INTERPRETATION OF SCHIZOPHRENIA

Other Aspects of Psychotherapy

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I
Participation in Patient's Life: The Therapeutic Assistant

The treatment of the schizophrenic cannot consist only of the sessions, but an active participation in his life is necessary, as many authors have reported. The patient needs to feel that many events in his life are shared by the therapist. Rosen (1947) went to the extent of shopping with patients or of spending as much as ten hours daily with some of them. Sechehaye (1951a, *b)* spent practically the whole day with her only patient. These procedures are exceptional and are not compatible with ordinary practice. When the patient is very sick and his requirements are immense, I have resorted to the help of a therapeutic assistant. A psychiatrically trained nurse, or a former patient when a nurse cannot be found, is the best qualified to act as a therapeutic assistant. Federn (1952) and Rosen (1953) were the first to report this procedure. Federn used as a therapeutic assistant a nurse, Gertrude Schwing, to whom we have already referred in

Chapter 35. I wish to stress that the use of the therapeutic assistant is not necessary in every case, but only in the most difficult ones, or when for some particular reasons hospitalization is not advisable in spite of the seriousness of the condition. If the patient has to be hospitalized, the therapeutic assistant may be a trained psychiatric nurse working in the hospital.

When the very ill patient is treated only with psychotherapy, he requires much attention. At times one person must be at the continuous and exclusive disposal of the patient. The therapeutic assistant stays with the patient during the day, except, of course, for the time of the psychotherapeutic session. She cooperates with the patient and duplicates the general attitude of the therapist. The assistant is there to help, to support, to share. It is particularly at a certain stage of the treatment that the therapeutic assistant is valuable. When the patient has lost concrete delusions and hallucinations, by virtue of the methods outlined in Chapter 37, he may nevertheless retain a vague feeling of being threatened, which is abstract and from which he tries to defend himself by withdrawing. The assistant is there to dispel that feeling. That common exploration of the inner life in which the patient and therapist are engaged is now

complemented by an exploration of the external life made together with the therapeutic assistant.

Peplau (1952, 1959) thinks that the nurse (or assistant) helps by establishing a feeling of "thereness." Somebody is *there,* available, always ready to help. There is somebody the patient can rely on, somebody whom he trusts, somebody who could dispel many fears. The therapeutic assistant, directly and realistically, paves the way to the external world. She shows that many of the things the patient is afraid of either do not exist or have no power to hurt. The therapeutic assistant is recognized not as a distant, potential, or magic helper, but as a person who is in physical proximity. She is the person who shows that by doing things together many obstacles will be overcome. For instance, the patient may not want to go to a store for fear of persecutors, but in the company of the assistant he will go. Needless to say, the therapeutic assistant would not be able to help the patient if the therapist had not prepared the ground with his inner exploration.

There is a tendency on the part of many patients who are helped by a therapeutic assistant to return to a condition of early childhood, but what is important in the treatment is not the similarity but the

difference between the present and the early situation. The therapeutic assistant does not stultify the growth of the patient, who is allowed to take his own initiative whenever possible.

The patient also wants tasks to be given to him and demands to be made on him, contrary to the way he felt at the beginning of the treatment. By fulfilling these tasks, the patient will make gains in self-evaluation. As I have already mentioned in Chapter 36, I have learned this technique in Pilgrim State Hospital. At that time I noticed that in some back buildings for chronic patients, where no physical treatment or psychotherapy was given, a considerable number of patients could be discharged. I have described how I came to the realization that these discharges were a consequence of the relatedness that had developed between certain nurses and certain patients. These nurses offered the patients an image of a good mother by being warm and kind, and appearing strong at the same time. The patients responded to this atmosphere of consistent warmth by becoming more active. The nurse or the female attendant then would give the patient tasks that the patient was certainly able to perform and would then praise the patient, who felt an incentive to do more. The patient felt that he deserved the praise of the nurse, and in this way his self-esteem

increased. Inasmuch as in wartime there was a serious shortage of employees, the nurses naturally had a tendency to show preference for those patients who would help. This feeling, however, was not experienced as having strings attached to it.

The relation to the nurse had the following characteristics:

1. The patient did not have conflictual areas with the nurse as he had with the parents.

2. The assignments were not out of proportion to the capabilities of the patient. The patient was asked to do what could reasonably be expected of him, and therefore his insecurity was not increased.

3. The patient would definitely and consistently get some kind of approval or preferential treatment, which increased his self-esteem.

To summarize, what I think was happening was that the nurse, a very maternal person, not at all hostile but love inspiring, with her general attitude was able to remobilize the patient. Once the patient was made to move as a result of this attitude, he became involved in a method of increasing his self-esteem. Not all patients responded to this procedure, but a fairly large number did.

When we assign tasks to patients, we must take their wishes into consideration and not try to fit them into traditional occupational therapy classes. Patients, like everybody else, are more willing to do what they like. It is useful to remember that schizophrenics, more frequently than average persons, have artistic inclinations (Chapter 20). Many of my patients, during treatment, started to study painting, music, or classical dancing, with considerable success. Quite a number of them started literary careers.

Although the artistic work of the patient may be useful to the therapist as a means of acquiring additional insight and of evaluating the psychological status of the patient, it should be assessed independently as an artistic work and as an accomplishment.

The therapeutic assistant is particularly useful with hard to mobilize or motivate patients. It is inadvisable to entrust the treatment of the very vulnerable psychotic patients to one person only, the therapist. If, for some unexpected reasons, the therapist must discontinue treatment, the patient should not feel isolated or alone. Secondly, at least two useful interpersonal relationships are needed in very difficult cases for a healthy reintegration and socialization. We

should not forget that even in the original situations, there are two persons, the two parents, who help the child to introject and to grow. Thirdly, it is a physical impossibility for the therapist, in the structure of our society, to devote to one patient as much time as he may require.

It is a good practice to use as therapeutic assistants persons who have undergone psychoanalysis or intense psychotherapy. However, in my opinion, well-adjusted persons with warm, radiating, maternal personalities have done well even if they had not undergone treatment.[1]

Rosen has been assisted by two nurses who had previously suffered from schizophrenia and who had recovered as the result of his treatment. I have been greatly helped by my former patient Sally Lorraine, about whom I wrote in Chapter 10. A former patient who has been successfully treated and has a fresh memory of the experience he went through may have a feeling of empathy and understanding difficult to match (Lorraine, 1972).

Another main function of the nurse or therapeutic assistant

consists of giving a kind push—not a total push a la Myerson, but a soft push. The feeling of relatedness for the patient, rather than preconceived ideas, planned programs, or daily activities, will tell the therapeutic assistant when to practice the soft push to combat the tendency to be inactive or to withdraw. The patient may nevertheless resent the pushing. We know that schizophrenics feel "pushed around" throughout their lives. The push will more probably be accepted and not resented if it is soft, if it is accompanied by tenderness and by a hopeful glimmer of success. The patient must be encouraged to take his own initiative whenever possible. For instance, we could tell him something like this: "The other day when you did this, you enjoyed yourself; would you like to do it again?" In this way the initiative is still on the part of the patient, but he has been helped to make a decision.

The therapeutic assistant may help the patient to overcome some harmful or disruptive habits. Unless corrected, these habits tend to perpetuate themselves, to become more ingrained and more intense. The physician may not be aware of these habits, either because he does not have the opportunity to observe them or in some cases because in the session they pass unnoticed. For instance, many therapists do not know when a patient is going to hallucinate. But

some nurses know, sometimes from familiarity with the patient's facial expression or body posture, that in a few minutes or seconds the patient is going to hallucinate and perhaps act-out with impulsive behavior. The nurse gently should go to him, distract him, and involve him in other things so that he is prevented from hallucinating.

Whereas the therapist tries to interpret and make the symptoms unnecessary, the therapeutic assistant offers the patient ways to avert them. This aversion therapy has nothing to do with mechanical conditioned-reflex therapy, but has everything to do with the warm intervention of another human being. By aversion of symptoms, I mean (just as in the given example concerning hallucinations) creating situations in which symptoms are not likely to occur and avoiding situations in which they may easily occur. For instance, if the patient has the tendency to indulge in rituals when he is alone, he should be left alone as little as possible. Aversion therapy is much more than symptomatic treatment; symptoms and habits become stronger and more resistant the more frequently they occur.

Marram (1970) has described how some problems in the management of the patient consist of helping him promote social

adaptation, discouraging social isolation, and decreasing overtaxing demands of the environment.

Several complications may develop in the work of the therapeutic assistant. Many of them involve the assistant as a person who undergoes feelings of countertransference similar to those described in the therapist (Chapter 38). In quite a few cases the therapeutic assistant tends to see the patient as a person who needs help very much, even when he has improved considerably. She may be unwilling to spend less time with the patient or to decrease his care. The assistant must be instructed by the therapist to recognize and acknowledge the improvement of the patient.

Another difficulty lies in the hostility that the patient in some cases develops for the assistant, either because he resents being dependent on her or because he is afraid of the warmth he has for her or because he identifies her with a figure of his past and sees her through paranoid distortions. All these situations, of course, must be reported to the therapist, who will analyze them with the patients. Another difficulty may arise on account of those triangular social processes first described by Stanton and Schwartz (1949a, *b).* They

occur in ambulatory patients also, although the most intense entanglements have been reported in hospitalized patients. If the patient feels that there is a nonexpressed disagreement between the therapist and the therapeutic assistant about his own treatment, or between the therapist or therapeutic assistant and a parent, he is bound to become disturbed. This disturbance is relatively mild because the patient generally feels that the therapist is on his side in disagreements between therapist and therapeutic assistant, or that the therapeutic assistant is on his side when the patient disagrees with the parent. When the problem is openly discussed or an agreement is reached, the disturbance tends to disappear. The disturbance in some cases is caused by a reactivation of the patient's childhood feeling that he was the cause or the victim of the dissension that existed between his parents.

Federn (1943, 1952) wrote that the helper may be even a relative or a friend. This question comes up often, because in many cases it may be economically impossible to resort to a therapeutic assistant. In my opinion, a relative, especially a close relative such as a parent or the spouse, is not a good helper because he is too much involved in the problems of the patient. Even if the relative has, through his own

psychoanalysis or psychotherapy, overcome his own emotional problems, the patient's problems in connection with this person will make the task a very difficult one. I have encountered a few cases where the husband acted as a therapeutic assistant, but these attempts were not successful. The patients tended to resume a symbiotic relationship with their husbands. They tended to become passive bodies that had to be taken care of completely. Of course, in these cases the hostility for the husbands was given this opportunity to express itself.

II
Advanced Stage of Treatment

At an advanced stage of treatment the patient becomes increasingly similar to a neurotic patient. The therapist should not be overly impressed with the change and should remember that the recovering psychotic remains always more vulnerable and unstable than the neurotic and that some relapses often occur. Conversely, if minor relapses do occur, the therapist should not feel unduly discouraged. The occurrence of them and the relative mildness of them in comparison to the initial attack of the illness should be

explained to the patient and his family.

One of the difficulties encountered at a later stage of treatment is the fear of improvement. This fear may be caused by many factors. One of the most common is the fear of having to face life again and of not succeeding. Being healthy implies the responsibility of living with all the threats that life presents. Again life has to be reinterpreted to the patient, and the fears have to be analyzed and reduced to their normal proportions.

The patient may also feel that he does not deserve to improve, feels guilty for feeling well, and may want to live in accordance with the negative image of himself.

Another idea that may discourage him from improving is the thought of getting well for somebody else's sake, not for his own. Actually, contrary to his belief, improvement will make him freer, not more dependent, not more obligated to others. In the process of reasserting himself, the patient may reexperience the feeling that tormented him in his prepsychotic stage, when he thought that to be himself meant to be odd or queer, and that therefore it was advisable

for him to be as others wanted him to be. Actually this feeling will not last a long time after its return because the patient is learning to accept himself as he is and to have respect for his own feelings, ideas, and judgment. He sees himself more and more as a person in his own right.

Some of the habits he rigidly adhered to are finally abandoned. For instance, a patient would never be seen without sun glasses. If she did not wear them, people would notice her feelings. She could survive only if she had something to hide behind. She felt she had wrecked her life. However, there was still in her the desire to save herself. Eventually she did not have to hide any more what was inside of her, and she stopped wearing dark glasses.

At an advanced stage of therapy the basic dynamic patterns are established and can be clearly formulated and related both to current behavior and general relations with the world (see case of Mark in Chapter 40).

One of the things to consider is whether at an advanced stage of treatment it is worthwhile to bring up the memories, circumstances,

and characteristics of the acute psychotic episode. There are several psychotherapists who are against such a procedure. Muller (1963), for instance, believes that the amnesia for the psychotic episode not only should not be prevented, but made a therapeutic vehicle. This point of view is in line with Federn's concept that in schizophrenia, “where ego was, id should be.” I do not share this point of view. If what we aim at is only a symptomatic treatment, such as, for instance, what we achieve with electric shock treatment, then amnesia is valuable. Perhaps one of the means by which electric shock treatment is effective is by producing this amnesia. However, I saw the best therapeutic results in those patients who at an advanced stage of treatment remembered the acute episode, were able to analyze its content, to interpret it, and to understand it in the context of their life history. In other words, they came to understand it as an attempt to escape from, or to cope with, the conflicts.

Of course I too think that if the patient is quickly recovering from an acute episode, he should not be pressured to remember it because the conflicts are still pathogenic and may again bring about decompensation. However, before the episode is completely forgotten, I direct the patient to reexamine it. In my experience, in the security

offered by the therapeutic relationship, the exposure to the memory of the psychotic episode is useful. The patient is now in a position to free his conflicts, to understand them partially, and may even begin making some tentative steps toward the solution of them. I have almost invariably found that patients who forget their acute episode sooner or later are going to have another one.

Kelman (1973) has reported that some schizophrenics maintain a secret that they do not want to reveal to the therapist. As long as they do so, improvement is delayed. The secret that some patients safeguard does not generally concern the psychotic episode but the meaning they give to their life, the unfulfilled aspirations, the sense of defeat, the fear of others, the vision of the self.

A controversial point in the psychotherapy of schizophrenia concerns the nature of the fragility of the schizophrenic patient, to which we have already referred. Some therapists believe that the patient is very vulnerable; and some others, Searles (1965), for instance, state that the fragility of the schizophrenic is a myth. I disagree with either extreme position. When relatedness is established with the patient, he is able to accept the basic truth about his

predicament in life. The truth, revealed with candor and authenticity, is less of a threat to him than artificial embellishments and beating around the bush. The schizophrenic patient, however, remains very vulnerable at the beginning of treatment concerning such events as separation from the therapist during vacation time, or because he gives a symbolic meaning of despair or utter rejection to some events or words or actions of the therapist. The schizophrenic is more ready than the neurotic to hear the truth about himself but less ready to stand duress, adversity, and drastic changes. If he is more ready to accept the truth, it is not because he is already conscious of mechanisms that are usually unconscious to the average person. This is a myth. We have seen repeatedly in this book that the schizophrenic too, either because he represses or distorts or uses primary process thinking, is not aware of many aspects of his personality and interpersonal relations.

Why, at a more or less advanced stage of treatment, is the patient not devastated by the truth? First of all, we must remember that once he knew the truth or was very close to it. When he rediscovers the truth, he has a feeling of familiarity. Moreover, now he hopes in spite of what he knows. He relates and knows and feels much more than the

neurotic that the therapist shares the burden of the knowledge of the truth. Whereas a major part of his previous life—that is, the totality of his prepsychotic and psychotic mechanisms—can be seen as a gigantic maneuver to hide or compensate for the truth or experiential truth, now he is ready for a confrontation with the truth.

Whenever the therapist feels that the patient is ready for a decrease in the number of sessions, this step should be taken. The patient generally dislikes a reduction in treatment because of his dependency, which may remain great in spite of the improvement.

At an advanced stage of treatment, the patient may become distressed by typical neurotic symptoms. Rosen (1953) also has mentioned this common occurrence. One of the urges commonly found, especially in former catatonics, is the compelling necessity to do everything best and to avoid mistakes. The patient must buy the best suit, must go to the best doctor, must read numerous times what he writes for fear of having made mistakes, and so on. These symptoms are generally easy to explain. The protection of inactivity is no longer available, but the patient still wants to please the incorporated parental figure from whom he wants approval. He wants to avoid

mistakes at any cost or identify with mother and do the best. The "power" to avoid the mistake is searched for also as proof of the ability to fight a feeling of powerlessness that now and then reemerges. If the patient is able to avoid the mistake or able to obtain "the best results," he feels he has power; he does not need to feel hopeless or to go back to the state of withdrawal. The patient has to hear again and again that mistakes are indicative of the human condition and not of a state of unworthiness and irreparable inadequacy.

One of the problems that must be considered at a certain point in the treatment of nonhospitalized patients who are improving concerns the separation of the patient from his family. Should he live by himself? This is always a major step. On the one hand, we may think that it is in the family that the troubles of the patient started, and there probably, that they are maintained. On the other hand, we may feel that to remove the patient from his family would not really be helpful because this would be merely a removal from the external situation, not from the introjected conflicts. As a matter of fact, one might even think that this separation might reexacerbate the symptoms. We shall see in Chapter 40 that Geraldine, a patient who was improving, started to hallucinate again when she was separated from her mother.

Actually, in my experience, separation from the family is a positive step to be considered when the other conditions, to be mentioned later, permit. It is true that the introjected members of the family will continue to act within the patient. However, the schizophrenic patient must also mature at a conscious reality level, and this process of maturation, of striving toward independence and self-reliance, is handicapped by his living with his family. Of course, minor reexacerbations of symptoms must be anticipated and coped with immediately by discussing them with the patient or even by warning him of their possible occurrence.

Separation from the spouse or a sibling has approximately the same psychological significance as separation from the mother, with whom this sibling or spouse is generally unconsciously identified.

The other problem is to determine when the patient is ready for separation. I think we must be prepared to take some risks. Again in my experience, several patients who appeared dependent and helpless proved to be able to take care of themselves much better than the members of the family or I had anticipated. Of course, in some cases we must make return possible—a return accompanied not by a sense

of defeat but by the willingness to try again a little later.

The patient will be able to live by himself if he is given more than what he is deprived of; that is, if he is given by the therapist a sense of trust, confidence, and belief in the unfolding of his potentialities. The patient should also be told that he will be able to stay again for short periods of time with the members of his family when he is in a position not to be hurt any longer by what they represent.

Generally when the patient is able to live alone, another type of relatedness is established, to which we have already alluded in Chapter 36. The more the patient improves, the more he becomes a peer of the therapist. How can patient and therapist become peers? By age, sex, background, training, they are most of the time quite different. Certainly they can have common interests, but I do not believe that is enough. Therapist and patient can be peers if they share values. We hit here a crucial and controversial point. The therapist is no representative of the values of society, nor does he advocate any value that the patient does not accept. However, let us not delude ourselves, as many psychoanalysts have done in the past. An intense relatedness, like the one required for the therapy of the psychotic, and,

by the way, for any healthy human encounter, necessitates the experience of sharing values. In the past the psychoanalyst in training was instructed not to invade the realm of values. Values, of course, do not need to be expressed in words; they can be sensed. A surgeon or a general practitioner can perform a service without sharing values with the patient, except those concerned with the pursuit of health and life. In the psychotherapy of the psychotic, the situation is entirely different. We must search for and find common values with the patient (Arieti, 1971b). We have seen in Chapter 8 that some therapists (Siirala, 1961, 1963; Laing, 1967) have found these common values in their belief that schizophrenics have an understanding of social injustice that is superior to that of the average person, an understanding that the therapist should accept. In Chapter 8 we have also seen that although the schizophrenic may be alert to realistic hostility, malevolence, and evil more than the normal person, we would do him and ourselves a disservice to accept his experience of this hostility, with the psychotic structure, deformations, and exaggeration that he has superimposed on it.

We must, however, be always aware of the possibility that the patient has positive values and that these positive values can be

retrieved in their original purity once we remove the psychotic overlay. Even if we feel that the patient, in both his prepsychotic and psychotic stages, responds abnormally to the world or misinterprets the world, we should not necessarily evaluate his position in a negative way. Let us first of all become aware of the fact that normality, or what we call normality, may require mental mechanisms and attitudes that are not so healthy. At times what is demanded of us is callousness to the noxious stimuli. We protect ourselves by denying them, hiding them, becoming insensitive, or finding a thousand ways of rationalizing them or adjusting to them. We become a silent majority. By being so vulnerable and so sensitive the patient may teach us to counteract our callousness. By spending so much energy in adapting we survive and live to the best of our ability, but we pay a big price that may result in the impoverishment of a part of our personality. This impoverishment of the personality is particularly pronounced, not always but often enough, in the nonpsychotic members of the patient's family. They were able to avoid the psychosis, but often the rigidity, peculiarity, compromises, and distortions that they underwent, mutilated important parts of their personality and deprived them of some dimensions of living.[2]

When the preschizophrenic and schizophrenic see society as a Darwinian jungle, we must remind ourselves that not the patient but Darwin himself made the first analogy in the reverse order. After having studied society in Malthus's writings, Darwin in the Galapagos Islands saw the jungle as a reproduction of society. Inequality, competition, struggle, and power prevail in the two situations. Unless checked by human will, power wins out in both society and jungle. The future schizophrenic is certainly not the fittest in any jungle. When he becomes psychotic, he is not literally a prophet but a reminder of the inimical powers that most of the time win and say, "Woe to the vanquished." He is not a prophet but a significant voice; and yet, in spite of its significance, this voice is most of the time too humble, too weak, too deprived of adaptational value to be heard. The therapist must hear this voice. At the same time he must dismantle or help dismantle the psychotic scenario that deforms the message. The philosopher, the dissenter, and the revolutionary, like the schizophrenic, lack adaptability, but they compensate for this lack with their creativity. With a few outstanding exceptions, the schizophrenic is not as creative as they are. If we want to hear his disguised voice and transmit his message to the world, we must overcome the obstacles

built by the psychosis.

What is the real voice, the value that the schizophrenic tries to express before it is distorted by the disorder? It is the basic value of the human being. He wants to be the sovereign of his will (Arieti, 1972a). He wants to be totally himself, but he does not know how. He finds, as a matter of fact, sovereigns all over, but not in himself. He attributes to them hostile intents, and he himself harbors a great deal of hostility.

We are willing to accept and transmit his message, but this action may possibly help only future generations. We want to help the patient himself. We will be in a position to help him, to transmit to him our own message if he experiences us as human beings who share his values and as peers. When he feels that some of the real or fantastic forces that disturb him disturb us also, he will start to relate to us without distrust. By accepting his perception of hostility from a general point of view, we shall be in a position to help him later to cut or dismantle the delusional distortions of this hostility. Gradually the patient's main goal becomes not that of fighting persecutors but of fighting evil and searching for love and fulfillment. Thus, his first and

ultimate values will also be our values.

When the patient realizes that we stand neither for his madness nor for that of society, but that we are his companions in both madnesses, treading cautiously but hopefully on the narrow path on which the intangible universal values of individualism reside, the prognosis is good.

III
Complications

Complications arising during the course of the treatment or existing even before the beginning of it at times make psychotherapy more difficult.

The first is the development of depression while the patient is gradually losing the schizophrenic symptoms. We have already seen in Chapter 3 that recently the number of patients changing from a schizophrenic to a depressed symptomatology is increasing. Thus we do not necessarily have to attribute this development to psychotherapy. However, it seems evident that at least in some cases psychotherapy has hastened, made more probable, or actually

determined this change.

In some cases the reason for the depression seems clear. The patient has the feeling that he has lost something precious. The symptoms might have been disagreeable and painful, but they permitted a certain tie with the world and constituted an important part of the inner life. Without them the patient feels empty; he almost wishes to have the symptoms back. One of Roth's patients pleaded over and over, "Please, please, let me be crazy again" (Roth, 1970).

In some cases this type of depression manifests itself not with the usual feeling of melancholia but with a form of apathy, or apathetic nihilism. In these instances the therapist and, whenever available, his assistant must become more active in entering the life of the patient and offering those non-anxiety-producing possibilities that may fill somewhat the huge gaps.

However, a much more complicated mechanism is often at the basis of the depression sustained by the recovering schizophrenic. When he was paranoid, he projected the bad image of himself to the external world. The persecutors were accusing him, but he felt he was

an innocent victim and gained in self-esteem. When, as a result of treatment, he is deprived of these paranoid mechanisms, he may tend to reintroject the bad image of himself, to consider himself worthless and guilty, and consequently he may feel extremely depressed. Generally in these cases tendencies toward retention of a bad self-image with strong depressive overtones existed even before the psychosis started. However, after the onset of the psychosis the schizophrenic projective mechanisms prevailed.

The self-accusatory tendency has to be analyzed, discussed, traced to the origin, and corrected. These cases present some risks because at times the improvement in the symptomatology of depression revamps the schizophrenic symptomatology. In other cases we do not have a recurrence of schizophrenia, but the patient retains personality defects, like emotional instability, paranoid tendencies, propensity to misinterpret.

Most authors, including myself, do not as a rule consider the occurrence of this depression in negative terms but, on the contrary, as a sign of growth and good prognosis. However, other authors have given different psychodynamic meanings to its occurrence. Spiegel

(1973) advanced the daring hypothesis that the "schizophrenic response" may be a depressive equivalent. Hoedemaker (1970) considers the depression an almost appropriate response on the part of the patient to the recognition of his inner emptiness and utilization of unreal defenses. The patient sees reality for the first time, his lack of individuation, and develops feelings of desperation. For Miller and Sonnenberg (1973) depression occurs when the patient, as a result of psychotherapy, experiences an impetus to further autonomy. But the patient is afraid of functioning at a more autonomous level, especially if the end of treatment is contemplated, and such fear makes him depressed.

A second complication is the development of psychopathic traits during psychotherapy. The patient becomes very promiscuous or may even steal or refuse to pay debts. Unless the patient was originally a psychopath who also became psychotic, the outlook is not as alarming as it may seem. Psychopathic traits in recovering schizophrenics generally signify difficulties in the attempts to readjust, vindictiveness toward society, or desire to assert oneself or to make up for what the patient believes he has lost in life. As a rule they soon disappear and progress is made.

A third complication is homosexuality. The two conditions, homosexuality and schizophrenia, may have some common predisposing factors residing in the original disturbed family environments. However, the two conditions have many different characteristics and different psychological organizations. Generally, in my experience if the schizophrenic is homosexual, his chance of recovering from the psychosis decreases. Since he lives in a heterosexual society that is prone to condemn homosexuality, the patient has additional important reasons for feeling anxious, threatened, rejected. Especially in early youth, for instance, in college or at work, when he succumbs to the first homosexual seductions, he may go into a state of panic leading to a schizophrenic psychosis. Of course, the psychosis is determined not only by the anxiety that is related to the emerging homosexuality but also and especially by the anxiety of the whole life history and especially of the childhood experiences. Nevertheless homosexuality constitutes an important aggravating factor and may be responsible for precipitating and maintaining psychotic episodes. In these cases when therapy has reached the stage during which psychodynamic analysis is the main endeavor, the patient should be encouraged to recognize his conflict

and to accept his homosexual orientation without anxiety. It will be impossible for him to do so if he feels that even his therapist rejects his homosexuality and would like him to be or become heterosexual. In my experience only if the patient loses his anxiety over his homosexuality can we treat his schizophrenia with any hope of success. Exceptions are those few cases where the occurrence of the psychosis had nothing to do with the patient's homosexuality. In my opinion in all these cases our goal should be that of treating schizophrenia and not homosexuality. Incidentally, in my opinion it is easier to recover from schizophrenia than to change sexual orientation. Perhaps it is not difficult to understand why. A homosexual orientation is compatible with a rich life, although in its pure forms it is not compatible with reproduction. It is also compatible with pleasure achievement and with the fulfillment of the fundamental human potentialities. Many of the problems connected with homosexuality are derived from the fact that the patient must live in a heterosexual society.

The situation is very much different in schizophrenia. In most severe cases this psychosis is not a condition compatible with life, unless, of course, the patient is taken care of by nonpsychotic

members of the human species. It is fundamentally a process of progressive disorganization in spite of the organization of psychotic patterns and is not compatible in most cases with pleasure-attainment and with the fulfillment of the potentialities of man. It is thus natural for the teleologic or regenerative capacities of the psyche and of the whole organism to participate in the fight against schizophrenia but not in fight against homosexuality. Of course the foregoing does not imply that the psychodynamic mechanisms that led to homosexuality should not be examined. It also does not imply that acceptance of the goal of combating only the psychosis is a definite attitude that psychiatrists should take at all times or in all cases. I think, however, that at the present stage of our knowledge, it is in most cases an insurmountable, as well as undesirable, task to remove therapeutically both schizophrenia and homosexuality.

IV
Precautionary Measures: Legal Responsibility

A situation from which the therapist must protect himself is the possible accusation of having sexual relations with the patient. Sexual

intentions are often attributed to the therapist even by neurotic patients. However, with neurotics, this is not a serious problem. It is easy to discuss these feelings and to interpret them. The situation is much more complicated with a psychotic, who, in his tendency to concretize ideas, does not speak of intentions of the therapist, but of real acts. Because the nature of the therapy is such that it does not allow for the presence of a nurse or an attendant during the session, the physician must master the situation in other ways. First of all, the young therapist is warned against taking these accusations too seriously. He should not put himself in a position of defense, but whenever possible he should interpret these sexual feelings to the patient, as he would do with a neurotic patient. Generally the psychotic patient who does not dare to have feelings of closeness has to distort anything resembling them. As Sullivan illustrated, "in a malevolent way" he transforms his own longing for closeness or the therapist's warm attitude into sexual acts initiated by the therapist. The therapist should take notes, reporting the expressions of these accusations, not out of context but in an account of the session that is as complete as possible. In the proper context these ideas will appear delusional to everybody and can be used if the paranoid patient, who

cannot stand closeness with the therapist, interrupts treatment and makes legal charges against him. A record of the session would be very useful. As was mentioned before, the presence of a witness when the patient has the feeling that the therapist uses him or her sexually is not recommended. In a certain respect this recommendation is contrary to what has been suggested in cases of uncontrollable hostility.

If the paranoid patient feels that the therapist wants to abuse her sexually, the presence of another person may reinforce her belief. A young resident was attempting psychotherapy on a hospitalized antagonistic paranoid who soon accused him of some kind of sexual activity when he was alone with her in the office. The doctor asked an attendant to be present at the subsequent interviews. Such a procedure did not dispel the ideas of the patient but reinforced them. According to her, the therapist, now having a paid witness on his side, could really do whatever he wanted with her. She really believed that sexual affairs were taking place, even in the presence of the attendant. The resident then assumed a disparaging, contemptuous attitude, after which these sexual fantasies disappeared because there was no longer any fear of closeness. The rapport was lost, however, and treatment had to be discontinued.

If the patient who harbors such ideas is a minor, and if interpretations have not been successful, the therapist should inform the relatives of the existence of such ideas and should advise treatment with a therapist of the same sex. One should not forget that the relatives are often disturbed people and that in their unconscious desire to blame others for their troubles they are bound to believe the patient's allegations unless they have been informed by the therapist in advance. Revelation of such ideas to the relatives may be harmful as far as the treatment is concerned, but we cannot expect the therapist to be a masochist who does not want to protect himself.

I have not read or heard of actual physical sexual attacks being made by psychotic patients on therapists, although they have been made on nurses, attendants, and other patients. Undressing in front of the therapist to a state of complete nudity occasionally occurs. Homosexual desires generally manifest themselves in symbolic forms. As we have seen in Chapter 36, declarations of love toward the therapist of the opposite sex are not rare, especially in paranoids who express these feelings in a bizarre, generally harmless manner. These erotic feelings are different from the usual transference feelings of neurotics. They generally, although not always, indicate ways to gain

self-esteem, acceptance, and protection. If the therapist would yield and have sexual relations with the patient, that fact would be proof to the patient of the therapist's acceptance of him. Incidentally, similar feelings, expressed openly by some psychotic patients, for the parents of the opposite sex seem to me often to indicate the same thing. Physical love is a concrete symbolization of what is really wanted: love and reassurance. It is true that the psychosis may uncover an Oedipus complex. But the Oedipal aims are now in the service of attempts to rebuild the self-image.

It is obvious that the treatment of a psychotic individual, especially ambulatory treatment, presents a certain risk. On the other hand, it is also evident that some therapists of psychotic patients, especially young therapists, are often afraid of the patient. First of all the therapist should try to find out why he is afraid. Often his personal problems more than the actual actions of the patient engender such fear. If the therapist is in personal analysis or supervision, he should discuss this fear with his own analyst or supervisor. If he is not in analysis or supervision, he should discuss the matter with a competent colleague. As we mentioned before, the treatment of some schizophrenics is bound to elicit in the therapist a disturbing

countertransference. A colleague, by being less emotionally involved, is able at times to help the exhausted therapist. However, if, in spite of this help, the therapist continues to be afraid of the patient, he should not treat him. The patient senses this fear and becomes more hostile toward himself because he feels that he is so bad as to cause fear even in the therapist. He may also become more resentful toward the therapist and may burst into acts of violence.

At times during treatment the patient may become worse and may require hospitalization. Whenever possible the patient should be told the truth by the therapist and should be reassured that the treatment will be continued while he is in the hospital. Sometimes, however, the situation is out of the hands of the therapist because the patient, generally a defiant paranoid, refuses hospitalization. The family should be informed of the situation. In a minority of unfortunate cases the patient is so hostile and openly or potentially dangerous that he cannot even be told by the therapist that he needs hospitalization. Here, too, special arrangements have to be made with the family.

Occasionally the patient may not have appeared to the therapist

to be dangerous to himself or others, and yet he may suddenly burst out in episodes of violence. Such risk cannot be completely eliminated. We must stress that in almost all cases the risk is minimal. As a matter of fact, in facing such risk more therapists tend to be rather too cautious than too liberal. However, liberality is increasing. Those instances in which the simple presence of a psychotic symptom made consideration of hospitalization mandatory are remote now, if not in time, at least in conception and outlook. On the other hand episodes of violence in unsuspected patients and, more frequently, in patients who could not be hospitalized have occurred. A few psychiatrists or members of families of the psychiatrist have been killed by patients or former patients. In the instances that have come to my attention through newspapers or even psychiatric journals, I was not able to ascertain whether the therapist had actually done intensive psychotherapy.

If the patient has paranoid ideation involving the therapist, and therapy is not able to dissolve it, the therapist should consult a colleague and should consider the possibility of referring the patient to a therapist of different age, sex, or background for whom the patient is less likely to develop these trends. Switching to physical therapy or

hospitalization is to be seriously considered. No precautionary measure that we know of today can be absolutely sure of safeguarding the therapist or the patient from these fortunately extremely rare episodes.

Errors in predicting whether or not the patient will be violent or antisocial are rare, but they occur and in most cases are unavoidable. In order to eliminate them (not totally, but to some extent) we would have to be so cautious as to hospitalize or to restrict forcibly a large number of patients, thus preventing their recovery and often aggravating the symptomatology.

What is the legal responsibility of the psychotherapist of a patient who commits an antisocial act? Obviously if the act was unpredictable because the patient had shown no indication of it, the therapist has no responsibility whatsoever. The therapist seems to me also to have no responsibility if the antisocial act was mentioned as a mere, distant, or almost hypothetical possibility with no evidence of actions being carried out to implement it. Again it would be impossible and antitherapeutic to hospitalize all patients who belong in this category. The therapist also has no responsibility if he was not in a position to

prevent the activity of the patient, because of the legal requirements of the place where the patient resided or other reasons.

The legal problems connected with the psychotic are numerous and complicated. They cannot possibly be discussed in this book. The reader is referred to textbooks of forensic psychiatry.

V
Further Growth of the Patient and Termination of Treatment

When treatment is successful, the patient continues to grow and eventually to blossom, actualizing some of his potentialities to a degree by far superior to that achieved during his prepsychotic period of life.

How the patient is going to be at the end of treatment is impossible to predict. It depends obviously on the inherent qualities of his total personality. In a minority of cases that have come to my attention, the patient became more of a conformist, decreased his expectations from life, increased all his capacities for adaptation, and became, I would say, what the majority of people would consider an

average person. I am not including in this group the patients who had defects consequent to the psychosis, but people whom I would consider completely recovered.

I am glad to report, however, that the majority of patients who terminated treatment upon my advice disclosed clearly a great expansion of their personality, a vaster range of interest, a grasp of what is beyond the world of appearance. Recovering or almost recovered patients return to the normal use of the secondary process but retain the awareness that an important part of their life is going on in the primary process. Although in the average person this part of life eludes a cognitive grasp, it is accessible to the patient who is thus psychologically enriched. Although it is true that he too will gradually lose this ability the more he reconnects himself with the things of the world, he will continue to have at his disposal a wider spectrum of views than the average person.

When can a patient be considered ready for termination? Loss of symptoms is not enough. Even the changes in dreams that we discussed in Chapter 38 are not sufficient indication for termination.

Termination of treatment of a schizophrenic patient presents greater problems than termination with other patients. The whole philosophy of the treatment enters into the attitude toward termination. At the time when the end of the treatment is contemplated, the therapist must evaluate whether the patient has sufficiently modified his self-image and his vision of life and of the world. That is, his self-identity must be more definable and his awareness of inner worth must have increased. Reality must be experienced as less frightening and less impinging. The patient must be ready to return to the world with less fear and more understanding. If he is ready for termination, he no longer experiences a sense of enormous passivity; that is, he does not see himself any longer purely as the object of fate, chance, nature, persecutors, spouse, parents, children, and so forth, but as somebody who thinks and acts as independently as the other members of society. He must have succeeded in maintaining an active and satisfactory role in his work activities, interpersonal relations, and especially in situations of intimacy.

It is not true, as some therapists, perhaps influenced by Rado's concept of unhedonia, believe, that recovering schizophrenics and

former schizophrenics never achieve a level of normal sexual relations. It is also not true that female patients can eventually achieve only clitoral orgasm. The case of Geraldine, described in Chapter 40, will disprove this point.

Attention must be stressed on another point. We often read in psychoanalytic literature that termination of treatment should occur only when the transference and countertransference are solved. But in the treatment of psychotics and former psychotics the transference and countertransference are hardly ever solved, if by these terms we mean strong reciprocal feelings. Certainly inappropriate feelings should have undergone drastic changes, but the continuation of a strong attachment is what reality demands.

The patient cannot cease to have positive feelings for the former therapist, just as a child does not cease to love his parents when he grows and does not need them any longer. The grown child has also become an adult peer of his good parents. In similar manner the therapist cannot forget or relinquish his feelings for a patient with whom he had such a long and close relation—a person with whom he shed "blood, sweat, and tears," a person with whom he reaffirmed

ideas and values about life and the human predicament. Therapists remember with great pleasure the feeling of joy and the atmosphere of festivity quickly created when former schizophrenic patients come to visit them several years after the end of the treatment. Former psychotic patients never become index cards or collections of data on yellowed medical records. They remain very much alive in the inner recesses of the therapist's psyche to the end of his days.

VI
Cure and Outcome

Is schizophrenia curable? Before attempting an answer we must define the word *cure*.

If it is difficult to define *cure* in the field of medicine in general, it is even more difficult to do so in the field of psychiatry. Traditional medicine considers a cure a *restitutio ad integrum* or to the *statu quo ante,* that is, a return to the state that existed prior to the onset of the illness. This concept loses some of its significance in psychiatry because in many psychiatric conditions the so-called premorbid state was already morbid and very much related to the subsequent condition. If by cure we mean simply loss of manifest schizophrenic

symptomatology, then the answer is definitely yes. But we have already seen that no psychotherapist should be satisfied with this type of recovery, with a return to the prepsychotic personality.

If by cure we mean the reestablishment of relatedness with other human beings, closeness with a few persons, love for the spouse and children, a reorganization of the personality that includes a definite self-identity, a feeling of fulfillment, or of purpose and hope—and this is the cure we want—the answer is still yes. In my experience we can obtain these results in a considerable number of cases. I have already mentioned that as a result of psychotherapy many patients achieve a degree of psychological maturity by far superior to the one that existed prior to the psychosis.

There are, however, other questions to which my answer, at the present stage of our knowledge, must be different. If by cure we mean achieving a state of immunity, with no possibility of recurrence later in life, my reply is that we are not yet in a position to make a definite statement because not enough years have passed since intense psychotherapy has been applied to schizophrenia, and the cases are not yet so numerous as to permit reliable statistics.

I believe that if we have succeeded in altering the fundamental psychodynamic patterns and have been able to effect a basic reorganization of the personality, a recurrence is much less likely to occur.

In reviewing the cases that have been treated satisfactorily with intense psychotherapy, I have come to the conclusion that my optimistic predictions proved to be accurate in by far the majority of cases, but not in all. To my regret, I remember a few patients whom I treated to a degree that I deemed satisfactory and who nevertheless had relapses. They remained vulnerable to fear-provoking situations. I must stress, however, that in most of these cases the relapses were moderate in intensity and the patients promptly recovered.

The evaluation of the recurrence of psychotic attacks in patients who have undergone psychotherapy is completely different from that given in the era prior to the advent of psychotherapy. I remember that when I was a resident in psychiatry, the third attack (or hospitalization) was considered the crucial one. The third episode meant that the patient was irreparably moving toward chronic schizophrenia. Today, in patients who have been treated with

psychotherapy, second or third attacks are recognized as milder than the previous one or ones and of shorter duration. By no means do they indicate poor prognosis, and the patient and his family should be so reassured.

In cases in which we cannot obtain a complete cure, we nevertheless achieve a way of living in which social relations, conjugal life, and work activities are possible to a level superior to the one prevailing prior to the psychosis. In some unsuccessful cases the patients learn to recognize situations to which they are vulnerable. By avoiding them in most instances they are able to live an acceptable life.

Some of my patients whom I consider cured have achieved important positions in life, in the academic world as well as in other activities. If I forced myself to look for a negative common denominator in patients successfully treated by me, I would say that frequently they have married persons intellectually inferior to them. But this is hardly a negative factor (because spouses are seldom equally endowed) and reveals an intellectual bias on my part. The common positive quality that stands out in all of them is that eventually they were able to find love in life, although in varying

degrees.

This statement does not imply that all the troubles of the patient are over after successful psychotherapy. We must repeat here the famous words of Fromm-Reichmann that we cannot promise a rose garden. It would be Utopian to believe that the promise of life is a promise of a life comparable to a rose garden, Utopian for the patient, and Utopian for us, his peers. But I think it is not Utopian to promise to the patient what we promise to ourselves, his peers; namely, that sooner or later in life we will have our own little garden.

VII
Relations with the Family and Family Therapy

The relations of the therapist with the family of the patients are always difficult, even when the patient is hospitalized or receiving only drug therapy. In these cases the relation consists of attempts to obtain an adequate history of the patient and of a few short exchanges of information about the present condition of the patient and his prognosis.

Much more complicated are the relations with the relatives of the

patient who is in psychotherapy. First of all, the patient, especially if he is a defiant paranoid, often resents any intrusion on the part of the family. On the other hand, in the treatment of psychotics it is difficult to preserve this inaccessibility of the therapist as it is generally done in the psychoanalytic treatment of neuroses or personality difficulties. The patient is in a much more serious condition and causes great anxiety and alarm. The family wants to be kept informed. Moreover, the family members often have to receive instruction from the therapist. Should the patient live with the family? Should he be allowed to go on vacation alone, and so on?

As we mentioned in Chapter 38, the therapist too often acquires toward the relatives the same negative attitude that the patient has. His dislike may be so great that he tries, consciously or most of the time unconsciously, to make it difficult for the relative to communicate with him. Because of his deep involvement with, and empathy for, the patient, he may be afraid of not controlling himself, as he believes his professional role would require, and of showing his hostility to the relative. The therapist, of course, must be fully aware of what we have emphasized in Chapters 5 and 38, that the negative traits of the family are intensely lived by the patient, so intensely that they acquire

unrealistic proportions. Galli (1963) described how the therapist may be dragged into a situation that he calls “adoption of the patient.” “The therapist adopts the patient and he lives the family’s interventions as a father lives the strangers’ interventions into his own children’s upbringing.” Galli warns against falling into this pitfall.

Whether the family or the patient himself has “hired” the therapist for treatment is not important from the point of view of privacy and noninterference. The point is whether the patient is able to assume responsibility for his own welfare and actions in general, or whether such responsibility is to be shared with other members of the family. In the latter case, contacts with relatives are necessary, but these must diminish or stop entirely as the patient regains his ability to assume responsibility for himself. On the other hand, the fact that the patient cannot assume total responsibility for himself may give the relative unwelcome free rein, and he may take advantage of the situation for at least two reasons:

1. He suspects that in the course of the intense psychotherapy he is often discussed. He feels threatened by some moral evaluation of himself and may rush to defend himself. He wants the therapist to know that he did not

really do what he is accused of, or that at least his intentions were good.

2. The family may rush to find scapegoats for their hostility and may welcome any opportunity of contacts in order to discharge their discontent on the therapist, who may be mercilessly blamed.

In hospital therapy, of course, the use of a social worker will smooth all the problems between the therapist and the patient's family, but a social worker is not generally used for these purposes in office psychotherapy.

The role of the relative in a psychotherapeutic program for hospitalized patients has been very well outlined by Gralnick and other therapists associated with High Point Hospital. Gralnick and Schween (1966) treat the patient together with one or more family members in conjoint sessions over a period of time. The therapist continues to see the patient in individual therapy. No individual therapy has ever been discontinued in favor of family therapy. They list six indications for family therapy with psychotic patients:

1. Impasse in the patient's progress, particularly if it is the result of an unsolved conflict between him and a family

member.

2. The patient cannot communicate to the relative significant material that needs to be known for the resolution of intrafamily conflicts. He can more easily do so in the presence of the therapist.

3. Presence of obvious symbiotic relationships or other severe pathological relationships.

4. Imminent and premature rupture of marital or other relationships.

5. Nonacceptance of patient's illness.

6. Distorted understanding between patient and relative that may threaten treatment.

Lefebure and colleagues (1958) found relatives useful not only as a source of information, but also because they show how distortions operate in the family. The authors viewed the attitudes of the relatives as due to anxiety and as defensive operations against such anxiety. The authors mentioned the following as possible causes of anxiety in the relatives: the shame with regard to mental illness; "the dawning awareness that he or she is threatened with having to adjust to, or live with, a psychotic person"; financial difficulties when the family

breadwinner is incapacitated by mental illness.

In my experience, predominantly with families of patients treated on an ambulatory basis, the mentioned motives for anxiety existed, but they were not the most frequent ones nor the ones that caused the most profound disturbances. The main form of anxiety, in my experience, was the family's growing feeling of having, because of realistic reasons or distortions, played a role in the patient's illness. The family member may have a strong need to defend himself either from the fear of continuing to make mistakes in his relation with the patient or from the self-accusation or patient's accusation of having played a role in his illness. He may thus assume the following undesirable attitudes: (1) he may become inaccessible, or distant emotionally or physically; (2) he may sabotage the treatment; (3) he may displace hostility on the therapist.

If the therapist, especially in the case of hospitalized patients, succeeds in making the relative feel that he is an ally in a common endeavor, somebody who could help a great deal, the family member may become a very useful person. As Gralnick (1962) says, he stops feeling like *la bete noire.* At the same time that the therapist uncovers

the peculiar family styles, he enters into an understanding of the family myths.

The High Point Hospital group, under the leadership of Gralnick (1969), has studied and practiced conjoint family therapy in the hospital setting. Rabiner, Molinsky, and Gralnick (1962) state that in spite of a variety of theoretical orientations, the common aim of family therapy is that of encouraging a maximum interplay between family members, with the therapist serving (1) to decode veiled communications and (2) to provide role clarification for the involved family members while protecting the participating individuals against joint assault. In a hospital, with a majority of schizophrenic patients, Rabiner and co-workers found that as a result of family therapy the patient decreases his feeling of hopelessness in facing the world. The authors have attributed these changes to the patient's following experiences:

1. "If the therapist dares to stand up to the omnipotent parent, perhaps he or she is less formidable than I believed."

2. "If the therapist can make him or her understand me, perhaps I can too," and conversely, "If the therapist cannot understand, no wonder I can't."

3. “If he or she (family member) can accept, without falling apart or viciously retaliating, the therapist’s criticism (confrontations, interpretations), then maybe I too can risk self-assertion.”

4. Spontaneous remarks by relatives, for example, “I never looked at it that way before,” as well as shifts in family alliances, no matter how transient, create the impression that change is possible.

To these four very well formulated possibilities I would add a fifth one that is in my opinion at least equally important: the recognition, with the help of the therapist, of the patient’s own distortions and misinterpretations of the relative’s actions and words. The distortion is seen immediately *in statu nascendi,* that is, at the moment of origin. If the distortion is an old one, the present example will be the prototype of a series of similar situations that thus will be clarified.

I would also add a sixth possibility: the discussion and resolution of family myths, as described by Ferreira (1963, 1967). Although I do not believe, as Ferreira does, that the psychosis is an exaggeration of the family myths, these myths (or false beliefs accepted or taken for granted as reality) are definitely important in the psychodynamics of

schizophrenia, and therefore should be eliminated (see Chapter 8).

Rabiner and co-workers feel quite optimistic about the effect of family therapy in a hospital setting. They state that the involved family members can arrange to come to the hospital at least once a week. The defenses of each family member are not so fixed and desperate as to lead to decompensation upon conjoint exploration of them. Family members and the patient have an unfulfilled mutual need to relate to each other in a more gratifying way. The patient has already developed a sufficient positive transference to the therapist, and so the initial stress of joint family interview is overcome and inquiry into the hidden determinants of the patient's own behavior becomes possible in the joint setting without jeopardizing the existing rapport between him and the therapist.

VIII
Rehabilitation

In a context of intense individual psychotherapy a program of rehabilitation loses the significance and importance that it has in other types of treatment. In therapies other than intense individual psychotherapy, the planning for the patient's future is made with the

help of a social worker, vocational counselor, psychiatrists who discharge the patient from the hospital, and other persons. At times a rehabilitation team consisting of a psychiatrist, a social caseworker, and a vocational or rehabilitation counselor, plans the future activities and setting of the patient. The assets and liabilities of the patient and the opportunities presented by his family and life situation are evaluated. Important in this respect are the book by Black (1963) and the article by Braceland (1966). Braceland describes in a succinct and clear way the patient's rehabilitation in relation to the therapeutic community, day hospital, halfway house, occupational rehabilitation, expatients' clubs, and family care.

The rehabilitation procedures for patients treated with physical therapies or for chronic schizophrenics who have been hospitalized for long periods of time generally investigate such problems as the ability of the patient to adjust at a behavior level, to be able to support himself or to engage in some kind of useful occupation, to socialize without difficulties. Although these goals are legitimate, they are inadequate for the patient treated with intense psychotherapy. Rehabilitation is part of the psychotherapy itself, except that instead of stopping at a managerial level, or at a level of acceptable or

nonacceptable behavior, it goes deeper and examines the psychodynamic essence of the patient's difficulty or progress in his process of maturation. The tendencies to withdraw and to be passive, or to be hostile or too forward, are definitely discussed. Any interpersonal relation that becomes the source of difficulty is examined and clarified.

Termination of psychotherapy is inconceivable if the patient has not yet found his place in the community and does not yet feel reintegrated. Thus there is no need of rehabilitation at the end of psychotherapy: the patient must have been rehabilitated before therapy ends. He must have improved his personal relationships and must be able to prevent the social crises that may lead to hospitalization whether these crises occur within the family or in society at large.

The problem of whether the patient should be considered rehabilitated when he has acquired economic independence is to be solved in view of other circumstances: the age of the patient, the physical health, his previous status, the length of illness, and so on. However, if he cannot become independent, it is desirable that he

become at least less dependent (Wing, 1967).

In connection with rehabilitation in the community, we must mention the very interesting book by Pasamanick, Scarpitti and Dinitz (1967). Unfortunately this book does not deal with patients treated with intense psychotherapy. The authors found that the group of patients treated with drug therapy who were returned home immediately and were not hospitalized did much better than those who were hospitalized. Thus rehabilitation was started as soon as the patient was diagnosed as a schizophrenic. This book, in my opinion, strikes a hard blow at hospitalization. The authors have demonstrated that home care for schizophrenic patients is feasible and that drug therapy was effective in preventing hospitalization. The authors state that "in all of the many specific measures, home care patients were functioning as well as or better than the hospital control cases. If counseling and appropriate utilization of community resources were used, probably the results would have been even more satisfactory." Of course one would like to ascertain whether the patients were really recovered or whether the recovery was only symptomatic. Although I am working from another angle, I myself long ago reached the conclusion reached by Pasamanick and colleagues that only part of the

patients who are hospitalized actually need hospitalization.

Notes

[1] Since my early experiences with psychotherapy of schizophrenia, nurse training has undergone a dramatic improvement. Now it is possible to find many psychiatric nurses who are able to do excellent work with psychotic patients.

[2] See Chapter 40, case of Geraldine.

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