not that simple. The patient, again, may have inordinate difficulty recognizing that the work is stalled and that the therapist is confused. If the therapist is unaware of the patient's cognitive problems, then he or she assumes the untenable position of the person who urged the leopard to change his spots.

**Interface with Other Disorders**

Blocked from success in work and love, these patients are vulnerable to other psychiatric disorders. No studies presently exist to describe the incidence of comorbidity, but it seems likely that these patients are inordinately predisposed to neurological and mental disorders.

Although the "as if" personality never reached DSM status, it has been influential in analytic thinking about the borderline personality. Such writers as Meissner accord it a place in describing the spectrum of this condition. The borderline personality characteristically is given to stormy, unregulated, even exaggerated outbursts of affect. Might a part of the problem lie in an inability to properly express and modulate feeling states? Similarly, these patients are prone to vastly exaggerate the affective productions of others. The characteristic idealization and devaluation of these patients may have, at its base, a faulty mechanism for processing incoming affect. One obvious consequence of such a deficit is the brief intense relationships of borderline patients. The relationships are quickly entered into and equally quickly abandoned at the first hint of rejection.

Patients with nondominant-hemisphere deficits exist along a wide spectrum. As with any syndrome in medicine, ranging from something as "simple" as pneumonia to something as "complex" as diabetes mellitus, variation in clinical presentation is the rule. This variation is in part the product of patients' defensive attempts to protect themselves from the grief of separation and loss. "The defenses that children erect to avoid fear, pain and loneliness eventually lead to symptoms and characteristic disorders," said Alpert. "In other words, the defenses often carry a cost of their own: it maladaptive defensive behavior produces symptoms such as anxiety, depression, phobias, compulsions and somatization."

Simply stated, the task of the AET therapist is to help the patient bear grief with passion and seemingly safe environment for patients to rapidly drop defenses are the underpinnings of Accelerated Empathic Therapy (AET), a new brief therapy technique taught at the S.T.D.P. (short-term dynamic psychotherapy) Institute at St. Clare's-Riverside Medical Center in Denville, N.J. and also at the AET Institute at New York City.

About 40 therapists-including psychiatrists, psychosocial workers and psychologists—today practice AET techniques, one of several short-term approaches recently discussed at the S.T.D.P. Institute-sponsored 4th annual Brief Therapy Conference in New York. The two-day conference presented six main speakers, including David Malan, M.D., of the Tavistock Clinic in London and George Vaillant, M.D., professor of psychiatry at Harvard University.

Developed about four years ago by S.T.D.P. Institute founder and director Michael C. Alpert, M.D., and his colleagues, AET is one of a wave of brief treatments that dramatically shorten the traditional two to 10 years patients often spend in dynamic therapy. Some 50 different types of short-term therapies exist, usually ranging in length from one to 60 sessions. Such therapies are receiving increasing attention, according to Alpert, because of their proven therapeutic effectiveness and also because they comply with today's overall economic mandates for cost-effective health care.

**Managed Care**

"There is every likelihood that short-term therapies will be increasingly utilized because of the trend toward managed care and the likelihood of health care reform," said Alpert. "And while one of the problems facing most models of psychotherapy is the dearth of outcome studies, Malan has studied efficacy of short-term therapies and demonstrated in five- and 10-year follow-up studies the disappearance of symptoms is real and long standing."

Alpert—who is now applying for research grants and collecting AET cases for Malan's review—said the AET model postulates the neurotic and characterologic pathology is the product of patients' defensive attempts to protect themselves from the grief of separation and loss. "The defenses that children erect to avoid fear, pain and loneliness eventually lead to symptoms and characteristic disorders," said Alpert. "In other words, it defenses often carry a cost of their own: it maladaptive defensive behavior produces symptoms such as anxiety, depression, phobias, compulsions and somatization."

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Blocked from success in work and love, these patients are vulnerable to other psychiatric disorders. No studies presently exist to describe the incidence of comorbidity, but it is easy to imagine a marked overlap of nondominant-hemisphere deficits with substance abuse and affective illness.

It is in the area of character pathology that nondominant-hemisphere deficits may make the most significant and often unrecognized contribution to psychopathology. In 1942, the analyst Helena Deutsch wrote a paper describing what would become a famous psychiatric typology, the "as if" patient. The cases presented by Deutsch were young women who drift from one very different psychiatric typology, the "ascribing what would become a famous psychopathology. In 1942, the analyst Helena Deutsch wrote a paper describing what would become a famous psychiatric typology, the "as if" patient. The cases presented by Deutsch were young women who drift from one very different social setting to another, appearing to take on the superficial trappings of whichever group they are with, and fading into the background. She compared them to passionless actresses, unable to communicate with warmth: "...the individual's whole relationship to life has something about it which is lacking in genuineness and yet outwardly runs along 'as if' it were complete. Even the lazarus sooner or later inquires, after meeting such an 'as if' patient: 'What is wrong with him or her?' Outwardly the person seems normal. There is nothing to suggest any kind of disorder. Behavior is not unusual, intellectual abilities appear unimpaired, emotional expressions are well ordered and appropriate. However, despite all this, something intangible and indefinable obrutes between the person and his fellows, giving rise to the question, 'What is wrong?' The answer to that question may well lie in nondominant-hemisphere deficits.

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Patients with nondominant-hemisphere deficits exist along a wide spectrum. As with any syndrome in medicine, ranging from something as "simple" as pneumonia to something as "complex" as diabetes mellitus, variation in clinical presentation is the rule. This variation is all the more apparent in a syndrome involving an organ that is nearly infinitely complex, the human brain.

References