Based on the personal treatment of over 100 unselected chronic psychotics at a Creedmoor Psychiatric Center aftercare clinic between 1978 and 1981.

EFFECTIVE PSYCHOTHERAPY OF CHRONIC SCHIZOPHRENIA

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Attitudes toward, and results with, the treatment of chronic psychosis, and schizophrenia in particular, have varied considerably at different times. Stephens'[1] review of 38 long-term follow-up studies, which divides outcomes into "recovered," "improved" and "unimproved" categories, cites "recovered" percentages ranging between 6% and 53%, and "unimproved" percentages ranging between 18% and 83%. Roff's[2] 1975 follow-up, after a mean of 22 years, which means that treatment was stopped for the most part before the use of tranquilizers started (about 1955), presents a recovery rate of 44%, with only 18% unimproved.

Study of recidivism rates in schizophrenia suggests that treatment results may indeed have worsened since the advent of tranquilizers. Anthony et al.'s[3] survey of 45 analyses of recidivism (readmission) rates within specified periods after discharge from hospital presents rates of 67%, 70%, 70% and 75% in the four studies conducted after five years – all carried out in the mid-1960s, after the psychopharmacological "revolution" – whereas Hillside's four-year follow-up[4] of its 1950 predrug cohort revealed only a 48% recidivism rate. A five-year follow-up study[5] of the entire New York State Hospital system 1943–1944 first-admitted schizophrenic cohort (N = 2,941) revealed a recidivism rate (percentage of those discharged who required rehospitalization) of 28%. This latter figure is, of course, flawed by the fact that so many of the original cohort remained in hospital for the full five-year period without ever being discharged; yet, even when these are fully taken into account, the failure rate (retentions plus readmissions) still becomes only 56%. Neither earlier study is, incidentally, mentioned either by Stephens or the Anthony group.

The notion that schizophrenics can get better, even though obscured by

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psychiatry's recent enchantment with drugs, has, therefore, existed for many years. This paper suggests that psychotherapy may be more effective than is usually thought when a few basic philosophical-attitudinal and technical changes are made and when full recognition is given to the importance of the therapist's strength, integrity, courage, and continuity.

Through such modified but individually tailored psychotherapy, patients' needs for medications can often be markedly reduced, even eliminated, thus removing possible iatrogenic complications. Such treatment, directed toward restoring patients to their highest possible levels of functioning, and actively conducted by psychiatrists, seems far less expensive in the long run than our present methods of using nonmedical staff as primary caretakers for chronic patients, who are consequently continued almost indefinitely in treatment.

PHILOSOPHICAL-ATTITUDINAL CHANGES

The most important such change is to regard patients' symptoms primarily as the *reflections* which we see (1) of difficulties in their interpersonal relationships, and (2) of discrepancies between what they are and what they think they should be. The primary focus on the interpersonal relationships themselves, and on their behavioral manifestations and consequences, rather than primarily on their subjective consequences (the details of fears and delusions, for example) is derived from H. S. Sullivan's definition of psychiatry as the science of interpersonal relationships.[6,p.7] The concept that what we experience within is primarily a reflection of what is going on around us comes from Lenin's theory of reflection, which is presented in his *Materialism and Empirio-Criticism*[7]—as valuable for its contribution to the philosophy of science and psychology as his ideas about political science are pernicious. Baeck's[8] differentiation of classical religions (which primarily emphasize deeds and objective reality) from romantic religions (which concentrate more on feelings and on subjective "reality") underlies the relatively scant attention paid here to the patient's every stray thought and feeling.

The symptoms of the chronic psychotic are regarded primarily as reflections of difficulties in his relationships with key individuals in his life. The distress experienced from these difficulties, or from his distortions and misperceptions of them, tends to cause panicky disorganization within him.[9] Sometimes restitutive or accessory symptoms,[10,p.94] such as hallucinations or delusions, are elaborated out of his pain, panic, and isolation.

The fear and disorganization themselves tend to elicit all-or-nothing responses—Cannon's "fight or flight" responses[11]—instead of the carefully graded behavioral and emotional responses required for establishing and

maintaining successful relationships with others. The resultant alienation of and from others—particularly of those who are closest—aggravates the panic, disorganization, incapacity, withdrawal, and loss of self-esteem.

Acute schizophrenia is thus regarded essentially as panicky disorganization, and chronic schizophrenia as primarily the partially maladaptive reorganization of an individual who has suffered from the acute condition.[12] In the chronic state, which can be characterized as "demoralized," the continuing fears, withdrawal, diminished ability to function, stigma of mental illness, and diminished realistic self-esteem combine to help maintain the patient's tendency to react in all-or-nothing ways—a pattern most marked, of course, during the acute psychotic episode.

Relatively few overt interpersonal problems arise when tranquilizer-medicated patients react inadequately to noxious environmental stimuli. However, when the patients do overreact—the other side of the all-or-nothing reaction pattern—reverberating interpersonal difficulties often follow, and rehospitalization of the patient is not an infrequent consequence. These overreactions are, of course, usually in response to difficulties existing in the relationship between the patient and a "significant other."

The tranquilizers can, therefore, be seen most simply as "damping down" all of the patient's emotional reactions. They thus prevent overreactions to interpersonal difficulties, but at the cost of marked emotional blunting and of effectiveness in negotiating the shoals of relationships. They also place patients at risk for tardive dyskinesia later.

If explosions arise from difficulties in interpersonal relationships, as Sullivan's definition implies, the delineation and correction of such relational difficulties is the central focus of treatment. If these relational difficulties can be defined and reduced,[13] the likelihood of explosion, and the need for drugs, would seem reducible also. As the patient learns to correct his maladaptive methods of dealing with interpersonal situations,[14] and with the issues underlying such unresolved differences, his interpersonal effectiveness and his need for medication will therefore change also. As he needs less medication, his feelings become increasingly available to him as accurate signals for helping him shape his behavior.[15,15a,b] With the increasing success, the greater self-esteem, and the increased emotional perceptiveness all following reduction of drug dosage, and all reinforcing one another, the need for medication can sometimes be eliminated completely.

If the formulation of specific treatment and activity goals for the patient is also begun early in the treatment, the process itself indicates to the patient in the most concrete fashion that hope is not lost; such hope is a major therapeutic enemy of the hopelessness accompanying the demoralization characterizing chronic schizophrenia.

TECHNICAL METHODS

"Talk" would seem to be the key characterization of the psychotherapist's appropriate mode of relating to chronic (or, for that matter, acute) psychotics, in contrast to "listen," which is usually considered his motto with neurotics. Similarly, behavior is his prime attentional target with psychotics, in contrast to thoughts with neurotics.

The central therapeutic task is then to define the patient's maladaptive behaviors and help him to correct them. They will manifest themselves toward the therapist in the transference, and in situations involving others: both as reported from past and current history and as observed in interactions with significant others. Unthreatening definition of these maladaptive behavior patterns, plus efforts to change, are sometimes sufficient to accomplish such change. But ideational elements requiring unraveling often lie behind such maladaptive behavior, and if they exist, they must be dealt with before efforts to change can succeed.

The initial step is the active engagement of the patient from the moment he is first seen, in order to establish a firm, affectively intense therapeutic relationship. When necessary and appropriate, street language should be used, as Rosen did,[16] to help strengthen that relationship.

During the initial encounter, the therapist may recognize many interpersonal inadequacies or repellent behavior patterns in the patient. These should be defined and pointed out to him unbelittlingly as soon as possible, if not at once. They should be characterized as habits into which the patient has fallen, which require his changing if improvement is to occur. Such immediate appeals to the patient's capacity to understand himself, and to change, are respectful and supportive to his self-esteem, as well as defining quite early the expectation that he will himself assume most of the burden for making the changes that are necessary. The doctor's belief that the patient can change, and his expectation that he will, is thus conveyed at the very beginning of the treatment.

This immediate response to the patient, and reflecting back to him as soon and as unthreateningly as possible his maladaptive behavior, differs markedly from our usual methods, both of psychiatric examination and of psychoanalytically oriented psychotherapy. In both these latter situations, we behave relatively passively, thus essentially encouraging the patient to build a case up against himself, so we can make our pathology-focused diagnosis,[17] or understand what we consider the underlying psychodynamics. In doing so, however, we lose our best opportunity to help him change rapidly.

The direct and open attitude includes another technical change: showing the patient at once the notes we write about him. Rather than keeping our records confidential from him, which can foster misunderstandings of what

he has said (thus enabling errors to enter the records—and everyone knows how difficult correction of an error on a chart can be!), sharing the notes increases their accuracy as well as permitting the patient to understand clearly how the psychiatrist sees his situation.

It is remarkable how rapidly our use of labels that to the patient may seem stigmatizing can be replaced by more objective descriptions; rather than merely stating that a patient was paranoically delusional, for example, as though that were almost a permanent biological state, we might record, so he can read it, that in response to the stresses he was under, he began misperceiving neutral or even positive stimuli as dangerous, and giving specific examples: a nonbelittling description of the psychotic process which the patient can understand and agree with. Better insight into process is thus produced, which is preferable to insight defined merely as a patient's awareness that he has been ill in some mysterious way. Such stripping of the mystery from mental illness is of immense benefit to patients.

Another early therapeutic step is the establishment of a conjoint therapeutic relationship involving the patient's "most significant other(s)" also —spouse, parents (*both* parents if he lives with them), foster parents, or roommate.[13,14] Conflicts between the patient and them are dealt with at once, at least in a preliminary way, if the conflicts are actually or potentially of current significance. The reason, explained to all involved, is that when such conflicts get out of hand, interpersonal explosions and symptomatic eruptions are likely to occur—probably the reason for the patient's having come to psychiatric attention in the first place.

Although the content of conflicts must be examined in this conjoint mode, even closer attention must be given to the interactional, mushrooming fashion in which interpersonal differences can reverberate back and forth—sometimes building up within seconds into major battles. Both individual and conjoint sessions are usually required to deal with this type of interactional explosion and to slow the interaction down so each can see how he has contributed to the mounting and, eventually, explosive tension between them. Such conjoint sessions require considerable skill and a firm hand. Staff attempting conjoint sessions with the usual relatively passive therapeutic approach can produce explosions. The harm such lack of skill produces can cause staff erroneously to avoid this valuable treatment modality.

A third early therapeutic task is the evaluation and, usually, the reduction of medication. This is undertaken only after a firm therapeutic relationship has been established and current major interpersonal problems have been defined, with initial steps having been taken toward correcting them, and only when the patient is in a relatively calm and stable atmosphere. Medication reduction is regarded as a joint endeavor for patient, psychiatrist, and

"other," and its being dealt with successfully serves as a model to the patient for other negotiatory interactions.

The patient and the "other" are advised that, usually, the less medication an individual takes, the better. The emotion-suppressing effects of the medications are reviewed and the fact is underlined that a slight reduction in medication (all that is usually done at one time) will usually produce a slight increase in the patient's emotionality. His assertiveness, argumentativeness, or provocativeness may then increase also, slightly augmenting the danger of conflict which, they are warned, may get out of hand.

Consensus is required among patient, "other," and psychiatrist for each step along the medication reduction path. The psychiatrist has the obligation to reduce the medication as much and as quickly as *is clinically safe*, which he will want to do more quickly than some patients want and more slowly than others do. The first reduction may be almost trivial, if the patient or the "other" is fearful, and reductions are prescribed *only* when external affairs in the patient's life are relatively stable; if they are not, medication reduction should be postponed until they become so once again. Agreement of all three parties is desirable at first, but after the first one or two such steps, the presence of the "other" becomes unnecessary; he can usually either be spoken for by the patient or contacted by telephone.

Each medication-reducing step causes a little more emergence of the patient's earlier interpersonal and intrapsychic problems, although the emergence occurs at relatively low levels of emotional intensity. This makes the problems more amenable to therapeutic examination and possible resolution. As this occurs, it becomes possible, when necessary, to begin examining, in a psychoanalytically oriented way, the past roots of today's inappropriate behavior, as well as continuing to scrutinize current activities, motivations, and the consequences of today's behavior.

The reemergence from the encapsulation induced by major tranquilizers will probably require even more services to help the individual regain certain competences: food and shelter services so he can live; rehabilitative services so he can work; conjoint, marital-type counseling so he can love; schooling or other intellectual stimulation, on his own level and directed toward his own interests, so he can think; and all of them together, so he can laugh.

Significant problems and risks exist with such medication reduction. As indicated above, heavy medications prevent rehospitalizations by dampening patients' capacity to respond emotionally. Reducing dosages allows patients' affectivity to reemerge, with the resultant possibility of additional painful explosions and possible rehospitalization. This is much harder, in the short run, on both relatives and staff than the endless drugged chronicity we so often permit; particularly when case loads are heavy, staff—especially

the least trained – are afraid to take such risks and may therefore consciously or unconsciously sabotage efforts being made toward taking them. They may, for example, fail to report back promptly to the psychiatrist that a particular reduction in medication has elicited an excessive response in an individual.

If such clinical problems are reported at once, the psychiatrist can reevaluate the situation promptly; he can define and correct the particular new and painful interpersonal conflict which has emerged, increase medications again, or both. If the doctor is not notified immediately, the negative mushrooming interactions can require rehospitalization which the staff, accustomed to the unthreatening chronicity of patients, can then use to claim that methods to reduce medications cannot succeed, though they are theoretically desirable.

Patients and their families are also often afraid to reduce or eliminate medications; at times, psychiatrists may keep their chronic patients on truly homeopathic doses, the only value of which is symbolic or placebo. If the benefits and dangers are clearly explained, and enough time is taken for the reduction, however, within the general principle that reduction should be taken as far as possible, patients and relatives will usually comply.

The combination of patients' and/or relatives' fear of reducing medication, with covert staff reluctance to do so too, can lead to considerable difficulty. If prompt feedback is not supplied to the psychiatrist, the patient may leave the clinic (especially if other facilities are readily available), and the staff, which is partly responsible through its failure to report promptly, may scapegoat the doctor.

CLINICAL ILLUSTRATIONS

Some of the techniques and problems of this approach can be demonstrated by two brief case reports about chronic patients at both extremes of possible expectations for them.

Case 1. Paul is a brilliant, single, 33-year-old man who was first hospitalized at the age of 22 in 1967, spending four months at Payne Whitney. He was placed on medication which he discontinued after three months. Symptoms returned and he was treated without improvement as an outpatient, receiving megavitamins and long-acting prolixin. After again stopping treatment, he slowly decompensated further at home, and was hospitalized from March to July 1975 at Creedmoor with the diagnosis of paranoid schizophrenia. He was treated thereafter at the out-patient clinic at Creedmoor with biweekly injections of 2.0 cc of prolixine decanoate. He was delusional at that time.

I first saw him on January 31, 1979, because of marked tremors and in-

tense delusions: as soon as I said "hello," he insisted absolutely that he had seen me four years previously and that wires which the National Security Agency had lodged in his brain were responsible both for his current tremors and for his childhood asthma. He had left college after two years and lived since with his parents, whom I also saw at the first visit and at most subsequent visits as well.

I suspected that the tremor-producing effects of the medication were at least partly responsible for his delusions and therefore tried gradually to reduce dosage. By April 5, after nine weeks and five visits of about 20 minutes each, I was able to discontinue medication altogether. Over the next few months, the tremors disappeared completely, except for slight and transient return when he was under pleasurable or painful emotional pressure.

At the first visit, I had raised the possibility of his taking a college course at some time in the future and, at the third, he discussed some ideas he had formulated concerning systems in the universe and a relationship he had noticed between Euler's theorem in geometry and Gibbs' phase rule in physical chemistry. Rather than dismissing his ideas as paranoid maunderings because I did not understand them, I asked him to prepare a one-page precis of what he was talking about. He prepared two; the first turned out to be an independent reformulation of the ideas presented in a most important paper on the philosophy of science by Novikoff in 1945, and the other, mathematics professors at Yale and Columbia (whom we asked), told us described a similarity between two different fields, previously unknown to them, whose meaning had never been elucidated.

On May 24, after seven biweekly visits, he announced that he would no longer come to the clinic because he was not under court order to do so, as he said he thought he had been. Since I could not persuade him, I continued seeing his parents at about the same frequency, discussing his activities and behavior with them, and how they could best encourage him; he continued to improve. That summer I tried to get him to participate in our clinic's day program in order to help him improve his ability to socialize, but, after one day, he refused to come back either there or to me.

He applied in September for a course in computer science at a nearby university, but his enrollment there was questioned by the school when he mentioned to them that the National Security Agency was bothering him. The college called me, but before getting back to them, I called him to tell him that I could not say anything for him without seeing him. He returned to treatment.

He started with one course that semester and two the next. His grades have been excellent, and he is also doing very well at home with chores and tasks, and with his parents and other family members. He is still too shy

and frightened to socialize, though, but he can now laugh fairly easily when I kid him. When the subject of socializing is mentioned, however, he immediately reverts to talking about the NSA, and about how everything today really happened the same way five years ago.

I saw him 27 times over 15 months, for an average of about 20 minutes each time. Now I see him monthly, and he is in considerably better condition than when first seen. Little if any more psychiatric time has been spent with him on a per annum basis since I started than had been spent with him previously. But that time was used quite differently.

This write-up has been reviewed with him, and includes the corrections he made.

Case 2. Helen is a 68-year-old single woman, who was hospitalized at the age of 33 in 1944 at Creedmoor and was not released until 28 years later, in 1972. She was then placed in a foster home, where she has remained since, attending our clinic every two weeks for medication and a socialization group run by one of our nurses.

I first saw her February 1, 1979, with her foster caretaker, because she was becoming increasingly disorganized. Over the next two weeks, I increased thioridizine from 100 to 400 mg. daily, without success; I then switched to trifluoperazine, gradually reaching 50 mg. daily by March 20. We then were able to reduce dosages quite rapidly, and discontinued medication altogether on May 24.

On June 14, I saw her with the socialization group's nurse-leader and with her caretaker and raised the possibility, since the patient had stopped attending the group and needed no medication, that she make a connection, with our help, to a community group, after which we could discharge her from our clinic rolls.

On July 5 she attended the clinic group again, and the nurse noted that she sat talking and laughing to herself. The patient herself was advised to contact me, but the nurse did nothing; the patient's silly behavior at group meetings continued until our next scheduled appointment on August 17. I then restarted her on 100 mg. daily of thioridizine.

On October 16, I noted that I had given the patient "a choice of getting a little more medication immediately before the socialization group," at which she tends to become a little disorganized, "or of controlling herself; she insists she can do the latter, and we will try things on that basis." We did, and it worked.

When this was written, the patient was receiving 20 mg. of liquid thioridizine daily, with her dosage adjusted by the caretaker when the patient becomes upset; I have taught the caretaker how to do this. Even though the nurse's notes continue to emphasize the patient's difficulties, the caretaker's

and my own direct observation both indicate a maintenance of the status quo or a slow improvement toward the patient's taking more responsibility for herself.

SUMMARY

A method has been described to modify psychotherapy attitudinally and technically so that it is helpful with chronic psychotics—patients in a state hospital aftercare clinic. The method usually enables medications to be reduced and sometimes to be discontinued altogether. Two cases have been presented to demonstrate how the various new elements of the treatment method relate to each other, and to the rehabilitative services most chronic psychotics need.

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